Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Cork University Maternity Hospital
Address of healthcare service:	Wilton Road Cork Co. Cork T12 YE02
Type of inspection:	Announced
Date of inspection:	26 and 27 October 2022
Healthcare Service ID:	OSV-0001026
Fieldwork ID:	NS_0018

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

Cork University Maternity Hospital is a statutory hospital, which is a member of and is managed by the South/South West Hospital Group* on behalf of the Health Service Executive (HSE). The hospital provides obstetrics, gynaecology and neonatal services to the population of the South/South West Hospital Group, which is approximately 900,000 people across the counties of Cork, Kerry, Waterford and South Tipperary, and has a supra-regional catchment area of 1.2 million. The hospital was purpose built 15 years ago following the merger of the maternity services from the Erinville Hospital, St. Finbarr's Maternity Hospital, Bon Secours Maternity Unit and gynaecology services from Cork University Hospital.

The hospital is co-located with a tertiary referral adult acute hospital — Cork University Hospital, both hospitals are linked structurally by an interior corridor. In 2021, there were 7,467 births at the hospital, a decrease of 5.7% on the hospital's birth rate in 2020, but nevertheless making it one of the busiest maternity hospitals in the country. The decrease in birth rate at the hospital is consistent with a decreasing birth rate nationally.

The following information outlines some additional data on the hospital.

Model of Hospital	Maternity
Number of beds	▪ 10-bedded delivery suite ▪ three room induction suite ▪ 87-bedded postnatal ward ▪ 24-bedded antenatal ward ▪ 31-bedded gynaecology ward (23 gynaecology and eight dedicated pregnancy loss beds) ▪ Neonatal Intensive Care Unit comprising 37 cots — 25 special care unit cots, six high-dependency unit cots and six intensive care unit cots. Outreach maternity services clinics are also carried out in St Mary's Health Campus, and primary care centres in Mallow,

* The South/South West Hospital Group comprises ten hospitals — Cork University Hospital, Cork University Maternity Hospital, University Hospital Waterford, University Hospital Kerry, Mercy University Hospital, South Tipperary General Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital, Mallow General Hospital and Lourdes Orthopaedic Hospital Kilcreene.

	Mitchelstown, Carrigaline and Carrigtwohill providing supportive care as outlined in the *National Maternity Strategy*.[†]

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a two-day announced inspection at Cork University Maternity Hospital to assess compliance with a number of standards from the *National Standards for Safer Better Healthcare*. The national standards assessed during the course of the inspection were mapped to the national standards from the *National Standards for Safer Better Maternity Services* (see Appendix 1), which sit within the overarching framework of the *National Standards for Safer Better Healthcare.*

To prepare for this inspection, healthcare inspectors[‡] reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and South/South West Hospital Group, unsolicited information[§] and other publically available information.

During the inspection, inspectors:

- spoke with women who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to women and babies who received maternity care and treatment in the hospital
- observed care being delivered, interactions with women who used the service and other activities to see if it reflected what women told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what women told inspectors during the inspection.

A summary of the findings and a description of how the hospital performed in relation to the national standards assessed during the inspection are presented in the following sections, under the capacity and capability and quality and safety

[†] *National Maternity Strategy-Creating a Better Future Together* 2016-2026 sets out a plan for maternity and neonatal care, to ensure its safe, standardised, of high quality and offer a better experience and more choice to women and their families.
[‡] Inspector refers to an 'authorised person' appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.
[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

dimensions. Findings are based on information provided to inspectors at a particular point in time — before, during and following the on-site inspection at the hospital.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that good quality and safe maternity services are being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place at the hospital, and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support women using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person centred and safe. It also includes information about the healthcare environment where women and babies receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how Cork University Maternity Hospital performed has been made under each national standard assessed. The judgments are included in this inspection report.

HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the 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 on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the 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 people using the service.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 October 2022	09.00 to 17.00hrs	Denise Lawler	Lead
27 October 2022	09.00 to 15.45hrs	Emma Cooke	Support
		Aoife Healy	Support

Background to this inspection

This inspection focused on national standards from four of the eight themes of the *National Standards for Safer Better Healthcare*. These national standards were also mapped to comparative national standards from the *National Standards for Safer Better Maternity Services*. The inspection focused on four key areas of known harm, these were:

- infection prevention and control
- medication safety
- the deteriorating patient** (including sepsis)††
- transitions of care.‡‡

The inspection team visited the following clinical areas:

- Emergency department
- 4-South (antenatal ward) where pregnant women received cared
- Birthing Suite where women were cared for during labour and birth
- 3-South (postnatal ward) where women and babies were cared for after birth.

** The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

†† Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

‡‡ Transitions of care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

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

- Representatives of the hospital's Executive Management Team:
  - Clinical Director for Maternity Services, South/South West Hospital Group
  - Director of Midwifery, Cork University Maternity Hospital
  - Head of Operations, Ireland South Women and Infants Directorate
  - Quality and Patient Safety Manager, Ireland South Women and Infants Directorate
  - Clinical Lead for Neonatology, Cork University Maternity Hospital
  - Clinical Lead for Quality and Patient Safety, Ireland South Women and Infants Directorate
  - Human Resource Manager, Cork University Maternity Hospital
  - Finance Manager, Ireland South Women and Infants Directorate
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Consultant Lead and Chief Resident for Non-Consultant Hospital Doctors, Cork University Maternity Hospital
- Discharge Coordinator for the Neonatal Unit, Cork University Maternity Hospital
- A representative from each of the following hospital committees:
  - Infection Prevention and Control
  - Medication Safety Committee
  - Antimicrobial Stewardship and Sepsis Committee.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank women using the service who spoke with inspectors about their experiences of receiving care at the hospital.

What people who use the emergency department told inspectors and what inspectors observed in the clinical areas visited

On the days of inspection, inspectors visited the emergency department and three clinical areas; 4-South, Birthing Suite and 3-South.

The emergency department was located on the ground floor of the hospital. The department provided care for pregnant and postnatal women who presented to the hospital with pregnancy and postnatal related illness. Attendees to the department presented by ambulance, were referred directly by their general practitioner (GP) or self-referred.

The emergency department has a total planned capacity of four bays comprising a:

- triage room with one trolley
- four single self-contained cubicles in the main emergency department area

- one single room used for isolation purposes, if needed.

On the first day of inspection, the emergency department appeared to be functioning well with five women receiving care in the department.

4-South was a large 24-bedded ward comprising nine two-bedded multi-occupancy rooms and six single rooms with en-suite bathroom facilities. The clinical area accommodated women categorised with a high-risk pregnancy that require admission for inpatient assessment and care. One single room was used to accommodate women after birth requiring a closer level of observation and care. The clinical area had adequate communal toilet and bathroom facilities for women to use. On the first day of inspection, 23 of the 24 beds were occupied.

The Birthing Suite had 10 spacious single birthing rooms with en-suite bathroom facilities, plus a birthing pool room for immersion in water during labour and three single self-contained cubicles used for women when having an induction of labour. There were adequate communal toilet and bathroom facilities for women to use. The unit also had a High Dependency Unit with three beds equipped to care for pregnant and postnatal women who required a higher level of observation and or invasive cardiac monitoring. The High Dependency Unit is usually staffed by midwives who have completed additional educational qualifications in high-dependency care. The hospital Operating Theatre Department was interconnected with the Birthing Suite. This facilitated the timely access to the obstetric operating theatre 24/7, when needed for an obstetric or neonatal emergency. On the first day of inspection, four women were in the Birthing Suite — two women were having their labour induced and two women were receiving care in the High Dependency Unit.

3-South was a large 31-bedded ward comprising 11 two-bedded multi-occupancy rooms and nine single rooms with en-suite bathroom facilities. The clinical area accommodated postnatal women and babies and on occasion accommodated pregnant women requiring admission for inpatient assessment and care. The clinical area had adequate communal toilet and bathroom facilities for women to use. On the first day of inspection, 30 of the 31 beds were occupied.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available in all clinical areas visited. Hand hygiene signage was clearly displayed throughout all clinical areas. Staff were observed wearing appropriate personal protective equipment (PPE), in line with public health guidelines at the time of inspection.

Inspectors observed effective communication between staff and women in all clinical areas visited. Staff were also observed actively engaging with women in a respectful and kind way, taking time to talk and listen to women. In each clinical area visited, staff were focused on ensuring that a woman's individual needs were responded to promptly. This was confirmed by women who spoke with inspectors.

In general, women were satisfied with the care received and described midwifery, medical and support staff as being *'very good', 'so friendly, approachable and helpful'* and *'knowledgeable'.* Women felt '*well looked after'* and told inspectors that midwives *'had time to give them'* and that *'midwives looked out for both mother and baby'*, and it was like *'your mother, always looking out for you'.* Midwives tried to create a *'home away from home'* atmosphere.

When asked what was good about the care received, women responded by saying staff were *'very respectful', 'always treated me with dignity'.*

In general, women's experiences of receiving care, as told to inspectors during inspection, were consistent with the findings from the hospital's 2020 National Maternity Experience Survey,[§§] where the majority of women (86%) who completed the survey had a very good or good experience while attending the hospital for maternity care. In the survey, women rated their experience of:

- antenatal care as 7.5, marginally higher than national average of 7.4
- care during labour and birth as 8.7, marginally higher than the national average of 8.6
- care after birth as 7.4, marginally lower than the national average of 7.5.

Women in the clinical areas visited who spoke with inspectors described how they, or a family member would speak to a member of staff or go online if they wanted to make a complaint. Inspectors did not observe information leaflets about the HSE's complaints process *'Your Service, Your Say'* displayed in the clinical area visited on the days of inspection. Hospital management could make these leaflets available.

Overall, women were very complimentary about the staff they met, the level of engagement and interaction with the staff and of the care received in all clinical areas visited. Furthermore, women's experiences as told to inspectors were consistent with the findings from the 2020 National Maternity Experience Survey.

[§§] The National Care Experience Programme, is a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health. It was established to ask women about their experiences of care in order to improve the quality of maternity services in Ireland. The National Maternity Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from women's feedback in order to improve maternity care. The findings of the National Maternity Experience Survey are available at: https://yourexperience.ie/maternity/national-results/.

Capacity and Capability Dimension

Inspection findings from the inspection related to the capacity and capability dimension are presented under three national standards (5.2, 5.5 and 5.8) from the theme of leadership, governance and management. Key inspection findings informing judgments on compliance with these national standards are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

The hospital had integrated corporate and clinical governance arrangements in place with clearly defined responsibilities and accountability throughout the service. Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management. They also outlined hospital management's reporting arrangements to the Chief Executive Officer of the South/South West Hospital Group. These arrangements were consistent with what HIQA found during inspection.

