The Regulation and Quality Improvement Authority

Review of actions taken on recommendations from a Critical Incident Review within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust

October 2008

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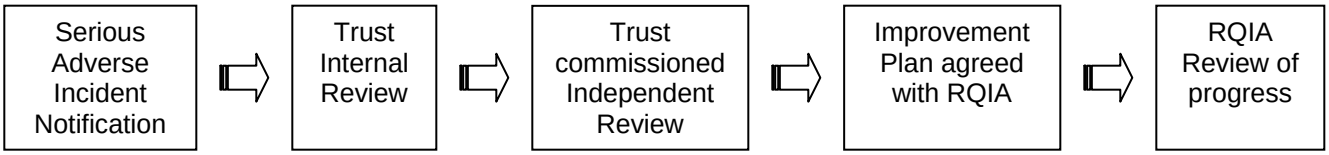
1.0 The Role & Responsibilities of the Regulation & Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Personal Social Services (HPSS) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

2.0 Context for Review

The context of this review is outlined below: -



Over a six week period during July and August 2006, Altnagelvin Hospital reported four serious adverse incidents of obstetric death attributed to neonatal encephalopathy. This was a much higher incidence than expected against the usual rate in the hospital which is consistently below the regional and national rates.

This raised concerns within the Directorate who subsequently worked with the Trust Risk Management team to review the four cases in detail to determine the circumstance of each case, to ascertain if there were any common features and identify any actions required to prevent any re-occurrence.

One of the recommendations of the Internal Review was that an independent External Review of Maternity Services be commissioned by the then Altnagelvin HPSS Trust to determine if the appropriate action was being taken by the Trust.

The Terms of Reference for the External Review of Maternity Services were to evidence: -

1. The polices, procedures, protocols and clinical guidelines in use in the labour ward in Altnagelvin Trust.
2. The efficacy of any audits of practice against the above policies /guidelines.
3. The efficacy of training undertaken by midwifery and obstetric staff in the labour ward.

4. The effectiveness of multidisciplinary team working in the labour ward to include obstetric anaesthetics.
5. The effectiveness of the current models of service provision.
6. Recommendations for improvement in any of the above areas.
7. To review the four cases which had initiated the internal review.

Following completion of the review, the RQIA Incident Review Group considered the outcomes of the External Review of Maternity Services along with the Trust's original internal critical review (11 September 2006). In July 2007, the Trust was asked to put in place an appropriate improvement plan, with timescales, to address the following issues: -

- The efficacy of Cardio Toco-Graph (CTG) training
- Registrar shift working
- Increasing the capability of midwifery prescribing
- Risk management capability
- Review of Polices and Procedures
- Formal handover between staff at shift change
- Communications and Documentation
- Switchboard management of an obstetric emergency

It was proposed that progress against this improvement plan would be reviewed as part of the Regulation and Quality Improvement Authority programme of Clinical and Social Care Governance reviews in 2007/08. As part of the review process the review team also assessed progress against a number of the original terms of reference in the original external review of the incidents. (Terms of Reference 1,2,4,5 above)

3.0 The Review Methodology

The RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems which can identify performance standards and support the learning necessary for improvement.

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the HPSS Quality Standards. The distilled information from the self-assessment will be subjected to reality testing when review teams visit organisations.

This review was undertaken following a period of major transition for organisations further to the Review of Public Administration (RPA). The management structures within the new organisations, in the main, are now in place. The review team have taken account of these developments within this report.

4.0 The Review Team Findings

Development of policies, procedures, protocols and clinical guidelines used in the labour ward in Altnagelvin Hospital.

In their self assessment submission, dated 31 January 2008, the Trust indicated that work had commenced on trust-wide policies, procedures and protocols and clinical guidelines for use in the labour ward(s). The Trust further stated that a Trust policy template was being used and that policies were submitted to the audit committee for approval. In addition to this, the Trust advised that from 1 February 2008, the Practice Development Midwife, based in Altnagelvin, would dedicate two days per week to the development and harmonisation of policies, protocols and clinical guidelines.

The review visit took place across two days, the 8 and 9 April 2008. The review team were provided with evidence of policies and procedures both completed and in development, work which had been undertaken by a multidisciplinary group. The review team were informed by the Trust that the Women's and Children's Directorate was responsible for policy development and that a governance system was in place to ensure that all polices were forwarded to the Corporate Management Team and ultimately Trust Board for ratification.

