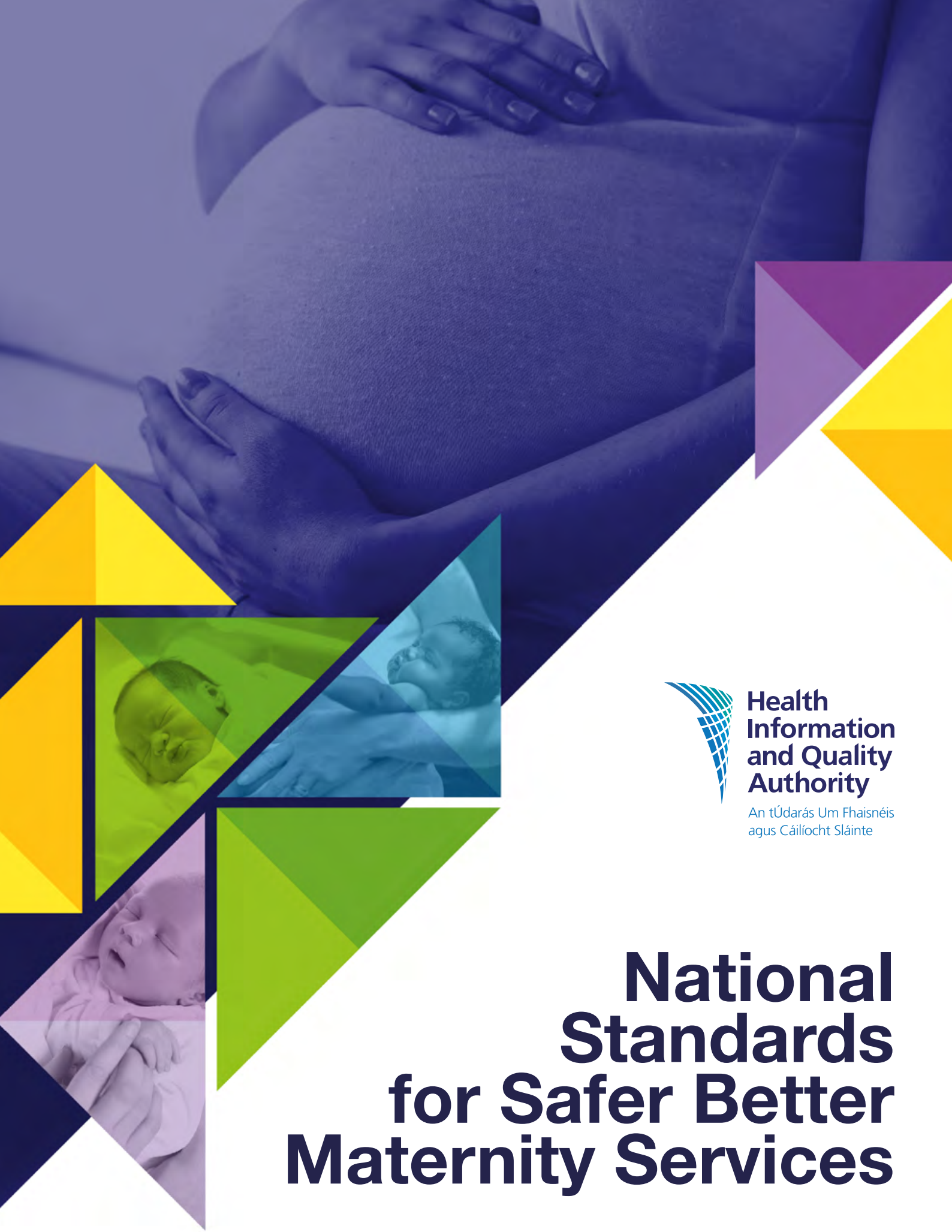

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Standards for Safer Better Maternity Services

Safer Better Care

2016

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

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

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children's Services** — Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Note on terms and abbreviations used in these Standards

A full range of terms and abbreviations used in these Standards is contained in a glossary at the end of this report.

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Introduction

1. Background

Pregnancy and childbirth are normal physiological life-changing events. For women, giving birth to a healthy baby should be one of the most normal, rewarding and positive life experiences. While most women are healthy and well and have a straightforward pregnancy, some women require additional care and support. Our maternity services must be responsive to the needs of all women. Good maternal health and safe, high-quality maternity care throughout pregnancy and after birth can have a marked effect on the health and life chances of newborn babies, on the healthy development of children and their resilience to problems encountered later in life. Promoting and supporting the health of mothers and babies is vital to ensure the health and wellbeing of future generations.

For most women pregnancy and childbirth are safe and are associated with a happy outcome. Sadly, this is not the reality for all families, and at times this has been due to service failings. A need to improve Irish maternity services has been identified in a number of recent reviews and investigations, undertaken by the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health. It has been highlighted that women have faced serious failings in their maternity care and a series of significant service deficits have been identified. These failings have undermined confidence in Irish maternity services and have impacted significantly on staff morale.

It is recognized internationally that the setting and implementation of quality standards are levers to improve care. Standards help to set public, provider and professional expectations and enable services to safeguard people using their services and to improve the quality of care they provide.

HIQA launched the *National Standards for Safer Better Healthcare* in June 2012. These National Standards describe a vision for safe, high-quality healthcare. While the National Standards cover all healthcare settings, a need was identified to develop service-specific standards for maternity services in Ireland. HIQA raised significant concerns about inconsistencies in the safety and quality of maternity services and recommended that all women should have appropriate access to the right level of maternity care at any given time. HIQA's 2015 Portlaoise investigation report[±] and its 2013 Galway investigation report[†] both identified the need for a national maternity services strategy to be agreed and implemented. A need was also identified for this strategy to be supported by nationally mandated maternity standards.

Ireland's first National Maternity Strategy (*Creating a Better Future Together*) was launched by the Minister for Health in January 2016. The National Standards that support the implementation of the National Maternity Strategy are set out in this document. The Standards will sit within the overarching framework of the *National Standards for Safer Better Healthcare* with the aim of promoting improvements in conjunction with the new National Maternity Strategy.

The National Maternity Strategy and the National Standards, when implemented, represent necessary building blocks to providing a consistently safe, high-quality maternity service, which will in turn work towards restoring public confidence in the service.

[±] Report of the investigation into the safety, quality and standards of service provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise.

[†] Investigation into the safety, quality and standards of service 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 of Savita Halappanavar.

2. A vision for safe, high-quality maternity services

The National Maternity Strategy aims to improve the safety and quality of maternity services and to standardize care across maternity services. The vision for maternity services, articulated in the Strategy, is an Ireland where: women and babies have access to safe, high-quality care in a setting that is most appropriate to their needs; women and families are placed at the centre of all services, and are treated with dignity, respect and compassion; parents are supported before, during and after pregnancy to allow them to give their child the best possible start in life.

The Strategy identifies four strategic priorities to achieve this:

- A health and wellbeing approach should be adopted to ensure that babies get the best start in life. Mothers and families should be supported and empowered to improve their own health and wellbeing.
- Women have access to safe, high-quality, nationally consistent, woman-centred maternity care.
- Pregnancy and birth is recognized as a normal physiological process, and insofar as it is safe to do so, a woman's choice in pregnancy and birth is facilitated.
- Maternity services are appropriately resourced, underpinned by strong and effective leadership, governance and management arrangements, and delivered by a competent workforce, in partnership with women.

The Strategy recognizes that all women need a certain level of support, but some need more specialized care. The Strategy classifies women and babies into three risk groups: normal-risk, medium-risk (requiring a higher level of oversight), and high-risk (requiring a more intensive level of care, either throughout or at a particular stage of care). The Strategy specifies that a choice of three maternity care pathways (supported, assisted and specialized) are available based on the risk profile of the woman and baby.

The overarching priorities outlined in the Strategy are consistent with attributes of a safe, high-quality maternity service identified through HIQA's standards development process.

The main attributes are that:

- Women are treated with kindness, compassion, consideration and respect and have the information they need to make informed decisions about their care.
- Maternity service providers put women's needs and preferences at the centre of the service.
- Women and their babies have access to the right care and support at the right time.
- Maternity services are based on best available evidence and strive for excellence by monitoring how they perform, identifying strengths and deficiencies and making any necessary changes to improve.
- Maternity services are designed for reliability, minimizing inconsistency, variation in service provision and the likelihood of things going wrong.
- The safety of women and their babies is paramount and steps are taken to anticipate and avoid something going wrong, to reduce the impact if they do and to avoid reoccurrence.
- Maternity service providers work in partnership with women to improve each woman's health and wellbeing.
- Maternity services work with other agencies to promote ongoing safety and wellbeing of women and babies throughout pregnancy, birth and the postnatal period.

- There is clarity about who is responsible and accountable for the safety and quality of each maternity service.
- People working in maternity services are recruited, trained, developed, supervised and supported so that they have the skills, competencies and knowledge to deliver safe, high-quality care.
- Maternity services manage and review their use of finite resources in order to provide safe, high-quality care.
- Accurate and timely information is used to inform decision-making in the planning and delivery of care.

These attributes can be applied to any maternity service.

3. Purpose of the National Standards

The National Standards aim to give a shared voice to the expectations of women using maternity services, service providers and the public. They are intended to show what safe, high-quality maternity services should look like, and in particular they:

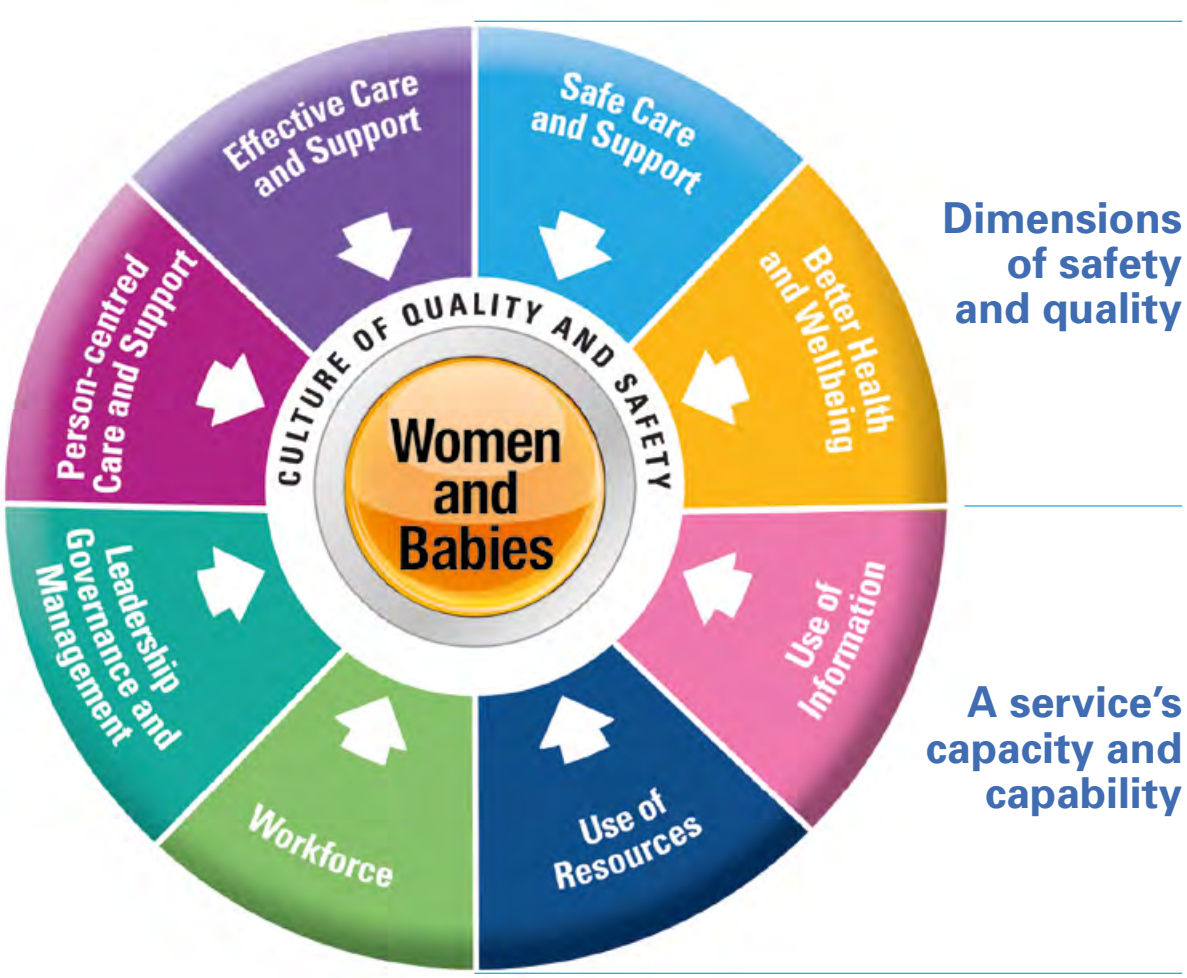
- create a basis for improving the safety and quality of maternity services by identifying strengths and highlighting areas for improvement
- can be used in day-to-day practice to provide a consistent level of safety and quality in all maternity services across the country
- can be used by women to understand what safe, high-quality maternity care looks like and what to expect from a service
- promote practice that is up to date, effective and consistent and based on best available evidence.

The National Standards, which underpin the *National Standards for Safer Better Healthcare*, have been designed so that they can be implemented in all maternity services. This means that maternity service providers can use these standards to improve the safety and quality of their care by assessing and managing the performance of their services, and those provided on their behalf.

4. Themes for safety and quality

The National Standards were developed using the framework of the *National Standards for Safer Better Healthcare*, launched by HIQA in 2012. Figure 1 illustrates the eight themes under which the National Standards are presented. The four themes on the upper half of the circle relate to the dimensions of safety and quality in a service, while the four on the lower portion of the circle relate to the key areas of a service's capacity and capability.

Figure 1. Themes for safety and quality.



The four dimensions of safety and quality are:

- **Person-centred Care and Support** — how services place the woman and her baby at the centre of their delivery of care. This includes the concept of access, equity and protection of rights.
- **Effective Care and Support** — how services deliver best achievable outcomes for women and their babies in the context of that service, reflecting best available evidence and information. This includes the concepts of service design and sustainability.
- **Safe Care and Support** — how services avoid, prevent and minimize harm to women and their babies and learn when things go wrong.
- **Better Health and Wellbeing** — how services work in partnership with women to improve their health and wellbeing and that of their babies.

Delivering improvements within these quality dimensions depends on service providers having capacity and capability in four key areas, as follows:

- **Leadership, Governance and Management** — the arrangements put in place by a service for clear accountability, decision-making and risk management as well as meeting its strategic, statutory and financial obligations.
- **Workforce** — planning, recruiting, managing and organizing a workforce with the necessary numbers, skills and competencies.
- **Use of Resources** — using resources effectively and efficiently to deliver best possible outcomes for women and their babies.
- **Use of Information** — actively using information as a resource for planning, delivering, monitoring, managing and improving care.

5. Structure of the National Standards

The National Standards are set out in full in the pages that follow within the framework of eight themes as documented in Section 4. The eight themes are intended to work together. Collectively, they describe how a maternity service provides safe, high-quality care.

Each standard consists of three sections:

- **Standard** — describes the high-level outcome required to contribute to safety and quality of the service.
- **Features** — these, taken together, will enable progress towards achieving the standard.
- **What this means for you as a woman using maternity services** — guidance for women using maternity services on what each standard means for them.

6. Scope of the National Standards

The National Standards are intended to cover pre-pregnancy, pregnancy, labour, birth and postnatal care for both the mother and baby (up to six weeks after the birth), and are designed to apply to all maternity services.* These services include, but are not limited to, maternity units, maternity hospitals, and primary and community care settings. Assisted human reproductive services are outside the scope of these Standards. While it is expected that all maternity services will work to achieve each standard, not all features within each standard are relevant to all maternity services. For example, a number of the features refer specifically to requirements for maternity units and maternity hospitals that are not applicable to primary or community care settings.

The National Standards do not describe the detail of specific clinical practice which is best addressed in clinical practice guidelines.

* While the scope of these standards is from pre-pregnancy to six weeks postnatally, HIQA recognizes that further care and support is needed beyond the six week period and a network for referrals needs to be in place at this point.

The National Clinical Effectiveness Committee is a Ministerial committee established as part of the Patient Safety First initiative. Its role is to prioritize and quality assure National Clinical Guidelines and National Clinical Audit before recommending them to the Minister for Health to become part of a suite of National Clinical Guidelines and National Clinical Audit. The National Clinical Guidelines are quality assured by the National Clinical Effectiveness Committee and endorsed by the Minister for Health for implementation in the Irish health system. Additional sources of Irish clinical practice guidelines that apply to maternity services include the National Obstetrics and Gynaecology Clinical Programme, the National Clinical Programme for Paediatrics and Neonatology and the National Clinical Programme for Critical Care.

These National Standards set the expectation that where clinical practice guidelines are in place, they are implemented and that this is demonstrated by the maternity service provider.

7. Terminology

Maternity service: throughout the National Standards, the term 'maternity service' is used to describe any location where maternity care is provided to women and their babies from pre-pregnancy up to six weeks post-birth. This includes care of the neonate up to six weeks after birth.

Examples include, but are not limited to, maternity units, maternity hospitals, and primary and community care settings. Community care settings include services provided by community midwives, self-employed community midwives, public health nurses and general practitioners.

Maternity service provider: this term refers to any person, organization or part of an organization delivering maternity services.

Maternity unit or maternity hospital: this term includes both maternity units and maternity hospitals that provide maternity care to women and their babies either in a maternity unit situated in a general hospital or in a stand-alone maternity hospital. Alongside birth centres and specialized birth centres are situated within maternity units and maternity hospitals.

Women: throughout the National Standards, the term 'women' is used to refer to women using the maternity services and includes female children under 18 years of age. In some cases, 'women and their babies' is used specifically where this is appropriate. Occasionally, the term 'women and their families' is used where appropriate. This is to reflect that it may not always be appropriate to involve the family and this should be done where the woman has indicated that she wishes for them to be involved, or for example where they may be involved through providing feedback or making a complaint. Where the term 'women and their families' is used, this is broadly intended to include women and:

- their partners
- their parents, guardians, carers
- their nominated advocates.

Healthcare professional: a person who exercises skill or judgment in diagnosing, treating or caring for women and their babies and preserving or improving their health. For the purpose of this document, the term includes midwives, nurses, doctors and health and social care professionals as defined in the Health and Social Care Professionals Act 2005.

8. How the National Standards were developed

A review of international and national literature was undertaken and used to inform the development of the National Standards. This review took account of published research, investigations and reviews of maternity services in Ireland, standards and guidelines in other countries, Government policy (including the National Maternity Strategy) and expert opinion. HIQA has aimed to make the National Standards as clear and easy to follow as possible.

HIQA convened a Standards Advisory Group made up of a diverse range of interested and informed parties, including women who had recently used the maternity services, patient advocates, healthcare professionals, and representatives from the Department of Health and the HSE. The function of the group was to advise HIQA, support consultation and information exchange, and advise on further steps. HIQA would like to acknowledge with gratitude the hard work and commitment of the Standards Advisory Group. Membership of this group is listed in Appendix 1.

HIQA also undertook a series of focus groups with women and their partners and with front-line staff working in maternity services. This was to discuss their experience of maternity services and to obtain their opinion as to what the national standards should address. HIQA conducted 12 focus groups in six locations nationally, meeting with a total of 138 participants. HIQA would like to acknowledge with gratitude those who participated for taking the time to attend the sessions and joining the standards development process in such a meaningful way.

A national public consultation was carried out during an eight-week period from 21 March to 16 May 2016. During the public consultation process, 127 submissions were received. Following the consultation, HIQA analyzed submissions and revised the Standards as appropriate. A summary of these submissions will be presented in a Statement of Outcomes document on www.hiqa.ie.








Summary of the National Standards for Safer Better Maternity Services

Theme 1: Person-centred Care and Support

Standard 1.1	The planning, design and delivery of maternity services are informed by the identified needs and preferences of women and their babies.
Standard 1.2	Women and their babies have equitable access to maternity services based on their assessed needs.
Standard 1.3	Women and their babies experience maternity care which respects their diversity and protects their rights.
Standard 1.4	Women are empowered to make informed decisions about their care.
Standard 1.5	Informed consent to care is obtained in accordance with legislation and national policy.
Standard 1.6	The dignity, privacy and autonomy of each woman and baby is respected and promoted.
Standard 1.7	Maternity service providers promote a culture of caring, kindness, compassion, consideration and respect.
Standard 1.8	Maternity service providers ensure additional supports are in place for women and families who experience bereavement or pregnancy complications.
Standard 1.9	Complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Theme 2: Effective Care and Support

Standard 2.1	Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies.
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.
Standard 2.3	Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services.
Standard 2.4	An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby.
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.
Standard 2.6	Maternity services are provided through a model of care designed to deliver safe, high-quality maternity care.
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.
Standard 2.8	The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.

Theme 3: Safe Care and Support

Standard 3.1	Maternity service providers actively support and promote the safety of women and their babies as part of a wider culture of safety and quality.
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.
Standard 3.3	Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally.
Standard 3.4	Maternity service providers implement, review and publicly report on a structured quality improvement programme.
Standard 3.5	Maternity service providers effectively identify, manage, respond to and report on patient safety incidents.
Standard 3.6	Maternity service providers fully and openly inform and support women and their families as soon as possible after a patient safety incident becomes known, and continue to provide information and support as needed.
Standard 3.7	Maternity service providers ensure all reasonable measures are taken to protect women and their babies from all types of abuse.

Theme 4: Better Health and Wellbeing

Standard 4.1	Healthcare professionals work with women to promote, protect and improve the health and wellbeing of women and their babies.

Theme 5: Leadership, Governance and Management

Standard 5.1	Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care.
Standard 5.2	Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care.
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.
Standard 5.4	Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services.
Standard 5.5	Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.

Standard 5.6	Leaders at all levels promote and strengthen a culture of safety and quality throughout the maternity service.
Standard 5.7	Staff at all levels are empowered to exercise their professional and personal responsibility for the safety and quality of maternity services provided.
Standard 5.8	Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.
Standard 5.9	Maternity service providers monitor the safety and quality of services provided on their behalf.
Standard 5.10	Maternity services are compliant with relevant legislation.
Standard 5.11	Maternity service providers act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies.

Theme 6: Workforce

Standard 6.1	Maternity service providers plan, organize and manage their workforce to achieve the service objectives for safe, high-quality maternity care.
Standard 6.2	Maternity service providers recruit people with the required competencies to provide safe, high-quality maternity care.
Standard 6.3	Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.
Standard 6.4	Maternity service providers support their workforce in delivering safe, high-quality maternity care.