Since HIQA's last inspection at the hospital in 2019, hospital management and the hospital group had progressed with the establishment of a new directorate structure — Ireland South Women and Infants Directorate — for maternity services in the South/South West Hospital Group. Executive authority for the service was devolved to the South/South West Hospital Group's Clinical Director for Maternity Services. Since then, the directorate has continued to progress with the development of a clinically-led network as per the National Maternity Strategy, comprising the four maternity services within the hospital group — Cork University Maternity Hospital, University Hospital Waterford, South Tipperary General Hospital and University Hospital Kerry.

The South/South West Hospital Group's Clinical Director for Maternity Services, supported by the Executive Management Committee, was assigned with the responsibility for leading and managing the Ireland South Women and Infants Directorate. The Clinical Director reported to the Chief Executive Officer of the South/South West Hospital Group. At the time of inspection, the Clinical Director did not have responsibility and accountability for the governance, management or delivery of maternity, neonatal and gynaecological services at University Hospital Kerry, University Hospital Waterford or South Tipperary General Hospital. However, each of these maternity units had a director of midwifery and a dedicated clinical lead for obstetric services who were members of the Ireland South Women and Infants Directorate's Executive Management Committee. Clinical activity and issues relating to the maternity, neonatal and gynaecological services at these maternity units were shared daily via a teleconference 'hub call' with the Ireland South Women and Infants Directorate's head of operations (or nominated representative).

The Director of Midwifery was a member of the hospital's senior management team and was assigned with the responsibility for the organisation and management of nursing and midwifery services at the hospital. The Director of Midwifery reported to the Clinical Director for Maternity Services, and had a close working relationship with the Chief Director of Nursing and Midwifery for the South/South West Hospital Group.

Ireland South Women and Infants Directorate's Executive Management Committee

The Ireland South Women and Infants Directorate's Executive Management Committee supports the Clinical Director in the day-to-day operational management, strategic planning, and with oversight of the maternity, neonatology and gynaecological services across the South/South West Hospital Group. The committee, chaired by the Clinical Director for Maternity Services met every week, more frequently than the timeframe indicated in the committee's terms of reference. The committee had oversight of the clinical, operational and quality and safety issues across the directorate. The committee delegated elements of its assigned responsibility and function in the areas of quality and patient safety, information governance, education and training, and research and innovation to standing committees. Each standing committee had a defined and formalised accountability and reporting arrangement to the Directorate's Executive Management Committee.

The Directorate's Executive Management Committee's multidisciplinary membership includes members from the Ireland South Women and Infants Directorate — head of operations, clinical lead for quality and patient safety, quality and patient safety manager, chair of the local information governance group, finance manager, the director of midwifery and clinical leads for obstetric services from all four maternity services in the South/South West Hospital Group and clinical leads for gynaecology and neonatology at Cork University Maternity Hospital.

Minutes of meetings of the Directorate's Executive Management Committee submitted to HIQA were comprehensive. They showed that the committee had oversight of issues such as the level of activity, staffing levels, staff training and education, and service planning and innovation that impacted on the effective functioning of the maternity, gynaecology and neonatal services across the South/South West Hospital Group. It was evident that meetings of the committee followed a structured format, were action-orientated and the implementation of agreed actions was monitored from meeting to meeting. Inspectors noted that the committee's terms of reference submitted to HIQA were dated 2017, which would indicate the terms of reference may need to be updated.

Members of the Directorate's Executive Management Committee attended formalised performance monthly meetings between the hospital and the South/South West Hospital

Group, in line with the HSE's performance accountability framework.*** Items such as finance, workforce planning, risks to the quality and safety of services, scheduled and unscheduled care access and activity were reviewed and discussed at these performance meetings. Inspectors were satisfied that the performance meetings were well attended by representatives from the hospital and hospital group, and that agreed actions were progressed from meeting to meeting.

Quality and Patient Safety Committee, Cork University Maternity Hospital

The hospital's Quality and Patient Safety Committee were assigned with overall responsibility for developing, delivering and evaluating the hospital's quality and safety programme and the structures, policies and processes to improve the quality and safety of maternity services at the hospital. The committee, chaired by the Ireland South Women and Infants Directorate's clinical lead for quality and patient safety, met every four weeks, in line with its terms of reference and meetings followed a structured agenda.

The committee's multidisciplinary membership included members of the Directorate's Executive Management Committee, representatives from the hospital's social work department, gynaecology services, pharmacy department, practice development coordinator and director of midwifery education. The committee delegated elements of its assigned responsibility and function in the areas of infection prevention and control, medication safety, antimicrobial stewardship and sepsis, and policies, procedures and guidelines to subcommittees. Each subcommittee had a defined and formalised accountability and reporting arrangement to the Quality and Patient Safety Committee.

Minutes of meetings of the Quality and Patient Safety Committee submitted to HIQA, were comprehensive and showed that the committee monitored and had oversight of the hospital's performance against established quality and safety performance indicators, trends in safety and quality indicators, quality improvement initiatives and progress in the implementation of quality improvement plans, serious reportable events, infection outbreaks, audit findings and the implementation of policies, procedures and guidelines. It was evident that meetings of the committee were action-orientated and progress in implementing agreed actions was monitored from meeting to meeting.

The Quality and Patient Safety Committee were accountable to, and reported to, the Ireland South Women and Infants Directorate's Executive Management Committee. Minutes of committee meetings were available to the directorate and South/South West Hospital Group. The terms of reference for the committee submitted to HIQA did not detail the frequency of reporting to the Ireland South Women and Infants Directorate's Executive Management Committee. Inspectors also noted that the title on the terms of reference was the quality and patient safety team rather than committee, and the document did not have an approval and or review date. The committee's terms of reference may need to be

*** The HSE's Performance Accountability Framework sets out the ways by which the HSE and in particular the national divisions, hospital groups and community healthcare organisations, are held to account for their performance.

reviewed and revised to ensure that the committee's frequency of reporting is clear and the terms of reference are up to date.

At operational level, HIQA was satisfied that there were clear lines of accountability with devolved autonomy and decision-making for three of the four areas of known harm — infection prevention and control, medication safety and deteriorating patient. In addition, the hospital had designated clinical leads in the specialties of obstetrics, neonatology and anaesthesiology that provided clinical leadership and were responsible for the organisation and management of their specialty.

The following three committees were in place, all of which reported, and were operationally accountable to the hospital's Quality and Patient Safety Committee:

- Infection Prevention and Control Committee
- Medication Safety Committee
- Antimicrobial Stewardship and Sepsis Committee.

At the time of inspection, the hospital did not have a Bed Management and or Discharge Committee.

Infection Prevention and Control Committee

The hospital had a well-established multidisciplinary Infection Prevention and Control Committee who were assigned with the responsibility for ensuring the effective governance and oversight of the infection prevention and control practices at the hospital. The committee provided assurance on infection prevention and control practices to the Ireland South Women and Infants Directorate's Executive Management Committee. The committee, chaired by the director of midwifery, met every three months, less frequently than the monthly timeframe indicated in the committee's terms of reference. The committee reported and was operationally accountable to the hospital's Quality and Patient Safety Committee every three months.

The committee's multidisciplinary membership included representatives from the Directorate's Executive Management Committee, members of the hospital's infection prevention and control team, consultant microbiologist, antimicrobial pharmacist, surveillance scientist, consultant neonatologist, cleaning supervisor, representatives from occupational health and public health, clinical nurse managers from the operating theatre department and the Neonatal Unit. The committee delegated elements of its assigned responsibility and function in the area of hygiene to a subcommittee, which had a defined accountability and reporting arrangement to the Infection Prevention and Control Committee.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA were comprehensive and showed that meetings followed a structured agenda, were well attended and that actions were progressed from meeting to meeting. It was evident

that the committee had oversight of the hospital's compliance with key infection prevention and control performance indicators and standards, infection prevention and control related audit activities and findings, patient-safety incidents and risks, service improvement and relevant infection prevention and control policies, procedures and guidelines.

An infection prevention and control working group supported the hospital's infection prevention and control team and Infection Prevention and Control Committee to promote and support effective infection prevention and control practices across the hospital. The group comprised one clinical midwife manager grade 3 (CMM 3), an assistant director of midwifery, a quality and patient safety representative and clinical midwife managers from different clinical areas across the hospital.

The Infection Prevention and Control Committee was responsible for developing and monitoring the implementation of the annual infection prevention and control plan, which detailed the infection prevention and control objectives and purposeful actions to be achieved at the hospital each year. This plan is discussed further under national standard 5.5.

Medication Safety Committee

The hospital had a well-established Medication Safety Committee, who had assigned responsibility for assisting the hospital's Quality and Patient Safety Committee and Ireland South Women and Infants Directorate's Executive Management Committee in promoting medication safety practices at the hospital. The committee, chaired by a consultant in obstetrics and gynaecology, met every two months, in line with its terms of reference. The committee was assigned with the responsibility to:

- promote a culture of medication safety
- promote initiatives that support safe medication practices
- review and adapt relevant medication policies disseminated by the Drugs and Therapeutics Committee in Cork University Hospital
- identify and mitigate medication safety challenges
- support best practice in medication
- support medication safety on the electronic healthcare record.

The Medication Safety Committee had a dual reporting arrangement. It reported and was operationally accountable to the hospital's Quality and Patient Safety Committee and the Drugs and Therapeutics Committee in Cork University Hospital. The Drugs and Therapeutics Committee had overall responsibility for medication management across the Cork University Hospital campus, which included Cork University Maternity Hospital. The

Medication Safety Committee submitted a report to the hospital's Quality and Patient Safety Committee every three months.

The committee's multidisciplinary membership included, the chief pharmacist for the maternity services, antimicrobial pharmacist, consultant neonatologist, consultant anaesthesiologist, non-consultant hospital doctors from the specialties of obstetrics and gynaecology, neonatology and gynaecology, clinical practice development coordinator, the director of the centre for midwifery education, midwifery management representatives, quality and safety manager and clinical informatics pharmacist. A member of the Medication Safety Committee attended meetings of the Drugs and Therapeutics Committee in Cork University Hospital. Feedback from meetings of the Drugs and Therapeutics Committee was shared at meetings of the Medication Safety Committee.

