Summary of Recommendations and High Level Themes from Clinical Reviews in Maternity Services Portiuncula University Hospital

Introduction

This document provides a high level summary and thematic analysis of the recommendations made by the clinical review teams into five individual reviews into individual cases which occurred in 2024 Maternity services in Portiuncula University Hospital (PUH).

Background

Between January and June 2024, five infants were born that required referral for Therapeutic Hypothermia (TH) out of a total of 1308 births in PUH that year. Each of these cases had a preliminary review completed and were presented to the Women's and Children's Serious Incident Management Team (SIMT).

Due to concerns set out in the preliminary reviews and by the HSE Obstetric Event Support Team (OEST) reviews, five individual systems analysis reviews were commissioned by the Clinical Director for Women's and Children's Network in HSE West North West. All reviews followed the HSE Incident Management Framework (2020) for Level 1 Reviews, and were external to PUH and the West and North West RHA.

Cases and Review team

All five cases were reviewed by a Consultant Obstetrician and Gynaecologist, Consultant Neonatologist and a Director of Midwifery and related to infants who required whole body neonatal therapeutic cooling following birth. The reviews have been finalised and are ready to be sent to families and other stakeholders the week of the 7th July 2025.

Recommendation

The clinical review team identified a number of recommendations which need to be addressed to enhance the safety of the service for women and infants in PUH. In the five reports a total of 34 recommendations have been made. A breakdown of these are included in the table below.

Case number	Number of recommendations
3	5
4	3
5	11
6	5
7	10
Total	**34**

Themes identified

The recommendations made in all the reviews, have been analysed thematically and fall into six broad themes.

1. Clinical Care
2. Multidisciplinary Staff Training
3. Multidisciplinary Team Communication
4. Communication with Woman and her Partner
5. Post Adverse Event

6. Environmental / Infrastructure Factors

A previous review of maternity care in PUH took place in 2018 (Walker report 2018) which highlighted similar concerns around governance, training and consultant presence. The Walker report also highlighted concerns in relation to reliance on locum consultants, communication and timely recognition of deteriorating clinical situations.

Although changes were made following the 2018 review, many of the same issues have been identified by this 2024 review process.

A more detailed breakdown of the identified areas of improvement under each theme is provided in the below section, some of which fall under more than one theme. *Note that many recommendation cover more than one theme.*

Clinical care

The clinical review teams identified practice areas for improvement in relation to the following aspects of clinical care:

a. Foetal Monitoring (recognition of abnormal antenatal and intrapartum CTG) including the use of direct monitoring and adjunct tests
b. The review team recommend that a comprehensive and immediate audit of all Category 1 Caesarean Sections be completed to identify any issues that might delay the interval between decision and delivery.
c. Management of antepartum haemorrhage and placental abruption
d. Management of Hypertensive disease in pregnancy
e. Saving paired umbilical cord bloods where indicated
f. Decision making on what is the appropriate choice of anaesthetic used in Category 1 Caesarean Sections
g. Out of hospital obstetric emergency pathway
h. Securing early airway management in a neonate in an active neonatal resuscitation
i. Securing early intravenous access in neonates in an active neonatal resuscitation

Multidisciplinary Staff Training

The clinical review teams recommended training for clinical staff in the following areas:

a. Multidisciplinary training on foetal monitoring in the antenatal and intrapartum period including use of adjunct tests
b. Multidisciplinary training on appropriate and effective escalation of care in the multi-disciplinary team (MDT)
c. Management of out of hospital obstetric emergencies for Ambulance staff.
d. Communication training for the MDT.
e. All clinical staff should complete training programmes management of Antepartum Haemorrhage and Placental Abruption
f. All clinical staff should complete training programmes on Open Disclosure
g. Increased multidisciplinary simulation training in obstetric emergencies
h. Increase MDT simulation training in neonatal resuscitation - with a focus on – early airway management and securing intravenous access.

