Delivering Safer Care 2014
Titanic Belfast
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Department of Health, Dublin

13th March 2014
Overview

• Patient Safety: National and International Imperative
• Patient Safety Unit established in the DoH 2006
• Health Information & Quality Authority established 2007
• Madden Commission Report August 2008
• HSE Quality and Patient Safety Directorate 2011
• HIQA National Standards for Safer Better Healthcare June 2012
Overview

• Updating of legislation governing healthcare professionals
• National Clinical Effectiveness Committee (NCEC) established 2010
• National Patient Safety Advisory Group 2011
• Preparation of Legislation for Licensing of Healthcare Providers
• Patient Safety Agency to be established 2014
• HSE Service Plan 2014 prioritises Patient Safety
Overview

• Despite patient safety initiatives and capacity building, patient safety incidents of national significance occur.

• Most recently:
  - Tallaght Hospital
  - University Hospital Galway
  - Midland Regional Hospital Portlaoise
Section 1
Review of Maternity Services Portlaoise

Context of Report

• *Primetime Investigates* programme 30th January 2014

• General complexity of risk management, patient safety and management of adverse incidents

• Patient safety initiatives in Ireland
Question: Can PHMS be described as safe?

An examination of:

- Extent of verifiable implementation of:
  - (A) recommendations for PHMS following adverse events
  - (B) relevant national policy.

Methods:

- Meetings
- Examination of risk assessment at PHMS – perinatal deaths, transfers out, incident reports, adverse event reports, desktops reviews, NIMT review, SCA claims data
- Examination of perinatal mortality reporting systems
- Walk around of PHMS.
Section 3

PHMS

• 200-bed hospital - catchment areas of Laois, Offaly, Kildare, Carlow and Tipperary with in-patient, day cases, emergency and outpatient services.
• Consultant-led obstetric and gynaecology service
• PHMS: 30 bed in-patient ward, 3 room assessment unit, 3 labour rooms and a 9-bed special care baby unit.
• Five day 9am-5pm obstetric and gynaecology emergency department including an early pregnancy assessment unit. Outside of these hours all attendances are facilitated through a 3 room assessment unit.
• PHMS is not a training location for midwifery nor is it recognised as a training location by the Institute of Obstetrics and Gynaecology in Ireland for the training of junior doctors.
• Workforce:
  • 3 WTE Consultants, 6 Registrars, 6 SHOs, 39 WTE midwives
  • 25% agency both medical and nursing
  • High vacancy rate midwifery posts
Section 4
Quantitative findings

Figure 4.1 Number of total births, Ireland 2000-2012
Approx. 17% increase in births

Figure 4.2 Number of total births Portlaoise Hospital 2000-2012
Approx. 50% increase in births
Figure 4.3 Perinatal Mortality Rate (stillbirths plus early neonatal deaths) comparison, 2008-2011

Note: Stillbirths in this graph refer to those weighing 500g or more or at a gestational age of 24 weeks or greater.

Table 4.2 Perinatal Mortality (Stillbirths weighing >=500 g or gestational age >= 24 weeks plus early neonatal deaths) numbers, Portlaoise Hospital 2006-2012 by source of data

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Figure 4.4 Number of transfers out per 1000 births, Portlaoise Hospital 2006-2012
Section 5
Qualitative findings

Theme 1: Patient-centredness
- Culture at PHMS
- Dealing with a perinatal death
- Response to patients and families following adverse incidents
- Open disclosure

Theme 2: Clinical governance
- Risk management
- Adverse incident reporting and investigations (time taken, variable quality, staff involvement, codes, nomenclature)
- Applying the learning – implementation of recommendations
Section 5
Qualitative findings

Theme 3: Clinical effectiveness in PHMS
- Clinical practice guidance
- Clinical handover
- Escalation of care

Theme 4: Escalation of incidents and role of National HSE
Theme 5: Leadership, staffing and workforce planning

- Midwifery workforce planning
- Continuing professional development
- Midwifery training needs assessment

Theme 6: Infrastructure and equipment

Theme 7: Legal and ethical issues
Overall conclusions

• Families and patients were treated in a poor and, at times, appalling manner with limited respect, kindness, courtesy and consideration.

• Information that should have been given to families was withheld for no justifiable reason.

• Poor outcomes that could likely have been prevented were identified and known by the hospital but not adequately and satisfactorily acted upon.
Overall conclusions

• The PHMS service cannot be regarded as safe and sustainable within its current governance arrangements as it lacks many of the important criteria required to deliver, on a stand-alone basis, a safe and sustainable maternity service.
• Many organisations, including PHMS, had partial information regarding the safety of PHMS that could have led to earlier intervention had it been brought together.
• The external support and oversight from HSE should have been stronger and more proactive, given the issues identified in 2007.
Overall recommendations

Recommendation O.R.1:
PHMS should apologise unreservedly to the patients concerned.

Recommendation O.R.2:
An immediate assessment of the patient safety culture at Portlaoise Hospital should be undertaken by HIQA.

Recommendation O.R.3:
A team should be appointed to run the PHMS pending implementation of Recommendation O.R. 4 below.

Recommendation O.R.4:
PHMS should become part of a Managed Clinical Network under a singular governance model with the Coombe Women & Infant University Hospital.
Recommendation O.R.5:
Other small maternity services should be incorporated into managed clinical networks within the relevant hospital group.

Recommendation O.R.6:
The HSE should address the implications of this Report for other services at Portlaoise Hospital.

Recommendation O.R.7:
Support should be provided to the Portlaoise Hospital senior management team. This should lead to a wider programme of support for frontline leaders, particularly in smaller hospitals, to ensure that they can and do provide safe and effective care.

Recommendation O.R.8:
HIQA should be requested to undertake an investigation in accordance with Section 9 (2) of the Health Act 2007.
Policy Lessons

• Notwithstanding progress in patient safety recent reports demonstrate the need for constant surveillance and vigilance
• National Standards for reviews of adverse incidents
• National and local surveillance
  ▪ Open Disclosure of adverse incidents
• Consistent Data definitions
• Code of Conduct for Employers