Minutes of meetings of the Medication Safety Committee submitted to HIQA were comprehensive and showed that meetings followed a structured agenda, were well attended, but there was no evidence that agreed actions were recorded and progressed from meeting to meeting. It was evident that the committee had oversight of high-alert medications, medication related patient-safety incidents and risks, relevant service improvements and medication related policies, procedures and guidelines. The committee's terms of reference submitted to HIQA were dated 2018, which would indicate the terms of reference need to be updated.

Antimicrobial Stewardship and Sepsis Committee

The hospital had an Antimicrobial Stewardship and Sepsis Committee who were assigned with the responsibility for overseeing the implementation of the hospital's antimicrobial stewardship programme.[†††] The committee, co-chaired by a consultant obstetrician and gynaecologist and a consultant microbiologist, met every three months, in line with its terms of reference. The committee had a dual reporting arrangement. It reported and was operationally accountable to the hospital's Quality and Patient Safety Committee and the Drugs and Therapeutics Committee in Cork University Hospital. The committee submitted a report every three months or as requested to the hospital's Infection Prevention and Control Committee. The committee also liaised with the Antimicrobial Stewardship Committee in Cork University Hospital.

The committee's multidisciplinary membership included a consultant microbiologist, chief pharmacist for maternity services, antimicrobial pharmacists — one from Cork University Maternity Hospital and one form Cork University Hospital, clinical pharmacist, Ireland South Women and Infants Directorate's quality and patient safety manager, surveillance scientist, consultant neonatologist, representatives from midwifery management, representative from the hospital's infection prevention and control team, a non-consultant hospital doctor representative and an assistant director of nursing for sepsis, flu and surgical site infection

[†††] An antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

surveillance for the South/South West Hospital Group. The committee's terms of reference submitted to HIQA did not have an approval and or review date, so it was difficult to determine if the terms of reference were up to date.

The hospital did not have a deteriorating patient improvement programme, but at the time of inspection, the hospital's level of compliance with national guidance on the early warning system[‡‡‡] and sepsis was monitored by the Antimicrobial Stewardship and Sepsis Committee. This committee was being reconfigured at the time of inspection. The reconfiguration process will result in the separation and alignment of the monitoring of antimicrobial stewardship and the deteriorating patient into two separate and distinct committees — Antimicrobial Stewardship Committee and Sepsis Committee. The monitoring, governance and oversight of the hospital's level of compliance with the relevant early warning system and sepsis national guidelines will be assigned to the newly realigned Sepsis Committee.

Bed Management Committee

The hospital had no formal bed management committee, who had assigned responsibility for the safe transitions of care. Data on scheduled and unscheduled care activity and inpatient bed capacity was discussed at meetings of the Ireland South Women and Infants Directorate's Executive Management Committee, and reviewed at monthly performance meetings between the hospital and South/South West Hospital Group.

Other structures were in place to support and facilitate the collaborative working arrangements and practices between Cork University Maternity Hospital and other maternity units in the South/South West Hospital Group. These included, the:

- Maternity Services Working Group for Midwifery: this group discussed ways to support and enhance the continuous improvement of midwifery care across the Ireland South Women and Infants Directorate. The group, chaired by the hospital group's Chief Director of Nursing and Midwifery, met every month and membership included the directors of midwifery from each of the four maternity services in the hospital group.
- Neonatology network: neonatology services within the Ireland South Women and Infants Directorate operated within a hub and spoke model whereby neonatologists from the tertiary centre — Cork University Maternity Hospital collaborated and provided advice and support for paediatricians in the maternity units who do not have the services of on-site consultant neonatologists.
- Maternity Directorate Consultant Forum: this forum provided consultants in the specialties of obstetrics and neonatology across the Ireland South Women and

[‡‡‡] Early Warning System (EWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned Intensive Care Unit admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

Infants Directorate with an opportunity to communicate and share learning and expertise. The forum met every month and meetings were chaired by the Clinical Director for Maternity Services.

Effective formalised governance structures and management are fundamental to the sustainable delivery of safe, effective person-centred maternity care. HIQA was assured that there was effective and robust integrated corporate and clinical governance arrangements with clearly defined reporting structures, responsibilities and accountability arrangements in place at the hospital and in the South/South West Hospital Group. There was also evidence of collaboration, cooperation and integration with infection prevention and control, and medication safety governance structures in Cork University Hospital. Governance arrangements at Cork University Maternity Hospital and hospital group levels were focused on ensuring and improving the quality and safety of maternity services for women and babies.

There was evidence of progress in establishing the Ireland South Women and Infants Directorate and collaborative working arrangements between Cork University Maternity Hospital and the other three maternity units in the South/South West Hospital Group, which is commendable. Notwithstanding these arrangements, a formalised clinical maternity network with a single governance structure, as recommended in the *National Maternity Strategy* was not fully established and implemented at the time of inspection. Arrangements characteristic of a managed clinical maternity network, such as joint appointments in the specialties of obstetrics, anaesthesiology or neonatology or paediatrics across the maternity services in the South/South West Hospital Group, were not in place. The South/South West Hospital Group, together with the hospital and national HSE, need to progress the implementation of the maternity network incorporating all four maternity services in the hospital group under a single governance structure as detailed in the National Maternity Strategy.

Judgment: Substantially compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

Findings relating to the emergency department

The emergency department was the point of entry into the hospital for pregnant and postnatal women requiring unscheduled or emergency care. Systems and processes were in place at the hospital to support the effective functioning and to manage the demand for emergency care. Operational governance and oversight of the day-to-day workings of the hospital's emergency department was the responsibility of the on-call consultant obstetrician and gynaecologist. On the days of inspection, the majority of attendees to the department were self-referrals. Operationally, the department appeared to be functioning

well with the timely triage, medical review and assessment of women who presented for care.

Findings relating to the wider hospital and three clinical areas visited

There were management arrangements in place at the hospital to support and promote the delivery of high-quality, safe and reliable maternity services in relation to the four areas of known harm and these are discussed in more detail below.

Infection, prevention and control

The hospital had an overarching infection prevention and control programme[§§§] as per national standards.[****] The hospital's multidisciplinary infection prevention and control team were assigned with the responsibility for the day-to-day running of the hospital's infection prevention and control programme. The team comprised:

- 0.6 whole-time equivalent (WTE)[††††] consultant microbiologist. At the time of inspection, this 0.6 WTE position was filled permanently. The microbiologist also has a 0.4 WTE commitment to Cork University Hospital. HIQA was assured that, with cross-cover from Cork University Hospital, clinical staff in Cork University Maternity Hospital had access to a consultant microbiologist 24/7
- one WTE CMM 3
- one WTE CMM 2 in infection prevention and control and one WTE staff nurse or midwife in infection prevention and control. At the time of inspection, hospital management were progressing the recruitment campaign to fill these two positions
- one WTE antimicrobial pharmacist
- 0.5 WTE surveillance scientist. At the time of inspection, this position was unfilled.

The hospital's infection prevention and control programme for 2022, submitted to HIQA was comprehensive and set out the infection prevention and control objectives and plan of work to be achieved in the year. These included developing and adopting an annual infection prevention and control plan, which focused on:

- recruiting and appointing a surveillance scientist
- increasing staff awareness and education of hand hygiene practices, infection prevention and control practices including standard and contact-based precautions

[§§§] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short-, medium- and long-term, as appropriate to the needs of the service.

[****] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

[††††] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

- promoting practices to reduce the rates of healthcare-associated infections
- developing, reviewing and updating infection prevention and control policies, procedures and guidelines
- reviewing and implementing relevant national guidelines
- carrying out relevant infection prevention and control audits
- surveillance monitoring — hospital-acquired *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* rates and hospital-acquired *Staphylococcus aureus* blood stream infections
- antimicrobial stewardship monitoring
- influenza prevention and COVID-19 control and management
- identifying, supporting and implementing quality improvement initiatives to improve infection prevention and control practices at the hospital.

Implementation of the infection prevention and control programme and annual plan was monitored and overseen by the Infection Prevention and Control Committee.

Medication safety

The hospital did not have a comprehensive clinical pharmacy service.[‡‡‡‡] Due to staff resourcing deficits in the hospital's pharmacy department, up until the end of 2021, the clinical pharmacy services for women were primarily dispensary-based. The hospital's pharmacy department comprised:

- 5.1 WTE pharmacists, which included a chief pharmacist (0.6 WTE), one clinical pharmacist for obstetrics and gynaecology, an antimicrobial pharmacist, a neonatal pharmacist, a basic grade pharmacist for obstetrics and gynaecology and an informatics pharmacist (0.5 WTE). At the time of inspection, all pharmacist's positions were filled
- one WTE pharmacy technician. At the time of inspection, the pharmacy technician's position was filled and hospital management were progressing a business case for a second permanent pharmacy technician position.

Building a comprehensive clinical pharmacy service across the hospital was a key objective set by the Medication Safety Committee for 2022 and it was evident that this objective was being progressed.

[‡‡‡‡] A clinical pharmacy service is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

Deteriorating patient

The hospital was using the appropriate national early warning systems for the various cohorts of women — the Irish National Early Warning System (INEWS) version 2 for adults (non-pregnant) and Irish Maternity Early Warning System (IMEWS)[§§§§] version 2 for pregnant and or postnatal women. While there was no deteriorating patient improvement programme at the hospital, there was an Irish Maternity Early Warning System Committee, who reported and was accountable to the Antimicrobial Stewardship and Sepsis Committee. At the time of inspection, the Antimicrobial Stewardship and Sepsis Committee was being reviewed and restructured with the intention of separating the functions and creating two separate committees. Governance and oversight of the deteriorating patient will be incorporated into the remit of the revised, restructured and realigned Sepsis Committee. There was a dedicated early warning system coordinator and a clinical skills facilitator for INEWS and IMEWS who ensured that staff received training in the use of and escalation protocols for the early warning systems.

The Cork University Hospital and Cork University Maternity Hospital campus had one WTE resuscitation officer in post. The resuscitation officer advised on the equipment, layout and the list of medications required for a cardiac arrest. The cardiac arrest team from Cork University Hospital attends any cardiac arrest that occurs in Cork University Maternity Hospital. The Ireland South Women and Infants Directorate was a recognised Irish Heart Foundation training site comprising 11 instructors providing staff with training in basic life support.

Transitions of care

Transitions of care incorporates internal transfers within the hospital, shift and interdepartmental handovers, external transfer of women and babies and discharge from the hospital. Internal transitions of care at the hospital comprised the transfer of women and or babies to and from:

- the Birthing Suite
- the high-dependency unit
- DOMINO[*****] care pathway
- Neonatal Unit
- different care pathways based on the woman's risk categorisation —

[§§§§] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

[*****] The Domino (Domiciliary Care In and Out of Hospital) care pathway allows the midwife and or GP to monitor the woman throughout her pregnancy, for the midwife to support the woman when attending the hospital for labour and birth, and for the midwife to provide care for the woman and baby after birth at home. The pathway supports continuity of care, facilitates a hospital-based birth and provides an early return home from hospital.

