Guide to HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies

Safer Better Care

June 2019

About the Health Information and Quality Authority (HIQA)

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

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

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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Revision history

Revision History	Publication date /revision date	Title/version	Summary of changes
Version 1	17 July 2018	Guide to HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies.	
Version 1.1	January 2019	Guide to HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies	This guidance was revised in January 2019 to reflect changes to HIQA's approach to receipt of feedback from hospitals on reports progressing through the drafting process.
Version 1.2	April 2019	Guide to HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies	This guidance was revised in March 2019 to reflect changes to HIQA's approach to describing each maternity hospital/maternity unit's compliance with specific National Standards.
Version 1.3	June 2019	Guide to HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies	This guidance was revised in June 2019 to reflect a change to the categories used to describe the maternity service's level of compliance with the National Standards monitored.

Purpose of this guide

The purpose of this guide is to give both service providers and members of the public an overview of HIQA's approach to monitoring against the *National Standards for Safer Better Maternity Services*. This is a new monitoring programme which HIQA commenced in 2018. This monitoring programme will place a particular focus on obstetric emergencies.

This guide may be revised periodically as this monitoring programme progresses and or changes.

This guide is structured as follows:

Section 1 gives background information about HIQA's monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies

Section 2 provides an overview of HIQA's monitoring process

Section 3 provides information about HIQA's hospital inspections

Section 4 provides an overview of HIQA's risk identification and notification process

Section 5 describes HIQA's process for reporting the findings of unannounced inspections including the level of compliance achieved against specific National Standards

Section 6 summarises the response expected from hospitals regarding unannounced inspection findings.

1. Background

Under the Health Act 2007,[1] part of HIQA's role is to set standards in relation to the quality and safety of healthcare and to monitor compliance with these standards. The *National Standards for Safer Better Maternity Services* [2] were published by HIQA in December 2016. The *National Standards for Safer Better Maternity Services* were developed using the same framework as the *National Standards for Safer Better Healthcare*, which were launched by HIQA in 2012.[3]

The *National Standards for Safer Better Maternity Services* support the implementation of the National Maternity Strategy,[4] which was launched by the Minister of Health in January 2016. The *National Standards for Safer Better Maternity Services*, when implemented, will support the provision of a consistently safe, high-quality maternity service. The implementation of National Standards helps to set public, provider and professional expectations and enables service providers to consistently provide safe, high-quality care.

This monitoring programme is designed to assess the implementation of the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies, in maternity hospitals and in maternity units in public acute hospitals. For the purposes of this monitoring programme, obstetric emergencies are defined as pregnancy-related conditions that can present an immediate threat to the well-being of the mother and child in pregnancy or around birth.

Pregnancy, labour and birth are natural physiological states, and the majority of healthy women have a low risk of developing complications. For a minority of women, even those considered to be at low-risk of developing complications, circumstances can change dramatically prior to and during labour and delivery, and this can place both the woman's and the baby's lives at risk. Women may also unexpectedly develop complications following delivery, for example, haemorrhage. Clinical staff caring for women using maternity services need to be able to quickly identify potential problems and respond effectively to evolving clinical situations. Such a response may include communicating effectively with colleagues so that the staff that have the necessary experience and competence can directly provide clinical support and or intervention when it is necessary.

All women should be assessed for risks antenatally. It can be expected that some women will have pre-existing medical conditions or may develop pregnancy-related complications that increases their risk of complications during labour and delivery. In such situations, it is essential that the woman's care is planned effectively and delivered in the most appropriate clinical care setting.

The National Maternity Strategy recognises that smaller maternity services cannot operate in isolation as standalone entities and supports the development of maternity networks. The strategy envisages that, through the establishment of maternity networks within the hospital groups, expertise can be shared so that smaller units can be strengthened and supported to provide safe quality services. This monitoring programme will examine if maternity services in hospitals are being provided within a maternity network structure as recommended in the strategy.

The monitoring programme will also examine if the National Standards in relation to leadership, governance and management have been implemented. The programme will assess maternity hospital and maternity unit capacity and capability to identify higher risk women and to provide or arrange for their care in the most appropriate clinical setting. In addition, maternity hospitals and maternity units will be assessed to determine if they are resourced to detect and respond to obstetric emergencies which occur and if there are sufficient numbers of clinical staff who are supported with specialised regular training to care for women and their newborn babies.

1.2 External stakeholder engagement

HIQA commenced the design and development of this monitoring programme in early 2018. A special purpose maternity advisory group was formed to provide advice to HIQA in relation to the development of this monitoring programme. Responsibility for the content of this guide and the monitoring programme design rests with HIQA. This group included clinicians, managers and people with expertise in the areas of midwifery, obstetrics and gynaecology, neonatology, surgery, perinatal epidemiology, anaesthesia, critical care, management and patient advocacy.

Membership of this group and the organisations that members represented is listed in Appendix 1 of this document.

HIQA would like to acknowledge and thank the members of the Special Purpose Maternity Advisory Group for their input and advice.

2. Monitoring programme overview

This monitoring programme is designed to assess a maternity hospital's/maternity units level of compliance with the specific *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies.

Figure 1 shows the eight themes under which the *National Standards for Safer Better Maternity Services* 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 half of the circle relate to the key areas of a service's capacity and capability.

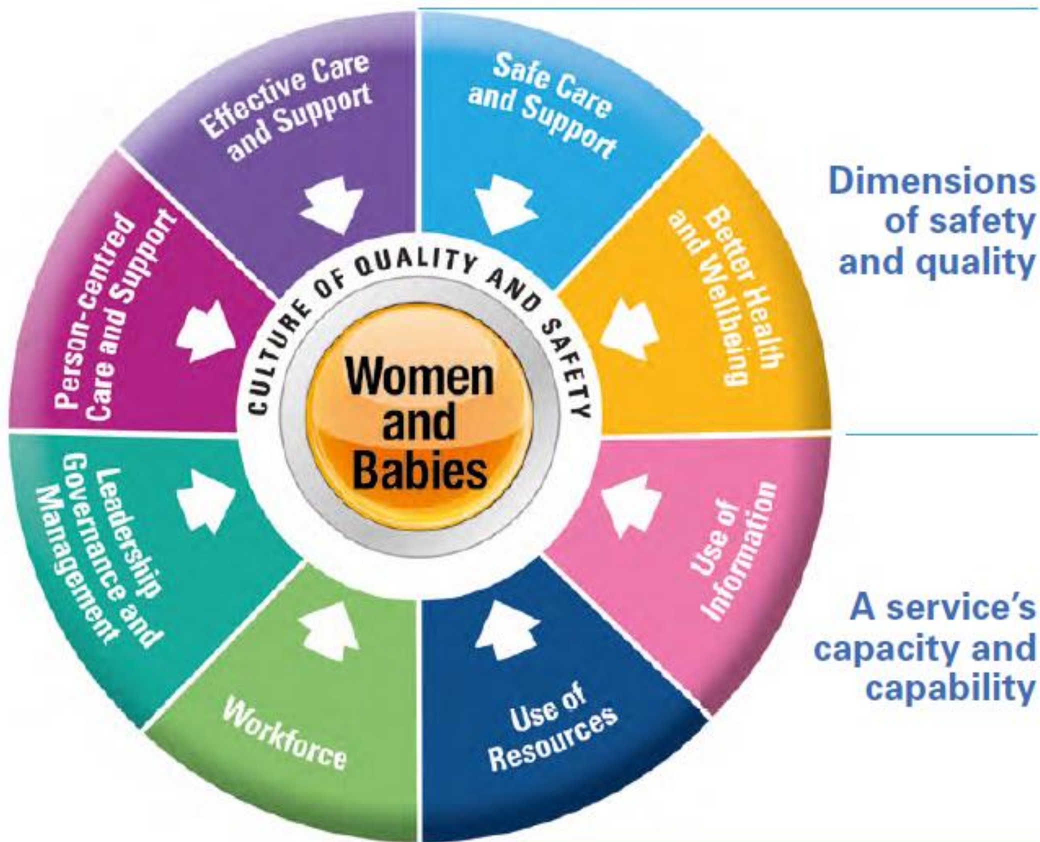


Figure 1: Standard themes for safety and quality

This monitoring programme against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies, looks at maternity service capacity and capability through standards for:

- Leadership, Governance and Management
- Workforce.

In addition, HIQA will look at maternity service provision under the dimensions of safety and quality through aspects of standards for:

- Effective Care and Support
- Safe Care and Support.

In order to monitor against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies. HIQA will use three lines of enquiry, namely:

- **Line of Enquiry 1**

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

- **Line of Enquiry 2**

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

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

- **Line of Enquiry 3**

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

The tables in Appendix 2 show the National Standards for Safer Better Maternity Services that relate to each of HIQA's lines of enquiry for this monitoring programme.