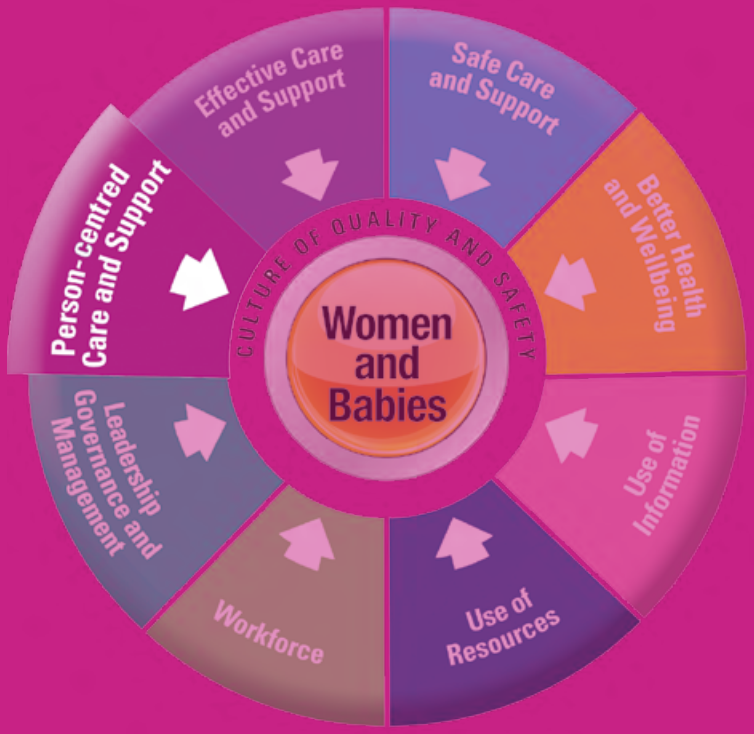
Theme 7: Use of Resources

Standard 7.1	Maternity service providers plan and manage the use of available resources to deliver safe, high-quality maternity care efficiently and sustainably.

Theme 8: Use of Information

Standard 8.1	Maternity service providers use information as a resource in planning, delivering, managing and improving the safety and quality of maternity care.
Standard 8.2	Maternity service providers have effective arrangements for information governance.
Standard 8.3	Maternity service providers have effective arrangements for the management of healthcare records.

Theme 1
Person-centred Care and Support



Theme 1

Person-centred Care and Support

Although maternity services are part of the overall profile of acute and community health services, they are unique in that they support women who in the main are experiencing a normal physiological process. All women need a certain level of support throughout pregnancy and childbirth, but some need more specialized care. Person-centred care and support places women and their babies at the centre of all that the maternity service does. Maternity service providers must be sensitive and responsive to the broad spectrum of circumstances that impact on the health and wellbeing of women and their babies. This includes the social determinants of health[1] that impact on the health and wellbeing of women and their babies and a woman's ability to make positive choices.

Service providers do this by advocating for the needs of women and babies, protecting their rights, respecting their values, preferences and diversity and actively promoting kindness, compassion, consideration and respect for women's dignity, privacy and autonomy.

Consideration of women's needs and preferences in the planning, design and delivery of care and support services enables women to have more positive experiences of using the services. This, in turn, can lead to improved outcomes for women and their babies. Person-centred care supports equitable access for all women so that they have access to the right care and support at the right time, based on their identified needs. A person-centred service focuses on what is most important from the woman's perspective and supports the development of a relationship of trust between a woman and her healthcare professionals.

[1] The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Women and their families are partners in their care and should be empowered to make informed choices in partnership with their healthcare professionals. Women are more likely to participate in their own care when they are comfortable with and confident in those providing care, and also when they understand the care choices being offered to them. Good communication and the provision of information based on best available evidence enable women to make informed decisions about their care, including giving or refusing consent to treatment.

Listening to women is essential to inform quality improvement initiatives. The ultimate purpose of gathering women's views is to improve the safety and quality of the care provided.

Positive experiences for women and their families are an important outcome for all maternity services. Having a fair and efficient complaints process provides women and their families with the opportunity to express their views when their experiences have not been what they expected and allows maternity service providers to identify areas for improvement. Good communication is central to successful complaints-handling and assists in reducing the likelihood of complaints arising in the first place.

Standard 1.1

The planning, design and delivery of maternity services are informed by the identified needs and preferences of women and their babies.

Features of a maternity service meeting this standard are likely to include the following:

1.1.1 A choice of services is available to women, and standardized, evidence-based information about their choices is easily accessible and clearly communicated. This information is also shared between service providers.

1.1.2 Standardized information about services is made available through a variety of media and in a variety of languages.

1.1.3 There is a formalized mechanism for women to feedback to service providers about their experiences in order to inform the planning, design and delivery of services. There is a structure for such feedback to be regularly reviewed, collated and acted upon.

1.1.4 Women who have used the services and advocacy groups are represented on and supported to engage with relevant hospital committees and groups, for example, maternity service liaison committees.[2] The process for selecting representatives is transparent.

1.1.5 Services are provided based on the regularly assessed needs of the population served, as defined by the maternity network and in consultation with other services, for example accessibility needs.

1.1.6 Services regularly assess access to their service and identify potential barriers to women accessing their services by systematically taking account of the reasons why some women find it difficult to access and maintain contact with maternity services. Services put in place measures to overcome these potential barriers and evaluate the effectiveness of such measures.

[2] Maternity service liaison committees are a forum for maternity service users and service providers to come together to design services that meet the needs of local women, parents and families. They comprise of service users and representative clinicians from all specialties involved.

1.1.7 Services are responsive to the needs of the population served, for example, providing a sufficient number of antenatal education classes to meet demand.

1.1.8 Maternity units and maternity hospitals have formalized antenatal appointment systems, with women being allocated specific appointment times that take account of their needs and are reflective of the time they are likely to be seen by a healthcare professional.

1.1.9 Services work with women in groups and communities who typically underuse services or who are at greater risk of poorer outcomes to improve their access to services.

1.1.10 Services monitor service uptake, quality of engagement with women and outcomes for women and their babies who typically underuse the service.

1.1.11 Services regularly evaluate and publish how they are meeting the identified needs and preferences of women using their services.

What this means for you as a woman using maternity services:

- You are given information about the range of choices available to you.
- You are given information about maternity services in a way that you can understand.
- The preferences and views of women inform the development and delivery of services.
- Women are involved in the planning and design of maternity services in their area.
- Maternity services regularly seek feedback from women about their experience and this is used to improve the safety and quality of services provided.
- Maternity services work with groups of women who underuse services to improve their access to services.

Standard 1.2

Women and their babies have equitable access to maternity services based on their assessed needs.

Features of a maternity service meeting this standard are likely to include the following:

1.2.1 Maternity care is free in publicly-funded services, fair, transparent and easily accessible to all women. In the case of a private service, the costs are clearly explained.

1.2.2 Service providers work to meet the needs of all women, in particular women who typically underuse the services.

1.2.3 Antenatal booking appointments[3] are allocated to women on the basis of assessed need, as determined by an appropriate healthcare professional.

1.2.4 Access to information and counselling is available to all women who need it and its importance is recognized for women with additional assessed needs.[4]

1.2.5 Service providers communicate information to women clearly and sensitively. Information is accessible and provided to women in plain English, in a variety of formats and presented in a way that all women can understand. It is culturally appropriate and free of jargon and is provided in other languages where possible.

1.2.6 Service providers have systems in place to ensure women with communication, comprehension and learning difficulties and or sensory difficulties have access to an interpreter and to a support person or co-decision-maker[5] nominated by the woman.

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[3] Antenatal booking appointment: the first antenatal appointment at which a woman is initially triaged to an appropriate care pathway.

[4] Additional needs could include women with pre-existing medical conditions, social needs, mental health needs or women who have had a previous poor experience or outcome.

[5] A person chooses a person to jointly make one or more decision on personal welfare or property and affairs. The person should be a relative or friend of the appointer who has had such personal contact over such period of time that a relationship of trust exists between them. The co-decision-maker will get the information needed to make a decision, advise on decisions and make decisions together with the appointer based on their will and preferences. The co-decision-maker will help the person express a decision and ensure that the decisions are implemented.

1.2.7 Service providers have interpretive services in place to make sure the care of any woman is not compromised by lack of communication and understanding. All staff are aware of the resources available for interpreting services. It is preferable that family members do not act as interpreters except in emergency situations.[6]

What this means for you as a woman using maternity services:

- It is clear to you how you can access maternity services.
- Service providers will communicate with you about your care in a way that you can understand, for example if you need an interpreter this is provided.
- You have access to counselling if you need it.

[6] Except in emergency situations, an interpreter proficient in the service user's language is required to help the service user give consent for interventions that may have a significant impact on his or her health and wellbeing. Where practicable, this is best achieved in most cases by using a professional interpreter. The use of family (in particular of minor children) and friends should be avoided if at all possible. Additional time will always be required for discussions involving an interpreter, and this should be planned for in advance.

Standard 1.3

Women and their babies experience maternity care which respects their diversity and protects their rights.

Features of a maternity service meeting this standard are likely to include the following:

1.3.1 Initial and ongoing access to maternity care complies with legislation and does not discriminate according to age, gender, sexual orientation, disability, civil status, family status, race, religious belief, or membership of the Traveller Community.

1.3.2 Service providers directly engage with women, particularly women from disadvantaged and minority groups and communities, for example members of the Traveller and Roma communities, through regular engagement with representative groups.

1.3.3 Services are flexible, accessible and culturally sensitive and planned individually to motivate all women — including vulnerable and marginalised women — to engage with services.

1.3.4 Healthcare professionals provide care and information in a respectful, non-judgemental and professional manner and in line with national guidelines.

1.3.5 Staff are trained to be culturally aware in their practices and are provided with cultural diversity training, as well as training in anti-racism and anti-discrimination legislation.

1.3.6 Staff respect individual values and beliefs, cultural norms and ethnicity. The care provided is underpinned by the principle of autonomous choice in line with legislation and national policy.

What this means for you as a woman using maternity services:

- You have access to maternity services regardless of your age, gender, sexual orientation, disability, civil status, family status, race, religious belief, or membership of the Traveller or Roma communities.
- You are encouraged to engage with the maternity services available to you.
- You receive maternity care that is sensitive to your cultural needs.
- Your values and beliefs are respected by your healthcare professionals in line with legislation and national policy.

Standard 1.4

Women are empowered to make informed decisions about their care.

Features of a maternity service meeting this standard are likely to include the following:

1.4.1 Healthcare professionals seek women's values, views, preferences and knowledge to provide the best care through shared decision-making and partnership.

1.4.2 Women are provided with information based on best available evidence, in a variety of formats, on the full range of options available to them throughout pregnancy, labour, birth and the postnatal period. This is to enable them to actively participate in their own care, if that is their choice. This includes information on the care pathways and birth settings available and information about birth and postnatal care.

1.4.3 Women have access to information based on best available evidence to assist them to make an informed decision about their preferred care pathway. This includes explicit information around what the individual care pathways and birth settings can offer.

1.4.4 Healthcare professionals provide women with the findings of clinical examinations and any test results in a timely manner. This is supplemented with information based on best available evidence to enable them to understand risks, benefits, alternatives and consequences of decisions throughout pregnancy, labour, birth and the postnatal period.

1.4.5 Women are encouraged to seek additional information and advice as required and are entitled to seek a second opinion.

1.4.6 Women and their families are given sufficient time to consider their choices and make decisions after an opportunity to process the information that they have been given, where such a decision is not time-critical.

1.4.7 Where there is documented evidence that a woman does not have capacity to make informed decisions, services facilitate assisted decision-making support in line with legislation and national policy.

1.4.8 Maternity units and maternity hospitals provide standardized comprehensive interactive programmes of antenatal education, in the community and or in the maternity unit or hospital, for childbirth and parenthood to women and their partners that suit their needs. Programmes are provided in such a way that all women and their partners are enabled to actively participate and include information based on best available evidence about:

- the physiological course of pregnancy, labour, birth and the postnatal period
- perinatal health and wellbeing (including mental health and wellbeing)
- maternity services available during pregnancy and in the postnatal period
- immunizations
- smoking cessation, alcohol consumption and substance misuse
- birthing options
- birth preferences
- diagnosis of labour
- practical skills for managing labour, for example, use of active positions, breathing and relaxation techniques and partner support
- available options for pain relief in labour and their impact
- common obstetric interventions and why these may be required
- breastfeeding, including information about supports available locally
- transition to parenthood and parenting skills
- the National Healthy Childhood Programme.

1.4.9 Services responsible for postnatal care provide information to women and their partners based on best available evidence in relation to:

- parenting skills
- infant care and wellbeing
- infant feeding[7]
- maternal mental health
- maternal physical wellbeing
- sexual health
- family planning and contraception
- how to access other relevant health and social care services and local community support groups.

What this means for you as a woman using maternity services:

- You receive evidence-based information that will help you to make informed decisions about your care.
- You are given information about what each maternity care pathway and birth setting can provide.
- You participate in making informed decisions about your care in partnership with your healthcare professional in line with legislation and national policy.
- The quality of antenatal education classes available to you is not determined by where you live.
- You are provided with information and practical skills to enable you to prepare for the birth.
- Your requests are listened to and acted upon, subject to legislation and national policy. For example, if you request further pain relief prior to continuing with a procedure, or request the healthcare professional to stop what they are doing.

[7] Infant feeding includes breastfeeding and formula feeding.

Standard 1.5

Informed consent to care is obtained in accordance with legislation and national policy.

Features of a maternity service meeting this standard are likely to include the following:

1.5.1 There is a culture of respect for each woman as an individual in all services such that the woman's autonomy is respected, that she is listened to and is cared for with compassion and that informed consent is obtained in line with legislation and national policy.

1.5.2 Services adhere to the National Consent Policy.[8] All circumstances in which women are informed by staff that their choice cannot be complied with, or in which legal opinion is sought, are clearly documented.

1.5.3 Appropriately trained healthcare professionals obtain informed consent or informed refusal for investigations and interventions, using supplementary written materials and interpretive services where necessary, and make sure that the information has been understood, and that consent is obtained and documented before proceeding.

1.5.4 Services encourage women to have a partner or support person with them to assist them in making informed decisions about their care.

1.5.5 Women who have been fully informed about a recommended course of action, and the potential consequences of not pursuing such action, have their choice of informed refusal respected and co-sign a written statement in the maternity record to that effect subject to legislation and national policy.[9]

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[8] Note from the National Consent Policy 2013: "In an emergency life-threatening situation where the urgency of the relevant intervention imposes time limitations on the ability of the service user to appreciate what treatment is required, the necessary treatment may be administered in the absence of the expressed consent of the service user. The application of this exception is limited to situations where the treatment is immediately necessary to save the life or preserve the health of the service user."

[9] Note — 7.1 Refusal of treatment in pregnancy: "The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the 'unborn', there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable fetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary." Article 40.3.3 of the Irish Constitution, as amended in 1983.

What this means for you as a woman using maternity services:

- All examinations and procedures are clearly explained to you and your questions are answered.
- Informed consent is sought for examinations and procedures.
- You are encouraged to bring somebody with you to help and support you to make decisions about your care.
- You are given time to think about any decision that you may need to make about your care, except in an emergency where this may not always be possible.
- Your decision to make an informed refusal of care is respected unless it is against Irish law.

Standard 1.6

The dignity, privacy and autonomy of each woman and baby is respected and promoted.

Features of a maternity service meeting this standard are likely to include the following:

1.6.1 Service providers respect the dignity and privacy of women and their babies at all times, and particularly in relation to:

- personal consultations
- personal examinations
- circumstances where confidential and or sensitive information is being discussed
- awaiting a response from a woman prior to entering a woman's personal space.[10]

1.6.2 Care is provided in a manner that is respectful to the woman's dignity and that takes account of her preferences and choices in line with legislation and national policy.

1.6.3 Women's concerns are listened to and addressed by staff. A culture of listening to women and what matters to them is promoted.

1.6.4 Women's psychological and psychosocial needs are assessed in private at the booking appointment, throughout pregnancy, labour, birth and in the postnatal period.

1.6.5 Staff respect privacy and confidentiality, and are aware of the sensitivity of personal information, for example, by requesting and sharing information in a discreet manner.

[10] This could be a single room or a cubicle in a ward setting.

1.6.6 Women are provided with information[11] and support in their chosen method of feeding, including access to peer support groups and voluntary organizations.

1.6.7 A woman's right to make an informed choice regarding the method of infant feeding is supported.

What this means for you as a woman using maternity services:

- Your privacy and dignity are respected by those caring for you.
- Your privacy in relation to your personal space and personal care is respected.
- Your preferences and choices are respected, for example your chosen method of infant feeding.

[11] Information that is based on the best available evidence.

Standard 1.7

Maternity service providers promote a culture of caring, kindness, compassion, consideration and respect.

Features of a maternity service meeting this standard are likely to include the following:

1.7.1 There is a culture of respect for each woman as an individual in all services such that the woman's autonomy is respected, in line with legislation and national policy, that she is listened to and is cared for with kindness, compassion, consideration and respect.

1.7.2 There is a culture of mutual respect and trust in services between women and healthcare professionals.

1.7.3 There is a culture of mutual respect and trust in services between healthcare professionals.

1.7.4 All staff ensure they wear their name badges with their name and title clearly visible.

1.7.5 All staff identify and introduce themselves before starting a discussion or examination with a woman and her partner.

1.7.6 A healthcare professional reviews a woman's health record and makes themselves aware of a woman's history before engaging with her.

What this means for you as a woman using maternity services:

- The people caring for you treat you with kindness, compassion, consideration and respect.
- The people caring for you talk with you in a clear, honest and sensitive manner while being mindful of your privacy.
- You are asked what your views and preferences are and these are respected and taken into account when your care is being planned.
- Those providing your maternity care are aware of your previous history.
- Your wishes in terms of cultural and religious supports are respected and facilitated.

Standard 1.8

Maternity service providers ensure additional supports are in place for women and families who experience bereavement or pregnancy complications.

Features of a maternity service meeting this standard are likely to include the following:

1.8.1 Service providers ensure that there are comprehensive, culturally sensitive, multidisciplinary policies, services and facilities for the management and support of families who have experienced a pregnancy loss or perinatal death, in line with national standards.[12]

1.8.2 Appropriately skilled senior healthcare professionals are available to support women and their families following pregnancy loss, perinatal death or pregnancy complications.

1.8.3 When reviewing women with early pregnancy complications, a suitable environment is provided for women and their families, with access to counselling and appropriate information.

1.8.4 Suitable rooms are available to facilitate private discussion and to provide support to women or parents when bad news is being broken.

1.8.5 Parents of babies who are stillborn, babies with identifiable medical or physical problems or babies who die in the neonatal period receive timely and appropriate care and support in a suitable physical environment.

1.8.6 All staff are aware of the psychological issues associated with pregnancy loss and perinatal death.

1.8.7 An alert denoting that a woman has experienced a pregnancy loss, a perinatal death or that her baby has a congenital fetal anomaly is used on the woman's healthcare records with her permission.

[12] National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death.

1.8.8 Women who experience pregnancy loss, perinatal death or pregnancy complications receive holistic care which includes emotional support in addition to physical care. Families are provided with information about local support groups, counselling services and contact details of a named healthcare professional in the maternity unit or maternity hospital who can provide follow-up care and support.

1.8.9 The parents of a baby with a suspected congenital fetal anomaly are supported prior to being seen in a fetal medicine unit.

1.8.10 A symbol that is recognized by all staff as indicating that a pregnancy loss or perinatal death has occurred is visible on the ward or in the department of a maternity unit or maternity hospital following discussion with the parents, and with their permission.

1.8.11 All care given to a baby that has died is discussed with the parents in advance. Parents are offered the choice of caring for the baby themselves, for example, washing and dressing the baby.

1.8.12 Staff take care that all personal belongings of a baby who has died are returned to the parents.

1.8.13 Parents of babies who are stillborn or die in the neonatal period are told about the purpose and benefits of a post-mortem examination of their baby. Parents are given this information by a senior healthcare professional in a sensitive, timely and accurate manner that facilitates informed decision-making.

1.8.14 Parents are given information about and an explanation of:

- burial and cremation options
- birth registration and death registration

and, where appropriate, coroner directed post-mortem examinations. Parents are given time to process this information and to ask questions.

1.8.15 In the event of a pregnancy loss or a perinatal death, healthcare professionals are aware of the requirement for rapid communication with the woman's general practitioner (GP) and appropriate community teams after discharge. A phone call with the relevant community healthcare professional is made on the day of the woman's discharge and followed up with written communication within one to two working days.

1.8.16 Following the death of a baby, parents are given the opportunity to meet with the lead healthcare professional responsible for their care or that of their baby. Information is communicated clearly in a transparent way as and when it becomes available; for example the results of interim medical tests, pending the availability of the results of placental and post-mortem histology.

1.8.17 Service providers have arrangements in place for women who have experienced a pregnancy loss,[13] stillbirth or severe maternal morbidity to have a follow-up medical appointment with their lead healthcare professional.

1.8.18 Service providers have arrangements in place for women who have experienced a neonatal death to have follow-up medical appointments with their consultant obstetrician and their baby's consultant neonatologist or paediatrician.

1.8.19 When a hospital post-mortem examination has been carried out, parents are offered an appointment to meet with their consultant obstetrician and or their baby's consultant neonatologist or paediatrician to discuss the findings of the post-mortem examination.

1.8.20 Service providers have arrangements in place for the parents of babies with a congenital anomaly to have a follow-up medical appointment with their baby's consultant neonatologist or paediatrician.

1.8.21 Maternity services coordinate access to appropriate services for babies born with a disability. Families are provided with information and follow-up support, including information on how to access relevant support groups.

1.8.22 A woman who considers she has experienced a traumatic and or difficult birth is offered emotional and physical care, including counselling, and provided with an opportunity to talk about her birth experience with the identified lead healthcare professional who has overall clinical responsibility for her care or an alternative person if she so chooses. Women are provided with information about local support groups and counselling services.

[13] Pregnancy loss is all types of loss including spontaneous and medically supervised terminations that occur during a pregnancy from the first to third trimester.

1.8.23 Counselling services are available for women and their partners following severe maternal morbidity.

1.8.24 Women who have experienced pregnancy loss, perinatal death or pregnancy complications are offered a medical appointment to formulate a plan for future pregnancies. For example, discussing serial transvaginal ultrasound cervical assessment with women who have had a previous preterm birth before 34 weeks' gestation.

What this means for you as a woman using maternity services:

- If you receive bad news, your healthcare professional discusses this with you in private and provides you with support in a suitable environment.
- If you experience pregnancy loss, perinatal death or pregnancy complications you receive the care and emotional support you need from the time this becomes known.
- If you experience pregnancy loss or perinatal death, you are involved in planning your own care and that of your baby, if you so wish.
- Information about a post-mortem examination is given to you by a senior healthcare professional and you are given the opportunity to ask questions that allow you to make an informed decision.
- A follow-up medical appointment with your lead healthcare professional is arranged for you and your baby.
- Counselling services are available to you and your partner if you have been critically ill around the time of the birth of your baby.
- You are offered an appointment with your lead healthcare professional prior to planning your next pregnancy if you wish.

Standard 1.9

Complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Features of a maternity service meeting this standard are likely to include the following:

1.9.1 Complaints procedures are clear, transparent, open and accessible, and take account of legislation, national guidelines and evidence-based information. These procedures assist women and their families to express their views about their pregnancy, childbirth and postnatal experiences.

1.9.2 The complaints procedure ensures a timely response in line with legal requirements, takes account of the requirement to fully address the issues raised, and ensures women and their families are made aware of the progress of their complaint or concern.