- supported,[†††††] assisted[‡‡‡‡‡] or specialist.[§§§§§]

External transitions of care from the hospital usually comprised transfers to the Intensive Care Unit in Cork University Hospital. Cork University Maternity Hospital was a tertiary referral hospital and received maternal and neonatal transfers from other maternity units within and outside the South/South West Hospital Group. A discharge coordinator for the Neonatal Unit and an assistant director of midwifery, had oversight of the issues contributing to and impacting on the transitions of care for women and babies within and outside the hospital.

The safe transfer of care from and to the hospital was underpinned by a formally ratified inter-hospital transfer policy. This policy sets out the mandatory acceptance and retrieval of women and babies to and from Cork University Maternity Hospital, and the other three maternity units within the South/South West Hospital Group, including women and babies requiring complex or specialist maternity care before, during and after birth. The numbers of in-utero transitions into and from the hospital were reported monthly as part of the HSE's Irish Maternity Indicator System[******] and Maternity Safety Statements,[††††††] and these numbers were reviewed at meetings of the Quality and Patient Safety Committee.

Midwifery and nursing, medical and support staff workforce arrangements

The human resource department was responsible for workforce management in the hospital. The department tracked and trended staffing levels and absenteeism rates, which were reported at monthly performance meetings with the South/South West Hospital Group. Absenteeism rates at the hospital over the six months preceding HIQA's inspection, averaged 7% (including COVID-19 related leave). The revised absenteeism rates, excluding COVID-19 leave was 4%, which was in line with the HSE's target for 2022.

[†††††] This pathway is intended for normal risk women and babies, with midwives leading and delivering care within a multidisciplinary framework. Responsibility for the coordination of a woman's care is 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, along with her healthcare professional, can choose where to give birth, in a birth centre situated alongside the hospital, or at home.

[‡‡‡‡‡] This pathway is intended for women and babies considered to be at medium risk, and for normal risk women who choose an obstetric service. Responsibility for the coordination of a woman's care is assigned to a named obstetrician, and care is provided by obstetricians and midwives, as part of a multidisciplinary team. Care is provided across both the hospital and community, and births take place within a hospital setting in a specialised birth centre.

[§§§§§] This care pathway for high-risk women and babies is led by a named obstetrician, and is provided by obstetricians and midwives, as part of a multidisciplinary team. Care is, in the main, provided in a hospital setting and births take place in the hospital, in a specialised birth centre.

[******] This Irish Maternity Indicator System encompasses a range of multidisciplinary metrics, including hospital management activities, deliveries, serious obstetric events, neonatal, and laboratory metrics. It provides within hospital tracking of both monthly and annual data. It also provides national comparisons across all maternity units, allowing hospitals to benchmark themselves against national average rates and over time.

[††††††] The Maternity Safety Statement contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents.

The hospital's total approved complement of midwifery and nursing staff was 474.47 WTE. At the time of inspection, 446.63 WTE positions were filled, which represented a variance of WTE 27.84 (6%). On the days of inspection, the number of midwifery and nursing staff between approved, filled and actual midwifery and nursing complement available to work was 390.28 WTE, which represented a variance of 84.19 WTE (28%). Midwifery and nursing staff deficits, as a result of the variance between the approved, filled and actual staff complement, were evident in the four clinical areas visited during inspection. The greatest impact of the midwifery staff deficits was evident in the Birthing Suite. Inspectors reviewed a sample of midwifery staff rosters from the Birthing Suite for the four weeks preceding HIQA's inspection, which showed that staffing deficits and short-term absenteeism did impact on the provision of midwifery one-to-one support[‡‡‡‡‡‡] for women in labour.

Shift leaders were in place for each shift in the Birthing Suite during and outside core working hours, but with the staffing deficits in place, it was difficult to see how these midwives could be supernumerary as they may be required to take a caseload. The rostered complement of midwifery staff was only maintained through the use of relief or agency staff.

The hospital had a total approved complement of 38.93 WTE consultant medical staff. At the time inspection, 30.8 WTE (79%) consultant positions were filled, which represented a variance of 8.18 WTE (21%) between the approved and actual consultant staff complement.

The hospital had an approved complement of 27 WTE consultant obstetrician and gynaecologist. At the time inspection, 22 WTE (81%) of these positions were filled, which represented a variance of five WTE (19%) between the approved and actual consultant obstetrician and gynaecologist staff complement. Hospital management had received approval to recruit an additional four WTE consultant obstetrician and gynaecologists, which when recruited will increase the overall consultant obstetrician and gynaecologist staff complement to 31 WTE. All permanent consultant obstetrician and gynaecologists were on the specialist register with the Irish Medical Council.

The hospital had an approved complement of 7.5 WTE consultant neonatologist. At the time of inspection, six WTE (80%) consultant neonatologist positions were filled, which represented a variance of 20% (1.5 WTE) between the approved and actual consultant neonatologist staff complement.

[‡‡‡‡‡‡] A woman in labour is cared for by a midwife who is assigned and looking after just her – this is called 'one-to-one care'. One-to-one care aims to ensure that the woman has a good experience of care and reduces the likelihood of problems for her and her baby. See: https://www.nice.org.uk/guidance/qs105/chapter/quality-statement-2-one-to-one-care#:~:text=A%20woman%20in%20labour%20is,for%20her%20and%20her%20baby.

The hospital had a total approved complement of 35 WTE healthcare assistants. At the time of inspection, all healthcare assistant positions were filled, but due to approved leave the hospital were short three WTE (9%) healthcare assistants.

Findings relating to the emergency department only

Medical staffing levels in the emergency department were maintained at levels to support the provision of 24/7 emergency care. A senior clinical decision-maker at consultant obstetrician and gynaecologist level was available 24/7. The emergency department had a medical team providing medical cover 24/7, which comprised a consultant obstetrician and gynaecologist and two non-consultant hospital doctors — one at registrar grade and one at senior house officer grade. The on-call consultant obstetrician and gynaecologist provided consultant cover and was the assigned clinical lead who was responsible for the day-to-day functioning of the department. The consultant was operationally accountable and reported to the Clinical Director for Maternity Services.

The on-call consultant obstetrician and gynaecologist provided consultant cover for women accessing public care in the emergency department during core and outside core working hours. If a woman was accessing private care, their consultant obstetrician and gynaecologist would review and assess them in the emergency department during core working hours. The on-call consultant obstetrician and gynaecologist assessed and reviewed these women outside core working hours.

The emergency department's approved midwifery and nursing staff (excluding management grades) complement was 16.51 WTE. At the time of inspection, the department's actual midwifery and nursing staff complement was 17.73 WTE, but with short-term absenteeism the actual midwifery and nursing staff complement was 16.59 WTE. A CMM 3 had overall nursing responsibility for the emergency department. A CMM 2 or CMM 1 was rostered on every shift. Midwifery staff were supported by a 0.7 WTE healthcare assistant.

The hospital's inability to recruit and retain suitably qualified medical, nursing and midwifery staff was a high-rated risk recorded on the hospital's corporate risk register. It was evident that hospital management had implemented controls and actions to mitigate the associated risk to patient safety and these controls were reviewed and updated at meetings of the Ireland South Women and Infants Directorate's Executive Management Committee. The South/South West Hospital Group had developed a nursing and midwifery workforce planning strategy for 2020 – 2025, but there was no evidence that a time-bound action plan developed to facilitate and enable the implementation of the strategy.

Staff training and education

At the time of inspection, hospital management were in the process of establishing a central mechanism to record and monitor the staff uptake of mandatory and essential training across the hospital. Attendance at essential and mandatory training by non-

consultant doctors was recorded on the National Employment Record (NER) system.§§§§§§ Attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at clinical area level by clinical midwife managers, but measures were underway to ensure that this information is recorded centrally. Staff uptake of mandatory and essential training is discussed further under national standard 3.1.

In summary, there were defined management arrangements in place at the hospital to manage, support and oversee the delivery of high-quality, safe and reliable maternity services in the four areas of known harm. HIQA was satisfied that there were defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of maternity services at the hospital. Arrangements were in place to address increases or decreases in service demand and ensure the safety and quality of care provided to women and their babies. Nonetheless, while HIQA acknowledges hospital management's efforts to recruit medical, midwifery and nursing staff, there were substantive deficits in the range of 20% or greater in the hospital's approved and actual rostered complement of medical, midwifery and nursing staff. This significantly impacts on the delivery of high-quality, safe maternity care, on the provision of one-to-one midwifery support for women in labour and presents a risk to patient safety. Hospital management and the South/South West Hospital Group should continue in their efforts to recruit and retain staff to ensure the safety and quality of care provided to women and babies at Cork University Maternity Hospital.

Judgment: Partially compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring the quality and safety of maternity services

Performance data was collected, collated and published on a range of different clinical measurements related to the quality and safety of maternity services — Maternity Safety Statements and Irish Maternity Indicator System, in line with the national HSE reporting requirements. Performance data was also submitted to the National Perinatal Epidemiology Centre (NPEC)******* and, where relevant, Vermont Oxford Network.††††††† Collated

§§§§§§ The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

******* The National Perinatal Epidemiology Centre conducts ongoing national audits of perinatal mortality, maternal morbidity and home births in Ireland.

††††††† The Vermont Oxford Network is a voluntary collaborative group of health professionals committed to improving the effectiveness and efficiency of medical care for newborn infants and their families through a coordinated programme of research, education, and quality improvement projects.

performance data was reviewed at meetings of the Quality and Patient Safety Committee and monthly performance meetings with the South/South West Hospital Group.

Risk management

HIQA was assured that the hospital had formalised structures and processes in place to proactively identify, analyse, manage, monitor and escalate risk. Risks were identified, managed and monitored at local clinical area and senior hospital management levels. Clinical midwife managers were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential patient safety risk. Identified risks and corrective actions and controls to mitigate any potential patient safety risk were recorded on the hospital's corporate risk register, which was updated by hospital management every four months. High-rated risks not managed at hospital level were escalated to the South/South West Hospital Group. The management of risks related to the four areas of known harm is discussed further under national standard 3.1.