2.1 Pre-inspection self-assessment

On 30 May 2018, all 19 maternity units and maternity hospitals were asked to complete a self-assessment tool which was developed by HIQA. A copy of the self-assessment tool which was sent to hospitals is shown in Appendix 3. At this time, hospitals were also asked to submit to HIQA by 20 June 2018 some preliminary documents and data, which are listed in Appendix 4.

The reason for requesting hospitals to complete the self-assessment tool was to gather provisional information prior to onsite hospital inspection in relation to the maternity services provided and also in relation to local management arrangements.

Following on from the self-assessment component of the monitoring programme, HIQA will commence inspections onsite in maternity units and maternity hospitals in Quarter 3, 2018.

A table showing the 19 hospitals providing maternity services that HIQA will inspect in relation to the *National Standards for Safer Better Maternity Services* is included in Appendix 5 in this document. This table also shows the number of births in each hospital in 2017.

The aims of this monitoring programme are to:

- **assess** if public maternity hospitals and maternity units have essential elements in place to provide safe and effective care, in line with the *National Standards for Safer Better Maternity Services* with a focus on obstetric emergencies
- **establish** if public maternity hospitals and maternity units have implemented the *National Standards for Safer Better Maternity Services* so that they have the capacity and capability to identify higher risk patients. In addition, to establish if maternity service providers can detect and respond effectively to obstetric emergencies and can facilitate the care of women and their newborn babies in the most appropriate clinical care setting
- **provide** public maternity hospitals and maternity units with the findings of inspections to highlight how hospitals are implementing the National Standards and to identify areas for improvement
- **publish** the findings of inspections on HIQA's website www.hiqa.ie.

2.2 Scope of this monitoring programme

In this monitoring programme, HIQA will monitor aspects of some, but not all of the *National Standards for Safer Better Maternity Services*. This programme will, at the request of the Minister for Health, focus on obstetric emergencies.

Preparation for obstetric emergencies requires

- advance planning and good interdisciplinary teamwork
- having early warning systems in place
- regular training drills to ensure that everyone knows what to do
- designated specialised emergency response teams
- resources to deal with an emergency when it occurs.

Good communication and teamwork with a reliable early warning system will further increase the efficiency and effectiveness of the emergency response.[5]

When focusing on how maternity hospitals and or maternity units detect and respond to obstetric emergencies, HIQA will endeavour to look at how maternity services provided in maternity hospitals and maternity units:

- are led and governed.

Furthermore, HIQA will examine how these services are resourced and managed so that:

- pregnant women at greater risk of developing complications are identified and their care is managed in the most appropriate setting
- hospitals have the resources to detect and respond to obstetric emergencies when these arise
- women and newborns that are at risk of developing complications or become ill have access to specialist care and are managed in the most appropriate setting.

The following issues are outside the scope of this monitoring programme

- maternity care that is delivered in the community, for example, by general practitioners and self-employed community midwives
- clinical care and management of individual women and individual newborns
- clinical decision making by healthcare professionals
- the longer term care of women and newborns following an obstetric emergency
- review or investigation of individual patient experiences or clinical incidents.

3. Hospital inspections

All hospitals providing maternity services were informed that onsite inspections by HIQA would commence in Quarter 3, 2018. The date of individual hospital inspections will be unannounced. This allows inspectors to see services in the way they usually operate at a particular point in time. Hospital inspections will be carried out over two consecutive days.

The following section provides an overview of the unannounced hospital inspection process.

3.1 Before a hospital inspection

Prior to an unannounced hospital inspection, key pieces of information relating to the arrangements in place to deliver quality and safe maternity services will be reviewed by HIQA. This information includes:

- completed self-assessment tools and related documents submitted by the hospital to HIQA for this monitoring programme
- previous HIQA inspection reports
- relevant unsolicited information received by HIQA in relation to the hospital
- reports of external reviews or investigations in relation to maternity services at the hospital.

3.2 The days of inspection

On arrival at the hospital, the inspection team will ask to meet with the person with overall accountability and responsibility for the maternity service, for example, the General Manager, Master* or Chief Executive Officer. If the person with overall accountability and responsibility for the maternity service is not onsite, the inspection team will ask to meet with the nominated person in charge of the hospital for the day in order to explain the inspection approach and proposed schedule.

A request for documentation, data and information will be provided to the General Manager, Master or Chief Executive Officer at the start of the inspection. An example of the type of documentation that inspectors will request from hospital management is included in Appendix 6 of this document.

The inspection team will request to arrange suitable times to carry out interviews with clinical leads in the specialities of obstetrics and gynaecology, anaesthesia and neonatology/paediatrics. Inspectors will aim to meet with the Executive Management Team on the second day of the inspection. The purpose of these interviews is to gather information about how the maternity service is led and managed, how risks are identified and managed and how the management team is assured that the maternity service provided is safe and effective.

Members of the inspection team will also visit a sample of clinical areas and gather information through speaking with clinical area managers, midwifery staff and non-

* In each of the three Dublin maternity hospitals, the Master is both Chief Executive Officer and lead consultant obstetrician and gynaecologist, with overall corporate and clinical responsibility for the maternity service.

consultant hospital doctors. Inspectors will carry out visual inspection of the clinical environment and will also review policies, procedures and guidelines and local area risk registers. By speaking with front line staff and observing the clinical environment, inspectors will gather information in relation to:

- local management arrangements
- risk management
- communication between staff, for example, through clinical handover and how staff access clinical support when required or in an emergency situation
- policies, procedures and guidelines
- staffing levels
- staff training and sharing of learning.

Inspectors will review the documentation and data requested from hospital management.

Preliminary feedback will be provided to the General Manager, Master or Chief Executive Officer at the close of the inspection.

Figure 2 on the next page shows a sample two day hospital inspection plan.

Figure 2. Sample two day hospital inspection plan

Day 1

- Overview of inspection purpose and proposed inspection plan
- Preliminary information gathering
- A documentation and data request will be requested from the General Manager, Master or Chief Executive Officer

Days 1 and 2

- Members of the inspection team will visit a sample of clinical areas, speak with clinical staff, observe the clinical working environment and review documents.
- Members of the inspection team will arrange to speak with clinical specialty leads to find out how the service is led and managed
- The documentation and data requested will be reviewed.

Day 2

- The inspection team will meet with the General Manager or Master or Chief Executive Officer and some members of the Executive Management Team to determine how the maternity service is led, governed and managed, including how risks are identified and managed and how the management team is assured that the maternity service is safe and effective
- Preliminary feedback will be provided to the General Manager or Master or Chief Executive Officer at the close of the inspection.

3.3 Practical information about hospital inspections

During the inspection, inspectors will:

- request access to a secure room for the purpose of documentation review
- carry visitor name badges or door-access cards required to facilitate movement throughout the hospital. These should be made available to the inspection team as soon as possible following arrival onsite, and they will be returned at the end of the inspection.
- inform the person with overall accountability for the maternity service at the hospital of any risks identified during the inspection which require action.

Hospital inspection teams

Hospital inspection teams will comprise of HIQA staff who have been appointed by HIQA as 'authorised persons' under the Health Act 2007 and work within the powers described in the Act to monitor compliance with standards.

Inspectors are obliged to comply with HIQA's Code of Conduct for staff, which is available at www.hiqa.ie.

Confidentiality

In line with current data protection legislation, HIQA requests that unless specifically requested to do so, hospitals do not send named patient information or information that could identify an individual patient to HIQA by email or by post. Hard copy documents provided to inspectors for removal from the hospital should not contain information that identifies individual patients.

Freedom of information

HIQA is subject to the Freedom of Information Act 2014 and for guidance refers to the Freedom of Information Decision Makers Manual (Freedom of Information Central policy Unit, Department of Public Expenditure and Reform Parts 1 and 2).

4. Risk identification and notification process

Risk identified by HIQA during this monitoring programme will be escalated to the accountable person in line with HIQA's risk management process as follows.

- Risk identified during a hospital inspection which requires immediate mitigation will be brought to the attention of the General Manager, Chief Executive Officer or Master during the inspection. This is to allow him or her to immediately implement the actions necessary to mitigate such risk.

- Formal written notification of any identified risk arising during this monitoring programme will be issued to the accountable person by email within two working days of the risk identification, with the requirement to formally report back to HIQA stating how the risk has been mitigated within a further two working days.
- In the case of risk which does not require immediate mitigation, formal notification of the identified risk will be issued to the accountable person by email within two working days of the identification of the risk, with the requirement to formally report back to HIQA with an action plan to reduce and effectively manage the risk within a further five working days of this correspondence from HIQA.

HIQA's risk escalation process is outlined in a diagram in Appendix 7.

A copy of any correspondence may also be sent to the relevant hospital group Chief Executive Officer and the HSE's National Director Acute Operations.