1.9.3 There is a coordinated response to women or families who make a complaint, including when their care is shared between healthcare professionals or transferred from one service provider to another.

1.9.4 Services clearly display the complaints procedure in a public area.

1.9.5 Women or families who make a complaint are helped with accessing support services, such as independent advocacy services. A service-appointed dedicated liaison person is provided as part of the complaints structure.

1.9.6 The dedicated liaison person is the principal point of contact for the woman and her family.

1.9.7 A woman's care is not negatively affected as a result of having made a complaint or expressed a concern.

1.9.8 Complaints are dealt with in a way that respects the privacy of the woman and her family with no unnecessary disclosure of identifying information to people who do not need this information.

1.9.9 Information is made available to women and their families about how to have their complaint addressed outside of the service, for example, the Office of the Ombudsman.

What this means for you as a woman using maternity services:

- Your complaints and concerns are listened to and responded to in a timely manner.
- If you make a complaint, the maternity service ensures that it understands the matters you would like addressed and takes these into account when it looks into the complaint.
- If you make a complaint and your care is shared between different healthcare professionals or maternity services, you receive a coordinated response to your complaint.
- If you make a complaint, you can be assured that the care you receive will not be negatively affected at the time or in the future.

Theme 2
Effective Care and Support

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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.

For the delivery of maternity care to be effective, it needs to be well-planned, organized and managed. Planning means that the maternity service and its outcomes must be clearly described, including the outcomes intended for the women using it. The effectiveness of care is supported by the environment in which maternity care is delivered. Effective maternity care is provided in a safe and secure environment, which is responsive to women's physical and sensory needs and which supports their health and wellbeing. Some maternity services are part of a wider network of services, for example within a maternity network, and in order for care to be effective there needs to be arrangements in place for services to share resources across a range of sites.

Effective care is also about ensuring that each woman receives well-coordinated care and support at the right time and in the right place. Continuity of care(r) is important for each woman to ensure that no woman, and no part of her care, falls through potential gaps in the services. This requires that each woman must know who is responsible and accountable for her care at all times and that the right information is available at the point where clinical decisions are being made. In maternity care, women make decisions about their care and the care of their babies in partnership with their healthcare professionals. Decisions are based on a balanced assessment of the benefits and risks of the proposed care.

An effective maternity service continually looks for opportunities to improve how it cares for women and their babies. Monitoring the quality of care and support, including feedback from women, their families and the workforce, allows a maternity service provider to know if the care it is providing is effective and to address any areas for improvement which may be identified as part of that monitoring.

In 2016, Ireland's first National Maternity Strategy was published. The Strategy is underpinned by the principle of multidisciplinary team working. The care of each woman and her baby should be led and coordinated by an identified healthcare professional who is part of a multidisciplinary team. The Strategy recognizes that all women need a certain level of support, but some need more specialized care. The Strategy proposes an integrated care model that encompasses all the necessary safety nets in line with patient safety principles, which delivers care at the lowest level of complexity, yet has the capacity and the ability to provide specialized and complex care quickly, as required.

The Strategy classifies women and their babies into three risk groups: normal-risk, medium-risk (requiring a higher level of oversight), and high-risk (requiring a more intensive level of care, either throughout or at a particular stage of care). Across all risk levels there is the potential need for an increased level of care, while the importance of a smooth transfer between care pathways is recognized.

A choice of maternity care pathways will be available based on this risk profile. Each pathway lends itself to shared care with the GP provided for under the Maternity and Infant Care Scheme. The Strategy states that care pathway options should be available across each managed clinical network. Each maternity service provider will provide maternity care in line with the pathways that it can deliver safely and effectively. The three pathways, outlined in detail below, are a supported care pathway, an assisted care pathway and a specialized care pathway. A woman will be supported to make an informed choice with regard to her care pathway and will have her care delivered by a particular team. All care pathways should support the normalization of pregnancy and birth. All women, irrespective of their care pathway, will have a midwife and a GP involved in their care.

Supported care pathway

The supported care pathway is intended for mothers and babies who are considered to be at normal-risk, with midwives leading and delivering care within a multidisciplinary framework.

Responsibility for the coordination of a woman's care will be assigned to a named clinical midwife manager, and care will be delivered 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 about the birth setting, which may be in an alongside birth centre in a maternity unit, a maternity hospital, or at home. An alongside birth centre is a birth centre situated in the immediate vicinity of a specialized birth centre, that is to say, a delivery suite in an Irish maternity unit or maternity hospital. A woman may need to transfer, either temporarily or permanently, to another model of care because of an emerging risk. She may also choose to transfer to another care pathway, for example, if she wants an epidural, or if she chooses to be under the care of a consultant obstetrician.

Assisted care pathway

The assisted care pathway is intended for mothers and babies who are considered to be at medium-risk, and for women at normal-risk who choose an obstetric service. Care will be led by a named obstetrician, and care will be delivered by obstetricians and midwives as part of a multidisciplinary team. Care will be provided across the maternity unit or maternity hospital and the community, and births will take place in a specialized birth centre. Postnatal care will start in the maternity unit or maternity hospital and move to the community on discharge.

Specialized care pathway

The specialized care pathway is intended for mothers and babies who are considered to be at high-risk and will be led by a named obstetrician. Care will be delivered by obstetricians and midwives as part of a multidisciplinary team. Care will, in the main, be provided in the maternity unit or the maternity hospital, and births will take place in a specialized birth centre.

An individualized, multidisciplinary, multi-specialty approach to care and care planning (for both the maternity unit or maternity hospital and the woman) should be used. Where possible, antenatal care should be provided in the community. Postnatal care will start in the maternity unit or maternity hospital and transition to the community on discharge.

The Strategy states that women's choices about their preferred care pathway are facilitated insofar as it is safe to do so, in line with safety, their clinical needs and best practice. To determine the most appropriate care pathway in each individual case, an initial assessment of clinical risk or need will be carried out. This risk-stratification approach will underpin the discussion between the woman and the healthcare professional, and will help to support the care pathway choice. In determining the care pathway at an individual level, the findings of the needs and risk assessment should be discussed with the woman.

It is recognized that personal preferences may change during the pregnancy, and particularly during labour. Risk can also escalate and de-escalate during the course of the pregnancy, and the woman's risk profile should be reviewed at each interaction with the maternity service. A woman may need to move to a different model of care at any stage during her pregnancy. Regardless of the reasons for change, transitions between care pathways should be seamless and in accordance with the National Clinical Effectiveness Committee's National Clinical Guidelines, the National Obstetrics and Gynaecology Clinical Programme, the National Clinical Programme for Paediatrics and Neonatology and the National Clinical Programme for Critical Care.

Standard 2.1

Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies.

Features of a maternity service meeting this standard are likely to include the following:

2.1.1 Service providers use the National Clinical Effectiveness Committee's National Clinical Guidelines, national programme guidelines and nationally agreed protocols, care bundles and care pathways and have policies and procedures in place to implement them.

2.1.2 Service providers ensure they operate in line with the most up-to-date National Clinical Effectiveness Committee's National Clinical Guidelines and national programme guidelines and act to address any identified gaps to ensure these guidelines are implemented.

2.1.3 Where the National Clinical Effectiveness Committee's National Clinical Guidelines and national programme guidelines are not available decisions are based on best available evidence.

2.1.4 Healthcare professionals are supported to make evidence-based decisions through the provision of access to evidence-based information that will maximize benefits to women and their babies, and minimize unnecessary treatment and care.

2.1.5 Service providers regularly audit the care provided to women and their babies to ensure that it is being provided in line with the National Clinical Effectiveness Committee's National Clinical Guidelines and national programme guidelines.

What this means for you as a woman using maternity services:

- Services follow the available National Clinical Effectiveness Committee's National Clinical Guidelines and national programme guidelines to make sure you and your baby receive safe, high-quality care, and that care is consistent nationally.
- Maternity services review the care they provide to ensure it continues to be aligned to these guidelines.

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.

Features of a maternity service meeting this standard are likely to include the following:

2.2.1 A multidisciplinary team approach is taken to the care of all women and babies.

Antenatal care

2.2.2 Services in the community have arrangements in place to refer women for an antenatal booking appointment following confirmation of pregnancy.

2.2.3 Maternity units and maternity hospitals have an early pregnancy assessment unit, with suitable ultrasound equipment and facilities for 'same-day' beta-hCG testing,[14] run by appropriately trained healthcare professionals.

2.2.4 Women are triaged at the antenatal booking appointment to the most appropriate care pathway by an experienced healthcare professional in partnership with the woman. This includes a comprehensive assessment of:

- past medical history,
- previous obstetric history,
- social history,
- and psychosocial needs

to ensure that every woman has an individualized plan of care.

[14] A beta-human chorionic gonadotrophin test measures the level of pregnancy hormone in a woman's blood.

2.2.5 Women are asked about their mental health and wellbeing by an appropriately trained healthcare professional using a recognized tool at the antenatal booking, in order to identify the need for additional support.

2.2.6 Service providers actively monitor waiting lists for antenatal booking appointments to ensure that women are seen within the first trimester, or urgently if pregnancy is diagnosed after the first trimester.

2.2.7 A woman's risks, needs and preferences are assessed, re-evaluated and documented by a healthcare professional at clinically appropriate intervals.

2.2.8 Each maternity unit and maternity hospital has the capacity to provide standardized comprehensive programmes of antenatal education to all women irrespective of their care pathway. There is flexibility about where and when the education programme is provided. The programme is provided in such a way that women and their partners are enabled to actively participate.

2.2.9 All women are screened for domestic violence as part of their antenatal social history, in line with national guidelines. Questions about domestic violence are discreetly introduced during antenatal appointments. The result of domestic violence screening is documented in all health records and appropriate referrals are made in line with national guidelines.

2.2.10 Women are provided with continuity of care(r) during pregnancy, labour, birth and in the postnatal period.

2.2.11 Each antenatal appointment is of appropriate duration and structured with a focused content. The healthcare professional checks that the woman has understood the information provided. Wherever possible, appointments should incorporate routine tests and investigations to minimize inconvenience to women and their families.

2.2.12 Women are offered immunizations in pregnancy in line with national policy, for example to protect against influenza and pertussis.

2.2.13 Healthcare professionals use the Irish Maternity Early Warning System (IMEWS) to monitor women with a confirmed clinical pregnancy and up to 42 days in the postnatal period admitted to an acute setting irrespective of age, location or reason for admission.

2.2.14 Maternity units and maternity hospitals have access to multidisciplinary team clinics, which include a variety of healthcare professionals such as endocrinology, renal, cardiology, psychiatry and neurology. Where this is not available within the maternity unit or maternity hospital they are accessed through the maternity network structures.

2.2.15 Maternity units and maternity hospitals have an anaesthetic pre-assessment clinic so that the anaesthetic service is given sufficient advance notice of women at a higher risk of potential complications.

2.2.16 Maternity units and maternity hospitals have an agreed system in place whereby the neonatal service is given sufficient advance notice of babies who are likely to require additional care where possible.

2.2.17 Healthcare professionals are competent in recognizing, advising and referring women who would benefit from more specialist services.

2.2.18 Women and their partners are provided with information about the different purposes of a first trimester ultrasound.

2.2.19 Women and their partners are provided with information about antenatal anomaly screening,[15] while respecting individual values and beliefs, cultural norms and ethnicity.

2.2.20 At the antenatal booking appointment, women and their partners are given information about a detailed fetal-assessment ultrasound between 20 and 22 weeks' gestation and given the opportunity to have the assessment with an appropriately trained healthcare professional, if they so wish.

2.2.21 Maternity units and maternity hospitals are staffed with trained ultrasonographers who can provide the following obstetric ultrasound service to all women as a minimum:

- early pregnancy assessment, including number of fetuses, viability and assessment of gestational age during the first trimester
- a detailed fetal-assessment ultrasound at 20–22 weeks' gestation with the ability to differentiate between 'likely normal' and 'likely abnormal', thereby allowing referral to a fetal medicine unit which can provide multidisciplinary assessment, management and support

[15] Antenatal anomaly screening includes first trimester screening and detailed fetal assessment ultrasound from 20 – 22 weeks' gestation.

- fetal wellbeing assessment beyond 24 weeks' gestation, to include fetal biometry, amniotic fluid volume, umbilical artery Doppler and biophysical profile score
- placental localization in the second and third trimesters.

2.2.22 During pregnancy, all women who are at identified risk of serious perinatal mental illness are assessed by a psychiatry team with expertise in perinatal mental health and an individualized care plan is prepared in partnership with the woman, where this is appropriate.

Intrapartum care

2.2.23 A lead senior midwife (shift coordinator) is identified and is available for each shift in the alongside and specialized birth centres in addition to the other midwifery staff required.

2.2.24 Continuous one-to-one support is provided to women once labour is diagnosed.

2.2.25 Service providers have facilities in place to support and enable normal labour and birth.

2.2.26 Clear protocols and pathways are in place for the referral and transfer to a specialized birth centre[16] of women in alongside birth centres[17] or women in labour who have planned a home birth.

2.2.27 Complicated births are attended to by appropriately trained and skilled healthcare professionals.

2.2.28 Specialized birth centres have:

- resident on-call non-consultant hospital doctors in obstetrics, anaesthetics and paediatrics and or neonatology
- consultants in these specialties present in the maternity unit or maternity hospital during core working hours
- on-call consultants in these specialties that are accessible at all times and are available on site within 30 minutes

[16] A specialized birth centre is a delivery suite in an Irish maternity unit or maternity hospital.

[17] An alongside birth centre is a birth centre situated in the immediate vicinity of a specialized birth centre (a delivery suite in an Irish maternity unit or maternity hospital).

- a dedicated obstetric anaesthetic service
- a staffed dedicated obstetric theatre in or adjacent to the specialized birth centre
- high-dependency or observation units in order to monitor, detect, communicate, escalate and intervene in the case of a woman's clinical condition deteriorating
- dedicated laboratory services
- timely access to blood in emergency situations
- processes in place to access other blood products and non-blood products in emergency situations.

2.2.29 Maternity units and maternity hospitals have governance arrangements in place to determine their need for a second on-call team, for example, in obstetrics and gynaecology and paediatrics and or neonatology.

Postnatal care

2.2.30 Women and their babies are assessed immediately after the birth[18] by an appropriately trained healthcare professional; again within 24 hours of birth; and then on an ongoing basis and at the time of transfer to community care.

2.2.31 The newborn examination is conducted by an appropriately trained healthcare professional with up-to-date training in neonatal examination techniques.

2.2.32 Anticipated length of stay in a maternity unit or maternity hospital is discussed with each woman, taking into account her health and wellbeing and that of her baby and the level of support available to them following discharge. A postnatal plan of care is developed with each woman as soon as is practicable after admission, and it is reviewed prior to her discharge from the maternity unit or maternity hospital.

2.2.33 Each woman, prior to her discharge from a maternity unit or maternity hospital, is provided with details of the healthcare professionals that will be involved in her subsequent care and that of her baby, including their roles and contact details.

[18] The assessment immediately after birth does not interrupt safe skin-to-skin contact unless clinically indicated.

2.2.34 Information based on best available evidence about giving vitamin K to the newborn baby is discussed with women and their partners antenatally and again soon after birth and is administered with parental consent.

2.2.35 Newborn screening is offered to all women and their partners at an appropriate time. This includes a focused history, a clinical examination, a hearing test, a blood spot screening test and pulse oximetry screening for congenital heart disease.

2.2.36 Women are provided with information based on best available evidence and support about feeding, nutrition and hydration of their babies by appropriately trained healthcare professionals.

2.2.37 Services are compliant with current policies and guidelines that encourage and enable breastfeeding.[19] Services continue to assess their compliance with these policies and guidelines.

2.2.38 Separation of mother and baby is kept to a minimum while taking the medical needs of the mother and baby into account.

2.2.39 Women have access to staff who are trained in supportive breastfeeding practices and lactation consultations in the maternity unit, maternity hospital and in the community.

2.2.40 Women are asked about their mental health and wellbeing by an appropriately trained healthcare professional using a recognized tool, in order to identify the need for additional support in the postnatal period.

2.2.41 Women are offered the opportunity to talk about their birth experiences and to ask questions about the care they received during labour.

2.2.42 A clear process is in place for women to have follow-up care after birth with appropriate healthcare professionals. This could include, for example a public health nurse, a community midwife, a self-employed community or general practitioner.

[19] At the time of publishing the National Standards these include: the Baby Friendly Health Initiative (BFHI); the Health Service Executive (HSE) Infant Feeding Policy for Maternity and Neonatal Services, the HSE Breastfeeding Policy for Primary Care Teams and in Community Healthcare Settings, the Ten Steps to Successful Breastfeeding (which are documented in Appendix 2) and the World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes.

What this means for you as a woman using maternity services:

- You and your baby receive safe, high-quality care in a setting most appropriate to your needs.
- Maternity service providers work to meet your individual needs when caring for you, while working to meet the needs of all women and babies using the service, for example in a clinical emergency.
- You and your healthcare professional determine you and your baby's maternity care needs together.
- Your maternity care is based on your personal choices in combination with your or your baby's assessed needs in line with legislation and national policy.
- The care you receive is regularly reviewed to make sure that it continues to be the most appropriate care for you, based on your individual needs and risks.
- If the maternity service cannot provide the care or support you need, it will consult with you about transferring your care to a service that can provide it.

Standard 2.3

Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services.

Features of a maternity service meeting this standard are likely to include the following:

2.3.1 Healthcare professionals work closely together to identify women with existing medical, psychological or social needs who may become pregnant, and ensure that these women have access to specialist advice pre-pregnancy.

2.3.2 A culture of multidisciplinary, high-quality, effective teamwork is promoted within and between maternity services. Healthcare professionals communicate effectively with each other and are supported by standardized referral care pathways that are fit for purpose.

2.3.3 Effective systems of communication are in place between all healthcare professionals, women and their families, for example using ISBAR.[20]

2.3.4 There is a clear relationship of trust and respect between all healthcare professionals providing services and there is a system in place to resolve differences of professional opinion.

2.3.5 Maternity units and maternity hospitals have effective arrangements in place, through their maternity network,[21] to access:

- a fetal medicine unit
- a consultant medical microbiologist
- an anti-microbial pharmacist
- perinatal mental health services
- a mother and baby unit
- in-utero transfer, neonatal transfer and retro transfer of infants

[20] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a communication tool created to improve safety in the transfer of critical information.

[21] It may be the case that for specific maternity units or maternity hospitals this may be sourced though other maternity networks.

- a paediatric intensive care unit
- a specialist perinatal pathology service for post-mortem examination and placental histology.

2.3.6 Service providers ensure that women have timely access to the following, as appropriate:

- clinical midwife specialists in, for example, lactation, ultrasound and bereavement, infection control and diabetes
- dietitians
- drug liaison midwives
- lactation consultants
- occupational therapists
- perinatal mental health services
- physiotherapists
- smoking cessation support
- social workers
- speech and language therapists.

2.3.7 Effective communication systems are established between acute care settings and maternity service providers.

2.3.8 Service providers have a system in place to ensure effective communication and safe transition of care between the maternity unit or maternity hospital and community services.

2.3.9 Pregnant women and women in the postnatal period who attend an emergency department for problems other than obvious minor injuries are seen by a registered practicing midwife, or a consultant obstetrician or their delegate. Where this is not possible, their advice is sought by phone.

2.3.10 Maternity services collaborate with local services who work with victims of domestic violence. Information about such services is made available to all pregnant women.

2.3.11 Maternity services have structured arrangements to engage with child protection services and staff are aware of the requirements in relation to child protection, such as Children First.

2.3.12 In maternity units and maternity hospitals, the on-call consultant obstetrician is informed about all women who have complex obstetric or medical needs.

2.3.13 Clear referral pathways are available in maternity units, maternity hospitals and at maternity network level. For example, for pre-existing medical conditions, monochorionic diamniotic twins, suspected congenital fetal anomaly, emergency in-utero transfer, the clinically deteriorating woman, neonatal transfer and retro transfer of infants.

2.3.14 The care of women presenting to a maternity unit with acute medical or surgical complications is provided in the clinical setting most appropriate to their clinical needs.

2.3.15 Maternity units and maternity hospitals that do not have on-site access to adult intensive care facilities, advanced imaging, cardiology and other specialist medical services have protocols in place for the care and transfer of women with significant medical, surgical or obstetric illness, to make sure that women are cared for in the most appropriate setting.

2.3.16 Maternity units and maternity hospitals that do not have on-site access to regional or tertiary neonatal units have protocols in place for the in-utero transfer or neonatal transfer of babies to make sure that that they are cared for in the most appropriate setting.

What this means for you as a woman using maternity services:

- All people involved in your care work together to make sure you receive safe, high-quality care.
- Your care is coordinated when you:
  - receive care from more than one healthcare professional
  - move within or between care pathways and or maternity services.
- Referral processes are designed so that you and your baby get the care you need when you need it.
- If your care is transferred between services, you are involved in the decision-making process, and provided with all necessary information.
- If you or your baby's care is transferred between services, all relevant information is given to the new healthcare professional or professionals responsible for your care to ensure that you receive the best care.

Standard 2.4

An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby.

Features of a maternity service meeting this standard are likely to include the following:

2.4.1 Each woman's care is led and coordinated by an identified lead healthcare professional who is part of a multidisciplinary team.

2.4.2 Services have a robust and transparent clinical governance framework in place to ensure that an identified lead healthcare professional has clinical responsibility for the care of a woman and that of her baby.

2.4.3 A lead healthcare professional in the community is identified for each woman and her baby in the postnatal period. Depending on the care pathway and the needs of the woman and her baby this will be a community midwife, a self-employed community midwife, public health nurse or a general practitioner (GP).

2.4.4 At the end of the postnatal period, the lead healthcare professional in the community ensures that the woman's physical, emotional and social wellbeing and that of her baby is reviewed.

What this means for you as a woman using maternity services:

- You know at all times the name of the lead healthcare professional or professionals responsible for your care and that of your baby.
- The name of the healthcare professional or professionals responsible for your care is documented in your healthcare record.

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.

Features of a maternity service meeting this standard are likely to include the following:

2.5.1 Communication within and between services is timely, accurate, complete, unambiguous and focused. Healthcare professionals use the ISBAR communication tool in line with the National Clinical Effectiveness Committee's National Clinical Guideline.

2.5.2 A clear two-way communication pathway exists between the general practitioner (GP) and the lead healthcare professional throughout the pregnancy and the postnatal period.

2.5.3 The baby's father's medical, family and social history is obtained where possible in the interest of the baby's health and wellbeing.

2.5.4 On-call consultants conduct morning ward rounds on Saturdays, Sundays and public holidays to review women and or babies that they are clinically responsible for.

2.5.5 The midwife caring for each woman and her baby is directly involved in the ward round at which their care is discussed.

2.5.6 There is a personal handover of care when shifts change in line with the National Clinical Effectiveness Committee's National Clinical Guidelines.

2.5.7 Concerns expressed by a woman about her wellbeing and or that of her unborn baby, for instance, in the case of decreased fetal movements, are listened to, assessed and acted upon where necessary by an appropriately trained healthcare professional.

2.5.8 Concerns expressed by parents about the wellbeing of their newborn baby are listened to, assessed and acted upon where necessary by an appropriately trained healthcare professional.