Multidisciplinary Team Communication

The clinical review teams recommended improvements in multidisciplinary communication in relation to:

a. Improve communication process between ambulance control and Maternity unit in the management of out of hospital obstetric emergencies.
b. Improve MDT coordination and communication of an obstetric and neonatal emergency.

c. Improve process for escalation of care and the threshold to request senior clinical input
d. All staff must have training on the ISBAR communication tool as part of the IMEWS education programme, as required.

Communication with the Woman and her partner

The clinical review teams recommended improvements in how women and their partners are communicated with in the following areas :

a. Ensure that where a new-born requires transfer to the neonatal unit the women and their partners are kept up to date on the clinical condition of their baby by a senior staff member, and that this is documented appropriately.
b. Improving communication with woman and their partner where English is not their first language.
c. Women and their partners should be offered an opportunity to be debriefed following an adverse outcome of difficult delivery from senior staff in an appropriate setting.
d. Women and their partner should be offered formal open disclosure as appropriate in line with the Patient safety Act 2024.

Post Adverse Event

The clinical review teams identified a number of areas for improvement relating to patient and staff following an adverse event:

a. Following an adverse event staff should be provided with the opportunity and encouraged to participate in an After Action Review (AAR).
b. The hospital should fully comply with the Patient Safety Act and HSE Open Disclosure policy.
c. Patient information and additional supports should be developed and be available for women and their partners whose infants require therapeutic cooling.
d. Following an adverse event or traumatic delivery sensitive consideration should be given to allocation of appropriate accommodation for the mother's privacy.

Environmental / Infrastructural Factors

The clinical review team identified a number of areas for improvement in the clinical environment:

a. The quality of telephone signal and pagers coverage in the hospital and immediate area is poor or inadequate should be addressed to ensure that the MDT is consistently contactable in all areas of the hospital and the immediate local area.
b. Cardio Toco Graph traces should be archived.
c. The scheduling process for elective caesarean sections needs to be reviewed to ensure caesarean sections happen as clinical indicated.
d. Implement the World Health Organisation "Safe site surgery "
e. Improve the ease of transfer of women to the operating theatre in an emergency
f. The hospital should purchase and use a portable CTG monitor to use during emergency transfers to theatre.

Steps being taken in response to the Reviews

1. Many of the recommendations made by the review team have already been well advanced by the External Management Team (EMT) which was put in place in January to oversee all aspects of maternity and neonatal care in PUH.

   Working closely with the Women's & Children's Network and the hospital, the EMT has made significant improvements in clinical governance, operational processes, patient care pathways, and multidisciplinary team collaboration. This work has enhanced structures for quality and patient safety oversight, training and education, mandatory training compliance and clinical performance monitoring. This has aligned the service more closely with national and regional standards. In addition, the EMT oversee all consultant and registrar rotas in Obstetrics and Paediatrics, and have clear guidelines and standards in place for locum doctors when required on the site.

   There has been a significant increase in training sessions, on the labour ward and through simulation. Communication training and human factors training have also taken place.

2. The EMT will create an updated implementation plan to reflect a comprehensive quality improvement plan around these 34 recommendations building on the work done above.

3. An implementation oversight team, led by the HSE West and North West Regional Director for Women's and Children's services (Prof John Morrison), is being set up to further support the PUH External Management Team in the implementation of these recommendations and provide assurance to the Regional Management Team/REO.

   Since the 2018 report into PUH maternity services, there is a well-established pathway in place for the transfer of high risk pregnancies to Galway University Hospital. In light of the safety issues highlighted in these reviews and the with 7 other ongoing reviews into the care of women at PUH maternity unit, this implementation team will expand this pathway to other groups of higher-risk women whose care will be transferred to GUH or the hospital of their choice, in the coming months.

   This implementation oversight team will include stakeholders from PUH maternity services, PUH External Management Team, HSE West and North West Women's and Children's network of care, National Women's and Infants Health Programme (NWIHP), patient/service user representatives and GP representatives. It will report through the HSE West and North West Regional Clinical Director and IHA Manager for Galway/Roscommon to the HSE West and North West Regional Executive Officer. A full Terms of Reference will follow.