5. HIQA's inspection report

An individual report will be generated for each maternity hospital and or maternity unit inspected and an overview report will be published on conclusion at www.hiqa.ie.

The reports will outline HIQA's findings in relation to areas where the hospital was found by HIQA to be compliant with the National Standards monitored, and reasons for judgements where the hospital was either substantially compliant, partially compliant or non-compliant with National Standards (Appendix 8).

Four categories will be used to describe the maternity service's level of compliance with the National Standards monitored. These categories included the following:

- **Compliant:** A judgement of compliant means that on the basis of this inspection, the maternity service is in compliance with the relevant National Standard.
- **Substantially compliant:** A judgement of substantially compliant means that the maternity service met most of the requirements of the relevant National Standard, but some action is required to be fully compliant.
- **Partially compliant:** A judgment of partially compliant means that the maternity service met some of the requirements of the relevant National Standard while others requirements were not met. These deficiencies, while

not currently presenting significant risks, may present moderate risks which could lead to significant risks for patients over time if not addressed.

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

Each hospital's report will include tables which outline HIQA's findings in relation to the hospital's compliance with the specific National Standards monitored.

The report will also include risks, if any, that was identified during the monitoring process and may include correspondence between HIQA and the hospital's CEO, General Manager or Master in relation to the management of such risk. Therefore HIQA recommends that the hospital does not include individual staff names in high risk correspondence. Inspection reports cannot be regarded as a comprehensive assessment of all aspects of management of a hospital or the quality of care delivery at a hospital. Report findings are generated from the information gathered during an inspection at a particular point in time based on the inspection lines of enquiry and methods described in this document.

In 2019, HIQA has revised its approach to receipt of feedback from hospitals on reports progressing through the drafting process. Under this new and enhanced process, each inspection report goes through three main stages as it is prepared for completion:

Stage 1 Inspection Report

A stage 1 inspection report will be issued with a feedback form, by email, to the hospital's CEO, General Manager or Master. A copy of the report will also be sent by email to the hospital group Chief Executive Officer.

Preliminary findings will have been given during the close-out meeting. However, following review of the Stage 1 report the hospital's CEO, General Manager or Master can return the feedback form to include any factual accuracy detail along with feedback on receipt of the stage 1 inspection report.

The hospital's CEO, General Manager or Master is encouraged to engage with the lead inspector if deemed necessary and in advance of completion of the formal written documentation, to discuss specific concerns or queries they may have regarding the judgments in this stage 1 inspection report. This can be completed by phone and/or email.

To complete the feedback process (and having engaged via telephone call or email with the lead inspector if deemed necessary) the hospital's CEO, General Manager or

Master should formally complete the factual accuracy and feedback form provided with the draft report, and return this to HIQA within **15 working days of receipt.**

Stage 2 Inspection Report

On receipt of feedback from the hospital on a stage 1 report, HIQA will consider the feedback in the context of evidence gathered on inspection. Consequently, a stage 2 inspection report will be produced which will include any required amendments made by the inspector resulting from the feedback process. This stage 2 report will then be again issued to the hospital for review.

If the hospital's CEO, General Manager or Master believes that the judgment(s) contained in the stage 2 inspection report are not based on the evidence made available to inspectors at the time of the inspection, or if they believe that the judgment(s) are disproportionate to the evidence reviewed, they may decide to make a formal submission to HIQA to challenge a regulatory judgment or judgments contained in the stage 2 report.

Should a hospital's CEO, General Manager or Master decide on making a formal submission this must be made within **10 working days of receipt of the stage 2 report.** The process for making a formal submission is detailed below. Should 10 days elapse without receipt of submission on a regulatory judgment, reports will proceed to stage 3 and as outlined below.

Stage 3 Inspection Report

A stage 3 inspection report is issued to the hospital's CEO, General Manager or Master prior to completion. The stage 3 report is the final version of the report and if a submission has been received the stage 3 inspection report will have taken into consideration any decisions of the Submissions Decision Panel.

The stage 3 inspection report will be sent to the hospital's CEO, General Manager or Master on completion. A copy of the report will also be sent by email to the hospital group Chief Executive Officer, and other relevant personnel as formally agreed with the HSE and Department of Health.

Making a submission on judgments contained in a Stage 2 Inspection Report

The hospital's CEO, General Manager or Master can make a formal submission if they believe that the judgment(s) contained in the stage 2 inspection report are not based on the evidence made available to inspectors at the time of the inspection or the judgment(s) are disproportionate to the evidence reviewed.

As part of this process, the hospital's CEO, General Manager or Master may formally submit comments, evidence or descriptors of circumstances that supports their case.

A hospital's CEO, General Manager or Master wishing to make a submission on a regulatory judgment must first engage in the feedback process with the lead inspector as described in the section above on page 19 'Stage 1 Inspection report'.

Further information on HIQA's submissions procedure and how to make a submission can be found on the HIQA website (www.hiqa.ie).

6. Expected hospital response following an unannounced hospital inspection

In the event that the inspection team identifies risks to patients (either immediate or non-immediate), it is the responsibility of the hospital to respond to these risks, as previously outlined in this guidance document.

The identified individual who has overall executive accountability, responsibility and authority for the delivery of high-quality, safe and reliable maternity services at each hospital inspected is responsible for acting on the findings of an inspection. This includes progressing the implementation of the National Standards, addressing risks and addressing any opportunities for improvement identified during this inspection process.

7. Reference

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

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

3. Health Information and Quality Authority. *National Standards for Safer Better Healthcare.* Dublin: 2012. Available online from: http://www.hiqa.ie/standards/health/safer-better-healthcare.

4. Department of Health. Creating a better Future together National Maternity Strategy 2016-2026. Dublin: Department of Health; 2016 Available online from: http://health.gov.ie/wp-content/uploads/2016/01/Final-version-27.01.16.pdf

5. The American College of Onstetricians and Gynaecologists. Preparing for clinical emergencies in obstetrics and gynaecology. Committee Opinion No 590. American College of Obsteticians and Gynaecologists. Obstet Gynecol 2014;123:722-5. Available online from: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co590.pdf?dmc=1

8. Appendices

Appendix 1: Membership of the Special Purpose Maternity Advisory Group

Member name	**Organisation**
Mary Brosnan[‡]	Irish Association of Directors of Nursing and Midwifery
Dr Gerry Burke	Royal College of Physicians of Ireland. Institute of Obstetricians and Gynaecologists
Professor Rory Farrelly[§]	Chief Directors of Nursing and Midwifery Forum
Mr Martin Feeley	Royal College of Surgeons in Ireland
Professor Richard Greene	National Perinatal Epidemiology Centre (NPEC)
Dr Niamh Hayes	HSE National Clinical Care Programme for Anaesthesia
Dr Peter Mc Kenna	HSE National Women and Infants Health Programme
Professor John Murphy	HSE National Clinical Programme for Paediatrics and Neonatology
Deirdre Walsh[**]	State Claims Agency
Roisin O' Leary	Patient Focus
Dr Michael Power	HSE Critical Care Programme
Anne Slattery	HSE Acute Services

[‡] Martina Cronin deputised for Mary Brosnan at one meeting

[§] Margaret Philbin deputised for Rory Farrelly at one meeting

[**] Dr Cathal O'Keeffe deputised for Deirdre Walsh at two meetings

Appendix 1: Membership of the Special Purpose Maternity Advisory Group continued

Member name	Organisation
Dr Mary Short	Irish College of General Practitioners
Dr Jeremy Smith	HSE National Clinical Care Programme for Anaesthesia
Professor Michael Turner	HSE National Clinical Programme for Obstetrics and Gynaecology
Nora Vallejo	Chief Directors of Nursing and Midwifery Forum – Delivery Suite Clinical Midwife Manager representative
Sean Egan	HIQA, Head of Healthcare Regulation (Chairperson)
Joan Heffernan	HIQA, Regional Manager (Programme Lead)
Siobhan Bourke	HIQA, Healthcare Inspector
Aileen O'Brien	HIQA, Healthcare Inspector
Dolores Dempsey Ryan	HIQA, Healthcare Inspector

Appendix 2: Monitoring programme lines of enquiry and relevant National Standards

Line of Enquiry 1:

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

Relevant *National Standards for Safer Better Maternity Services*:

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

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

Safe Care and Support

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.

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

Standard 5.11: Maternity service provider's act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies.

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.

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.

Line of Enquiry 2:

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

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

Relevant *National Standards for Safer Better Maternity Services*:

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.

Safe Care and Support

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.

Line of Enquiry 3:

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

Relevant *National Standards for Safer Better Maternity Services*:

Effective Care and Support

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.

Leadership, Governance and Management

Standard 5.5: Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.

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.