2.5.9 Concerns about the wellbeing of a newborn baby identified through clinical observations are listened to, assessed and acted upon where necessary by an appropriately trained healthcare professional.

2.5.10 The National Maternal and Newborn Clinical Management System is implemented in all maternity units and maternity hospitals in order to provide relevant, accurate and up-to-date information for clinical handover.[22]

2.5.11 Key information about a woman's pregnancy, including the number and timing of antenatal visits and antenatal investigations is known to the woman and is available to healthcare professionals working in the community and in the maternity unit or hospital, with the woman's consent.

2.5.12 A system is in place to ensure that the results of investigations and or diagnostic tests are actively followed up on and contemporaneously recorded by the relevant healthcare professionals in an agreed format within an agreed health record.

2.5.13 When a woman presents with problems and or complications that do not require admission to the maternity unit or maternity hospital, she is provided with sufficient verbal and written information to empower her to re-present should the need arise.

2.5.14 There is a defined communication pathway between community-based midwives and or self-employed community midwives and maternity unit or maternity hospital-based midwives at the point of transfer of care between services at any stage of pregnancy, labour or birth.

2.5.15 There is a defined communication pathway between maternity unit or maternity hospital-based midwives and or community-based midwives and or self-employed community midwives and public health nurses at the point of transfer of care to the public health nurse.

[22] Phased national roll out is due to commence in 2016.

What this means for you as a woman using maternity services:

- Your healthcare information is available to your healthcare professionals so that you do not have to repeat your obstetric, medical and social history.
- Your healthcare professionals can access all necessary information to make decisions with you about your care.
- The necessary information to inform your care is shared between maternity services when necessary in a timely manner.
- Findings of examinations and the results of tests are discussed with you and explained.
- If you express concerns about your wellbeing or that of your baby, these are listened to, assessed and acted upon where necessary by an appropriately trained healthcare professional.

Standard 2.6

Maternity services are provided through a model of care designed to deliver safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

2.6.1 Services provide a clear description of how care will be delivered, and communication of the scope, objectives and intended quality outcomes of the service through a publicly available statement of purpose.

2.6.2 Services have the necessary facilities and resources to deliver care in line with defined maternity care pathways that meet the assessed needs of the population served.

2.6.3 Effective arrangements are in place for transfer to another maternity care pathway when the original care pathway is no longer appropriate to meet the needs or preferences of the woman and or the needs of her baby.

2.6.4 Service providers regularly review the services provided and associated evidence that the maternity care pathways provided can be delivered safely. This review should include the:

- relevant legislation and national policy
- assessed needs of the population served
- size, complexity and specialities of service being provided
- numbers and casemix of women and their babies to maintain the skills and competencies of healthcare professionals required for each of the three pathways
- number of staff required to deliver the service
- skill-mix and competencies of staff required to deliver the service
- interdependencies of internal and external services

- findings from consultation with key stakeholders, including women and staff
- resources and facilities available.

Service providers take the required action where gaps are identified to ensure the safety and quality of services.

2.6.5 Services manage available resources, including staff, to meet legal requirements, and to deliver the defined maternity care pathways.

2.6.6 Services deliver care within the stated scope of what can be delivered safely and effectively.

2.6.7 Service providers plan, manage and deliver services to maintain the safety and quality of care when demand, service requirements, resources or capabilities change.

What this means for you as a woman using maternity services:

- A maternity service clearly sets out the services it provides and how it provides them. This information is easily available to you.
- A maternity service only provides care that it knows it can deliver safely.
- Your healthcare professionals have the necessary skills and experience to provide a high standard of care.
- If the maternity service where you are currently receiving care is unable to meet your needs, you will be supported to transfer to a service that can provide the necessary care.

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.

Features of a maternity service meeting this standard are likely to include the following:

2.7.1 The physical environment and or the building is fit for the purpose of delivering safe, high-quality maternity care and meets the requirements of relevant legislation, standards and guidelines.

2.7.2 The physical environment in which maternity care is provided is developed and managed to minimize the risk to women and their babies and members of the workforce from acquiring a healthcare associated infection.

2.7.3 The physical environment in which maternity care is provided promotes privacy and confidentiality.

2.7.4 Maternity care is provided in a physical environment that meets the needs of women with a physical disability.

2.7.5 The physical environment in which maternity care is provided takes into account the comfort of women and their partners using the services. For example, ensuring sufficient comfortable seating and drinking water is available in antenatal clinics.

2.7.6 The physical environment in which staff work has adequate catering, a comfortable staff room to have breaks, and adequate toilet and showering facilities with lockers.

2.7.7 Services facilitate breastfeeding and expression of breast milk.

2.7.8 Maternity units and maternity hospitals are tobacco-free campuses.

2.7.9 Maternity units and maternity hospitals have a maternity day unit with a suitable, designated space for clinical assessment, ultrasonography, investigation, counselling and a waiting area.

2.7.10 Maternity units and maternity hospitals that provide an emergency gynaecology service have an appropriately staffed Early Pregnancy Assessment Unit. The Early Pregnancy Assessment Unit has a suitable, designated space with rooms for clinical assessment, ultrasonography, investigation, counselling and a waiting area.

2.7.11 Specialized birth centres have:

- a high-dependency or observation unit to manage the clinically deteriorating woman
- a staffed dedicated obstetric theatre in or adjacent to it.

What this means for you as a woman using maternity services:

- The setting in which you receive maternity care is fit for the purpose of providing that care.
- A maternity service makes sure that all areas of the premises are clean.
- Your maternity care is provided in comfortable surroundings.

Standard 2.8

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

Features of a maternity service meeting this standard are likely to include the following:

2.8.1 Service providers use relevant national performance indicators and benchmarks, to monitor and evaluate the safety and quality of care provided to women and their babies.

2.8.2 Where such national metrics do not exist, service providers develop or adopt performance indicators and benchmarks in accordance with best available evidence. These will monitor and evaluate the safety and quality of the care provided to women and their babies.

2.8.3 Service providers use a variety of outcome measures to evaluate the effectiveness of maternity care including:

- audit of clinical outcomes
- women's perspectives on their outcomes
- women's experience of care
- concerns, complaints or compliments received from women using the service or from their families
- feedback from healthcare professionals
- patient safety incidents.

2.8.4 Maternity units and maternity hospitals, through their maternity network, participate in multidisciplinary perinatal morbidity and mortality meetings and maternal morbidity meetings. These meetings are attended by all relevant healthcare professionals, including the designated lead for each specialty.

2.8.5 Morbidity and mortality meetings are provided with administrative assistance so that an attendance record is kept and minutes taken. The outcome of discussion and any learning is shared with all relevant staff and in the case of a referral, with the referring maternity unit or maternity hospital and within the maternity network.

2.8.6 Information from monitoring and evaluation is used to improve services and key learning points are shared within and between services.

2.8.7 Services have clinical governance arrangements in place to ensure that findings from clinical audits[23] are reported and their implementation is monitored effectively.

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

2.8.9 The performance of the service is monitored and evaluated by developing and implementing clinical and non-clinical audits using an evidence-based methodology and implementing improvements based on the findings.

2.8.10 Information about the safety and quality of care delivered and quality improvement programmes in each service are publicly reported.

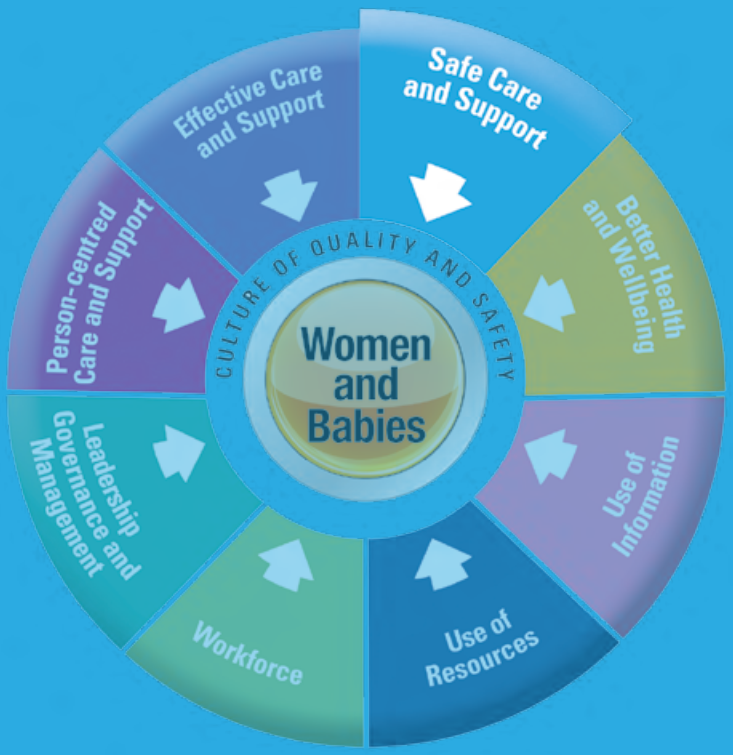
2.8.11 Requested information on the safety and quality of services is provided to relevant agencies, including national statutory bodies, in line with relevant legislation.

[23] Clinical audit is a process to improve patient care and outcomes involving a documented, structured and systematic review and evaluation against clinical standards of clinical care, and, where necessary, actions to improve clinical care. Clinical audit is carried out by, on behalf of or in association with one or more health services providers.

What this means for you as a woman using maternity services:

- Maternity services regularly review how well they are providing safe, high-quality care.
- Maternity services use the findings from these reviews to identify areas they need to work on and improve.
- You will be asked to provide feedback on your maternity service about the care you receive, so that the service can improve care for all women using it.
- Maternity services provide information about their activities and outcomes to relevant agencies who monitor the safety and quality of maternity services.
- Maternity services publicly report on the safety and quality of their care and what they are doing to improve care.

Theme 3
Safe Care and Support



Theme 3

Safe Care and Support

Safe care and support recognizes that the safety of women and their babies is paramount. 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. Although providing maternity care has some associated risk of potential harm, services should proactively manage all risks to try to prevent or minimize them from occurring.

There is much that can be done to:

- prevent harm and error
- identify it when it occurs
- take actions to mitigate its effect
- learn lessons from reviews and investigations so that actions can be taken to minimize the risk of future harm.

If a patient safety incident happens, where a woman or her baby is harmed, maternity services have formal arrangements in place to respond to this incident and support the woman and her family. Honesty and openness are essential elements of trust and confidence, which in turn are integral to the effective response to an incident if it occurs. A safe, high-quality service learns from all information including a situation where something has gone wrong.

Safety and quality improvement is part of the culture of a safe maternity service and is embedded in its daily practices and processes, rather than being viewed or undertaken as a separate activity. Protecting women and babies using the service from all types of abuse is integral to this culture.

All staff have a responsibility to identify and manage risk and use evidence-based decision-making to maximize safe outcomes for women and their babies. Quality improvement in maternity care is underpinned by a shared understanding of the inherent risks and how these may be minimized.

Quality improvement in maternity care includes:

- providing care for women and their babies that is based on best available evidence
- proactively identifying and managing all aspects of the maternity service that may have the potential to cause harm
- actively engaging in local, national and international initiatives to improve safety and minimize risk to women and their babies
- collecting, monitoring and managing information relevant to providing safe maternity services, including:
  - identifying risks
  - clinical outcomes
  - surveys from women and their families using the service
  - staff surveys, including patient safety culture surveys
  - audits
  - patient safety incidents
  - complaints and concerns
- promoting a supportive environment that emphasizes the importance of learning in order to improve the maternity service for all.

Quality improvement initiatives require maternity service providers to proactively identify risk and to plan, implement and evaluate necessary changes to improve the safety and quality of maternity services.

Standard 3.1

Maternity service providers actively support and promote the safety of women and their babies as part of a wider culture of safety and quality.

Features of a maternity service meeting this standard are likely to include the following:

3.1.1 Those governing and leading the service articulate and demonstrate a commitment to safety and quality.

3.1.2 There is evidence of a patient safety culture within the service. Specific arrangements that actively promote this culture include a mission statement, service design, code of conduct, allocation of resources and training, and development and evaluation processes.

3.1.3 Clear accountability arrangements are in place throughout the service that make sure all staff are aware of their responsibilities and contribute to improving the safety and quality of care for women and their babies.

3.1.4 Healthcare professionals have a clear understanding of the concept of risk assessment and management to improve the quality of care and safety for women and their babies, while reducing preventable patient safety incidents.

3.1.5 Women, their families and staff are assisted and encouraged to report concerns, and systems are in place to ensure that they are not negatively affected as a result of this reporting.

3.1.6 Maternity units and maternity hospitals complete and publish a monthly Maternity Patient Safety Statement,[24] which is publicly available.

[24] The first statements were published in early 2016. It is intended that this statement will be published each month and will become part of clinical governance arrangements.

What this means for you as a woman using maternity services:

- The people working in your maternity service place a high value on safety and quality and this can be seen in the way they provide care to you and your baby.
- The people working in your maternity service are all working together to make sure that the care you receive is safe and of a high quality.
- You, your family, and everyone working in the service are supported to raise concerns about the safety and quality of the maternity service.
- Information about the safety of your maternity service is easily available to you.

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.

Features of a maternity service meeting this standard are likely to include the following:

3.2.1 Service providers proactively monitor, analyze and respond to information relevant to providing safe services. This information includes:

- findings from risk assessments
- patient safety incidents and other incidents involving women and babies using the service and staff providing the service
- clinical outcomes
- complaints, concerns and compliments
- legal claims
- audits
- experience surveys (of both women using the services and staff)
- findings and recommendations from local, national and international reviews and investigations
- casemix,[25] activity and performance data.

3.2.2 Service providers proactively identify, evaluate and manage immediate and potential risks to women and their babies, and take necessary action to manage these risks. Actions taken are evaluated and reported through relevant governance structures.

3.2.3 Service providers proactively identify, evaluate and manage risks associated with changes to the design or delivery of services.

[25] The types of women and babies and the complexity of their conditions treated within a maternity service, including diagnosis, treatments given and resources required for care.

3.2.4 Service providers systematically look for aspects of the delivery of care that may be associated with increased risk of physical and psychological harm to women and their babies, and have structured arrangements in place to minimize these risks. These include but are not limited to:

- prevention and control of healthcare associated infections
- medicines management and safe prescribing
- management of blood and blood components
- transfers of care within and between service providers and other care providers
- management of nutritional needs
- system for uniquely identifying women and their babies
- alarm security system for babies
- management and use of equipment and medical devices
- fetal ultrasound
- fetal monitoring (cardiotocography)
- attempted vaginal birth after a previous caesarean section (VBAC)
- surgical and invasive procedures.

3.2.5 Safe and effective medicines management arrangements are in place from obtaining medicines through to their disposal, in line with legislation, national policy, national guidelines and best available evidence.

3.2.6 Arrangements are in place to safely and effectively manage medical devices and other equipment in line with legislation, national policy, national guidelines and best available evidence.

3.2.7 Arrangements are in place to aid the early recognition and treatment of maternal and or infant deterioration, for example, sepsis, through the National Clinical Effectiveness Committee's National Clinical Guidelines, national programme guidelines, care bundles and care pathways.

What this means for you as a woman using maternity services:

- Your maternity service actively looks for ways to make its care safer — rather than reacting only if something goes wrong.
- Your feedback on your experience of the maternity service is reviewed to learn how to improve the safety and quality of the maternity service.
- The maternity service learns from the best available evidence to keep you and your baby safe.

Standard 3.3

Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally.

Features of a maternity service meeting this standard are likely to include the following:

3.3.1 Staff who are responsible for managing risk, patient safety incidents and complaints are appropriately trained and supported to undertake these roles.

3.3.2 Arrangements are in place to conduct reviews of all patient safety incidents in line with national standards and national policy and to share learning with all staff.

3.3.3 Arrangements are in place to gather, analyze and learn from information relevant to providing safe services. This information is used to drive continual improvements to the safety of the service.

3.3.4 Learning from patient safety incidents is shared within and between services and recommendations are implemented as appropriate.

What this means for you as a woman using maternity services:

- If something goes wrong, the maternity service learns from it and takes steps to reduce the likelihood of future harm.
- The maternity service shares what it has learned about how to make care safer with other services and checks that learning leads to improvements in care.

Standard 3.4

Maternity service providers implement, review and publicly report on a structured quality improvement programme.

Features of a maternity service meeting this standard are likely to include the following:

3.4.1 Service providers have programmes in place to support the building of quality improvement and skills across the service.

3.4.2 Service providers have or appoint a designated lead for quality improvement with responsibility for a range of quality improvement initiatives, including clinical audit.

3.4.3 Service providers have a quality improvement programme in place based on identified needs and priorities, learning from patient safety incident reports and reviews, and national and international initiatives. This programme incorporates specific evidence-based interventions that are proportionate to the context, nature and scale of the service provided.

3.4.4 Service providers regularly review the quality improvement programme through performance indicators and benchmarks to identify both positive outcomes and areas for improvement. Any necessary actions to improve the safety and quality of the service are implemented and learning is shared locally, at maternity network level and nationally.

3.4.5 Service providers publicly report on the quality improvement programme's goals, the outcomes of its reviews and the actions, if any, to be taken. This ensures that all actions possible are taken to promote the safety and quality of services.

What this means for you as a woman using maternity services:

- Maternity service providers have plans in place to reduce the risk of harm occurring to you, your baby and other women and babies using the service. These plans are regularly reviewed to make sure they are improving the safety of services.
- Maternity service providers identify areas for improvement and look for ways to make them safer.
- Progress made in quality improvement is available to you.

Standard 3.5

Maternity service providers effectively identify, manage, respond to and report on patient safety incidents.

Features of a maternity service meeting this standard are likely to include the following:

3.5.1 Arrangements are in place to identify, respond to, manage, report and review patient safety incidents in a timely manner in line with legislation, national standards, national policy and guidelines. These arrangements are clearly communicated to all interested parties and the effectiveness of these arrangements is regularly reviewed.

3.5.2 There is a clear process that service providers can follow when a patient safety incident occurs for managing the situation, including caring for those affected by harm and dealing with immediate safety concerns. Managing patient safety incidents involves review, learning, communicating and where necessary, implementing changes to existing systems, training or staffing levels.

3.5.3 Service providers classify patient safety incidents using an agreed taxonomy[26] in line with national policy, standards, guidelines and guidance.

3.5.4 Arrangements are in place to identify patient safety incidents through structured incident-reporting mechanisms and the surveillance of information relevant to providing safe services.

3.5.5 Arrangements are in place to facilitate thorough, fair and effective reviews to identify the causes of patient safety incidents and to identify necessary actions.

3.5.6 Staff are provided with induction and ongoing training on the identification, management, response to, reporting and review of patient safety incidents.

[26] A taxonomy is a process or system of describing the way in which incidents are defined and related by putting them in groups.

3.5.7 Mechanisms are in place for the review of patient safety incidents and the sharing of key learning with relevant staff and other services.

3.5.8 Women and their families are kept informed and supported during the review process and are given the opportunity to be involved in the process.

3.5.9 Training is provided for senior healthcare professionals in dealing with women and their families in the context of patient safety incidents. All staff are aware of who to contact to liaise with women and their families in the case of a patient safety incident.

3.5.10 Where a review results in recommendations, the subsequent action plan includes a named person or persons with responsibility and accountability for implementing the recommendations.

3.5.11 Arrangements are in place to implement recommendations from reviews of patient safety incidents and investigations and to monitor and evaluate the effectiveness of actions taken.

3.5.12 Service providers regularly review the effectiveness of the arrangements for identifying, managing, responding to and reporting on patient safety incidents.

What this means for you as a woman using maternity services:

- Although maternity care can never be completely free from risk, your maternity service actively works to prevent something going wrong with your care or that of your baby.
- The maternity service has plans in place to help it recognize risks of harm to women or their babies. This allows maternity service providers to respond quickly to possible risks.
- If something goes wrong, the maternity service looks into what happened, how it happened and why it happened so it can take steps to prevent it from happening again.

Standard 3.6

Maternity service providers fully and openly inform and support women and their families as soon as possible after a patient safety incident becomes known, and continue to provide information and support as needed.

Features of a maternity service meeting this standard are likely to include the following:

3.6.1 Service providers promote a just culture, which includes open disclosure with women and their families following a patient safety incident, in line with national legislation, standards and policy.

3.6.2 Service providers promptly tell women and their families, in an open and honest manner about patient safety incidents that may have caused them harm. This is communicated by healthcare professionals that are appropriately trained in open disclosure.

3.6.3 Services have a formal system in place for reviewing patient safety incidents.

3.6.4 All staff who provide maternity care feel protected to disclose information about actual or potential patient safety incidents and are supported to participate honestly and openly in all review and investigation processes.

3.6.5 Following a patient safety incident, the woman, and where appropriate, her family, is given the opportunity to meet with the lead healthcare professional responsible for her care to discuss the incident.

3.6.6 Arrangements are in place to support women and their families following a patient safety incident. Women and their families are informed about and provided with information on support services, including independent patient support and how to access such services.

3.6.7 Women and their families have the opportunity to be involved in the review process following a patient safety incident, are kept informed of its progress and the outcome of the review is discussed with them.

3.6.8 Service providers actively seek and take into account the needs and preferences of women and families affected by a patient safety incident.

3.6.9 Fair and transparent arrangements are in place to support staff who have been involved in a patient safety incident in line with the principles of caring for the 'second victim'.[27] The fitness of such staff to return to work is determined in advance.

What this means for you as a woman using maternity services:

If something goes wrong while you are receiving care:

- The maternity service is open and honest with you and your family as soon as possible after it becomes known.
- The maternity service reviews what happened, how it happened and why it happened and you and your family are involved in the review to make sure the review includes issues you would like addressed.
- You and your family are supported to access additional support services if you need them.

[27] Second victim: a healthcare provider involved in an unanticipated adverse patient event, medical error and or a patient-related injury who becomes victimized through the trauma of the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patient. They often second-guess their clinical skills and knowledge base.

Standard 3.7

Maternity service providers ensure all reasonable measures are taken to protect women and their babies from all types of abuse.

Features of a maternity service meeting this standard are likely to include the following:

3.7.1 Arrangements are in place to ensure that appropriate action is taken in line with legislation and national policies and guidelines, where concerns of abuse are identified. This includes domestic violence and child protection (Children First) concerns.

3.7.2 Services cooperate with all relevant services and agencies both internally and externally, to protect women and their babies from abuse, in line with legislation and national policies.

3.7.3 Induction and ongoing training is provided to staff on the prevention, identification, response to and management of all types of abuse.

3.7.4 Arrangements are in place to manage the risk to women and their babies from all types of abuse from staff and others, with specific arrangements in place to protect women identified as being vulnerable.

3.7.5 Arrangements are in place to make sure that women who have experienced abuse, or are suspected of having experienced abuse, are helped to access appropriate services, including support services.

What this means for you as a woman using maternity services:

- The maternity service takes the necessary steps to protect you and your baby from all types of abuse when you are receiving maternity care, for example verbal and physical abuse.
- People working in the maternity service receive training so that they know how to support you and your baby and help to protect you both from abuse.
- If you have experienced any type of abuse you are helped, if you wish, to get in touch with support services.
- Any concerns of abuse that you may have are listened to by the people who are providing your care. Your concern is responded to and addressed fairly and in a timely manner.