Audit activity

There was no clinical audit committee at the hospital to oversee the conduct of clinical audit and implementation of findings and recommendations from audit activity at the hospital. The conduct and approval of clinical audits was overseen by the Ireland South Women and Infants Directorate's Local Information Governance Group, the chair of whom was a member of the Ireland South Women and Infants Directorate's Executive Management Committee. The Quality and Patient Safety Committee had an awareness of the clinical audit activity carried out at the hospital. However, it was unclear to inspectors what governance committee had oversight of the audit activity, were responsible for acting on audit findings and monitoring the implementation of recommendations or any quality initiatives to improve maternity care. This could be remedied by hospital management following this inspection.

Oversight of serious reportable events and patient-safety incidents

The hospital's Serious Incident Management Team (SIMT) were responsible for ensuring that all serious reportable events, serious incidents and patient-safety incidents were managed in line with the HSE's Incident Management Framework and there was timely implementation of recommendations from reviews. The SIMT was chaired by the Clinical Director for Maternity Services and membership included the director of midwifery, Ireland South Women and Infants Directorate's head of operations, clinical lead for quality and patient safety, Ireland South Women and Infants Directorate, consultant neonatologist, quality and safety manager and practice development coordinator. The SIMT met every two or three months or more frequently, if needed. The team was operationally accountable, reported and submitted a report to the Ireland South Women and Infants Directorate's Executive Management Committee every three months. It was evident that the number, type, location and category of reported serious reportable events were tracked and trended and the resulting information was reviewed at meetings of the Quality and Patient Safety Committee and monthly performance meetings with the South/South West Hospital Group.

Perinatal morbidity and mortality multidisciplinary meetings

Multidisciplinary perinatal mortality and morbidity meetings were held every week in the hospital with attendance from medical, midwifery and nursing staff from Cork University Maternity Hospital and the other three maternity units within the Ireland South Women and Infants Directorate. At this meeting, the hospital's performance and compliance with quality and safety indicators were reviewed, discussed and compared with similar data from other similar sized maternity services. A sample of attendance records submitted to HIQA showed that attendance at the meetings was generally good. Learning from perinatal mortality and morbidity meetings was shared with staff at clinical handover.

Feedback from women using the maternity services

Findings from the hospital's 2020 National Maternity Experience Survey were reviewed at meetings of the Quality and Patient Safety Committee. At the time of inspection, hospital management were working with the HSE to implement quality improvement initiatives, in response to the survey findings. The quality improvement initiatives focused on:

- improving access to antenatal educational classes
- improving access to health information about the physical and mental health changes that occur during pregnancy
- improving information about nutrition during pregnancy, birth and after birth
- formalising and enhancing the process for women wanting to discuss their labour and birth experience.

In addition, at the time of inspection, initiatives prioritised by the HSE's National Women and Infants Health Programme (NWIHP)[‡‡‡‡‡‡‡] — stop smoking service and making every moment count,[§§§§§§§] were being implemented at hospital.

Other quality improvement initiatives being developed and implemented at the hospital at the time of inspection, included:

- an Early Transfer Home[********] care pathway
- a postnatal hub to offer support for women following birth.

[‡‡‡‡‡‡‡] The National Women and Infants Health Programme was established by the HSE in January 2017, to lead the management, organisation and delivery of maternity, gynaecology and neonatal services, to strengthen the services currently delivered across primary, community and acute care settings and to ensure the consistent delivery of high-quality care in maternity services nationally.
[§§§§§§§] The making every moment count is a resource developed by the HSE whereby health professionals can encourage women using maternity services to make healthier lifestyle choices during routine contacts to help prevent and manage chronic diseases. See https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/.
[********] Early Transfer Home Service is designed for women who had a healthy full-term baby, who live within a defined catchment area and who want to return home early after birth (12-24 hours) to receive care after birth at home by the community midwifery team.

Overall, HIQA was satisfied that there were effective systematic monitoring arrangements in place at the hospital to identify and act on opportunities to continually improve the quality, safety and reliability of the maternity services. There were also systems and processes in place to identify, manage and minimise risks to women and babies using the maternity services. It was evident that information gained from the monitoring of performance was used to improve maternity services for women and babies. However, the governance, oversight and monitoring of audit activity and the subsequent implementation of recommendations and any quality initiatives from audits is an identified opportunity for improvement.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings informing judgments on compliance with national standards are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for maternity care.[††††††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of women who require care. It supports equitable access for all women using the maternity services so that they have access to the right care and support at the right time, based on their assessed needs. Inspectors observed staff in all the clinical areas visited promoting a person-centred approach to care.

Inspectors observed how staff promoted and protected the privacy and dignity of women when providing care. Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards women attending the department. Staff in the emergency department were also observed actively engaging and communicating with women in a respectful, kind and sensitive way.

[††††††††] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services.

Women receiving care in the emergency department were accommodated in self-contained cubicles, which facilitated and enabled the meaningful promotion of the woman's human rights especially privacy, dignity and confidentiality. This is consistent with the human rights-based approach to care promoted by HIQA.

Inspectors observed staff in the three inpatient clinical areas visited orientating and familiarising women with their surroundings. Staff sought women's consent for procedures. Staff were observed being responsive and attending to the woman's individual needs in a respectful way. Inspectors observed staff offering assistance with baby care and breast feeding.

In general, the physical environment in the inpatient clinical areas visited promoted the women's privacy, dignity and confidentiality. Privacy curtains were used when women were being assessed and receiving care in multi-occupancy rooms. These findings were consistent with the overall findings from the 2020 National Maternity Experience Survey, where the hospital scored similar or higher than the national average in questions related to feeling involved in decisions and being treated with respect and dignity during pregnancy, labour and birth, and after birth. However, findings from the survey did indicate areas that needed improvement, these included providing women with an opportunity to talk about their labour and birth experience, and involving women in the decision-making process after the birth. As discussed in national standard 5.8, there was evidence that quality improvement initiatives were being implemented to further improve women's experiences.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of women receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. At the time of inspection, hospital management were progressing with the implementation of a number of quality initiatives to improve maternity services for women and their babies.

Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Inspectors observed staff to be respectful, kind and caring towards women in the clinical areas visited. In general, staff were observed actively listening to and effectively communicating with women in an open and sensitive manner, in line with the woman's expressed needs and preferences. This was confirmed by women who spoke positively about their interactions with staff in the clinical areas visited.

A culture of kindness, consideration and respect was promoted at the hospital through the development of a number of practices. For example:

- women were called by their preferred name
- women were provided with information about their care and encouraged to be active in the decision-making about their plan of care
- a home away from home environment was encouraged for women needing to remain in hospital for long periods
- women's food preferences were facilitated where possible
- women's birth wishes were discussed and documented in a birth plan.

Overall, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for women receiving care at the hospital.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

There was a coordinated system and process in place at the hospital to respond to complaints and concerns at the hospital made by women using the maternity services and or their families. The hospital's quality and patient safety manager was the designated complaints officer, who had assigned responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. The Quality and Patient Safety Committee had effective oversight of the timeliness of responses and management of complaints at the hospital, and reviewed open and closed complaints every three months. Intricate complaints were escalated to the Ireland South Women and Infants Directorate Executive Management Committee.

The HSE's complaints management policy '*Your Service Your Say*'‡‡‡‡‡‡‡‡ was implemented in the hospital. Hospital management supported and encouraged point of contact complaint resolution in line with national guidance. Verbal complaints were managed at local clinical area level by clinical midwife managers and escalated to the CMM 3 if not resolved. Written complaints were manged by the CMM 3 for their area of responsibility, with input from midwives and or the clinical midwife managers, as appropriate. The hospital formally reported on the number and type of complaints received annually.

Hospital management received a total of 217 complaints — 195 written and 22 verbal complaints in 2021, a 19% increase on the number of complaints received in 2020.

‡‡‡‡‡‡‡‡ Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from: https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

While the majority of complainants (95%) received an acknowledgment within five days, only half of the complaints received in 2021 were resolved within the HSE's 30 working day timeframe, this is significantly lower than the HSE's target of 75%. Hospital management told inspectors that slippage in achieving the HSE's target for resolution was usually due to the fact that further information or investigation of the complaint was needed. When this occurred, the complainant was informed of the reason for the delay.

Complaints were tracked and trended by the hospital's quality and patient safety department to identify the emerging themes, categories and departments involved. Themes to emerge in 2021 were access to care and facilities, safe and effective care, communication and information, and dignity and respect. There was evidence that quality improvement initiatives were implemented to improve maternity services and care as a result of complaints received. For example, the induction room in the Birthing Suite was reconfigured and refurbished resulting in the creation of three single self-contained cubicles that promoted and protected the woman's privacy and dignity when labour was being induced.

Staff who spoke with inspectors reported that feedback and learning from the tracking and trending of complaints was infrequent and informal. Learning from complaints or the complaints resolution process was not shared across the hospital, which is an opportunity missed. Inspectors did not observe information about the HSE's '*Your Service Your Say'* displayed in the clinical areas visited.

The hospital did not have a dedicated patient advice and liaison service. In hospitals that have such a service, the service supports women and their families to provide feedback or make a compliant about the care received at the hospital. They ensure that the woman's voice is heard either through the woman directly or through a nominated representative. Women who spoke with inspectors were not aware of any independent advocacy services available to them. Inspectors did not observe information about independent advocacy services displayed in any of the clinical areas visited.

Overall, there were systems and processes in place at the hospital to respond to complaints and concerns raised by women who use the maternity services and or their families. HIQA was satisfied that these were fully effective in resolving complaints and concerns promptly and effectively. However, hospital management should aim to ensure the effective resolution of complaints within national HSE targets. Women receiving care at the hospital should be provided with information on the hospital's complaints process and on any independent advocacy services available to them. A formal standardised system should also be implemented at the hospital to facilitate the sharing of learning from complaints and the complaints resolution process with staff to help reduce reoccurrence of the same issues for women and babies using the services.