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

Appendix 3: Self-assessment tool

Self-assessment tool

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

Date of issue: 30 May 2018
Provisional information

Question	Answer	
What is the name of individual with overall accountability and responsibility for the maternity hospital/maternity unit?		
What is the title of individual with overall accountability and responsibility for the maternity hospital/maternity unit?		
Is this hospital part of a maternity network?	Yes	No
If this hospital is part of a maternity network, what other hospitals are in this maternity network?		
What is the name of individual who has overall accountability and responsibility for this maternity network?		

The following services for women and newborns are provided at the hospital

Please tick to indicate

Service	Yes	No
Early Pregnancy Assessment Unit (EPAU)		
Midwifery-led unit		
Level 2 Critical Care (High Dependency Unit)		
Level 3 Critical Care (Intensive Care Unit)		
Interventional Radiology		
Neonatal Services - Level 1 (Local) Unit		

Neonatal Services - Level 2 (Regional) Unit		
Neonatal Services - Level 3 (Tertiary) Unit		
Therapeutic hypothermia (neonatal cooling)		
Please insert additional comments or clarification below related to this section of the tool		

The following training programmes are facilitated at the hospital

Please tick to indicate.

Training type	Yes	No
Postgraduate midwifery training		
Undergraduate midwifery training		
Basic specialist training in obstetrics and gynaecology for doctors		
Higher specialist training in obstetrics and gynaecology for doctors		
Higher specialist training in anaesthetics for doctors		
Higher specialist training in neonatology for doctors		
Higher specialist training in paediatrics for doctors		

Please provide the following information in relation to the maternity hospital/maternity unit

Question	Answer	
What are the opening hours of the Early Pregnancy Assessment Unit from Monday to Friday?		
What are the core working hours for obstetric and gynaecology medical staff?		
What is the core working hours for anaesthetic medical staff?		
What are the core working hours for neonatology/paediatric medical staff?		
What times are shift clinical handovers (midwifery and medical staff) held in the Delivery Suite?		
What was the total number of births greater than or equal to 500g in this maternity hospital/maternity unit in 2017?		
What was the number of inpatient discharges for 2017 for gynaecological patients?		
How many women had gynaecological surgery in this maternity hospital/maternity unit in 2017?		
What are the core working hours for elective obstetric operating theatre lists from Monday to Friday?		
Does the maternity hospital/maternity unit perform elective obstetric and gynaecological surgery at weekends or on public holidays?	Yes	No
Is the Early Pregnancy Assessment Unit open at weekends?	Yes	No

Please provide information outlining the arrangements for the care of pregnant women who present to the hospital

Presentation type	Insert name and type of clinical area where initial assessment is performed in each of the boxes below
Pregnant women at less than or equal to 20 weeks gestation who present as an emergency to the hospital during core working hours (9-5pm)	
Pregnant women at less than or equal to 20 weeks gestation who present as an emergency to the hospital outside core working hours (between 5pm and 9am week days and on Saturdays, Sundays and public holidays)	
Pregnant women at greater than 20 weeks gestation who present as an emergency to the hospital during core working hours (9-5pm)	
Pregnant women at greater than 20 weeks gestation who present as an emergency to the hospital outside core working hours (between 5pm and 9am week days and on Saturdays, Sundays and public holidays)	
Pregnant women in labour who present to the hospital during core working hours (9-5pm)	
Pregnant women in labour who present to the hospital outside core working hours (between 5pm and 9am week days and on Saturdays, Sundays and public holidays)	

Section 1: Leadership, governance and management

1.1: Governance			
1.1.1	There is a named individual with overall accountability and responsibility for the maternity hospital/maternity unit	Yes	No
1.1.2	There is a designated person onsite, who is operationally in charge of the maternity hospital/maternity unit outside of core working hours including weekends and public holidays	Yes	No
1.1.3	There are formalised clinical governance arrangements for assuring the delivery of safe, high quality maternity care	Yes	No
1.1.4	The maternity hospital/maternity unit has a statement of purpose which describes services provided for women and their babies including how and where they are provided	Yes	No
1.1.5	The maternity hospital/maternity unit has a strategic plan that sets out clear short, medium and long term objectives for delivering safe, high-quality maternity care within a maternity network	Yes	No
1.1.6	There is continuous performance monitoring of local and nationally defined performance indicators for maternity care at hospital and network level	Yes	No
1.1.7	The maternity hospital/maternity unit has an agreed annual clinical audit plan	Yes	No
1.1.8	The maternity hospital/maternity unit has an active quality improvement programme in place to enhance patient safety	Yes	No
1.1.9	The maternity hospital/maternity unit publishes monthly Maternity Patient Safety Statements	Yes	No

1.2: Leadership			
1.2.1	The maternity hospital/maternity unit has a designated lead consultant obstetrician and gynaecologist	Yes	No
1.2.2	The maternity hospital/maternity unit has a designated lead consultant neonatologist	Yes	No
1.2.3	The maternity hospital/maternity unit has a designated lead consultant paediatrician for the neonatal service	Yes	No
1.2.4	The maternity hospital/maternity unit has a designated lead consultant anaesthetist	Yes	No
1.2.5	There is a Director of Midwifery who has overall responsibility for midwifery and nursing staff in this maternity hospital/maternity unit	Yes	No
1.2.6	The Director of Midwifery is represented on the hospital's executive management team	Yes	No

1.3: Management			
1.3.1	Each <u>woman's</u> care is led and coordinated by an identified lead healthcare professional who is part of a multidisciplinary team	Yes	No
1.3.2	Each <u>newborn's</u> care is led and coordinated by an identified lead healthcare professional who is part of a multidisciplinary team	Yes	No
1.3.3	The maternity hospital/maternity unit has systems in place to proactively identify, assess, record and treat risks related to the safety and quality of care provided to women and their newborns	Yes	No
1.3.4	The maternity hospital/maternity unit escalates risks within the maternity network or hospital group if they cannot be addressed locally	Yes	No

1.4: Monitoring and evaluation			
1.4.1	The maternity hospital/maternity unit reports all patient safety incidents onto the National Incident Management System (NIMS) within 30 days of occurrence	Yes	No
1.4.2	The maternity hospital/maternity unit tracks and trends patient safety incidents and makes any improvements indicated	Yes	No
1.4.3	The maternity hospital/maternity unit has a process to review all patient safety incidents in line with national guidelines	Yes	No
1.4.4	The maternity hospital/maternity unit reviews all serious incidents and serious reportable events	Yes	No
1.4.5	There is a mechanism for upward reporting and review of serious incidents and serious reportable events to maternity network level	Yes	No
1.4.6	The maternity hospital/maternity unit implements recommendations from reviews of patient safety incidents in a timely manner	Yes	No
1.4.7	The maternity hospital/maternity unit has a mechanism for spreading of learning from patient safety incidents with staff and across the maternity network and nationally where relevant	Yes	No
1.4.8	The maternity hospital/maternity unit proactively monitors, analyses and responds to the following information in relation to the maternity service:		
	▪ Complaints, concerns and compliments from women	Yes	No
	▪ Closed legal cases findings	Yes	No
	▪ Coroner's inquest recommendations	Yes	No

	▪ Clinical audit findings	Yes	No
	▪ Surveys of women's experience	Yes	No
	▪ Staff surveys	Yes	No
1.4.9	The maternity hospital/maternity unit participates in regular multidisciplinary maternal morbidity meetings:		
	▪ At maternity hospital/maternity unit level	Yes	No
	▪ At maternity network level	Yes	No
1.4.10	Maternal morbidity meetings are attended by all relevant healthcare professionals and managers	Yes	No
1.4.11	The maternity hospital/maternity unit participates in regular multidisciplinary perinatal morbidity and mortality meetings:		
	▪ At maternity hospital/maternity unit level	Yes	No
	▪ At maternity network level	Yes	No
1.4.12	Perinatal morbidity and mortality meetings are attended by all relevant healthcare professionals and managers	Yes	No
1.4.13	An attendance record and minutes are kept for all perinatal morbidity and mortality and maternal morbidity meetings	Yes	No
1.4.14	The outcome of discussion and any learning from maternal and perinatal morbidity/mortality meetings is shared with relevant staff in the maternity hospital/maternity unit and within the maternity network	Yes	No
1.4.15	The maternity hospital/maternity unit regularly audits compliance with implementation of the following National Clinical Guidelines:		

	▪ Irish Maternity Early Warning System	Yes	No
	▪ Clinical Handover in Maternity Services	Yes	No
	▪ Sepsis Management	Yes	No
1.4.16	An annual clinical report is produced for the maternity hospital/maternity unit	Yes	No
1.4.17	The maternity hospital/maternity unit has a system in place to respond to safety alerts in relation to medical devices	Yes	No
1.4.18	The maternity hospital/maternity unit has a system in place to respond to safety alerts in relation to medicines	Yes	No

Section 2: Safe and Effective Care

Systems to identify women at risk and to detect and respond to obstetric emergencies