Theme 4
Better Health and Wellbeing

Theme 4
Better Health and Wellbeing

Pregnancy and birth is a time when women have a unique opportunity to focus on their health and wellbeing and that of their baby. Positive choices made by women can give their babies the best start in life. Improving the health and wellbeing of women and their babies is not the sole responsibility of service providers or women themselves. Rather, they work together to enable a culture that promotes better health and wellbeing, enhances the care and support environment, and improves the experience for women and their families. By providing appropriate information and supports, healthcare professionals can make every contact count to support positive behavioural change in women, in particular around reducing lifestyle behaviours with harmful effects such as smoking, substance misuse and alcohol consumption. However, healthcare professionals must be mindful of the social determinants of health that impact on the health and wellbeing of women and their babies and on a woman's ability to make positive choices.

Maternal obesity is associated with increased risk of gestational diabetes, hypertension, fetal complications and obstetric interventions. Healthcare professionals can promote protective measures such as improved nutrition and physical activity. Immunization, both pre-pregnancy and during pregnancy improves the health and wellbeing of women and babies. In addition, it is important that supports and interventions for overall health and wellbeing, including mental health and sexual health, are addressed and supported. The promotion of health and wellbeing in pregnancy is important and can serve as motivation for families to make improved lifestyle choices. Some women need referral to healthcare professionals such as physiotherapists, dietitians, social workers and psychologists for more targeted interventions and support prior to and during pregnancy.

Healthy Ireland, the national framework for action to improve people's health and wellbeing, underlines that healthy choices before birth are as critical as giving ongoing support during a child's early years. Antenatal and early life experiences may have consequences for a child's health and wellbeing in infancy, through to adulthood and later life. As such, it is important for maternity services to encourage and enable breastfeeding, as per the best available evidence, in order to give every baby the best possible start in life.

Tobacco Free Ireland, the national tobacco control policy document, has a series of recommendations which aim to reduce smoking prevalence in the overall population and, in particular recommends the provision of targeted approaches in smoking cessation services for pregnant women and women in the postnatal period. In order to protect the health and wellbeing of both women and babies from the harms of smoking, maternity units and maternity hospitals should be tobacco-free campuses and have an on-site smoking cessation service available for pregnant women.

For women who experience social problems — such as social isolation, domestic violence or addiction — pregnancy and birth can provide an opportunity for them to access support for their safety and wellbeing, and that of their baby. Healthcare professionals working in maternity services are uniquely placed to help vulnerable women and their babies access support and protective services.

There are many benefits to intervening early and providing information based on best available evidence and support to women of reproductive age. Some of the risks associated with unplanned pregnancies could be mitigated if women of reproductive age were healthier. Women with pre-existing medical conditions may require specialized pre-pregnancy care which should be provided in both the community and the acute setting.

Standard 4.1

Healthcare professionals work with women to promote, protect and improve the health and wellbeing of women and their babies.

Features of a maternity service meeting this standard are likely to include the following:

Pre-pregnancy care

4.1.1 Healthcare professionals aim to maximize the health and wellbeing of women of reproductive age, recognizing the impact of pre-pregnancy health for both women and their babies.

4.1.2 Healthcare professionals explore opportunities to plan for pregnancy or contraception with women of reproductive age at appointments, where appropriate.

4.1.3 Maternity unit, maternity hospital and community-based healthcare professionals have access to up-to-date, evidence-based information on the safety of medication exposures in early pregnancy. This will facilitate pre-pregnancy counselling for women on medicines for pre-existing medical disorders who have an unplanned pregnancy.

4.1.4 Women of reproductive age with a pre-existing medical condition have the opportunity to plan for pregnancy or contraception at each contact with a medical practitioner, if appropriate.

4.1.5 Arrangements are in place for service providers to refer women to multidisciplinary pre-pregnancy clinics though the maternity network structure.

4.1.6 Pre-pregnancy information[28] given to women and their partners includes the following, as appropriate:

- contraception
- nutrition, in particular, folic acid supplementation

[28] Pre-pregnancy information should be based on best available evidence.

- physical activity
- optimization of pre-pregnancy weight
- sexual health
- best time for likelihood of conception
- cervical smears
- smoking cessation
- alcohol consumption
- substance misuse
- mental health and wellbeing
- pre-pregnancy immunizations, for example, rubella and varicella
- medicines (prior to and during pregnancy)
- antenatal screening for infectious diseases
- antenatal anomaly screening.

Antenatal

4.1.7 Throughout the antenatal period, women are provided with information[29] about:

- the physiological course of pregnancy, labour, birth and the postnatal period
- nutrition and healthy eating
- appropriate weight management
- physical activity
- smoking cessation
- alcohol consumption
- substance misuse
- immunizations, for example, influenza and pertussis
- resources available in preparation for childbirth
- breastfeeding

[29] Information should be based on best available evidence.

- transition to parenthood and parenting skills
- the National Healthy Childhood Programme
- vitamin D supplementation
- vitamin K prophylaxis
- newborn and child health surveillance and screening
- perinatal mental health and wellbeing, including the importance of self-care, the identification of supports and planning for after the birth.

4.1.8 Women and their partners are supported to make a confident and effective transition to parenthood based on their individual needs. For example, by identifying and supporting the postnatal health and social needs of the mother, including mental health and wellbeing, with particular reference to the importance of maternal-infant bonding for infant development.

4.1.9 Services comply with current national infant feeding policies and guidelines[30] that encourage and enable breastfeeding and continue to assess their compliance with these guidelines.

4.1.10 Height, weight and body mass index are measured and recorded at the antenatal booking appointment.

4.1.11 Service providers refer women to a dedicated dietetic service, where it is identified that they would benefit from this additional support.

4.1.12 Service providers refer women to a dedicated physiotherapy service, where it is identified that they would benefit from this additional support.

4.1.13 Service providers encourage healthy eating, for example through the provision of healthy snacks in appropriate areas throughout the maternity unit or maternity hospital.

4.1.14 Nutritious food is provided to women admitted to maternity units and maternity hospitals, with specific consideration given to women with diabetes, who are breastfeeding or with other dietary requirements. This includes the provision of culturally appropriate dietary choices.

[30] At the time of publishing the National Standards these include the Baby Friendly Health Initiative, the Health Service Executive (HSE) Infant Feeding Policy for Maternity and Neonatal Services, the HSE Breastfeeding Policy for Primary Care Teams and in Community Healthcare Settings, the Ten Steps to Successful Breastfeeding (see Appendix 2) and the WHO International Code of Marketing of Breast-milk Substitutes.

4.1.15 Women and their partners who smoke are provided with clear evidence-based information about the risks of smoking, and are offered smoking cessation support.

4.1.16 Women receive clear information that is based on best available evidence about the risks of alcohol consumption and substance misuse. Where misuse is identified, appropriate referrals are made.

4.1.17 Healthcare professionals recognize the important role of partners and, where the woman wishes, make sure they are encouraged and supported to take a full and active role in pregnancy, childbirth and the postnatal period.

4.1.18 Healthcare professionals and women are aware of emotional adjustments and mental health and wellbeing during pregnancy and the postnatal period.

Postnatal

4.1.19 Service providers support skin-to-skin contact[31] while taking the clinical circumstances into account. If for medical reasons the mother is unable to hold her baby in skin-to-skin contact immediately after birth, her partner or a family member is given the opportunity to do so until the mother is able to.

4.1.20 Healthcare professionals are aware of the importance of skin-to-skin contact and how to ensure maternal and infant safety whilst skin-to-skin contact is being performed.

4.1.21 Services responsible for postnatal care ensure that the emotional and mental health needs of women are recognized and addressed and healthcare professionals are aware of the referral pathways to mental health services.

4.1.22 Services encourage and enable breastfeeding and support women to initiate and sustain breastfeeding, with additional support being provided to women who have had a multiple birth, or have a premature or sick baby.

[31] Skin-to-skin contact is when your baby is placed on your chest, with your skin next to your baby's skin, immediately after birth or as soon as you are ready to hold your baby. Your newborn baby bonds through touch and smell, and their senses are tuned in to respond to your unique smell and the feel of your skin. The benefits accrued by skin- to-skin care, including favorable temperature, beneficial flora, and early opportunity to 'crawl' to the breast, all point to one of the best possible outcomes for mother and baby. It promotes maternal and newborn attachment, reduces maternal and newborn stress and helps the newborn transition to postnatal life.

4.1.23 Women who are taking medicines receive information based on best available evidence in relation to breastfeeding from an appropriately trained healthcare professional.

4.1.24 Women who are not breastfeeding are assisted to learn how to choose, prepare, handle and give artificial feeds and how to effectively clean and sterilize feeding equipment.

4.1.25 Information is provided to women about the community supports available postnatally and their point of contact in the community.

4.1.26 Healthcare professionals in the community support women and their partners to make a confident and effective transition to parenthood and to develop parenting skills.

4.1.27 Women are advised of breastfeeding supports in the community and provided with materials containing contact information for these groups.

4.1.28 The lead healthcare professional for the postnatal period[32] coordinates timely access to the following services for women and or their babies as required:

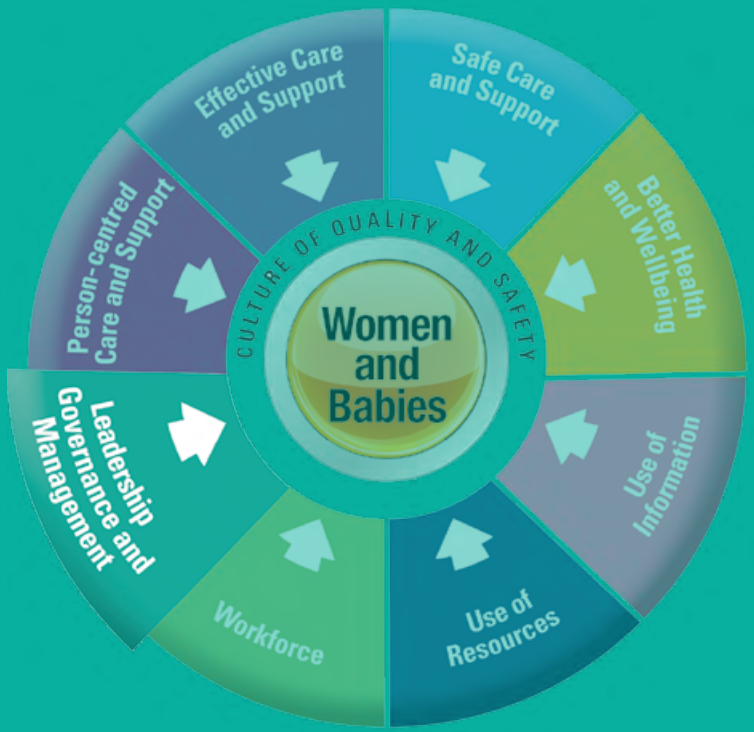
- counselling services
- dietitians
- family support services
- lactation consultants
- occupational therapists
- perinatal mental health services
- physiotherapists
- smoking cessation support
- social services.

[32] This will be a public health nurse, a community midwife, a self-employed community midwife, or a GP depending on the care pathway and the needs of the woman and her baby.

What this means for you as a woman using maternity services:

- Healthcare professionals work in partnership with you to help maintain and improve your health and wellbeing, and that of your baby.
- You, your partner and family are supported and empowered to make positive lifestyle choices before, during and after the pregnancy, to promote a healthier future for you all.
- Opportunities are available for you and your partner to participate in programmes or initiatives to improve your health and wellbeing and that of your baby.
- All of your maternity service providers work with each other and with national and voluntary agencies to promote better health and wellbeing for you and your baby.
- Your mental health needs during and after pregnancy are recognized and you are given the necessary support through referral to the most appropriate services to address your needs.
- Supports are in place in all maternity services to support you to breastfeed your baby.
- Maternity service providers recognize that pregnancy and birth are life-changing events and you are supported both physically and emotionally in the transition to parenthood.

Theme 5
Leadership, Governance and Management



Theme 5

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, statutory and financial obligations. Strong and effective leadership, governance and management arrangements are essential to create and sustain a safe and high-quality maternity service. Effective leadership, governance and management, in keeping with the size and complexity of the maternity service, are fundamental prerequisites for the sustainable delivery of good service, and safe, high-quality care and support. Maternity services, in some cases, are part of a wider group of services, for example within a maternity network. Leadership, governance and management arrangements should reflect these intricacies and the reporting arrangements to the executive management team at network level.

A well-governed maternity service is clear about what it does, how it does it, and is accountable to the women who use the services and the people who fund and support it. It is unambiguous about who has overall executive accountability for the safety and quality of services. In addition, formalized governance arrangements ensure that there are clear lines of accountability at individual, team and service levels. Therefore, healthcare professionals, managerial staff and everyone working in the maternity service are aware of their responsibilities and accountability. There must also be arrangements in place to plan and manage service change and transition effectively and safely.

Good governance arrangements acknowledge the interdependencies between organizational arrangements and clinical practice and integrate these to deliver safe, high-quality care. Maternity services with strong governance structures promote transparency and responsiveness by accurately describing in a public statement of purpose, the aims and objectives of the service, the services provided, including how and where they are provided.

If a maternity service proposes to change the services it delivers, or how it delivers them, then these changes need to be assessed and highlighted to those people funding and potentially using the service before being made. The maternity service provider's governance systems should always ensure that it only provides services within the scope of what it can provide safely, effectively and sustainably.

The management arrangements in a maternity service make sure that it fulfils its statement of purpose by planning, controlling and organizing the service to achieve its outcomes in the short, medium and long term. Effective management also includes deploying the necessary resources through informed decisions and actions to help with the delivery of safe, high-quality care.

Leaders and organizational arrangements support all members of the workforce to exercise their personal and professional responsibility for the safety and quality of the maternity services they are delivering. This provides an environment in which the workforce can do the right thing or make the right decision at the right time.

Achievement of safe, high-quality maternity care is dependent on the culture of a service. Leaders at all levels have an important role to play in promoting and strengthening a culture of quality and safe care. Individual and collective leadership builds support for this culture and inspires individuals and teams to strive and work together to achieve a common vision.

A well-governed and managed maternity service monitors its performance to ensure reliability so that the care it provides is of consistently high quality with minimal variation in provision across the system. The safety and quality of services that are sourced externally are monitored through formalized agreements. Safety and quality are also assured by compliance with legislation and acting on standards, guidance and recommendations from relevant statutory bodies.

Standard 5.1

Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

5.1.1 Services have an identified senior individual[33] who:

- has overall executive authority, responsibility and accountability for the delivery of safe, high-quality services
- leads a governance framework that clearly specifies delegates and integrates corporate and clinical governance
- formally reports on the safety and quality of the service through its relevant governance structures.

5.1.2 Where a service is located on more than one site, the identified individual delegates authority and responsibility for safety and quality of services to an identified person who is involved in the management and delivery of the service and is at an appropriate level within the governance structure.

What this means for you as a woman using maternity services:

- There is an identified person who has overall responsibility for the safety and quality of the maternity service you are using.

[33] For example, in a maternity unit or maternity hospital this currently is the Chief Executive Officer (CEO) or the Master.

Standard 5.2

Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

5.2.1 Integrated corporate and clinical governance arrangements are in place, with clearly defined responsibilities and accountability throughout the service. These governance arrangements are transparent and publicly available.

5.2.2 Governance arrangements are in place to ensure that the focus of the service is on women and their babies, and on the wellbeing and development of its staff.

5.2.3 Maternity units and maternity hospitals have clearly defined reporting structures within the service and through the relevant maternity network structures.

5.2.4 Governance arrangements are in place to ensure the interests of women and babies using the service are taken into consideration when decisions are made about the planning, design and delivery of services, such as including former patients and service users in these processes, for example, through a maternity service liaison committee.

5.2.5 The people involved in the governance of the service have the capacity, skills and competencies necessary to provide effective assurance of safe, high-quality care.

5.2.6 The core responsibilities of all staff are clearly defined.

5.2.7 A transparent process is in place whereby healthcare professionals are able to see how issues — that have been identified in a clinical governance and quality framework — are dealt with, and how learning is shared and implemented.

5.2.8 Those governing the service regularly review information on the safety and quality of the service and ensure that care is delivered in line with national standards, guidelines and policies.

5.2.9 Those governing the service publicly report on the safety and quality of care, for example, through the Maternity Patient Safety Statement.

What this means for you as a woman using maternity services:

- The people in charge of the maternity service are suitably qualified and experienced.
- The people in charge of the service make sure that you and your baby receive safe, high-quality care.
- People working in the service have a clear understanding of their role and responsibilities and who they report to within the service.
- When decisions are being made about the way the service is delivered, the views of women and their families are sought and considered.
- Information about the safety and quality of your maternity services is publicly available to you in a number of different ways.

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.

Features of a maternity service meeting this standard are likely to include the following:

5.3.1 A statement of purpose for the service is publicly available in various accessible formats and is communicated to all stakeholders, including women, using the service.

5.3.2 A statement of purpose details the:

- aims and objectives of the service, including how resources are aligned to deliver these objectives
- description of services provided
- models of care and aligned care pathways
- location or locations of service delivery.

5.3.3 Service providers evaluate proposed changes to services in consultation with relevant stakeholders to ensure the statement of purpose reflects what can be delivered safely, sustainably and within available resources. Any necessary approval is sought before changes are made.

5.3.4 Governance arrangements are in place to review and check that services are being delivered within the scope of the statement of purpose, in consultation with relevant stakeholders.

What this means for you as a woman using maternity services:

- You can easily find information about the care that maternity services provide, including the different types of services and where they are provided.
- Information about changes to services delivered is made available to the public in a timely manner.

Standard 5.4

Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services.

Features of a maternity service meeting this standard are likely to include the following:

5.4.1 Service providers have plans in place that set a clear direction for delivering safe, high-quality care in the short, medium and long term. In the case of maternity units and maternity hospitals, these are aligned to plans at maternity network level.

5.4.2 Service providers set SMART (specific, measurable, achievable, realistic, time-bound) objectives and their plans take account of the:

- national strategies, policies, standards and guidelines
- views of stakeholders
- needs of the population served
- best available evidence
- legislation
- resources available
- information relevant to the provision of safe services.

5.4.3 Service providers routinely engage with women to ensure their collective interests are represented and considered in decisions about the planning of services. Information underpinning key decisions in the planning of services is made publicly available.

5.4.4 Service providers monitor their performance against service objectives. Performance of the service is managed transparently and reported through the relevant governance structures.

What this means for you as a woman using maternity services:

- Maternity service providers have a clear plan that sets out how they deliver their services. You can easily access these plans if you wish.
- Maternity service providers find out what is important to women using the service and use this information to plan and deliver their service.
- Maternity service providers regularly look at the service they provide to make sure it is safe and of a high quality.

Standard 5.5

Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.

Features of a maternity service meeting this standard are likely to include the following:

5.5.1 Management arrangements are in place to effectively and efficiently achieve planned objectives. This includes reviewing and identifying gaps in management arrangements and taking action to address these. Management arrangements include, but are not limited to:

- workforce management
- performance management
- communication management
- information management
- risk management
- patient safety and quality improvement
- service design, improvement and innovation
- environment and physical infrastructure management
- financial and resource management.

5.5.2 Management arrangements are in place to address increases or decreases in service demand that help to ensure the safety and quality of care delivered to women and their babies.

5.5.3 Arrangements are in place to plan and manage service change and transition effectively. This includes:

- identifying an accountable individual who is responsible for leading and managing the change process
- setting clear objectives for the service change and transition

- assessing in advance service interdependencies at local, regional and national levels, where relevant
- modelling of demand and capacity through estimating current and future requirements
- considering the impact on stakeholders
- assessing staffing implications and determining staffing requirements
- implementing communication and engagement strategies
- developing and monitoring performance indicators relevant to change and service transition.

5.5.4 Each maternity unit and maternity hospital has or appoints a director of midwifery with responsibility for the organization and management of the midwifery service, and who is represented on the executive management team.

5.5.5 Directors of midwifery, nursing and clinical directors, have the necessary competencies and are given protected administrative time and support to effectively meet the requirements of their leadership and managerial roles.

5.5.6 Each maternity unit and maternity hospital has or appoints:

- a designated lead consultant obstetrician with responsibility for the organization and management of the obstetric service
- a designated lead consultant obstetrician with responsibility for the organization and management of the specialized birth centre
- a designated lead consultant neonatologist or paediatrician with responsibility for the organization and management of the neonatal service
- a designated lead consultant anaesthetist with responsibility for the organization and management of the obstetric anaesthetic service
- a designated lead for the health and social care professional services.

5.5.7 Clinical managers, clinical directors and midwifery clinical skills facilitators[34] are provided with training in supervision theory and practice.

What this means for you as a woman using maternity services:

- The right people work in the maternity service to provide you and your baby with safe, high-quality care.
- Maternity services manage their finances and premises to ensure they deliver safe, high-quality care for you and your baby.
- Maternity services have plans in place to deal with any increases or decreases in demand for the service.

[34] The primary purpose of the post of the midwifery clinical skills facilitator is to provide clinical support, education and instruction to midwives in developing skills and competencies in order to fulfil their roles and responsibilities.

Standard 5.6

Leaders at all levels promote and strengthen a culture of safety and quality throughout the maternity service.

Features of a maternity service meeting this standard are likely to include the following:

5.6.1 Service providers actively promote and work to strengthen a culture of safety and quality through the mission statement, service design, code of governance, allocation of resources and training, development and evaluation processes of their maternity service.

5.6.2 Staff in maternity units and maternity hospitals are encouraged to complete the Patient Safety Culture Survey and results are reported through the appropriate governance structures.

5.6.3 A clear commitment is demonstrated by leaders at all levels of the services to promote and strengthen a culture of safety and quality.

5.6.4 Service providers support leaders at all levels to maintain and improve their skills, knowledge and competencies to fulfil their roles and responsibilities in delivering safe, high-quality care.

5.6.5 Service providers regularly review and identify areas for improvement in the culture of the service, which incorporates structured feedback from women using the service and from staff.

What this means for you as a woman using maternity services:

- Maternity service providers support a culture of safety and quality.
- Maternity services help their staff to develop their leadership skills to promote the delivery of safe, high-quality services.
- Feedback from women and their families is used to provide an insight into the culture of the service as it is experienced by those who use it.
- Maternity service providers regularly review how they can improve the safety and quality of their care.

Standard 5.7

Staff at all levels are empowered to exercise their professional and personal responsibility for the safety and quality of maternity services provided.

Features of a maternity service meeting this standard are likely to include the following:

5.7.1 Staff are supported and managed to effectively exercise their professional and personal responsibility for the provision of safe, high-quality maternity care.

5.7.2 There is a culture of openness and accountability throughout the service. There are arrangements in line with legislation so that staff can report in good faith any concerns that they have in relation to the safety and quality of the service, and are not negatively affected as a consequence.

5.7.3 Staff who wish to make protected disclosures about the safety and quality of the service are assisted to make such disclosures in line with legislation.

What this means for you as a woman using maternity services:

- People working in the maternity service have a clear understanding of their responsibilities and when to seek advice and support.
- People working in the maternity service are supported to raise concerns about the safety and quality of the service.

Standard 5.8

Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.