Judgment: Substantially compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of service users.
Inspectors observed during inspection that overall, in the clinical areas visited, the hospital's physical environment was generally spacious, bright and welcoming, well maintained and clean with few exceptions. There was evidence of some general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning and posed an infection prevention and control risk. Environmental cleaning was carried out by staff from Cork University Maternity Hospital and an external contract cleaning company. Cleaning staff were available 24/7. Clinical midwife managers and cleaning supervisors had oversight of the standard of cleaning in their clinical areas of responsibility. Terminal cleaning§§§§§§§§ was carried out by designated staff when required. Clinical midwife managers who spoke with inspectors were satisfied with the level of cleaning resources in place during core and outside core working hours. Cleaning of equipment was assigned to healthcare assistants and a tagging system was used to identify clean equipment. In all clinical areas visited, the equipment was observed to be generally clean. Clinical areas also appeared to have adequate storage space. Supplies and equipment were stored adequately and appropriately. Hazardous material and waste was safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately. Clinical midwife managers had access to maintenance services and were satisfied with the level of access to these services. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available in all the clinical areas visited. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Hand hygiene sinks throughout the hospital conformed to requirements.********* Infection prevention and control signage in relation to transmission-based precautions was observed throughout the clinical areas visited. Appropriate PPE was available outside isolation rooms and multi-occupancy rooms where patients with confirmed or suspected infections were accommodated. Staff were also observed wearing appropriate PPE, in line with public health guidelines at the time of inspection. Physical spacing of one metre was observed to be maintained between beds in some multi-occupancy rooms in the clinical areas visited. However, this was not the case is all multi-occupancy rooms. Inspectors did find that the space in one two-bedded multi-occupancy room visited during inspection was restrictive. Inspectors were concerned about the level of space in one of the two-bedded multi-occupancy rooms visited, especially if access was needed during an obstetric and or neonatal emergency. This was escalated to the clinical midwife manager and hospital

§§§§§§§§ Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

********* Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

management at the time of inspection and a risk assessment was requested. A risk assessment was completed and appropriate corrective actions and controls were introduced to mitigate the potential risk to women and babies in the event of a maternal and or neonatal emergency.

There were processes in place to prioritise and ensure appropriate placement and management of women with suspected or confirmed communicable disease. This process was overseen by the infection prevention and control midwife. There were isolation facilities in all clinical areas visited, but the number of isolation rooms with en-suite bathroom facilities could be increased. Hospital management identified the need for more single rooms with en-suite bathroom facilities as a priority in future capital development plans. At times, when all single rooms were occupied, women with an infection risk or confirmed infective status requiring isolation were cohorted together in a two-bedded multi-occupancy room with en-suite bathroom facilities.

Emergency supplies and relevant medications to manage obstetric and neonatal emergencies such as maternal haemorrhage, eclampsia and neonatal resuscitation were readily available and accessible in all clinical areas visited. Emergency resuscitation equipment for women and babies was also available in all clinical areas visited. There was adequate evidence to show that this emergency equipment was checked daily and weekly, and serviced as per hospital policy to ensure accessibility and functionality.

In summary, the physical environment and clinical equipment was observed to be generally spacious, bright, clean and well maintained at the time of inspection. The overall number of single rooms with en-suite bathroom facilities in the hospital could be increased. Hospital management have identified that this was an area to be prioritised in any future capital development projects.

Judgment: Substantially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Hospital management monitored and reviewed information from multiple sources, including:

- quality and safety performance metrics
- findings from clinical audit activity
- risk assessments
- patient-safety incident reviews
- complaints, concerns and compliments received from women using the service and or families

- women's feedback surveys.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee had oversight of the monitoring of infection prevention and control practices at the hospital. Environment, equipment and hand hygiene audits were undertaken every month using a standardised approach. Compliance with peripheral vascular catheter and urinary catheter care bundles was also monitored monthly in the clinical areas visited.

Monthly environmental hygiene audits were carried out by clinical midwife managers and staff midwives. Environmental audit results submitted to HIQA showed that, generally there was a high level of compliance with expected hygiene standards in all the clinical areas visited. Quality improvement plans were developed when environmental hygiene standards fell below the expected standard. Clinical midwife managers and the infection prevention control midwife were responsible for and had oversight of the implementation of these plans. Progress on implementing quality improvement plans were reported to the Infection Prevention and Control Committee.

Monthly hand hygiene audits were conducted by clinical midwife managers and staff midwives. The hospital's overall hand hygiene audit compliance rate for 2021 was 93.8%, above the HSE's target of 90%. Hand hygiene audit results submitted to HIQA showed that, generally there was a high level of compliance with expected hand hygiene standards in the clinical areas visited. Quality improvement plans were developed when hand hygiene standards fell below the national HSE target of 90%. Findings from environmental, equipment and hand hygiene audits were shared with clinical staff at staff meetings and via a messaging application on smart mobile phones.

Monitoring of hospital's compliance with established performance metrics

Hospital management monitored and reviewed performance data collected and collated for the HSE's Maternity Safety Statements, Irish Maternity Indicator System, the National Perinatal Epidemiology Centre and, where relevant, Vermont Oxford Network. This data was used to monitor and evaluate the safety and quality of maternity and neonatal services. The data was compared and benchmarked to and against other similar sized maternity services in Ireland.

Hospital management also monitored and reviewed performance data in relation to the prevention and control of healthcare-associated infection.[†††††††††] Each month hospital management monitored and publically reported on rates of:

- maternal bacteraemia

[†††††††††] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf.

- early onset neonatal bacteraemia
- maternal sepsis
- retained swabs
- new cases of hospital-acquired *Clostridioides difficile*
- new cases of *Carbapenemase-Producing Enterobacterales*
- new cases of hospital-acquired *Staphylococcus aureus* blood stream infections
- cases of hospital-acquired COVID-19 and outbreaks.

Medication safety monitoring

Performance data relating to medication practices was collated monthly through the HSE' 'Test Your Care' metrics.[‡‡‡‡‡‡‡‡‡] Documentation submitted to HIQA showed a high level of compliance with these metrics in all clinical areas visited in the two months preceding HIQA's inspection. The hospital participated in the national antibiotic point prevalence study and some medication practices at the hospital were audited. Examples of medication audits carried year to date in 2022 included:

- medication reconciliation
- vancomycin use in the Neonatal Unit
- pyrexia in labour – prescribing/antibiotic de-escalation audit.

While it was evident that quality improvement plans were developed when medication practices were below expected standards, quality improvement plans reviewed by inspectors were not time-bound and did not always have a person assigned to implement the remedial actions identified to improve medication practices at the hospital. There was also limited evidence that measures introduced to improve medication practices were re-audited to determine the effectiveness of the improvements.

Deteriorating patient monitoring

Cork University Maternity Hospital was the first of the 19 maternity services in Ireland to implement the electronic healthcare record — the Maternal and Newborn Clinical Management System. The IMEWS and Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool[§§§§§§§§§] were integrated into the system. Staff who spoke to inspectors confirmed that they were trained and inducted on how to use the

[‡‡‡‡‡‡‡‡‡] Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.
[§§§§§§§§§] Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

system. A designated coordinator was onsite to support staff when using the electronic healthcare record.

Performance data relating to the escalation process and response when a woman's and or baby's clinical condition deteriorated was collated monthly through 'Test Your Care' metrics. Documentation submitted to HIQA showed a high level of compliance with the majority of IMEWS metrics and clinical record keeping in all clinical areas visited in the two months preceding HIQA's inspection.

Auditing of compliance with national guidance on INEWS and the ISBAR communication tool was carried out at the hospital using a standardised approach. This auditing activity did identify low compliance rates with some elements of the IMEWS escalation protocol — repeating IMEWS within protocol time and clinical notification. Actions to improve compliance with the escalation protocol were identified. These included the sharing of audit findings with staff and increasing staff training through optimisation sessions via the electronic healthcare record. However, no time-bound quality improvement plan was developed to support the implementation and evaluation of the effectiveness of these actions.

Transitions of care monitoring

A mandatory acceptance and retrieval policy supported the transfer of women and babies to and from Cork University Maternity Hospital, and the other three maternity units within the South/South West Hospital Group. The numbers and reasons for in-utero transfer into and from the hospital were reported monthly as part of the HSE's Irish Maternity Indicator System and Maternity Safety Statements. In 2021, 41 pregnant women were admitted to the hospital for specialist care and three pregnant women were transferred from the hospital to other hospitals for specialist care.

Documentation submitted to HIQA showed high levels of compliance with clinical midwifery handover in all clinical areas audited in the months preceding HIQA's inspection (July-September 2022).

Women's experience of using the maternity services

Staff in all clinical areas visited were not always aware of hospital's findings from the National Maternity Experience Survey. There was evidence that quality improvement plans were introduced to improve women's experience. For example, the Ashlinn Suite was an area in the hospital, repurposed and refurnished as a result of findings of the National Maternity Experience Survey. It was a designated area where multidisciplinary care was provided for women threatening or experiencing early pregnancy loss.

Overall, the hospital had robust systems in place to monitor and evaluate maternity services provided at the hospital and this information was used to improve services. Auditing of compliance with national guidance was occurring to identify areas for improvement and provide hospital management and women who use the maternity services with assurances

on the quality and safety of the services. However, quality improvement plans developed to improve standards and compliance with best practice were not always time-bound and did not always have a person assigned with the responsibility to implement the actions in the plans, this is an area that could be improved following this inspection.

Judgment: Substantially compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

The hospital had effective systems and processes in place to identify, evaluate and manage immediate and potential risks to women using the service in the four areas of known harm. Risks were identified and managed at clinical area level. Risks were recorded on the hospital's corporate risk register. The Quality and Patient Safety Committee and Ireland South Women and Infants Directorate's Executive Management Committee had oversight of the identified risks and effectiveness or not of corrective actions or controls introduced to mitigate the identified risks to patient safety.

At the time of inspection, nine risks related to the four areas of known harm were recorded on the hospital's corporate risk register. These included risks related to infection prevention and control surveillance, staff familiarity with the electronic healthcare record, incomplete and inadequate information shared at clinical handover and medical, midwifery and nursing staffing levels. During the inspection, there was evidence that the identified controls and corrective actions were being implemented to mitigate these risks.

Protecting women from the risk of harm in the emergency department

The emergency department at Cork University Maternity Hospital had a reported average attendance rate of 40 - 60 women per day. This represents a reported attendance rate of approximately 14,600 - 21,900 per year. All women attending the hospital's emergency department were triaged and assigned to one of three prioritisation categories according their clinical presentation — acute for immediate medical review, acute review as soon as possible and non-acute. Five women were receiving care in the department at 11.00am on the first day of inspection. The longest time in the department was two hours 38 minutes and the shortest was five minutes (woman was a new presentation to the department and was waiting to be triaged).

At 11.00am on the first day of inspection, the waiting time from:

- registration to triage ranged from 12 to 23 minutes. The average waiting time was 14 minutes
- triage to medical review was 45 minutes, with only one woman waiting to be medically reviewed

- no woman was waiting for an inpatient bed.

If women attending the emergency department were waiting over four hours to be reviewed, the on-call consultant obstetrician and gynaecologist and assistant director of midwifery with responsibility for the department were contacted and measures were implemented to reduce and ensure the timely medical review of women.