2.1: Assessment and/or admission			
2.1.1	Risk assessments are carried out for all pregnant women at the time of booking, during pregnancy and during and after delivery by the relevant healthcare professional	Yes	No
2.1.2	All women have regular risk assessments for venous thromboembolism during pregnancy and after delivery	Yes	No
2.1.3	The care of women at higher risk of developing complications and/or who have complex obstetric or medical needs is planned by a multi-disciplinary team	Yes	No
2.1.4	The care of women at higher risk of developing complications and/or who have complex obstetric or medical needs is provided or facilitated in the most appropriate setting	Yes	No

2.1.5	Where risks are identified during pregnancy, care is planned so that pregnant women receive the most appropriate level of care including referral to specialist care and services	Yes	No
2.1.6	Women who are assessed and deemed to have a higher risk pregnancy are delivered in a hospital with appropriate facilities and expertise to care for mother and baby	Yes	No
2.1.7	The maternity hospital/maternity unit has an anaesthetic pre-assessment service for the assessment of pregnant women at higher risk of potential complications	Yes	No
2.1.8	All pregnant women attending the maternity hospital/maternity unit have a formal dating scan by a trained fetal ultrasonographer in the first trimester of pregnancy	Yes	No
2.1.9	All pregnant women attending the maternity hospital/maternity unit are offered a detailed fetal assessment ultrasound at 20-22 weeks gestation	Yes	No
2.1.10	If clinically indicated, pregnant women attending the maternity hospital/maternity unit are offered a fetal wellbeing assessment ultrasound beyond 24 weeks gestation, to include fetal biometry, amniotic fluid volume and umbilical artery Doppler	Yes	No
2.1.11	If clinically indicated, pregnant women attending the maternity hospital/maternity unit are offered a fetal ultrasound to determine placental localisation in the second and third trimesters	Yes	No
2.1.12	Care pathways are in place for women who present as an emergency at the maternity hospital/maternity unit during core working hours	Yes	No
2.1.13	Care pathways are in place for women who present as an emergency at the maternity hospital/maternity unit outside core working hours including weekends and public holidays	Yes	No

2.1.14	Pregnant women who present to the general Emergency Department at the hospital are reviewed by a senior member of the obstetric team **Do not complete this question if the hospital is a standalone maternity hospital**	Yes	No

2.2: Access to specialist care and services and follow up care			
2.2.1	The maternity hospital/maternity unit has the following specialists - Please indicate in the boxes provided whether the following clinical specialists are accessible onsite at the hospital or at another hospital:		
	▪ Consultant surgeon (general)	Onsite	Other hospital
	▪ Consultant surgeon (vascular)	Onsite	Other hospital
	▪ Consultant surgeon (urology)	Onsite	Other hospital
	▪ Consultant respiratory physician	Onsite	Other hospital
	▪ Consultant cardiologist	Onsite	Other hospital
	▪ Consultant endocrinologist	Onsite	Other hospital
	▪ Consultant nephrologist	Onsite	Other hospital
	▪ Consultant neurologist	Onsite	Other hospital
	▪ Consultant psychiatrist	Onsite	Other hospital

2.2.2	There are referral pathways in place for the transfer and transport of pregnant and post natal women for specialised services such as critical care services at another hospital	Yes	No
2.2.3	There are referral pathways in place for in utero transfers (in the fetal interest) and transport to neonatal services at another hospital	Yes	No
2.2.4	There are referral pathways in place for the transfer and transport of newborns to other hospitals for specialised or advanced care	Yes	No
2.2.5	Maternity hospitals/maternity units have referral pathways, either in the same hospital, in their maternity network or in a tertiary referral centre to access a fetal medicine unit	Yes	No
2.2.6	The care of women presenting to the maternity hospital/maternity unit with acute medical or surgical complications is provided in the clinical setting most appropriate to their clinical needs	Yes	No
2.2.7	There is access to consultant microbiologist advice 24 hours a day, seven days a week	Yes	No
2.2.8	There is access to consultant haematologist advice 24 hours a day, seven days a week	Yes	No

2.3: Communication and team working			
2.3.1	There are formal arrangements in place for multi-disciplinary clinical handover in the Delivery Suite	Yes	No
2.3.2	The ISBAR communication tool is routinely used by staff for the communication of information in relation to deteriorating and or critically ill women	Yes	No
2.3.3	There is a formal communication and escalation process in place so that staff can summon additional help to respond to obstetric emergencies and deteriorating patients	Yes	No
2.3.4	There is a system in place to ensure that the consultant obstetrician and gynaecologist on call is informed about all admitted women with complex obstetric or medical needs	Yes	No

2.3.5	There is a system in place to ensure that the consultant anaesthetist on call is routinely informed about all admitted women with complex obstetric or medical needs	Yes	No
2.3.6	The maternity hospital/maternity unit has an agreed system in place whereby the neonatal service, where possible, is given sufficient advance notice of babies who are likely to require additional care	Yes	No
2.3.7	The hospital has guidelines when a consultant anaesthetist should be in attendance in the obstetric operating theatre	Yes	No
2.3.8	The hospital has guidelines for when a consultant obstetrician and gynaecologist should be in attendance in the Delivery Suite or the Obstetric Operating Theatre	Yes	No
2.3.9	The hospital has guidelines for when a consultant neonatologist/consultant paediatrician should be in attendance for a birth	Yes	No
2.3.10	The midwife shift leader in the Delivery Suite can contact the consultant obstetrician and gynaecologist on call directly if they have concerns about clinical care and/or patient safety	Yes	No
2.3.11	Non-consultant hospital doctors can contact the consultant obstetrician and gynaecologist on call directly if they have concerns about clinical care and/or patient safety	Yes	No

2.4: Policies, procedures, protocols and guidelines			
2.4.1	Policies, procedures, protocols and guidelines for the assessment, monitoring and management of women before, during and after delivery are based on national/international best available evidence	Yes	No
2.4.2	Up to date policies, procedures, protocols and guidelines for obstetric emergencies are readily accessible to clinical staff	Yes	No
2.4.3	Health Service Executive national guidelines are implemented in relation to the following:		

	▪ Venous thromboembolism prophylaxis	Yes	No
	▪ Open disclosure	Yes	No
	▪ Obesity and pregnancy	Yes	No
2.4.4	There is a major obstetric haemorrhage guideline which identifies lines of communication between relevant healthcare professionals	Yes	No
2.4.5	There is a standardised procedure/decision making aid for the estimation of maternal blood loss which involves volume and weight assessment	Yes	No
2.4.6	Maternity surgical checklists are completed for all maternity patients undergoing surgery	Yes	No

2.5: Infrastructure, facilities and resources			
2.5.1	An emergency obstetric operating theatre is available for use 24 hours a day, seven days a week	Yes	No
2.5.2	The emergency obstetric operating theatre is on the same floor/level as the Delivery Suite	Yes	No
2.5.3	The maternity hospital/maternity unit has operating theatre capacity and staff to simultaneously manage two emergency operating theatre cases outside of core working hours	Yes	No
2.5.4	There is an adequate supply of O-Negative unmatched red blood cells in the hospital that can be quickly accessed in an emergency for both women and newborns	Yes	No
2.5.5	A haematology laboratory service is available onsite to arrange provision of blood, blood products and non-blood products for the maternity service 24 hours a day, seven days a week	Yes	No
2.5.6	Essential haematology, biochemistry and microbiology laboratory results are available within an acceptable timeframe 24 hours a day, seven days a week	Yes	No

2.6: Equipment and supplies			
2.6.1	Resuscitation equipment for adults is available in clinical areas and is regularly checked	Yes	No
2.6.2	Resuscitation equipment for neonates is available in relevant clinical areas and is regularly checked	Yes	No
2.6.3	Resuscitation equipment for maternity patients includes difficult intubation equipment	Yes	No
2.6.4	Resuscitation equipment for maternity patients includes a perimortem caesarean section tray	Yes	No
2.6.5	Pre assembled supplies/kits are available for managing major obstetric haemorrhage	Yes	No
2.6.6	Pre assembled supplies/kits are available for managing pre eclampsia and eclampsia.	Yes	No

Section 3: Workforce

3.1: Specialist medical staffing for this maternity hospital/maternity unit			
3.1.1	Excessive use of locum and agency medical staff to cover unfilled permanent positions in maternity services is avoided	Yes	No
3.1.2	There is designated consultant obstetrician and gynaecologist presence in the Delivery Suite for a specified number of hours per week and this person is free from other clinical commitments such as elective surgery	Yes	No
3.1.3	On call consultant obstetrician and gynaecologists conduct morning ward rounds on Saturdays, Sundays and public holidays to review women that they are clinically responsible for	Yes	No