Features of a maternity service meeting this standard are likely to include the following:

5.8.1 Service providers proactively identify, manage and minimize risks to safeguard women and their babies using their services.

5.8.2 Service providers proactively identify, report, monitor and analyze patient safety incidents. Learning from these incidents is communicated within and between services and is used to improve the safety and quality of the service.

5.8.3 Healthcare professionals participate in regular multidisciplinary clinical audit and reviews of clinical services, including outcomes for women and their babies.

5.8.4 Service providers participate in national quality improvement programmes, where relevant.

5.8.5 Information from monitoring of performance is used to drive improvements in the safety and quality of services provided.

5.8.6 Complaints and compliments from women using the service are used and shared to promote learning throughout the service.

5.8.7 Service providers take a proactive approach to learning from findings and recommendations from local, national and international reviews and investigations.

5.8.8 Service providers communicate effectively with women and their families, support groups, external agencies and other service providers. Service providers are supported to identify opportunities to improve their services.

What this means for you as a woman using maternity services:

- Maternity service providers are constantly looking for ways to improve the services they provide to you and your baby.
- Complaints and compliments from women and their families are used to improve the safety and quality of the service.
- If something goes wrong with the care you receive, the maternity service makes changes to reduce the risk of the same thing happening again.
- Maternity service providers learn from the findings of reviews and investigations of other services to improve the safety and quality of their services.

Standard 5.9

Maternity service providers monitor the safety and quality of services provided on their behalf.

Features of a maternity service meeting this standard are likely to include the following:

5.9.1 Formalized agreements are in place for the provision and quality of services sourced externally. The contracts of agreement include the scope of service provided, resources required and the quality assurance and governance arrangements including compliance with relevant legislation, national standards and policies.

5.9.2 Service providers regularly monitor their formalized arrangements with external recruitment agencies to assure themselves that the agency complies with relevant legislation, national standards and policies.

5.9.3 Where staff are recruited through an agency, healthcare professionals in the relevant specialty are involved in their recruitment.

What this means for you as a woman using maternity services:

- Maternity services regularly assess that any services that they are not providing directly are safe and of a high-quality.
- If your maternity service uses an external recruitment agency, staff still have the necessary skills and experience to care for you and your baby.

Standard 5.10

Maternity services are compliant with relevant legislation.

Features of a maternity service meeting this standard are likely to include the following:

5.10.1 Services provide assurance through their governance structures that the service provided complies with relevant legislation.

5.10.2 Services have a clearly documented risk assessment if any gap in compliance with legislation is identified. Appropriate timely action is taken to achieve compliance.

What this means for you as a woman using maternity services:

- Your maternity service complies with relevant legislation.

Standard 5.11

Maternity service providers act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies.

Features of a maternity service meeting this standard are likely to include the following:

5.11.1 Services act promptly in response to alerts made by regulatory bodies relating to the safety and quality of their services.

5.11.2 Service providers review standards, recommendations and guidance issued by regulatory bodies in order to determine what is relevant to the service they provide. Action is taken to implement any necessary changes to address deficiencies.

What this means for you as a woman using maternity services:

- Your maternity service works to improve the safety and quality of their service by acting on relevant standards, recommendations and guidance issued by regulatory bodies that apply to their services.

Theme 6
Workforce

Theme 6
Workforce

The workforce providing a maternity service consists of all the people who work in the service, for it or on its behalf. All these personnel are integral to the delivery of a person-centred, safe, high-quality service. Service providers must be able to assure the public and their workforce that everyone working in the service is contributing to a safe, high-quality service. A multidisciplinary team approach is essential for this.

When a service sets its objectives it must determine the workforce requirements to deliver them. The individual members of a workforce must be skilled and competent, while the workforce as a whole must be planned, configured and managed to achieve these objectives.

Workforce planning involves determining the right staffing levels, mix and distribution of skills, competencies and capabilities within a workforce. This entails a number of key activities such as recruitment, the tracking of staff numbers and skills, learning, training and development and workforce deployment. Effective maternity services need processes to ensure that there are sufficient staff available at the right time, with the right skills, diversity and flexibility to deliver safe, high-quality care.

The workforce has a key role in delivering a safe, high-quality service and should be supported in doing this. Effective recruitment and workforce planning ensures that members of the workforce have the necessary competencies to undertake their role and fulfill the requirements of the service. People working in maternity services need ongoing supervision and feedback to ensure they are doing a good job and that they are getting the right training and support needed to deliver a safe, high-quality service.

Supporting the workforce includes providing a safe physical environment, protecting them from the risk of bullying and harassment, and listening and responding to their views. As aspects of maternity care provision change and develop over time, the workforce needs to be supported to continuously update and maintain their knowledge and skills, whether they are directly employed or in a contractual arrangement.

Arrangements also need to be in place to support the requirements of professional regulation for all staff that need to be registered and regulated by professional regulatory bodies.

Standard 6.1

Maternity service providers plan, organize and manage their workforce to achieve the service objectives for safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

6.1.1 Staffing levels are maintained at adequate and nationally accepted levels to meet service need.

6.1.2 Service providers use nationally agreed workforce planning tools and adhere to national guidelines on rostering.[35]

6.1.3 Workforce planning takes account of the need for rotation of staff to maintain competence and skills.

6.1.4 Workforce planning takes into account annual leave, study leave, maternity leave and sick leave. In maternity units and maternity hospitals, it also takes account of predictive modelling of needs such as the number of women booked and the respective estimated date of birth of their babies.

6.1.5 Service providers organize their workforce to provide team-based care in order to ensure continuity of care(r) to women and their babies.

6.1.6 The workforce plan includes a training needs analysis for all grades of staff.

6.1.7 Service providers continually audit workload, casemix, skill-mix and staffing levels. Safe staffing levels of all healthcare professionals and support staff are maintained, reviewed and audited annually for each service.

[35] The Chief Medical Officer's Portlaoise report recommends that the Health Service Executive (HSE) develops evidence-based workforce planning tools and data systems for midwives and maternity care assistants. It also recommends that the HSE develops national guidelines on rostering of midwifery staff in maternity units based on best evidence.

6.1.8 Service providers implement a system of contingency and succession planning of their workforce to seamlessly continue to deliver a safe, high-quality, sustainable service as staff leave the service.

6.1.9 Midwifery, nursing staff and maternity care assistants are not asked to work beyond their scope of clinical practice.

6.1.10 Service providers work to improve continuity of staffing through strategies for the retention of staff and ensure sufficient staffing levels to avoid excessive use of locum and agency staff.

6.1.11 The use of locum and agency staff is kept to a minimum and reliance on them is continuously reviewed.

6.1.12 Maternity units and maternity hospitals determine their need for advanced midwife, nurse and neonatal nurse practitioners, and midwife and nurse prescribers based on population and geographical need in conjunction with their maternity networks.

6.1.13 Workload distribution is regularly reviewed with protected time being allocated to staff for clinical audit, data collection and quality improvement activities.

What this means for you as a woman using maternity services:

- The people that provide your maternity service plan and organize their services to ensure that there are enough staff with the necessary qualifications, skills and experience to deliver safe, high-quality care for you and your baby at all times.
- Your service works to identify the training needs of staff.
- The workforce is managed in such a way to provide you with continuity of care(r).

Standard 6.2

Maternity service providers recruit people with the required competencies to provide safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

6.2.1 Selection and recruitment of staff is in line with relevant Irish and European legislation and is informed by human resource practices based on best available evidence.

6.2.2 Service providers have a system in place to monitor that all members of their workforce are registered with the appropriate regulatory bodies, and are indemnified by the appropriate organizations for their scope of practice.

6.2.3 Service providers recruit staff with the required experience, registration (where relevant), credentials and competencies. This includes recruitment of locum and agency staff where this is necessary.

6.2.4 Arrangements are in place to monitor and evaluate the effectiveness of recruitment processes and to address any gaps identified.

6.2.5 Where staff are recruited through an agency, healthcare professionals in the relevant specialty are involved in their recruitment.

6.2.6 Recruitment and selection procedures incorporate all reasonable measures to protect women and their babies from harm, for example, obtaining background checks for the people they employ.

6.2.7 Services appoint clinical midwife specialists across a variety of specialties based on service needs.

6.2.8 Sufficient numbers of trained ultrasonographers are in place so that an ultrasound service is available in all maternity units and maternity hospitals on a routine basis during core working hours and on an on-call basis at other times.

What this means for you as a woman using maternity services:

- Your service makes sure that healthcare professionals are registered with their professional regulatory body in line with registration requirements.
- The people caring for you and your baby have the necessary qualifications, skills and experience to provide safe, high-quality care.
- Maternity service providers protect women and their babies when recruiting staff, for example by checking the backgrounds of people they employ.

Standard 6.3

Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

6.3.1 A culture of lifelong learning for healthcare professionals is promoted and supported in line with individual learning needs and the needs of women using the service. Service providers engage in continuing professional development with relevant bodies to facilitate this.

6.3.2 All healthcare professionals are supported to maintain their professional knowledge, skills and competence in line with best practice and the needs of the population being cared for. They also fulfil the requirements of professional regulation.

6.3.3 Service providers ensure that healthcare professionals have the relevant competencies to fulfill their roles and are supported and mentored to do so.

6.3.4 Service providers have formalized arrangements in place to facilitate the rotation of staff to maintain competence and skills. These arrangements are based on regular review of competence and skills and take account of service demands and staffing levels. This includes:

- midwives including clinical midwife managers, with the exception of specialist midwives, rotating through antenatal, intrapartum and postnatal settings
- midwives, with the exception of specialist midwives, rotating between acute and community services
- rotation of staff between maternity units or maternity hospitals within the maternity network structure.

6.3.5 Education and training are formalized, planned and regularly reviewed to address identified deficiencies and ensure that staff have competencies appropriate to their role.

6.3.6 Maternity units and maternity hospitals facilitate access, through the maternity network structures, to multidisciplinary professional development groups for education and training.

6.3.7 Service providers have a multidisciplinary educational programme in place for team training and use approaches to training that are based on best available evidence.

6.3.8 All staff are facilitated and supported, for example, through rostering, to attend education and training appropriate to their roles, through the use of a dedicated education and training budget and staff wellbeing and development programmes. There is transparency around how this budget is spent.

6.3.9 Protected education and training time is allocated as appropriate to the learning and development needs of staff.

6.3.10 Service providers have a formal induction programme for all new staff that focuses on communication and delivering safe, high-quality care. Induction for all new staff takes place prior to, or as soon as possible after, taking up a new post. Induction attendance records are maintained.

6.3.11 Prevention and control of infection is included in the induction programme for new staff, and in training and ongoing educational programmes for all staff.

6.3.12 Standardized induction is provided to locum and agency staff, comprising important information necessary to safely undertake the role, takes place prior to starting work.

6.3.13 Each maternity unit and maternity hospital has a midwifery clinical skills facilitator.

6.3.14 Healthcare professionals are trained in the support and promotion of normal pregnancy, labour and birth.

6.3.15 Healthcare professionals undertake multidisciplinary team training, appropriate to their scope of practice, in cardiotocography (CTG) interpretation every two years, or sooner if the need is identified, for example through a training needs analysis. The skills gained are supported by CTG review meetings.

6.3.16 Healthcare professionals undertake multidisciplinary team training, appropriate to their scope of practice, every two years in:

- basic adult life support, including resuscitation of the pregnant woman
- neonatal resuscitation
- obstetric and neonatal emergencies.

The skills gained are supported by regular multidisciplinary team skills and drills.

6.3.17 Healthcare professionals providing ultrasound services are appropriately trained and their competence is regularly assessed. This training includes counselling skills, support techniques and other issues related to early pregnancy.

6.3.18 Healthcare professionals are trained to recognize the signs of domestic violence, either physical or psychological. They are trained in screening, rating and how to make appropriate referrals in line with the national clinical programme guideline.

6.3.19 Healthcare professionals and support staff receive training in support of the national infant feeding policies and guidelines appropriate to their role.

6.3.20 Healthcare professionals and support staff are provided with disability competence training to equip them with the skills and understanding to provide person-centred care and support to women with disabilities, appropriate to their role.

6.3.21 Healthcare professionals receive training in relation to medicines management appropriate to their role.

6.3.22 Healthcare professionals are trained to recognize where women would benefit from perinatal mental health services and how to make appropriate referrals.

6.3.23 Healthcare professionals have access to educational and training opportunities in the delivery of compassionate bereavement and end-of-life care in line with their roles and responsibilities.

6.3.24 Service providers undertake an annual training needs analysis to determine any additional training that is required. Healthcare professionals are involved in this process and have the opportunity to identify additional needs throughout the year.

6.3.25 A formal mentorship programme is in place for all non-consultant hospital doctors irrespective of whether or not they are on a recognized training programme. Mentors are appropriately trained.

What this means for you as a woman using maternity services:

- Your maternity service provider makes sure that everybody working within its service only provides care that they have the required skills, knowledge and expertise to provide.
- Your maternity service provider ensures that all new staff receive induction training, which contains the information they need to provide safe care.
- The people caring for you and your baby receive education and training to keep their skills and knowledge up-to-date.

Standard 6.4

Maternity service providers support their workforce in delivering safe, high-quality maternity care.

Features of a maternity service meeting this standard are likely to include the following:

6.4.1 Governance arrangements are in place to ensure that all healthcare professionals have the opportunity and support for continuing professional development, including agreed education and training sessions, as well as improving and updating their skills as required.

6.4.2 The working environment supports and protects staff to deliver safe, high-quality maternity care and meets legislative and national policy requirements.

6.4.3 Service providers have arrangements in place to protect staff by minimizing the risk of violence, bullying and harassment by other staff or people using the service.

6.4.4 There is a formalized mechanism for staff to provide feedback to the service provider in order to identify and propose areas for improvement in the delivery of services. Action is taken based on the feedback provided.

6.4.5 Staff are provided with clear descriptions of their roles, responsibilities and lines of accountability.

6.4.6 There is a sufficient number of dedicated support staff, for example, maternity care assistants and administrative staff, to ensure healthcare professionals can fulfil their core clinical duties as a priority.

6.4.7 All staff receive regular peer supervision and support from appropriately trained and experienced staff in the relevant area.

6.4.8 Service providers have a formal system of performance appraisal in place for all staff. This system is a forum to identify areas for training and skills development.

6.4.9 Fair and transparent procedures are in place for the effective management of under-performance. Procedures are in place to inform the relevant professional body where it is considered that the behaviour, conduct, practice, performance or health of a healthcare professional is not what would be expected of such a professional.

6.4.10 Fair and transparent procedures are in place to support and manage a member of staff if a complaint or a concern is expressed about them.

6.4.11 There is a culture of openness and accountability throughout the service, as well as arrangements in line with legislation, to allow staff to report in good faith any concerns that they have in relation to the safety and quality of the service without being negatively affected as a consequence.

6.4.12 The service regularly reviews, and responds to, feedback about staff from women using the services and other staff members.

6.4.13 In the event of an adverse outcome or a patient safety incident, the effect that this may have on staff is acknowledged, and support is available for them. Debriefing support is offered to staff, as required. Peer support and access to counselling services are also available.

6.4.14 Service providers ensure that where a training need is identified in the wake of an adverse outcome or a patient safety incident, this training is provided.

6.4.15 Staff that are involved in a patient safety incident are kept informed and supported during the review process.

6.4.16 Staff are provided with access to psychological support following an adverse outcome or patient safety incident.

What this means for you as a woman using maternity services:

- The people who work in the maternity service are supported by those in charge to provide a safe, high-quality service.
- Maternity service providers listen to the views and feedback of staff and use this information to improve your service.
- Staff are supported to speak freely about areas that they are concerned about.

Theme 7
Use of Resources

Theme 7
Use of Resources

How a maternity service uses its available resources impacts on the safety and quality of the care it provides. These finite resources include human, physical, financial and natural resources.

Safe, high-quality care is intrinsically linked to the use of resources, including how they are planned, managed and delivered. The effective, responsible stewardship of resources, including decisions on how they are allocated, is a fundamental factor in delivering safe, high-quality care.

In order to effectively plan, manage, design and deliver services it is first necessary for a maternity service to determine the current and future needs of the population. This information is crucial in deciding how resources are to be used and what resources are required in the future to continue to meet the needs of the population. Service providers need to regularly review whether the needs of a population are being met in order to determine if resources can be used more effectively or to identify if additional resources are required.

The way resources are used affects the safety, quality and sustainability of maternity services. The decisions and choices made by those responsible for resources must be informed and accountable. A well-run maternity service knows how it is using resources and needs to be able to access up-to-date evidence about cost-effectiveness to inform its resource decisions. Each maternity care pathway as outlined in the National Maternity Strategy has core components, each of which has specific resource requirements. Each maternity unit and maternity hospital manages and reviews its use of resources to determine its capacity to continue to deliver its specified care pathways safely and effectively.

The maternity service must maintain the quality of the care it provides while striving for greater efficiency with finite resources. Decisions about the deployment of resources take account of the needs of the other components of the maternity service. The way these decisions are made must be transparent and the rationale for these decisions presented to women, their partners and families, the public and staff in a way that they can understand.

Standard 7.1

Maternity service providers plan and manage the use of available resources to deliver safe, high-quality maternity care efficiently and sustainably.

Features of a maternity service meeting this standard are likely to include the following:

7.1.1 Services work within their maternity network structures and the network's available resources to ensure that they have adequate staffing levels, facilities, expertise and capacity to deliver safe, high-quality care, based on their service requirements.

7.1.2 Arrangements are in place for services to escalate resourcing issues within the maternity network where they pose a risk to the safety and quality of care of women and babies using the service.

7.1.3 Service providers allocate available resources, including staff, to provide safe high-quality care to women and their babies.

7.1.4 Arrangements are in place to manage financial performance and evaluate its impact on the safety and quality of services, in particular any deterioration in performance.

7.1.5 Service providers report on financial performance in line with legislation and government policy.

7.1.6 Resource decisions are informed by:

- explicit consideration of the safety, quality and ethical implications of such decisions
- risk assessment of the decisions
- best available evidence
- the assessed needs of the population served
- the views of staff and women using the service, for example through surveys and Maternity Service Liaison Committees.

7.1.7 Service providers procure external goods and services that achieve the best possible safety and quality outcomes for women and their babies for the money and resources used. Procurement is in line with national policy.

7.1.8 Service providers maintain medical devices and equipment in line with manufacturing requirements, such that they remain fit for purpose in line with national policy.

7.1.9 Service providers undertake a risk assessment of both ultrasound equipment and image quality at five-year intervals, or sooner if indicated.

What this means for you as a woman using maternity services:

- Maternity services make the best use of their available resources.
- All people working in maternity services use resources responsibly.
- Maternity services regularly check that they use their available resources to get the best possible results for the women and babies using their services.
- The decisions on how maternity services use their money are informed by the views of women using the services.

Theme 8
Use of Information

Theme 8
Use of Information

Quality information is an important resource for maternity service providers in planning, managing, delivering and monitoring safe, high-quality services. Quality information is accurate, valid, reliable, timely, relevant, legible and complete.

There are multiple sources of information including national and international evidence, healthcare records, audit findings, and feedback from women using maternity services. Using the available data on an ongoing basis is a straightforward and useful way for maternity services to monitor trends; this ensures that areas of possible concern for the service can be identified early and actions can be taken as required.

In order to accurately benchmark against other services nationally and internationally, it is important to use standardized definitions where they are available and to report data consistently in line with national reporting requirements.

To effectively use information, service providers have systems — including information and communications technology — to make sure the collection and reporting of high-quality information takes place within the context of effective arrangements for information governance.

Information governance provides a framework to bring together all the legislation, guidance and best available evidence that applies to the handling of information. It provides a consistent way for the workforce to deal with the many different legislative provisions, guidelines and professional codes of conduct that apply to handling information.

An information governance framework enables services and individuals to ensure all information, including personal information, is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of person-centred, safe, high-quality care and helps ensure that when sharing information across services, service providers protect and manage personal information in a sensitive and responsible manner.

Personal healthcare information of women and babies informs all aspects of their care. It is essential that personal information is treated in a confidential manner and that service providers have arrangements in place to make sure that this happens. The ability to identify an individual uniquely is important for safe effective care; therefore, service providers should have arrangements in place to uniquely identify each woman and her baby using their services.

Standard 8.1

Maternity service providers use information as a resource in planning, delivering, managing and improving the safety and quality of maternity care.

Features of a maternity service meeting this standard are likely to include the following:

8.1.1 Service providers have arrangements in place to collect information on the current and anticipated needs of the service and the population served, for example, ethnicity data (inclusive of the Travelling community of Ireland) and changes in the numbers of women using the service within a maternity network, to support effective decision-making. This information is used to plan, design, manage and deliver services.

8.1.2 Arrangements are in place to collect and manage accessible high-quality information[36] to support effective decision-making, for example, through collection and use of nationally agreed metrics. The effectiveness of these arrangements are regularly reviewed and steps are taken to address any areas identified for improvement.

8.1.3 High-quality information is used to support and inform decision-making in relation to the use of human, physical, natural and financial resources.

8.1.4 Arrangements are in place to ensure that healthcare professionals have access to high-quality information, including best available evidence to support and inform effective clinical practice.

8.1.5 Arrangements are in place to evaluate and manage the safety and quality of services provided through clinical audit and the use of key performance indicators to monitor trends.

8.1.6 Where information is reported either through the service's governance structures or outside the service, arrangements are in place to ensure feedback is given to staff in a timely manner and appropriate action is taken as necessary.

[36] To be most effective, the right data needs to be available to decision makers in an accessible format at the point of decision making. The quality of data can be determined through assessment against seven internationally accepted dimensions. High-quality data means data that is accurate, complete, legible, relevant, reliable, timely and valid.

8.1.7 Arrangements are in place to ensure necessary information is shared in a timely manner within and between services, in line with legislation, national standards and national guidance.

8.1.8 Information systems, whether electronic or paper-based, are integrated, and they interface with other systems to support the delivery of safe, high-quality care.

8.1.9 Reporting requirements, for example, to national data collections, are met in a timely manner through the use of consistent datasets and standardized definitions.

8.1.10 Surveys are used to measure the experience of both women and their families and staff to determine how the service is operating in practice. Women and their families and staff have the option to submit surveys without identifying themselves if they so wish.

8.1.11 Recommendations arising from investigations and reviews are communicated and shared with relevant service providers and used to inform quality improvement programmes.

What this means for you as a woman using maternity services:

- Healthcare professionals have access to, and use, good quality information when making decisions about the service.
- Your maternity service learns from the information it collects to improve the safety and quality of your care and the care of your baby.
- Your maternity service uses relevant quality information to continually check the safety and quality of the care provided.

Standard 8.2

Maternity service providers have effective arrangements for information governance.

Features of a maternity service meeting this standard are likely to include the following:

8.2.1 Arrangements are in place for information governance to ensure services are complying with legislation, using information ethically and using best available evidence, including national guidance if available, to protect service users' information.

8.2.2 Training in information governance for all staff is in line with their level of access to personal health information and facilitates them to fulfil their roles and responsibilities for information governance.

8.2.3 Information is collected, processed, used and shared, while respecting the privacy and confidentiality of the women and babies to whom it relates.

8.2.4 All data is collected, analyzed, used and shared in line with national standards, national guidance or nationally agreed definitions, to allow the comparing and sharing of information.