Infection outbreak preparation and management

Women were screened for multi-drug resistant organisms and COVID-19 at the first antenatal booking and the infection status was recorded on the electronic healthcare record. A COVID-19 management pathway was in operation at point of entry to the hospital. On arrival to the hospital, women were screened for signs and symptoms of COVID-19. If suspected or confirmed COVID-19, women were then referred to and assessed in the COVID-19 Assessment Unit. Women with signs and symptoms of COVID-19 had access to rapid testing.

Screening for *Carbapenemase-Producing Enterobacterales* was not carried out on all women, as per national guidance. Women with an infective status were isolated within 24 hours of admission or diagnosis as per national guidance. A prioritisation system was used to allocate patients to isolation facilities and the process was overseen by the infection prevention and control midwife.

HIQA was satisfied that the management of an infection outbreak was underpinned by a formalised up-to-date outbreak management policy and plan. Year to date in 2022, the hospital had two reported infection outbreaks — Vancomycin Resistant Enterococci (VRE) and Extended-spectrum Betalactamase (ESBL). Multidisciplinary outbreak teams were convened to advise and oversee the management of the VRE and ESBL outbreaks. The summary reports from both outbreaks, submitted to HIQA were comprehensive and outlined potential contributing factors, control measures introduced to mitigate the risk to patient safety in the short-term and learning points to reduce reoccurrence.

Medication safety

There were only limited clinical pharmacy services at the hospital and medication reconciliation was not undertaken for all women. A formalised prioritisation tool was used to identify women needing pharmacy-led medication reconciliation. Medication stock control in the clinical areas visited was carried out by pharmacy technicians every week. HIQA was satisfied that risk reduction strategies for high-risk medicines were used in the hospital. The hospital had a list of high-alert medications (HAMS) that included the core high-risk medications represented by the acronym 'A PINCH'.********** The use of high-risk medications at the hospital was underpinned by a formalised policy approved by the Medication Safety Committee. The hospital had a list of sound-alike look-alike medications.

********** Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

Inspectors observed the use of risk-reduction strategies, such as tall man lettering to support the safe use of medications at the hospital. The hospital's electronic medication formulary, prescribing guidelines and administration guidelines were available and accessible to staff at the point of prescribing and through an application for smart mobile phones.

Deteriorating patient

The hospital had implemented the IMEWS version 2 guideline and observation chart. Staff in the clinical areas visited were knowledgeable about the IMEWS escalation process. There were systems in place to manage women with a triggering early warning system. Staff reported that there was no difficulty accessing medical staff to review a woman whose clinical condition was deteriorating. The ISBAR communication tool was used when requesting medical review for a woman whose early warning system triggered. Inspectors reviewed a sample of healthcare records and found that IMEWS charts were not always calculated, were calculated incorrectly and or the escalation process was not always consistent with the IMEWS escalation protocol. These findings were escalated and discussed with the clinical midwife manager on the day of inspection.

Specialised consultants were available in Cork University Maternity Hospital, if needed in the specialties of respiratory medicine, cardiology, endocrinology, general surgery and psychiatry.

Safe transitions of care

The hospital had a system in place, underpinned by a formalised policy, to reduce the risk of harm associated with the process of maternal and neonatal transfer in and between maternity services in the South/South West Health Group. A discharge coordinator supported and facilitated the effective discharge planning of babies from the hospital's Neonatal Unit.

Policies, procedures and guidelines

The hospital had a suite of infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions and outbreak management. At the time of inspection, a number of these policies, procedures, protocols and guidelines were being reviewed and updated.

The hospital also had a suite of up-to-date medication policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff via a computerised document management system. The Ireland South Women and Infants Directorate had developed a number of policies, procedures and guidelines to standardise maternity care across all maternity services in the hospital group, these included:

- policy and procedures on inter-hospital transfer of women and or infants at Ireland South Women and Infants Directorate
- clinical guideline on the immediate care of the newborn including skin-to-skin contact and safe positioning after birth and baby safety postpartum

- guideline for postnatal care: the early transfer home scheme.

Uptake of mandatory and essential training

Since HIQA's last inspection at the hospital, hospital management had implemented initiatives to improve the staff attendance at and uptake of essential and mandatory training. These included the establishment of the MaternityONESouth project. This project was established to standardise policies, procedures, protocols and guidelines, and staff training on obstetric and neonatal emergencies across the four maternity services in the South/South West Hospital Group.

Hospital management were also in the process of developing a training portal as a repository for mandatory training and to record the uptake of staff training. Hospital management were working with the Centre for Midwifery Education to identify staff training needs, to develop a training strategy and to facilitate staff training in obstetric and neonatal emergencies. The Obstetric and Neonatal Emergencies Committee had oversight of the staff training in obstetric and neonatal emergencies. This committee, chaired by a consultant obstetrician and gynaecologist, met every two months. Membership included the following representatives: neonatologist, neonatal nursing, anaesthesiologist, midwifery, midwifery tutor, NPEC and University College Cork School of Nursing and Midwifery. The committee was operationally accountable and reported to the Quality and Patient Safety Committee.

Clinical midwife managers and clinical skills facilitators were responsible for maintaining a record and had oversight of the uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and IMEWS on the HSE's online learning and training portal (HSELanD). Midwifery, medical and support staff received formal induction training in the four areas of known harm.

HIQA noted some improvement in the attendance and uptake of staff training in obstetric and neonatal emergencies since the last inspection in 2019. However, staff uptake of mandatory and essential training, relevant to their scope of practice, is an area that could be further improvement. Midwifery and nursing staff uptake of mandatory and essential training in the last two years in:

- hand hygiene was 87%, below the HSE target of 90%
- standard and transmission-based precautions was 95%
- donning and doffing PPE was 100%
- medication safety was 98%
- basic life support was 86%
- IMEWS was 91%
- ISBAR communication tool was 95%

- obstetric emergency training (PROMPT)[††††††††††] was 80%
- fetal monitoring was 82%
- neonatal resuscitation was 88%.

HIQA did not receive training records outlining the uptake of training for medical staff.

In summary, there were effective systems in place at the hospital to identify and manage the potential risk of harm for woman and babies associated with the four areas of known harm. Notwithstanding this, a comprehensive clinical pharmacy service should be developed and implemented across all clinical areas to support safe medication practices. While noting the improvement in staff attendance at and uptake of training in obstetric and neonatal emergencies, and hospital management's efforts to improve oversight and uptake of staff training, this is an area that could be improved further. Hospital management should ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice at the required frequency, in line with national standards.

Judgment: Substantially compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

There were effective management systems in place at the hospital to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Patient-safety incidents related to the four areas of known harm were reported to the National Incident Management System (NIMS),[‡‡‡‡‡‡‡‡‡‡] in line with the HSE's Incident Management Framework. The hospital's rate of reporting of clinical incidents to NIMS suggest a good reporting culture at the hospital. In 2021, 1,685 clinical incidents were reported to NIMS, equating to an average reporting of 140 patient-safety incidents per month, which is comparable to other similar sized maternity hospitals in Ireland. Up to the day of inspection, a total of 603 patient-safety incidents were reported to NIMS, which would indicate a decrease in the number of incidents reported year to date in 2022 when compared to 2021 reported incidents. In the first six months of 2022:

- 310 patient-safety incidents were reported in the emergency department
- 164 patient-safety incidents were reported in the Birthing Suite
- 17 patient-safety incidents were reported in 3-South

[††††††††††] The **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining (PROMPT) course is an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies.
[‡‡‡‡‡‡‡‡‡‡] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

- 11 patient-safety incidents were reported in 4-South.

Staff who spoke with HIQA were knowledgeable about what and how to report and manage a patient-safety incident, and the most commonly reported incidents year to date in 2022 — needle stick injury and delay in administration of medications. Patient-safety incidents in relation to the four key areas of known harm were tracked and trended at the hospital and the resulting information was reviewed at meetings of the Quality and Patient Safety Committee.

Infection prevention and control patient-safety incidents

Infection prevention and control related patient-safety incidents were reviewed by the hospital's infection prevention and control team and reported to the Infection Prevention and Control Committee. The Infection Prevention and Control Committee had oversight of the effectiveness of any actions and control measures introduced to mitigate patient safety risks arising from patient-safety incidents.

Medication patient-safety incidents

Medication related patient-safety incidents were reported to the Medication Safety Committee. In 2021, 23 medication patient-safety incidents were reported in the hospital, which equates to 1% of all patient-safety incidents that year. Of the 23 medication incidents reported, 70% were drug administration errors and 30% were prescription errors. Increasing medication patient-safety incident reporting across the hospital is a key objective set by the Medication Safety Committee for 2023. Efforts to develop and optimise the electronic healthcare record was ongoing at the time of inspection to support safe medication prescribing and administration, and enhance medication practices at the hospital.

Transitions of care patient-safety incidents

Eleven patient-safety incidents related to clinical handover were reported in the hospital in 2021. Patient-safety incidents in relation to the deteriorating patient were not tracked or trended at the hospital.

There was evidence that quality improvement initiatives were identified following the tracking and trending of patient-safety incidents. However, inspectors did not see evidence of any time-bound action plans, with a person assigned with responsibility to implement these initiatives. The Quality and Patient Safety Committee, SIMT, Ireland South Women and Infants Directorate's Executive Management Committee and South/South West Hospital Group had oversight of the number, type, location and categories of reported patient-safety incidents. Feedback and recommendations relating to patient-safety incidents was shared with staff at the safety huddles held in the clinical areas. The review of any serious reportable events, serious incidents and patient-safety incidents at the hospital was supported by the newly established HSE's NWIHP's Obstetric Emergency Support Team.

Recommendations from reviews of patient-safety incidents were implemented with oversight from the Quality and Patient Safety Committee. HIQA was satisfied that learning from patient-safety incidents were shared with clinical staff in the hospital, at hospital group level and wider with other maternity services. This was evident by the sharing of learning from the neonatal encephalopathy§§§§§§§§§ review carried out at the hospital earlier this year. The neonatal encephalopathy review was commissioned by the Clinical Director for Maternity Services following a review of the hospital's neonatal outcomes in 2020, which identified that recorded numbers of cases of neonatal encephalopathy and therapeutic hypothermia********** at the hospital were above the reported national average for 2018 and 2019. The review report, submitted to HIQA was comprehensive and outlined potential contributing factors, areas for improvement and learning points for staff. Learnings from the review were shared with clinical staff in the hospital, with staff in the other three maternity services in the South/South West Hospital Group and nationally with all other maternity services through the creation of a learning notice developed by the HSE's NWIHP. The rate of neonatal encephalopathy at the hospital for 2021 was significantly decreased and marginally above the national target for that year.