3.1.4	When off site, the on call consultant obstetrician and gynaecologist is available to attend the hospital within 30 minutes when required	Yes	No
3.1.5	When off site, the on call consultant anaesthetist is available to attend the hospital within 30 minutes when required	Yes	No
3.1.6	An anaesthetist is immediately available 24/7 onsite for emergency work in the Delivery Suite and this anaesthetist is free from other duties	Yes	No
3.1.7	When off site, the on call consultant neonatologist or consultant paediatrician is available to attend the hospital within 30 minutes when required	Yes	No
3.1.8	All consultant obstetrician and gynaecologists who are employed on a permanent contract at the maternity hospital/maternity unit are registered as a specialist on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of obstetrics and gynaecology	Yes	No
3.1.9	All consultant anaesthetists who are employed on a permanent contract at the hospital are registered as a specialist on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of anaesthetics	Yes	No
3.1.10	All consultant neonatologists and or consultant paediatricians who are employed on a permanent contract at the hospital, are registered as a specialist on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in Ireland in the specialty of paediatrics	Yes	No

3.2: Specialist consultant medical staff numbers in this maternity hospital/maternity unit		
	Detail:	**Number:**
3.2.1	Number of whole time equivalent (WTE) consultant obstetrician and gynaecologist positions approved for the maternity hospital/maternity unit	

3.2.2	Number of WTE consultant obstetrician and gynaecologist positions filled on a permanent contract	
3.2.3	Number of WTE consultant obstetrician and gynaecologist positions filled by locum consultants	
3.2.4	Number of WTE consultant obstetrician and gynaecologist positions filled by agency staff	
3.2.5	Number of WTE consultant anaesthetist positions approved for the hospital	
3.2.6	Number of WTE consultant anaesthetist positions filled on a permanent contract	
3.2.7	Number of WTE consultant anaesthetist positions filled by locum consultants	
3.2.8	Number of WTE consultant anaesthetist positions filled by agency staff	
3.2.9	Number of WTE consultant neonatologist positions approved for the maternity hospital/maternity unit	
3.2.10	Number of WTE consultant neonatologist positions filled on a permanent contract	
3.2.11	Number of WTE consultant neonatologist positions filled by locum consultants	
3.2.12	Number of WTE consultant neonatologist positions filled by agency staff	
3.2.13	Number of WTE consultant paediatrician positions approved for the maternity hospital/maternity unit	
3.2.14	Number of WTE consultant paediatrician positions filled on a permanent contract	
3.2.15	Number of WTE consultant paediatrician positions filled by locum consultants	
3.2.16	Number of WTE consultant paediatrician positions filled by agency staff	

3.3: Non-consultant hospital doctor staffing numbers in this maternity hospital/maternity unit		
	Detail:	**Number:**
3.3.1	Number of obstetrics and gynaecology specialist registrars	
3.3.2	Number of obstetrics and gynaecology registrars who are not on a specialist training programme	
3.3.3	Number of senior house officers in obstetrics and gynaecology	
3.3.4	Number of interns on the obstetrics and gynaecology team	
3.3.5	Number of anaesthetic specialist registrars	
3.3.6	Number of anaesthetic registrars who are not on a specialist training programme	
3.3.7	Number of senior house officers on the anaesthetic team	
3.3.8	Number of neonatology/paediatric specialist registrars	
3.3.9	Number of neonatology/paediatric registrars who are not on the specialist training programme	
3.3.10	Number of senior house officers in the neonatology/paediatric service	

3.4: Availability of medical staff in the Delivery Suite and Obstetric Operating Theatre during core working hours		
	Detail:	**Number:**
3.4.1	How many hours per week is a consultant obstetrician and gynaecologist rostered to be present in the Delivery Suite (excluding elective surgery commitments)?	

3.4.2	How many registrars in obstetrics and gynaecology are rostered to the Delivery Suite from Monday to Friday during core working hours?	
3.4.3	How many senior house officers in obstetrics and gynaecology are rostered to the Delivery Suite from Monday to Friday during core working hours?	
3.4.4	How many registrars in anaesthetics are rostered to the Delivery Suite from Monday to Friday during core working hours?	
3.4.5	How many senior house officers in anaesthetics are rostered to the Delivery Suite from Monday to Friday during core working hours?	
3.4.6	How many registrars in anaesthetics are rostered to the Obstetric Operating Theatre from Monday to Friday during core working hours?	
3.4.7	How many senior house officers in anaesthetics are rostered to the Obstetric Operating Theatre from Monday to Friday during core working hours?	

3.5: Medical staffing arrangements outside of core working hours in this maternity hospital/maternity unit			
	Detail:	**Number, Tick or Yes/No**	
3.5.1	Number of consultant obstetrician and gynaecologists on call outside of core working hours for the maternity hospital/maternity unit		
3.5.2	Are consultant obstetrician and gynaecologists on call outside of core working hours required to be available to attend more than one hospital?	Yes	No
3.5.3	Usual frequency of nights on call outside of core working hours for consultant obstetrician and gynaecologists:		
	1:2 rota		
	1:3 rota		
	1:4 rota		

	1:5 rota		
	1:6 rota		
	1:7 rota		
	If other than the above, please describe in the comment box below		
3.5.4	Number of obstetric and gynaecology registrars onsite outside of core working hours who are on call for the maternity hospital/maternity unit		
3.5.5	Number of obstetric and gynaecology senior house officers onsite outside of core working hours who are on call for the maternity hospital/maternity unit		
3.5.6	Number of consultant anaesthetists on call outside of core working hours for the hospital		
3.5.7	Number of consultant anaesthetists exclusively on call outside of core working hours for the maternity hospital/maternity unit		
3.5.8	Is the consultant anaesthetist on call outside of core working hours required to be available to attend more than one hospital?	Yes	No
3.5.9	Usual frequency of nights on call outside of core working hours for consultant anaesthetists:		
	1:2 rota		
	1:3 rota		
	1:4 rota		
	1:5 rota		
	1:6 rota		
	1:7 rota		
	If other than the above, please describe in the comment box below		
3.5.10	Number of anaesthetic registrars onsite outside of core working hours who are on call for obstetric anaesthesia		
3.5.11	Number of anaesthetic senior house officers onsite outside of core working hours who are on call for obstetric anaesthesia		

3.5.12	Number of consultant neonatologists or consultant paediatricians on call outside of core working hours for newborn care		
3.5.13	Is the consultant neonatologist/paediatrician on call outside of core working hours required to be available to attend more than one hospital?	Yes	No
3.5.14	Is there a split rota for neonatology and paediatric medical staff for co-located maternity units?	Yes	No
3.5.15	Usual frequency of nights on call outside of core working hours for consultant neonatologists or paediatricians:		
	1:2 rota		
	1:3 rota		
	1:4 rota		
	1:5 rota		
	1:6 rota		
	1:7 rota		
	If other than the above, please describe in the comment box below		
3.5.16	Number of registrars in neonatology or paediatrics onsite outside of core working hours who are on call for newborn care		
3.5.17	Number of senior house officers in neonatology or paediatrics onsite outside of core working hours who are on call for newborn care		

3.6: Midwife and nurse staffing arrangements for this maternity hospital/maternity unit			
3.6.1	A nationally agreed workforce planning tool is used to determine midwife staffing requirements in this maternity hospital/maternity unit	Yes	No
3.6.2	There is a delivery suite manager at the hospital	Yes	No

3.6.3	A midwife shift leader is rostered for every shift in the Delivery Suite	Yes	No
3.6.4	The shift leader in the Delivery Suite is always supernumerary	Yes	No
3.6.5	Rosters are planned so that there is balanced staff skill mix	Yes	No
3.6.6	There is a midwifery clinical skills facilitator in this maternity hospital/maternity unit	Yes	No
3.6.7	Excessive use of locum and agency midwifery staff to cover unfilled permanent positions in maternity services is avoided	Yes	No

3.7: Midwife and nurse staffing numbers		
	Detail:	**Number:**
3.7.1	Approved number of WTE midwife positions filled on a permanent contract for this maternity hospital/maternity unit excluding neonatal unit and operating theatre	
3.7.2	Actual number of WTE midwife positions filled on a permanent contract excluding neonatal unit and operating theatre	
3.7.3	Recommended number of WTE midwives (using the birthrate plus tool) for this maternity hospital/maternity unit excluding neonatal unit and operating theatre	
3.7.4	Number of midwives assigned to the Delivery Suite from 8am to 8pm from Monday to Friday	
3.7.5	Number of midwives assigned to the Delivery Suite from 8am to 8pm on Saturdays, Sundays and public holidays	
3.7.6	Number of midwives assigned to the Delivery Suite from 8pm to 8am each night	
3.7.7	Number of operating theatre nurses assigned to operating theatres for obstetric operating theatre cases Monday to Friday during core hours	

3.7.8	Number of operating theatre nurses immediately available for emergency obstetric operating theatre cases outside of core working hours		
3.7.9	Does the hospital have a second operating theatre nursing team on call outside of core working hours should a need arise to simultaneously manage two emergency theatre cases?	Yes	No