8.2.5 Nationally agreed data is collected, and reported as appropriate, in a consistent, timely and comprehensive manner using standardized definitions.

8.2.6 Arrangements are in place to ensure that information is of a high quality.

8.2.7 Service providers evaluate, validate and report on the quality of information to support the provision of safe, high-quality care.

8.2.8 Arrangements are in place for sharing information within and between service providers that protects the security, privacy and confidentiality of personal health information.

8.2.9 Personal health information, both paper and electronic, is held securely and protected from unauthorized access.

8.2.10 Where e-Health records are used, they are contemporaneous, accurate, relevant and accessible to all service providers.

8.2.11 Arrangements are in place for women to access a copy of their healthcare record, on request, and to have factually inaccurate information corrected in line with legislation.

8.2.12 The use of information, both to support providing safe, high-quality care and for secondary purposes, for example research, is in line with legislation, national standards and guidelines.

What this means for you as a woman using maternity services:

- Your rights to privacy and confidentiality of your information are respected.
- Your information is only shared with others who are involved in your maternity care and following discussion with you, where this is possible.
- Your information is stored securely to prevent it from being accessed by people who do not need to see it.
- You can request and obtain a copy of your healthcare record, in line with legislation.
- Your personal information is not used for other purposes, such as research, without your permission.

Standard 8.3

Maternity service providers have effective arrangements for the management of healthcare records.

Features of a maternity service meeting this standard are likely to include the following:

8.3.1 Management of healthcare records is in line with legislation, national policies, national health information standards and guidance, and nationally agreed definitions, where these exist. This includes arrangements for the creation, use, storage and disposal of personal health information.

8.3.2 Arrangements are in place to make sure women, their babies and their records are identified uniquely to avoid duplication and misidentification.

8.3.3 Service providers evaluate the effectiveness of the service's records management practices and systems, and, where necessary, take action to address areas for improvement.

8.3.4 Healthcare professionals keep structured and accurate records, including records of observations made, care given, and any medicines administered to a woman or baby.

8.3.5 All information including a plan of care, clinical observations, diagnostic tests and progress notes are followed up, acted on and this is contemporaneously recorded by the relevant healthcare professional in an agreed format within an agreed health record.

8.3.6 A parent-held child health record[37] is given to parents as soon as possible after birth and its use is explained. The record includes immunizations, growth monitoring and developmental checks.

[37] Parent-held child health records will be rolled out over the next two to three years as part of the Nurture Programme – Infant Health and Wellbeing.

8.3.7 A system is in place to ensure that information about women and their babies is collated and transferred between services in a reliable, timely and secure manner.

8.3.8 Services comply with health information technical standards, to facilitate the interoperability of systems and sharing of information.

What this means for you as a woman using maternity services:

- Your healthcare record and your baby's healthcare record are stored securely and kept up-to-date.
- Information about you and your baby is recorded accurately.
- You are given a parent-held child health record that is completed by healthcare professionals to monitor your baby's growth and development and record immunizations.
- Information is shared with the relevant healthcare professionals in a timely manner as you or your baby move between services.

Glossary of terms and abbreviations

Abuse: a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to a person or violates their rights.

Accountability: being answerable to another person or organization for decisions, behaviour and any consequences.

Adverse outcome: an unfavourable or harmful consequence.

Advocacy: the practice of an individual acting independently of the service provider on behalf of, and in the interests of, a service user who may feel unable to represent themselves.

Alongside birth centre: an alongside birth centre is a birth centre situated in the immediate vicinity of a specialized birth centre.

Anaesthetist: a medical specialist who administers an anaesthetic to a patient before a medical procedure or surgery.

Antenatal anomaly screening: this includes first trimester screening and detailed fetal assessment ultrasound from 20 – 22 weeks' gestation.

Antenatal booking appointment: an appointment at which women are initially triaged to a maternity care pathway.

Antenatal care: care provided to a pregnant woman during her pregnancy.

Audit: the assessment of performance against any standards and criteria (clinical and non-clinical) in a health or social care service.

Autonomy: autonomy relates to being human and worthy of respect. In a practical sense, it is the ability of an individual to direct how they live on a day-to-day basis according to personal values, beliefs and preferences. In health and social care, this involves the person who uses services making informed decisions about the care, support or treatment that they receive. The ability to be autonomous, and make decisions can be supported and developed.

Best available evidence: the consistent and systematic identification, analysis and selection of data and information to evaluate options and make decisions in relation to a specific question.

Beta-human chorionic gonadotrophin test: this test measures the level of pregnancy hormone in a woman's blood.

Caesarean section: a surgical procedure used to deliver a baby through incisions created in the mother's abdomen and uterus.

Cardiotocography (CTG): an electronic means of recording the fetal heart beat and the uterine contractions during pregnancy. A cardiotocograph machine produces a trace known as a cardiotocography which illustrates the fetal heart rate and uterine activity.

Care bundles: a number of related evidence-based interventions, which when followed consistently for every patient each time care is delivered, result in improved outcomes for patients.

Care pathway: a multidisciplinary care plan that outlines the main clinical interventions undertaken by different healthcare professionals in the care of women or their babies with a specific condition or set of symptoms.

Casemix: the types of patients and complexity of their condition treated within a maternity service, including diagnosis, treatments given and resources required for care.

Child protection: the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Clinical audit: a process to improve patient care and outcomes involving a documented, structured and systematic review and evaluation against clinical standards of clinical care, and, where necessary, actions to improve clinical care. Clinical audit is carried out by or on behalf of or in association with one or more health services providers.

Clinical director: the primary role of a clinical director is to manage and plan how services are delivered and contribute to the process of strategic planning, influencing and responding to organizational priorities. The clinical director occupies the lead management role within the directorate. Each member of staff has a reporting relationship, through their line manager, to the clinical director.

Clinical governance: a system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This includes mechanisms for monitoring clinical quality and safety through structured programmes, for example, clinical audit.

Clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

Clinical midwife manager (CMM): this refers to midwives who undertake first- line midwife management posts with responsibility for professional leadership, staffing and staff development, resource management and facilitating communication. There are three grades of first-line midwife management: CMM1, CMM2 and CMM3.

Co-decision maker: a person chooses a person to jointly make one or more decision on personal welfare or property and affairs. The person should be a relative or friend of the appointer who has had such personal contact over such period of time that a relationship of trust exists between them. The co-decision-maker will get the information needed to make a decision, advise on decisions and make decisions together with the appointer based on their will and preferences. The co-decision maker will help the person express a decision and ensure that the decisions are implemented.

Code of conduct: a description of the values, principles and expected behaviours of individuals and teams working within a service.

Competence: the knowledge, skills, abilities, behaviours and expertise sufficient to be able to perform a particular task and activity.

Complaint: an expression of dissatisfaction with any aspects of service provision.

Concern: a safety or quality issue regarding any aspect of the provision of maternity services raised by a woman or her family, service provider, member of the workforce or general public.

Confidentiality: the right of individuals to keep information about themselves from being disclosed.

Congenital fetal anomaly: a structural or functional anomaly that occurs during intrauterine life and can be identified antenatally, at birth or later in life (as defined by the World Health Organization).

Core working hours: the hours when a department or area is fully functional. This has been historically classified as the working hours of 9am to 5pm, Monday to Friday.

Corporate governance: the system by which the service directs and controls its functions in order to achieve organizational objectives, manage business processes, meet required standards of accountability, integrity and propriety and relate to external stakeholders.

Credentials: evidence or proof of an individual's qualification, competence or authority.

Culture: the shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.

Data quality: this refers to data that is 'fit for purpose' or 'fit for use'. Quality data is accurate, valid, reliable, timely, relevant, legible and complete.

Dignity: the right to be treated with respect, courtesy and consideration.

Domestic violence: the use of physical or emotional force, or the threat of physical force in close adult relationships. It can also include emotional abuse, the destruction of property, isolation from friends, family and other sources of support, threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone.

Effective: a measure of the extent to which a specific intervention, procedure, treatment, or service, when delivered, does what it is intended to do for a specific population.

Efficient: use of resources to achieve best results with minimal waste.

Ectopic pregnancy: a pregnancy in which the fetus develops outside the womb, typically in a fallopian tube.

Early pregnancy assessment unit: Maternity units and hospitals have an early pregnancy assessment unit, with suitable ultrasound equipment and facilities for 'same-day' beta-hCG testing, run by appropriately trained healthcare professionals.

Family: those closest to the patient in knowledge, care and affection and who are connected through their common biological, legal, cultural, and emotional history.

Features: these, when taken together, will enable progress towards achieving the standard.

First trimester: the time period extending from the first day of the last menstrual period through 12 weeks of pregnancy.

First trimester screening: this screening provides parents with an accurate assessment of the chances that their baby may be affected by Down syndrome or other chromosomal abnormalities.

Harm: impairment of structure or function of the body and or any detrimental effect arising from this, including disease, injury, suffering, disability and death. Harm may be physical, social or psychological.

Health: the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

Health information: any information relating to an individual that is collected for or in connection with the provision of a health or social care service.

Healthcare professionals: a person who exercises skill or judgment in diagnosing, treating or caring for women and their babies and preserving or improving their health. For the purpose of this document, the term includes midwives, nurses, doctors and health and social care professionals as defined in the Health and Social Care Professionals Act 2005.

Histology: the study of the microscopic structures of tissues.

HIQA: the Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland.

Infant feeding: infant feeding includes breastfeeding and formula feeding.

Informed consent: the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable them to understand the nature, potential risks and benefits of the proposed intervention or service.

Integrated care: healthcare services working together, both internally and externally to ensure service users receive coordinated care.

Interpreter: a person who facilitates communication between users of different languages by use of oral translation or sign language methods, either simultaneously or consecutively.

Irish Maternity Early Warning System: a system for the early detection of illness during pregnancy and after a woman has had a baby.

Just culture: a just culture seeks to balance the need to learn from mistakes and the need to take disciplinary action.

Key performance indicator: specific and measurable elements of practice that can be used to assess quality and safety of care.

Lactation consultant: an International Board Certified Lactation Consultant (IBCLC) is a healthcare professional with specialist knowledge and clinical expertise in breastfeeding and human lactation. IBCLCs are certified by the International Board of Lactation Consultant Examiners, Inc. (www.iblce.org).

Locum: a healthcare professional with the required competencies who is employed to temporarily cover the duties of another healthcare professional who is on leave.

Maternity and Infant Care Scheme: every woman who is pregnant and ordinarily resident in Ireland is entitled to maternity care under the Maternity and Infant Scheme. Ordinarily resident means you are living here, or you intend to remain living here for at least one year. The Maternity and Infant Care Scheme provides an agreed programme of care to all expectant mothers who are ordinarily resident in Ireland.

Maternity care: care for women from when they first look for care before and during pregnancy through to labour and birth and includes the care of the woman and her baby after birth.

Maternity care assistant: healthcare assistants, trained to level 5 FETAC, with specific skills applicable to maternity care.

Maternity network: the system whereby maternity units and maternity hospitals are interconnected within hospital groups.

Maternity Patient Safety Statement: this contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents. It is published monthly and forms part of clinical governance arrangements.

Maternity service: any location where maternity care is provided to women and their babies from pre-pregnancy up to six weeks post-birth. This includes care of the neonate up to six weeks after birth.

Maternity service provider: any person, organization or part of an organization delivering maternity services.

Maternity unit and maternity hospital: this term includes both maternity units and hospitals that provide maternity care to women and their babies either in a maternity unit situated in a general hospital or in a stand-alone maternity hospital. Alongside birth centres and specialized birth centres are situated within maternity units and maternity hospitals.

Midwife: a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located; who has acquired the requisite qualifications to be registered and or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

Miscarriage: the loss of a baby before viability. A miscarriage may occur during the first trimester (early miscarriage) or during the second trimester (late miscarriage).

Mother and baby unit: a specialist psychiatric unit where a mother with a mental illness is admitted with her baby and supported to care for her baby whilst having the care and treatment she needs.

Multidisciplinary: an approach to the planning of treatment and the delivery of care for a service user by a team of healthcare professionals who work together to provide integrated care.

National Clinical Effectiveness Committee: the National Clinical Effectiveness Committee is a Ministerial committee established as part of the Patient Safety First initiative. Its role is to prioritize and quality assure National Clinical Guidelines and National Clinical Audit so as to recommend them to the Minister of Health to become part of a suite of National Clinical Guidelines and National Clinical Audit. The National Clinical Guidelines are quality assured by the NCEC and endorsed by the Minister for Health for implementation in the Irish Health system.

Needs assessment: systematic identification of the needs of an individual or population to determine the appropriate level of care or services required.

Neonatal death: the death of a baby occurring within 28 completed days of birth.

Neonatologist: a doctor who has specialized in neonatology.

Neonatology: a sub-speciality of paediatrics which relates to the medical care of newborn babies.

Non-consultant hospital doctor: doctors that have not yet reached hospital consultant grade. Non-consultant hospital doctors include specialist registrars, registrars, senior house officers and interns.

Obstetrician: a doctor who has specialized in obstetrics.

Obstetrics: the branch of medicine concerned with pregnancy and childbirth.

On call: the provision or availability of clinical advice in addition to or outside of core working hours.

Open disclosure: a comprehensive and clear discussion of an incident that resulted or may have resulted in harm to a service user while receiving care. Open disclosure is an ongoing communication process with service users and their families or advocates following a patient safety incident.

Paediatrician: a doctor who has specialized in paediatrics.

Paediatrics: the branch of medicine concerned with the treatment of infants and children.

Pathologist: a specialist in pathology.

Pathology: a branch of medical science primarily concerning the examination of organs, tissues and bodily fluids in order to make a diagnosis of disease.

Patient safety incident: as defined in the Health Information and Patient Safety Bill Revised General Scheme (2015) a 'patient safety incident' means:

a) any unintended or unanticipated injury or harm to a service user that occurred during the provision of a health service,

b) an event that occurred when providing a health service to a service user that did not result in actual injury or harm but there are reasonable grounds to believe that the event concerned placed the service user at risk of unintended or unanticipated injury or harm,

c) an incident that was prevented from occurring due to timely intervention or chance and which there are reasonable grounds for believing could have resulted, if it had not been so prevented, in unintended or unanticipated injury or harm to a service user during the provision of a health service to that service user.

Perinatal death: the death of a baby in the weeks before birth or up to four weeks after birth. This includes stillbirths and neonatal deaths.

Placenta: vascular tissue in which oxygen and nutrients can pass from blood of a mother into that of the fetus. Waste products can pass the other way.

Placental histology: study of the microscopic structures of the placenta.

Policy: a written operational statement of intent which helps staff make appropriate decisions and take actions, consistent with the aims of the service provider and in the best interest of women and their babies.

Post-mortem: an examination of a dead body to find out the reason for the death.

Post-mortem histology: the study of the microscopic structures of the organs examined at a post-mortem.

Postnatal care: care provided to a mother and baby in the first six weeks after birth.

Pregnancy loss: all types of loss, including spontaneous and medically supervised terminations that occur during a pregnancy from the first to third trimester.

Quality information: data that has been processed or analyzed to produce something useful. Quality information is accurate, valid, reliable, timely, relevant, legible and complete.

Regulation: a sustained and focused control exercised by a public agency over activities that are valued by a community.

Retro transfer: the facilitation of the transfer of stable infants from tertiary neonatal units back to local or regional units.

Risk: the likelihood of a patient safety incident or adverse outcome.

Risk management: the systematic identification, evaluation and management of risk. It is a continuous process with the aim of reducing risk to an organization and individuals.

Second trimester: the time extending from the 13th to the 27th week of pregnancy.

Second victim: a healthcare professional involved in an unanticipated adverse patient event, medical error and or a patient-related injury who becomes victimized through the trauma of the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patient. They often second-guess their clinical skills and knowledge base.

Serious incident: an incident that results in death or serious harm.

Severe maternal morbidity: a pregnant or recently-pregnant woman who experienced severe complications such as major obstetric haemorrhage, uterine rupture, peripartum hysterectomy, eclampsia, renal or liver dysfunction, pulmonary oedema, acute respiratory dysfunction, pulmonary embolism, cardiac arrest, coma, cerebrovascular event, status epilepticus, septicaemic shock, anaesthetic complications, admission to an intensive care or coronary care unit, interventional radiology or other severe morbidity.

Shared decision-making: information exchange is a two-way process in the consultation. Deliberation and decision are made by both the healthcare professional and patient.

Skill-mix: the combination of competencies including skills needed in the workforce to accomplish the specific tasks or perform the given functions required for safe, high-quality care.

Specialized birth centre: a specialized birth centre is a delivery suite in an Irish maternity unit or maternity hospital.

Staff: the people who work in a maternity service, including but not limited to healthcare professionals, maternity care assistants, laboratory staff, administrative staff, catering staff, cleaning staff, security staff and portering staff.

Stakeholder: an informed or interested party or person, group or organization that affects or can be affected by the actions of, or has an interest in, the services provided.

Standard: in the context of this document, a standard is a statement which describes the high-level outcome required to contribute to quality and safety.

Statement of purpose: a description of the aims and objectives of a service, including how resources are aligned to deliver these objectives. It also describes in detail the range, availability and scope of services provided by the overall service.

Stillbirth: a child weighing 500 grams or more, or having a gestational age of 24 weeks or more who shows no sign of life (Stillbirths Registration Act 1994).

Termination of pregnancy: a medically directed miscarriage, using pharmacological or surgical means, prior to independent viability.

Third trimester: the time period extending from the 28th week of pregnancy until the birth of the baby.

Tissue viability management: the prevention and management of all aspects of skin and soft tissue wounds.

Tusla, or the Child and Family Agency: the dedicated State agency responsible for improving wellbeing and outcomes for children.

Ultrasound: a procedure in which high-energy sound waves are bounced off internal tissues or organs and make echoes. The echo patterns are shown on the screen of an ultrasound machine, forming a picture of body tissues called a sonogram.

VBAC: vaginal birth after caesarean section.

Workforce: the people who work in, for or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or anyone who is responsible or accountable to the organization when providing a service to the service user.

Resources

Acharya G. Pragmatism, dynamism and flexibility in research and clinical practice. *Acta Obstetricia et Gynecologica Scandinavica.* 2015; 94(4): pp.345-6. Allan C, Carrick-Sen D, Martin CR. What is perinatal well-being? A concept analysis and review of the literature. *Journal of Reproductive and Infant Psychology.* 2013; 31(4): pp.381-98.

Andreatta P, Frankel J, Smith SB, Bullough A, Marzano D. Interdisciplinary team training identifies discrepancies in institutional policies and practices. *American Journal of Obstetrics and Gynecology.* 2011; 205(4): pp.298-301.

Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association. *OAA/AGBI Guidelines for Obstetric Anaesthetic Services 2013*.

Baby Friendly Health Initiative in Ireland. *Overview of the Baby Friendly Health Initiative in Ireland* [Online]. Available from: http://www.babyfriendly.ie/images/Overview%20of%20the%20Baby%20Friendly%20Health%20Initiative%20in%20Ireland%20Aug%202015.pdf. Accessed on: 22 October 2015.

Bains S, Rowe H, Wilby KJ. Pharmacists and maternal-fetal medicine:development of a tool to characterize knowledge and current clinical practice. The *Journal of Maternal-Fetal & Neonatal Medicine.* 2013; 27(7): pp.753-5.

Barker, DJ. Sir Richard Doll Lecture. Developmental origins of chronic disease. *Public Health.* 2012; 126(3); pp.185-9.

Barker L, Field D. Neonatal quality measures: time to show developmental progress? *Archives of Disease in Childhood-Fetal and Neonatal Edition.* 2014; 99(6); F505-9.

Boulkedid R, Sibony O, Goffinet F, Fauconnier A, Branger B, Alberti C. Quality indicators for continuous monitoring to improve maternal and infant health in maternity departments: a modified Delphi survey of an international multidisciplinary panel. PLOS ONE. 2013; 8(4): p.e60663.

Boylan, P. A *Review of 28 Maternity Case Notes by a Clinical Review Team Undertaken at the Request of the Health Service Executive.* Dublin: Health Service Executive; 2015.

Brier N. Grief following miscarriage: a comprehensive review of the literature. *Journal of Women's Health.* 2008; 17(3): pp.451-64.

Catling-Paull C, Johnston R, Ryan C, Foureur MJ, Homer CS. Non-clinical interventions that increase the uptake and success of vaginal birth after caesarean section: a systematic review. *Journal of Advanced Nursing.* 2011; 67(8): pp.1662-76.

Chakravarty E, Clowse ME, Pushparajah DS, Mertens S, Gordon C. Family planning and pregnancy issues for women with systemic inflammatory diseases: patient and physician perspectives. *British Medical Journal Open.* 2014; 4(2): p.e004081.

Children First Act. Dublin: The Stationery Office, Dublin; 2015.

Cleminson J, Oddie S, Renfrew MJ, McGuire W. Being baby friendly: evidence based breastfeeding support. *Archives of Disease in Childhood-Fetal and Neonatal Edition.* 2015; 100(2): p.F173-F178.

College of Anaesthetists of Ireland and the National Clinical Programme in Anaesthesia. *Providing Quality, Safe and Comprehensive Anaesthesia Services in Ireland - A Review of Manpower Challenges.* Dublin: Health Service Executive; 2014.

Confidential Maternal Death Enquiry in Ireland. *Report for Triennium 2009-2011*, Cork: Maternal Death Enquiry; 2012.

Cook E, Avery M, Frisvold M. Formulating Evidence-Based Guidelines for Certified Nurse-Midwives and Certified Midwives Attending Home Births. *Journal of Midwifery & Women's Health.* 2014; 59(2): pp.153-9.

Cooper S, Cant R, Porter J, Bogossian F, McKenna L, Brady S, et al. Simulation based learning in midwifery education: a systematic review. *Women and Birth.* 2012; 25(2): pp.64-7.

Corcoran P, Manning E, Meaney S, Greene RA, on behalf of the Maternal Morbidity Advisory Group. Severe maternal morbidity in Ireland annual report 2012 and 2013. Cork: National Perinatal Epidemiology Centre, 2015.

Correa-Velez I, Ryan J. Developing a best practice model of refugee maternity care. *Women and Birth.* 2012; 25(1): pp.13-22.

Crenshaw J. Healthy Practice #6: Keeping mother and baby together – it's best for mother, baby, and breastfeeding. *Journal of Perinatal Education.* 2014 Fall; 23(4): pp. 211-217.

Daemers DO, Wijnen HA, van Limbeek EB, Bude LM, de Vries RG. Patterns of gestational weight gain in healthy, low-risk pregnant women without co-morbidities. *Midwifery.* 2013; 29(5): pp.535-41.

Darwin Z, McGowan L, Edozien LC. Identification of women at risk of depression in pregnancy: using women's accounts to understand the poor specificity of the Whooley and Arroll case finding questions in clinical practice. *Archives of Women's Mental Health.* 2016; 19(1); pp. 41-9.

Department of Children and Youth Affairs. *Children First: National Guidance for the Protection and Welfare of Children.* Dublin: Department of Children and Youth Affairs; 2011.

Department of Health. *Creating a Better Future Together: National Maternity Strategy 2016 - 2026*. Dublin: Department of Health; 2016.