Inspectors also observed posters displayed in the clinical areas visited, outlining the steps in the 'ASSIST' model of communication†††††††††† to guide staff when disclosing the occurrence of a patient-safety incidents to women and their families.

Overall, HIQA was satisfied there was a robust system in place at the hospital to identify, report, manage and respond to patient-safety incidents. Infection prevention and control patient-safety incidents, medication incidents and transitions of care were tracked and trended, but those related to the deteriorating patient were not, which is an area that could be improved following this inspection. Recommendations from patient-safety reviews were implemented to improve maternity services for women and babies. Learnings from patient-safety incidents was shared with clinical staff in the hospital and other maternity services, which is important for the safety and continual improvement of services for women and babies.

Judgment: Substantially compliant

§§§§§§§§§ Neonatal encephalopathy is a condition occurring in babies born over 35 week's gestational age where there is disturbed neurological function.

********** Therapeutic hypothermia is a therapy where an infant is cooled within six hours of birth to a targeted core body temperature of between 33°C to 34°C for a duration of 72 hours. Following the 72 hour period, the infant is rewarmed to normal body temperature over a 6-12 hour period.

†††††††††† The **A**cknowledge, **S**orry, **S**tory, **I**nquire, **S**olutions, **T**ravel (ASSIST) model of communication was developed by the Medical Protection Society to assist staff in the discussion of adverse events with people who use healthcare services, and or their families or support person(s).

Conclusion

HIQA carried out an announced inspection of Cork University Maternity Hospital to assess compliance with national standards from the *National Standards for Safer Better Health*. The national standards assessed during the course of the inspection were mapped to the national standards from the *National Standards for Safer Better Maternity Services*, which sit within the overarching framework of the *National Standards for Safer Better Healthcare.*

The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was found to be;

- compliant with two national standards assessed
- substantially compliant with seven national standards assessed
- partially compliant with one national standard assessed.

Capacity and Capability

HIQA was satisfied that there were formalised corporate and clinical governance arrangements in place at the hospital for assuring the delivery of high-quality, safe and reliable healthcare with effective oversight by the South/South West Hospital Group. These governance arrangements were focused on ensuring and improving the quality and safety of maternity services for women and babies. At operational level, HIQA was also satisfied that there was clear lines of accountability with devolved autonomy and decision-making for three of the four areas of known harm — infection prevention and control, mediation safety and deteriorating patient.

There was evidence that hospital management and the hospital group had progressed the establishment of a formalised clinical maternity network with a single governance structure — the Ireland South Women and Infants Directorate, as recommended in the National Maternity Strategy. Notwithstanding this progress, the network was not fully established and implemented. Characteristics of a managed clinical maternity network, such as joint appointments in the specialties of obstetrics, anaesthesiology or neonatology or paediatrics across the maternity services in the South/South West Hospital Group, were not in place. The South/South West Hospital Group, together with the hospital and national HSE, should continue to progress the implementation of the maternity network incorporating all four maternity services in the hospital group under a single governance structure as set out in the National Maternity Strategy.

There were management arrangements at the hospital to manage and oversee the delivery of high-quality, safe and reliable maternity services in the areas of infection prevention and control, medication safety and deteriorating patient. HIQA was also satisfied that there were arrangements in place to address increases or decreases in service demand and ensure the safety and quality of maternity care for women and their babies. HIQA acknowledges

hospital management were actively working to recruit midwifery, nursing and medical staff. Nevertheless, there were substantive deficits in the range of 20% or greater in the hospital's approved and actual rostered complement of medical, midwifery and nursing staff, which posed a significant risk to patient safety and impacted on the provision of one-to-one midwifery support for women in labour. While acknowledging that staff recruitment and retention is a system-wide issue, hospital management and the South/South West Hospital Group should continue in their efforts to recruit and retain staff to ensure the safety and quality of care provided to women and babies at Cork University Maternity Hospital.

HIQA was satisfied that there were systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the maternity services provided at the hospital. While there was evidence of a good audit culture in the hospital, the governance and oversight of audit activity and the monitoring of implementation of actions to improve maternity services and care following auditing is an identified opportunity for improvement. Quality improvement plans developed following monitoring activity were not always time-bound and or had named persons assigned who were responsibility for ensuring the implementation of actions to improve clinical practice and ensure compliance with standards and guidance.

Quality and Safety

The hospital promoted a person-centred approach to maternity care. Inspectors observed staff being kind and caring towards women using the service. Hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of women receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. Women who spoke with inspectors recounted positive experiences of receiving care at the hospital and were complimentary of staff. Hospital management were acting on findings from the National Maternity Experience Survey and used feedback from women who used the maternity services to identify areas for improvement.

HIQA was satisfied that the systems and processes in place to respond to complaints and concerns raised by women who received care at the hospital, and or their families were effective in resolving complaints and concerns promptly and effectively. However, a formal standardised system should be implemented to facilitate the sharing of learning from compliments and complaints, and the complaints resolution process with staff to reduce reoccurrence of the same issues.

The hospital's physical environment did support the delivery of high-quality, safe, reliable maternity care. HIQA acknowledges that hospital management were progressing with the repurposing and refurbishing of some clinical areas to support the delivery of high-quality, safe care. Notwithstanding this, the isolation facilities were insufficient and some of the multi-occupancy rooms was challenged for space. This was recognised by hospital management and was being prioritised in future capital development plans for the hospitals.

There were effective systems in place at the hospital to proactively identify, manage and minimise unnecessary or potential risk of harm to women and babies. However, hospital management should work to ensure that a comprehensive clinical pharmacy service is developed and implemented across all clinical areas to further support safe medication practices at the hospital. Hospital management had oversight of staff attendance at and uptake of mandatory and essential training. HIQA acknowledges the measures introduced since the last inspection in 2019 to ensure greater levels of staff attendance and uptake of training in obstetric and neonatal emergencies, but further improvement is required in this area.

There were effective and robust systems in place at the hospital to identify, manage and oversee the management of reported patient-safety incidents in three of the four areas of known harm — infection prevention and control, medication safety and the deteriorating patient, but less so in the transitions of care. Furthermore, there was evidence that recommendations from patient-safety incidents were implemented and learning from incident reviews was shared with clinical staff in the hospital, across the hospital group and nationally with other maternity services, which is important to reduce reoccurrence of the same incident.

Overall, HIQA found a good level of compliance with the national standards assessed during the inspection, but as outlined in this inspection report, opportunities for improvement were identified. Following this inspection, HIQA will, through the compliance plan submitted by hospital management (see Appendix 2), as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions identified and being employed to bring the hospital into full compliance with the *National Standards for Safer Better Healthcare*.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection of Cork University Maternity Hospital was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the 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 on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the 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 people using the service.

Capacity and Capability Dimension	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Judgments relating to overall inspection findings	
Theme 5: Leadership, Governance and Management	
NSSBH Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare. NSSBMS Standard 5.2: Maternity service providers have formalised governance arrangements for assuring the delivery of safe, high-quality maternity care.	Substantially compliant
NSSBH Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. NSSBMS Standard 5.5: Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.	Partially compliant
NSSBH Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. NSSBMS Standard 5.8: Maternity service providers systematic monitor, identify and act on opportunities to improve the safety and quality of their maternity services.	Substantially compliant

Quality and Safety Dimension	
Judgments relating to overall inspection findings	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Theme 1: Person-Centred Care and Support	
NSSBH Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. NSSBMS Standard 1.6: The dignity, privacy and autonomy of each woman and baby is respected and promoted.	Compliant
NSSBH Standard 1.7: Service providers promote a culture of kindness, consideration and respect. NSSBMS Standard 1.7: Maternity service providers promote a culture of caring, kindness, compassion, consideration and respect.	Compliant
NSSBH Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. NSSBMS Standard 1.9: Complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
NSSBH Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. NSSBMS 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 welfare of women and their babies.	Substantially compliant
NSSBH Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved. NSSBMS Standard 2.8: The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.	Substantially compliant

Quality and Safety Dimension	
Judgments relating to overall inspection findings	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Theme 3: Safe Care and Support	
NSSBH Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. NSSBMS 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.	Substantially compliant
NSSBH Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. NSSBMS Standard 3.5: Maternity service providers effectively identify, manage respond to and report on patient safety incidents.	Substantially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for Cork University Maternity Hospital

Compliance Plan for Cork University Maternity Hospital OSV-0001026

Inspection ID: NS_0018

Date of inspection: 26 and 27 October

Introduction This document sets out a compliance plan for service providers to outline intended action(s) following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare*. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.
This compliance plan only relates to:

- standards that were deemed **partially or non-compliant** by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

It is the service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the standard(s) that the organisation had failed to meet.

Instructions for use

The service provider must complete this plan by:

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

The provider's compliance plan should be SMART in nature:

- Specific to the standard.
- Measurable so that it can monitor progress.
- Achievable.
- Realistic.
- Time bound.

Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems they have in place to ensure compliance with a particular standard, under which a partially or non-compliance judgment has been identified.
- Service providers should change their systems as necessary to bring them back into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent action and plans for improvement related to high risks already identified by HIQA during inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate action(s) to address the areas of risk, previously identified by HIQA inspectors, may require continued monitoring including further inspection activity. It may also result in further escalation in the HSE to the relevant accountable person in line with HIQA policy.

Long-term and medium-term work to meet compliance with the standards

HIQA recognise that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium- and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the service plans to improve the level of compliance with the relevant national standard.

In addition to detailing longer term solutions, HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on short- and medium-term mitigation measures to manage risks and improve the level of compliance with standards should be included on the compliance plan

- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the 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 on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the 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 people using the service.

Compliance Plan

Compliance Plan Service Provider's Response

National Standard	Judgment
NSSBH Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. NSSBMS Standard 5.5: Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

(a) Risk assessment to be undertaken of staff levels to ensure safe and effective care for patients

(b) Review of risk rating of staff level risk assessment on hospital risk register. For escalation to South/South West Hospital Group. Date of completion at 10 February 2023

- *Continuous campaigning to recruit from national and international agencies- ongoing*
- *New posts and rolling campaigns recruited through SSWHG structures*
- *Replacement posts through national NRS*
- *International recruitment through SSWGH*
- *Increase to student intakes through midwifery programmes*

Service Provider Use	
Service Provider	
CEO/General Manager/ Master Signature	
Date	

HIQA Official Use	
Date Reviewed	
Authorised Person(s)	
Signature	