3.8: Staff who perform fetal ultrasound			
3.8.1	There is a sufficient number of trained fetal ultrasonographers in place to provide a fetal ultrasound service in line with National Standards on a routine basis during core working hours	Yes	No
3.8.2	There is a sufficient number of trained fetal ultrasonographers in place to perform fetal ultrasounds outside of core working hours	Yes	No

3.9: Emergency response teams			
3.9.1	There is a designated team on call onsite to rapidly respond to obstetric emergencies 24 hours a day, seven days a week	Yes	No
3.9.2	There is a designated cardiac arrest team on call onsite to rapidly respond to cardiac arrests 24 hours a day, seven days a week	Yes	No
3.9.3	There is a designated team available to rapidly respond to neonatal emergencies 24 hours a day, seven days a week	Yes	No

3.10: Training and education of clinical staff			
3.10.1	There is a formal system of performance appraisal in place for clinical staff	Yes	No
3.10.2	There is an annual review and assessment of mandatory training and education needs of clinical staff	Yes	No
3.10.3	There are clearly defined mandatory training requirements for all clinical staff	Yes	No
3.10.4	Staff induction programmes are held at regular intervals	Yes	No
3.10.5	Locum and agency staff are provided with induction education	Yes	No
3.10.6	Skills and drills training for clinical staff is multi-disciplinary and attendance is documented	Yes	No
3.10.7	Clinical staff undertake skills and drills training for obstetric emergencies	Yes	No
3.10.8	Multi-disciplinary team training in obstetric emergencies is provided at the maternity hospital/maternity unit	Yes	No
3.10.9	If you have answered 'Yes' to 3.10.8; please indicate which training programme or programmes are provided to clinical staff:		
	▪ PRactical Obstetrics Multi-Professional Training (PROMPT)	Yes	No
	▪ MOET (Managing Obstetric Emergencies and Trauma) training	Yes	No
	▪ Advanced Life Support Training in Obstetrics (ALSO)	Yes	No
	Other multi-disciplinary obstetric training – please describe in comment box below		
3.10.10	Nursing and midwifery managers who are responsible for the maternity service outside core working hours undergo training in the following:		
	▪ Multi-disciplinary obstetric emergency training	Yes	No

	▪ Adult basic life support	Yes	No
	▪ Neonatal Resuscitation	Yes	No
3.10.11	Training and education in relation to the following national guidelines is provided to all relevant staff:		
	▪ Irish Maternity Early Warning System	Yes	No
	▪ Clinical Handover in Maternity Services	Yes	No
	▪ Sepsis Management	Yes	No
	▪ Open disclosure	Yes	No
3.10.12	Basic adult resuscitation training is provided to clinical staff at least every two years	Yes	No
3.10.13	Advanced adult resuscitation training is provided to clinical staff appropriate to their scope of practice at least every two years	Yes	No
3.10.14	Neonatal resuscitation training is provided to clinical staff at least every two years	Yes	No
3.10.15	Healthcare professionals undertake multi-disciplinary team training, appropriate to their scope of practice in cardiotocography (CTG) interpretation every two years, or sooner if the need is identified	Yes	No
3.10.16	All staff who perform fetal monitoring such as cardiotocography (CTG), regularly attend CTG review meetings	Yes	No
3.10.17	Healthcare professionals who perform fetal ultrasound are formally trained in fetal ultrasonography in line with their scope of practice and their competence is regularly assessed	Yes	No

3.10.18	There are arrangements in place to facilitate the rotation of staff to maintain competence and skills within the maternity hospital/maternity unit	Yes	No
3.10.19	There are arrangements in place to facilitate the rotation of staff to maintain competence and skills within the maternity network	Yes	No
3.10.20	Midwives and nurses are effectively supported and supervised to develop and achieve competency in their area of work	Yes	No
3.10.21	Midwives only independently undertake invasive procedures such as episiotomy and perineal suturing in which they have been assessed and deemed competent	Yes	No
3.10.22	Non-consultant hospital doctors in obstetrics and gynaecology are effectively supported and supervised to develop and achieve competency in their area of work	Yes	No
3.10.23	Non-consultant hospital doctors on a training scheme, only independently undertake invasive procedures such as perineal suturing, surgery and instrumental deliveries in which they have been assessed and deemed competent	Yes	No
3.10.24	Non-consultant hospital doctors who are not on a training scheme, only independently undertake invasive procedures such as perineal suturing, surgery and instrumental deliveries in which they have been assessed and deemed competent	Yes	No
3.10.25	Hospital management has a process in place to ensure that locum or agency medical doctors have the skills and experience required to deliver safe and effective care	Yes	No

Appendix 4: Pre-inspection documentation and data request

Document description
Organisational diagrams outlining the corporate and clinical governance structures for maternity services at the hospital, including lines of accountability and reporting relationships up to hospital group level
Statement of purpose for the maternity service at this hospital
Annual clinical report for maternity services for 2017
Clinical audit plan for 2018 in relation to maternity services
List of clinical audits performed in 2017 in relation to maternity services
Irish Maternity Indicator System (IMIS) overview report for 2017 for this maternity hospital/maternity unit
Irish Maternity Indicator System (IMIS) monthly reports for this maternity hospital/maternity unit for the period January to May 2018
2016 National Perinatal Epidemiology Centre (NPEC) perinatal mortality report for this maternity hospital or maternity unit
2016 National Perinatal Epidemiology Centre (NPEC) maternal morbidity report for this maternity hospital or maternity unit

Appendix 5: Maternity hospitals or hospitals with maternity units

Hospital Name	Number of births in 2017
National Maternity Hospital	8,619
Rotunda Hospital	8,409
Coombe Women and Infants University Hospital	8,166
Cork University Maternity Hospital	7,221
University Maternity Hospital Limerick	4,425
Our Lady of Lourdes Hospital Drogheda	3,021
University Hospital Galway	2,894
Regional Hospital Mullingar	2,114
University Hospital Waterford	1,840
Wexford General Hospital	1,762
Letterkenny University Hospital	1,671
Portiuncula University Hospital	1,664
St Luke's General Hospital Kilkenny	1,609
Cavan General Hospital	1,596
Mayo University Hospital	1,543
Midland Regional Hospital Portlaoise	1,531
University Hospital Kerry	1,368
Sligo University Hospital	1,312
South Tipperary General Hospital	982

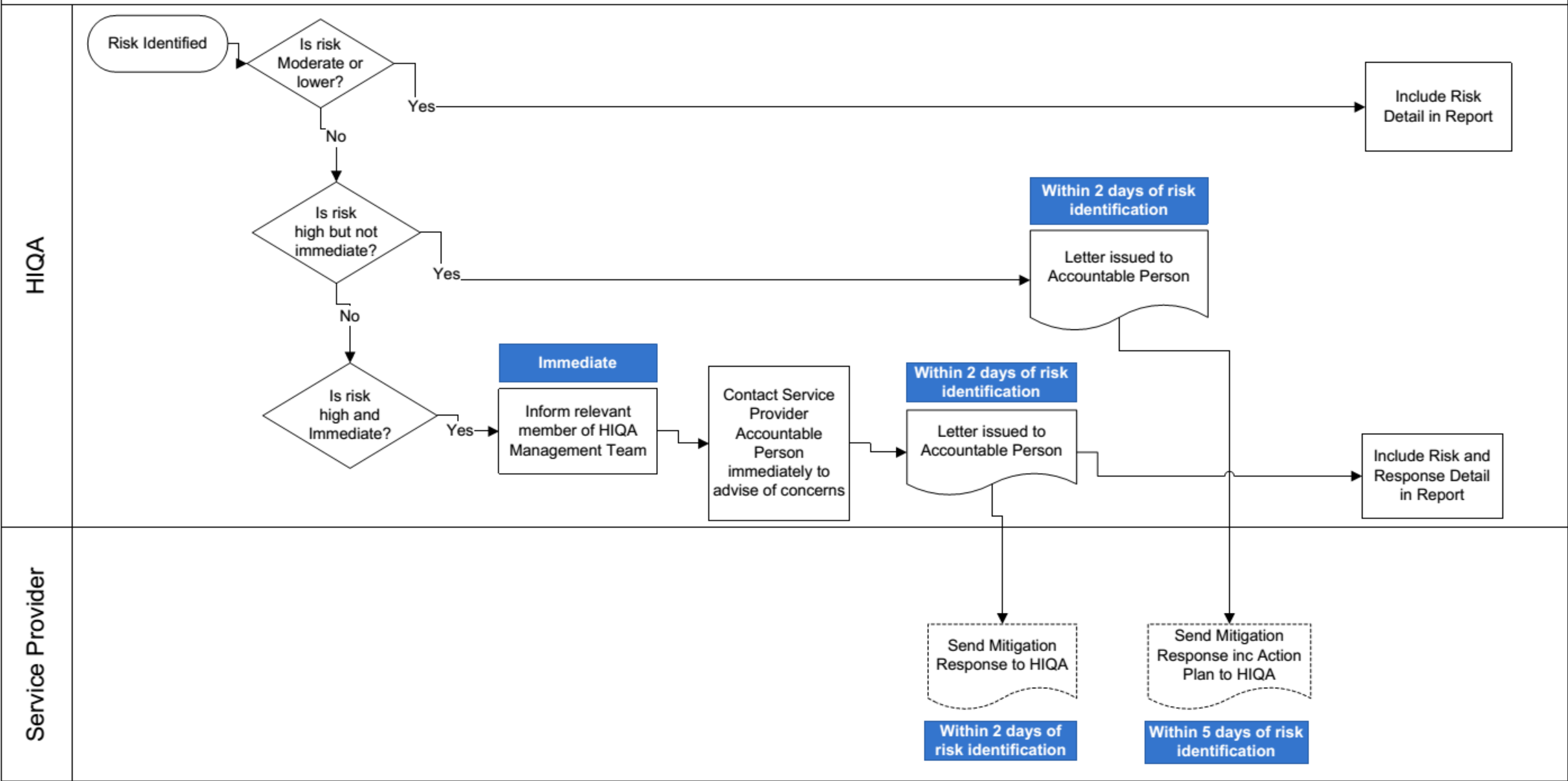
Appendix 6: Sample inspection documentation and data request