Department of Health. Healthy Ireland – *A Framework for Improved Health and Wellbeing 2013 – 2025. Dublin: Department of Health;* 2013.Department of Health.

Department of Health. *HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) - Report to the Minister for Health Dr James Reilly TD from Dr Tony Holohan Chief Medical Officer.* Dublin: Department of Health; 2014.

Department of Health. Health Information and Patient Safety Bill: Revised General Scheme. Dublin: Department of Health. 2015; pp 1-129.

Department of Health, UK. *Maternity Matters: Choice, access and continuity of care in a safe service.* UK: Department of Health; 2007.

Department of Health, UK. *National Guidelines for Maternity Services Liaison Committees (MSLCs)*. UK: Department of Health; 2006.

EHealth Ireland. *Maternal & Newborn Clinical Management System (MN-CMS)*. Available from: http://www.ehealthireland.ie/Strategic-Programmes/MNCMS/. Accessed on: 26 January 2016.

European Board and College of Obstetrics and Gynaecology Standards. Standards of Care for Women's Health in Europe: Obstetric and Neonatal Services. European Board and College of Obstetrics and Gynaecology Standards; 2013.

Flenady V, Macphail J, New K, Devenish-Meares P, Smith J. Implementation of a clinical practice guideline for smoking cessation in a public antenatal care setting. *Australian and New Zealand Journal of Obstetrics and Gynaecology.* 2008; 48(6): pp.552-8.

Flenady V, Middleton P, Smith GC, Duke W, Erwich JJ, Khong TY et al; Lancet's Stillbirths Series steering committee. *Stillbirths: the way forward in high-income countries.* Lancet. 2011; 377(9778): pp.753-5.

Flory D. A *Review of the Governance of Maternity Services at Cavan/Monaghan Hospital.* Dublin: Health Service Executive; 2015.

Goodman SH, Dimidjian S. The developmental psychopathology of perinatal depression: implications for psychosocial treatment development and delivery in pregnancy. *Canadian Journal of Psychiatry.* 2012; 57(9): pp.530-6.

Graham ID, Carroli G, Davies C, Medves JM. Episiotomy rates around the world: an update. *Birth.* 2005; 32(3): pp.219-23.

Green JM. Integrating women's views into maternity care research and practice. *Birth.* 2012; 39(4): pp.291-5.

Guidelines and Audit Implementation Network, Northern Ireland. *Guidelines for Admission to Midwife-Led Units in Northern Ireland and Northern Ireland Normal Labour and Birth Care Pathway.* Belfast; Guidelines and Audit Implementation Network; 2016.

Gulmezoglu AM, Langer A, Piaggio G, Lumbiganon P, Villar J, Grimshaw J. Cluster randomised trial of an active, multifaceted educational intervention based on the WHO Reproductive Health Library to improve obstetric practices. BJOG: *An International Journal of Obstetrics & Gynaecology.* 2007; 114(1): pp.16-23.

Hankey CR. Obesity and maternal weight gain. *Current Obesity Reports.* 2015; 4(1): pp.60-4.

Harding Clark, M. *The Lourdes Hospital Inquiry: An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda.* Dublin: The Stationery Office; 2006.

Haugen M, Brantsaeter AL, Winkvist A, Lissner L, Alexander J, Oftedal B, et al. Associations of pre-pregnancy body mass index and gestational weight gain with pregnancy outcome and postpartum weight retention: a prospective observational cohort study. *BioMed Central Pregnancy and Childbirth.* 2014; 14(1): p.201.

Health Act. Dublin: The Stationery Office, Dublin; 2007.

Health Information and Quality Authority. *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 and as reflected in the care and treatment provided to Savita Halappanavar.* Dublin: Health Information and Quality Authority; 2013.

Health Information and Quality Authority. *National Standards for Residential Services for Children and Adults with Disabilities.* Dublin: Health Information and Quality Authority; 2013.

Health Information and Quality Authority. *National Standards for Safer Better Healthcare.* Dublin: Health Information and Quality Authority; 2012.

Health Information and Quality Authority. *Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission.* Dublin: Health Information and Quality Authority; 2012.

Health Information and Quality Authority. *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.* Dublin: Health Information and Quality Authority; 2015.

Health Service Executive. *Breastfeeding Policy for Primary Care Teams and Community Healthcare Settings.* Dublin: Health Service Executive; 2016.

Health Service Executive. Chickenpox (varicella) vaccination. [Online]. Available from: https://www.hse.ie/eng/health/az/C/Chickenpox-varicella-vaccination/. Accessed on: 18 April 2016.

Health Service Executive. *Final Report of the investigation of Incident 50278, from the time of the patient's self referral to hospital on the 21st of October 2012, to the patient's death on the 28th of October, 2012.* Dublin: Health Service Executive; 2012.

Health Service Executive. *Guidelines for the Systems Analysis Investigation of Incidents.* Dublin: Health Service Executive; 2015.

Health Service Executive. *HSE Standards and Recommended Practice for Healthcare Records Management V3.0.* Dublin: Health Service Executive; 2011.

Health Service Executive. *Infant feeding policy for maternity and neonatal services. National Breastfeeding Strategic Implementation Monitoring Committee Health Promotion.* Dublin: Health Service Executive; 2012.

Health Service Executive. *Medical Devices/Equipment Management Policy (Incorporating the Medical Devices Management Standard).* Dublin: Health Service Executive; 2009.

Health Service Executive. *Midland Hospital Portlaoise Systems Analysis Review Report: Review of Care of Shauna Keyes.* Dublin: Health Service Executive; 2016.

Health Service Executive. *National Consent Policy.* Dublin: Health Service Executive; 2014.

Health Service Executive. *National Healthcare Charter – You and Your Health Service.* Dublin: Health Service Executive; 2016. [Online]. Available from: http://www.hse.ie/eng/services/yourhealthservice/hcharter/. Accessed on: 08 June 2016.

Health Service Executive. *National Miscarriage Misdiagnosis Review.* Dublin: Health Service Executive; 2011.

Health Service Executive. *Procurement Policy.* Dublin. Health Service Executive; 2006.

Health Service Executive. *Report in to the circumstances pertaining to the death of Mrs Tania McCabe and her infant son Zach at Our Lady of Lourdes Hospital, Drogheda on Friday 9 March, 2007.* Dublin: Health Service Executive; 2008.

Health Service Executive. *Safety Incident Management Policy.* Dublin: Health Service Executive; 2014.

Health Service Executive. *Standards for Bereavement Care following Pregnancy Loss and Perinatal Death - Draft Document.* Dublin: Health Service Executive; 2015.

Health Service Executive. *Systems Analysis Review into the death of Baby Mark Molloy.* Dublin: Health Service Executive; 2015.

Health Service Executive. *'Your Service, Your Say' HSE Complaints Policy.* Dublin: Health Service Executive; 2015.

Health Service Executive and Department of Health and Children. *An Integrated Workforce Planning Strategy for the Health Services.* Dublin: Health Service Executive and Department of Health and Children; 2009.

Health Service Executive and National Disability Authority. *National Guidelines on Accessible Health and Social Care Services.* Dublin: Health Service Executive and National Disability Authority; 2014.

Health Service Executive and the Crisis Pregnancy Agency. *Guidelines for Health Professionals working in Maternity Settings on the Care of Women with Concealed Pregnancies.* Dublin: Health Service Executive; 2012.

Helms E, Coulson CC, Galvin SL. *Trends in weight gain during pregnancy: a population study across 16 years in North Carolina.* American Journal of Obstetrics and Gynecology. 2006; 194(5): p.e32-e34.

Howard LM, Megnin-Viggars O, Symington I, Pilling S. *Antenatal and postnatal mental health: summary of updated NICE guidance.* British Medical Journal. 2014; 349 p.g7394.

Inclusion Ireland, National Association for People with an Intellectual Disability. *Assisted Decision-Making – What does it mean?* Dublin: Inclusion Ireland; 2016.

Informing Families Of Their Child's Disability. 2016. [Online]. Available on: http://www.informingfamilies.ie/. Accessed on: 07 June 2016.

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Directorate of Quality and Strategy Health Service Executive. *Clinical Practice Guideline: Antenatal Routine Enquiry Regarding Violence in the Home.* Dublin: Health Service Executive; 2012.

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Clinical Strategy and Programmes Directorate, Health Service Executive. *Obesity and Pregnancy Clinical Practice Guideline.* Dublin: Health Service Executive; 2011.

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Clinical Strategy and Programmes Directorate, Health Service Executive. *Delivery after Previous Caesarean Section - Clinical Practice Guideline.* Dublin: Health Service Executive; 2011.

International Code of Marketing of Breast-milk Substitutes. Geneva. World Health Organization; 1981.

Jagerstad M. Folic acid fortification prevents neural tube defects and may also reduce cancer risks. *Acta Paediatrica.* 2012; 101(10): pp.1007-12.

Johnston J, Gusmano MK, Patrizio P. Preterm births, multiples, and fertility treatment: recommendations for changes to policy and clinical practices. *Fertility and Sterility;* 2014; 102(1): pp.36-9.

Johnson O, Lanford RW. Proof of Life: A protocol for pregnant women who experience pre-20-week perinatal loss. *Critical Care Nursing Quarterly.* 2010; 33(3): pp. 204-11.

Keriakos R, Chaudhuri S. Operative interventions in the management of major postpartum haemorrhage. *Journal of Obstetrics & Gynaecology.* 2012; 32(1): pp.14-25.

Kesmodel US, Jolving LR. Measuring and improving quality in obstetrics - the implementation of national indicators in Denmark. *Acta Obstetricia et Gynecologica Scandinavica.* 2011; 90(4): pp.295-304.

Kirkup, B. *The Report of the Morecambe Bay Investigation.* UK: The Stationery Office; 2015.

Knight M, Berg C, Brocklehurst P, Kramer M, Lewis G, Oats J, et al. Amniotic fluid embolism incidence, risk factors and outcomes: a review and recommendations. *BioMed Central Pregnancy and Childbirth.* 2012; 12(1): p.7.

Lewis G. Saving Mothers' Lives: the continuing benefits for maternal health from the United Kingdom (UK) Confidential Enquires into Maternal Deaths. *Seminars in Perinatology*; 2012. pp. 19-26.

Li Y, Townend J, Rowe R, Brocklehurst P, Knight M, Linsell L, et al. Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology.* 2015; 122(5): pp.741-53.

Lindgren H, Kjaergaard H, Olafsdottir OA, Blix E. Praxis and guidelines for planned homebirths in the Nordic countries-an overview. *Sexual & Reproductive Healthcare.* 2014; 5(1): pp.3-8.

Little MO, Lyerly AD, Mitchell LM, Armstrong EM, Harris LH, Kukla R, et al. Mode of Delivery: Toward responsible inclusion of patient preferences. *Obstetrics and Gynecology*. 2008; 112(4): p.913.

Mamun AA, Callaway LK, O'Callaghan MJ, Williams GM, Najman JM, Alati R, et al. Associations of maternal pre-pregnancy obesity and excess pregnancy weight gains with adverse pregnancy outcomes and length of hospital stay. *BMC Pregnancy and Childbirth.* 2011; 11(1): p.62.

Manning E, Corcoran P, Meaney S, Greene RA, on behalf of the Perinatal Mortality Group. Perinatal Mortality in Ireland Annual Report 2013. Cork: National Perinatal Epidemiology Centre; 2015.

Medical Council. *Guide to Professional Conduct and Ethics for Registered Medical Practitioners.* Dublin: Medical Council; 2009.

National Clinical Effectiveness Committee. *Communication (Clinical Handover) in Maternity Services - National Clinical Guideline No. 5.* Dublin: Department of Health; 2014.

National Clinical Effectiveness Committee. *The Irish Maternity Early Warning System (IMEWS) - National Clinical Guideline No. 4.* Dublin: Department of Health; 2014.

National Clinical Effectiveness Committee. *Sepsis Management - National Clinical Guideline No. 6.* Dublin: Department of Health; 2014.

National Clinical Programme for Obstetrics and Gynaecology. *Consultant Workforce Planning 2015 Supplementary Report.* 2015.

National Clinical Programme for Obstetrics and Gynaecology. *Guidelines for the Critically Ill Woman in Obstetrics.* Dublin: Health Service Executive; 2014.

National Clinical Programme for Paediatrics and Neonatology. *Models of Care for Neonatal Services in Ireland.* Dublin: Health Service Executive; 2015.

National Healthy Childhood Programme. Health Service Executive; 2016. [Online]. Available from: https://www.hse.ie/eng/health/child/nurture/healthy_childhood_prog.pdf

National Institute for Health and Care Excellence. *Postnatal care up to 8 weeks after birth.* UK: National Institute for Health and Care Excellence; 2014. (revised)

National Institute for Health and Care Excellence. *Intrapartum Care for Healthy Women and Babies.* UK: National Institute for Health and Care Excellence; 2014.

Nursing and Midwifery Board of Ireland. *Practice Standards for Midwives.* Dublin: Nursing and Midwifery Board of Ireland; 2015.

Nuti S, Bonini A, Murante AM, Vainieri M. *Performance assessment in the maternity pathway in Tuscany region.* Health Services Management Research. 2009; 22(3): pp.115-21.

O'Hare MF, Manning E, O'Herlihy C, Greene RA on behalf of MDE Ireland. *Confidential Maternal Death Enquiry in Ireland, Report for 2009 - 2012*. Cork: MDE Ireland; 2015.

O'Sullivan, C., O'Connell, R. and Devane, D. A Descriptive Survey of the Educational Preparations and Practices of Antenatal Educators in Ireland. *Journal of Perinatal Education.* 2014; 23(4): pp.174-7.

Oxford Dictionaries. Oxford University Press; 2016. [Online]. Available from: http://www.oxforddictionaries.com/

Paschetta E, Berrisford G, Coccia F, Whitmore J, Wood AG, Pretlove S, et al. Perinatal psychiatric disorders: an overview. *American Journal of Obstetrics and Gynecology.* 2014; 210(6): pp.501-9.

Pavee Point Traveller and Roma Centre. *Challenging Barriers and Misconceptions. Roma Maternal Health in Ireland. Roma Seminar Series. Theme Two.* Dublin: Pavee Point; 2014.

Poot EP, Bruijne MC, Wouters MG, Groot CJ, Wagner C. Exploring perinatal shift-to-shift handover communication and process: an observational study. *Journal of Evaluation in Clinical Practice.* 2014; 20(2): pp.166-75.

Robson EJ, Campbell JP, Yentis SM. The value of surveys in obstetric anaesthesia. *International Journal of Obstetric Anesthesia.* 2015; 24(1): pp.46-52.

Rondahl G, Bruhner E, Lindhe J. Heteronormative communication with lesbian families in antenatal care, childbirth and postnatal care. *Journal of Advanced Nursing.* 2009; 65(11): pp.2337-44.

Rothberg BEG, Magriples U, Kershaw TS, Rising SS, Ickovics JR. Gestational weight gainand subsequent postpartum weight loss among young, low-income, ethnic minority women. *American Journal of Obstetrics and Gynecology.* 2011; 204(1): p.52-e1-11.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Standards of Maternity Care in Australia and New Zealand.* Victoria, Australia: RANZCOG Publications; 2014.

Royal College of Obstetricians and Gynaecologists. *Standards for Maternity Care.* London: RCOG Press; 2008.

Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists and Royal College of Paediatrics and Child Health. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* London: RCOG Press; 2007.

Royal College of Physicians of Ireland. *An expert report on how to clinically manage and treat obesity in Ireland: Policy Group on Obesity.* Dublin: Royal College of Physicians of Ireland; 2015.

Royal College of Physicians of Ireland. *The race we don't want to win. Tackling Ireland's obesity epidemic.* Dublin: Royal College of Physicians of Ireland; 2014.

Saastad E, Vangen S, Froen JF. Suboptimal care in stillbirths - a retrospective audit study. *Acta Obstetricia et Gynecologica Scandinavica.* 2007; 86(4): pp.444- 50.

SAFE Ireland. *A Framework, Principles and Standards for Specialist Domestic Violence Services in Ireland. Co. Westmeath: SAFE Ireland;* 2015.

Schneider S, Huy C, Schuetz J, Diehl K. *Smoking cessation during pregnancy: a systematic literature review. Drug and Alcohol Review.* 2010; 29(1): pp.81-90.

Schroeder E, Petrou S, Patel N, Hollowell J, Puddicombe D, Redshaw M, et al. Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study. *British Medical Journal.* 2012; 344

Shoushtarian M, Barnett M, McMahon F, Ferris J. Impact of introducing practical obstetric multi-professional training (PROMPT) into maternity units in Victoria, Australia. *BJOG: An International Journal of Obstetrics and Gynaecology.* 2014; 121(13): pp. 1710-8.

Sinai Talaulikar V, Arulkumaran S. Medico-Legal Issues with CTG interpretation. *Current Women's Health Reviews.* 2013; 9(3): pp.145-57.

Skirton H, Goldsmith L, Jackson L, Lewis C, Chitty L. Offering prenatal diagnostic tests: European guidelines for clinical practice. *European Journal of Human Genetics;* 2014; 22(5): pp.580-6.

State Claims Agency. C*linical Incident and Claims Report in Maternity and Gynaecology Services – A Five Year Review 2010 – 2014*. Dublin: The State Claims Agency; 2015.

Stillbirths Registration Act. Dublin: The Stationery Office, Dublin;1994 Stuart-Parrigon K, Stuart S. *Perinatal Depression: An update and overview. Current Psychiatry Reports*; 2014; 16(9): pp. 1-9.

Sword W, Busser D, Ganann R, McMillan T, Swinton M. Women's *Care-Seeking Experiences After Referral for Postpartum Depression. Qualitative Health Research*; 2008; 18(9): pp.1161-73.

The Nuture Programme - Infant Health and Wellbeing. Dublin. Health Service Executive; 2016.

The Task Force on Violence Against Women. *Report of the Task Force on Violence Against Women.* Dublin: The Stationery Office, Dublin; 1997.

Tobacco Free Ireland. Report of the Tobacco Policy review Group Department of Health. October 2013.

Truong YN, Yee LM, Caughey AB, Cheng YW. Weight gain in pregnancy: does the Institute of Medicine have it right? *American Journal of Obstetrics and Gynecology.* 2015; 212(3): pp.362. e1-8.

Tusla: Child and Family Agency. Dublin: Tusla: Child and Family Agency; 2016. Available at: http://www.tusla.ie/. Accessed on: 09 June 2016.

Wagner B, Meirowitz N, Shah J, Nanda D, Reggio L, Cohen P, et al. Comprehensive perinatal safety to reduce adverse obstetric events. *Journal for Healthcare Quality.* 2012: 34(1): pp. 6-15.

World Health Organization. *Congenital Anomalies Fact sheet No. 370.* [Online]. Available from: http://www.who.int/mediacentre/factsheets/fs370/en/. Accessed on: 23 June 2016.

Wu, A. Medical error: the second victim. *British Medical Journal;* 2000; 320(7237): pp. 726-7.

Zhou S, Rosenthal DG, Sherman S, Zelikoff J, Gordon T, Weitzman M. Physical, behavioral, and cognitive effects of prenatal tobacco and postnatal secondhand smoke exposure. *Current Problems in Pediatric and Adolescent Health Care;* 2014; 44(8): pp. 219-41.

Appendices

Appendix 1

Membership of the Standards Advisory Group convened by HIQA and HIQA Maternity Standards Project Team

Member	Representing
Bernie Conolly	Nursing and Midwifery Board of Ireland
Brigid Doherty	Patient Focus
Dr Caroline Mason Mohan	Health Service Executive (HSE), Department of Public Health
Cita Crefeld	Cuidiú (Caring Support for Parenthood)
Claire O'Regan*	State Claims Agency
Dr Colm O'Herlihy	Medical Council
Cora McCaughan	HSE, Quality Assurance and Verification Division
Professor Declan Devane	Professor of Midwifery, National University of Ireland, Galway
Deirdre Walsh	State Claims Agency
Elaine Fallon	HSE, Quality Improvement Division
Professor Fergal Malone	Royal College of Surgeons in Ireland
Joan Heffernan	Health Information and Quality Authority (HIQA)
Joan Regan	Acute Hospitals Policy Unit, Department of Health
Dr Joanne Fenton	College of Psychiatrists of Ireland

* Claire O'Regan attended one meeting of the Advisory Group in January 2016 and was subsequently replaced by Deirdre Walsh.

Member	Representing
Professor John Murphy	HSE, National Clinical Programme for Paediatrics and Neonatology
Dr Karen Robinson±	State Claims Agency
Dr Kathleen MacLellan	Office of the Chief Medical Officer, Department of Health
Dr Krysia Lynch	Association for Improvement in Maternity Services
Lynsey Kavanagh	Pavee Point Traveller and Roma Centre
Mairie Cregan	Féileacáin (Stillbirth and Neonatal Death Association of Ireland)
Margaret Philbin	Irish Association of Directors of Nursing and Midwifery
Marie Kehoe-O'Sullivan	Health Information and Quality Authority, HIQA (Chair)
Professor Michael Turner	Health Service Executive (HSE), National Clinical Programme for Obstetrics and Gynaecology
Michelle Gardner	Cuidiú (Caring Support for Parenthood)
Michelle Kelly	Service User
Dr Niamh Hayes	College of Anaesthetists of Ireland
Pat O'Dowd	Primary Care Division, HSE
Dr Peter Boylan	Chair, Institute of Obstetricians and Gynaecologists
Professor Richard Greene	Director, National Perinatal Epidemiology Centre
Sheila Sugrue	Lead Midwife, Office of the Nursing and Midwifery Services Director, HSE
Dr Sinead Murphy	Irish College of General Practitioners
Siobhan Bourke	HIQA
Susan Kent	Chief Nursing Officer's Office, Department of Health
Sylda Langford	Chair, National Maternity Strategy Steering Group
Tonya Myles	Cairde

± Dr Karen Robinson was a member of the Advisory Group until January 2016, at which point she was replaced by Claire O'Regan.

HIQA Maternity Standards Project Team

Name	Title
Linda Weir	Project Lead
Fiona Cullinane	Expert Clinical Lead
Rachel Dardis	Project Research Officer*
Michelle O'Connor	Project Research Officer‡

* Since February 2016.

‡ From April 2015 to September 2015.

Appendix 2

Ten Steps to Successful Breastfeeding

First published in a joint World Health Organization and UNICEF statement in 1989 – Protecting, promoting and supporting breastfeeding: the special role of the maternity services.

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in-allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

The global BFHI and thus Irish BFHI underwent a revision process in 2006-2009. The main revisions relate to inclusion of criteria for mother-friendly labour and birth practices; clarity on inclusion of mothers of infants who are not breastfeeding ensuring information and support for these mothers; and strengthened implementation of the International Code of Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions International Code of Marketing of Breast-milk Substitutes.

Step 4: "Help mothers initiate breastfeeding within a half-hour of birth", is now interpreted as : Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.

Global Baby Friendly Hospital Initiative:

http://www.who.int/nutrition/topics/bfhi/en/index.html
http://www. Unicef.org/nutrition/index_breastfeeding.html

Baby Friendly Hospital Initiative in Ireland:
http://www.ihph.ie/babyfriendlyinitiative

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