Document description
Strategic Plan
Current strategic plan for maternity service at this hospital
Minutes of meetings
Terms of teference and minutes of executive management team meetings for the last six meetings (and documents circulated at those meetings)
Terms of reference and minutes of quality and safety committee (risk management) meetings for the last six meetings (and documents circulated at those meetings)
Minutes of serious incident management team meetings for the last six meetings (and documents circulated at those meetings)
Minutes of maternity service clinical governance meetings for the last six meetings (and documents circulated at those meetings)
Minutes of maternal morbidity and mortality meetings for the last six meetings (and documents circulated at those meetings)
Minutes of perinatal morbidity and mortality meetings for the last six meetings (and documents circulated at those meetings)
Performance reports
All maternity service performance and monitoring reports for the past six months
Monthly Irish Maternity Indicator System (IMIS) reports
Number of women transferred out of the maternity hospital/maternity unit to an intensive care unit (level 3) since January 2018
Annual clinical report 2017 and or 2018 (if not already submitted)
Maternity Patient Safety Statements for the past six months
Report outlining maternity Serious Reportable Events and serious incidents overview for 2018
Current action plans and or quality improvement plans in relation to the delivery of maternity care

Appendix 6: Sample inspection documentation and data request continued

Document description
Clinical audit and quality improvement projects
Reports of any projects undertaken at the hospital that enhanced patient safety in relation to maternity care
Maternity surgical checklist
Risk registers
Risks on the current hospital risk register (corporate risk register) that relate to the maternity service
Current risks in the delivery suite risk register
Current risks in the operating theatre department risk register that relate to the maternity service
Staff training
List of mandatory training requirements for midwives, doctors and nurses working in the maternity service
Training schedule for 2018/2019 for midwives, doctors and nurses working in the maternity service
Percentage of clinical staff who attended mandatory training in the past two years (broken down by discipline and training type)
Content of obstetric emergency training programme (for example, powerpoint presentations or training manuals)
Policies, procedures, protocols and guidelines
List of current obstetric emergency management policies, procedures, protocols and guidelines
List of clinical situations/risk factors/risk categorization of women who require care transferred to tertiary centre within network
Risk management policy

Appendix 7: HIQA's risk escalation process



Note: Accountable Person: identified individual who has overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services.

Key:inc= including, days = working dys.

Appendix 8: HIQA's judgments against the National Standards for Safer Better Maternity Services that were monitored during inspection

Dimensions: Quality and Safety			
Theme 2- Effective Care and Support			
Standard number	**Standard statement**	**Key findings**	**Judgment**
2.1	Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies.		
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.		
2.3	Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services.		
2.4	An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby.		
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 number	Standard statement	Key findings	Judgment
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.		
2.8	The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.		
Theme 3 Safe and Effective Care			
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.		
3.3	Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally.		
3.4	Maternity service providers implement, review and publicly report on a structured quality improvement programme.		
3.5	Maternity service providers effectively identify, manage, respond to and report on patient safety incidents.		

Dimensions: Capacity and Capability			
Theme 5 Leadership, Governance and Management			
Standard number	**Standard statement**	**Key findings**	**Judgment**
5.1	Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care.		
5.2	Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care.		
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.		
5.4	Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services.		
5.5	Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.		

5.8	Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.		
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 number	**Standard statement**	**Key findings**	**Judgement**
6.1	Maternity service providers plan, organize and manage their workforce to achieve the service objectives for safe, high-quality maternity care.		
6.3	Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.		
6.4	Maternity service providers support their workforce in delivering safe, high-quality maternity care.		

9. Glossary of terms

This glossary details key terms and a description of their meaning within the context of this document.

Assurance: a term that means being sure or certain about systems, processes and procedures and standing over business objectives. It involves monitoring risk and implementing controls to mitigate that risk.

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.

Evaluation: a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.

Governance: in healthcare this refers to an integration of corporate and clinical governance. It is the systems, processes and behaviours, by which services lead, direct and control their functions in order to achieve their objectives, including the quality and safety of services for service users.

Irish Maternity Indicator System (IMIS): a standardised data-based management tool for individual maternity hospitals and or maternity units and national analysis. Data are collected and reviewed monthly. National reports are published annually.

Maternity care: care for women from when they first look for care before and during pregnancy through to labour and birth. It includes the care of the woman and her baby after birth.

Maternity network: the system whereby maternity units and maternity hospitals are interconnected within hospital groups.

Maternity unit or maternity hospital: a term that includes both maternity units and maternity hospitals that provide maternity care to women and their babies in a maternity unit situated in a general hospital or in a stand-alone maternity hospital.

Monitoring: the systematic process of gathering information and tracking change over time. Monitoring provides a verification of progress towards achievement of objectives and goals.

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.

Maternity Patient Safety Statement (MPSS): initiated by the Department of Health, the MPSS is published for all maternity hospitals and maternity units on a monthly basis and is intended to provide assurance that maternity services are delivered in an environment that promotes open disclosure.

National Perinatal Reporting System (NPRS): the principal source of national data on perinatal events. Information on every birth in the Republic of Ireland is submitted to the NPRS by trained hospital administrative staff and all practicing independent midwives. The time frame to which the information relates is from 22 weeks gestation to the first week of life.

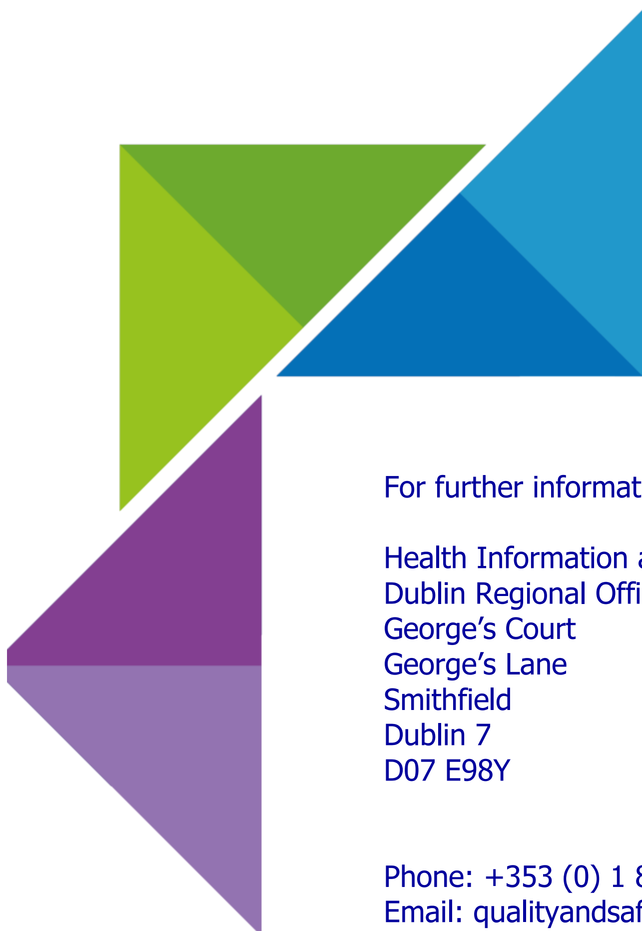
Obstetric emergencies: pregnancy-related conditions that can present an immediate threat to the well-being of the mother and child in pregnancy or around birth.

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 interests of service users.

Quality improvement: a systematic approach using specific methods to improve quality through achieving successful and sustained improvement.

Risk management: coordinated activities to direct and control an organisation with regard to risk.

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.



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