A database for all policies, which will sit within the Quality and Safety Directorate, was under development, however at the time of the review, policies were available to all staff via the intranet and in hard copy. There was no formal Directorate policy in place to dictate the timescale for the review of policies, however despite this the review team were advised that policies were reviewed each August by a named Obstetric Consultant. This process was to be formalised from August 2008 to a three year review cycle with ad hoc review as dictated by new evidence.

On review of the evidence, the review teams concluded that this was a realistic approach in the context of the integration of several trusts and harmonisation of existing Trust policies, however the review team felt that this should progress as a matter of urgency and were concerned about the amount of time that had elapsed since the original internal review (September 2006) and the agreed improvement plan (July 2007). The review team agreed that the process of policy development and review should be formalised within the Directorate.

Assessment of the efficacy of audits of practice against the above policies/guidelines.

The self assessment response submitted by the Trust indicated that a number of audits were being undertaken that were specific to standards in maternity services; however, during the course of the review no evidence was found indicating that the Trust had examined the impact of the audits undertaken or their relevance in improving services.

During the review the Trust provided evidence of audits, both completed and underway and in discussion with the review team a number of staff indicated their active participation in audit. The review team noted that from the list of audits provided 21 were carried out in 2007.

several of these were discussed with staff during the course of the review including an audit of nursing documentation and an audit of Cardiotocography (CTG) against the NICE guidance. The review team noted that there was an absence of action plans in a number of the audits and that the audit cycle was incomplete in some areas.

In assessing the efficacy of audit, the review team concluded that the process for feedback was insufficiently developed within the directorate. It appeared that there was no formal mechanism to ensure that the outcome of the audits went to the Obstetric Directorate Risk Management Committee or to the divisional meeting.

Recommendation 1: The Trust should formalise the process of policy development and review within the Directorate.

Recommendation 2: The Trust should strengthen the processes for dissemination of action required and feedback from audits. Audit reports should be monitored by the Obstetric Directorate Risk Management Committee, presented to divisional meetings with lessons learned being communicated to staff.

In discussion, the Trust Governance Lead assured the team that following an audit strategy day in January 2008, recommendations included the need for an individual Directorate audit programme to ensure that re-audit occurs and that information is not lost when personnel changes.

Recommendation 3: The Trust should implement an individual Directorate audit programme by 30th November 2008.

Efficacy of training undertaken by midwifery and obstetric staff in the labour ward, including Cardiotocography (CTG) training.

The Trust reported that a number of training opportunities were provided for staff by the Beeches Management Centre. Staff also had access to on-line K2 training and in house multidisciplinary case discussion.

The Trust further indicated that midwives were personally responsible and accountable for maintaining their skills and competence in relation to their sphere of practice, including updating their skills and knowledge of CTG interpretation. During the review visit, the review team confirmed that this is discussed as part of midwives annual statutory supervisory review.

The review team found extensive evidence of midwifery and medical staff having access to a variety of CTG training including K2 training, interactive study days at the Beeches and monthly multidisciplinary CTG workshops. The review team were satisfied that these training opportunities were in line with other Trust training strategies across Northern Ireland. The Trust gave no indication as to the quality or outcomes of the in-house case review and clinical teaching in the delivery suite.

The senior management team and operational staff reported that records of training for midwives were kept by the Delivery Suite Manager in their personal files and that medical staff have their training recorded in their annual appraisal documents. Whilst personal files and appraisal documentation were not submitted as evidence, a statistical report was provided as evidence. During interviews the review team endeavoured to validate the availability and uptake of training; staff expressed feeling very supported and reported feeling confident in their ability to read CTG's. There was evidence of reflective practice in the multidisciplinary labour ward forum and staff reported participation in drills and simulated cases.

Assessment of the effectiveness of multidisciplinary team working in the labour ward including obstetric anaesthetics

The Trust stated that a weekly labour ward forum takes place and is attended by obstetricians, junior medical staff, midwives and the obstetric anaesthetist. The Trust stated that all staff participate in obstetric skills and drills and that risk incidents are reviewed through monthly risk management meetings. During the review visit, sample minutes from the labour ward forum and the risk management meeting were tabled but this did not give the team assurance that meetings took place as regularly as reported.

Recommendation 4: The in-house case review and clinical teaching on CTG should be strengthened by the identification of a coordinator of CTG training and interpretation.

Recommendation 5: In accordance with Safer Childbirth, the minimum standards for the organisation and delivery of care in Labour (October 2007)[1], meetings of the labour ward forum should take place at least once every three months and the risk management group should meet at least every six months. These meetings should be formally recorded and minutes should be made available to all staff.

In discussion, staff reported to the review team that there was an effective system of multidisciplinary team learning, development and working. This was evidenced from labour ward forum activity which included feedback from multidisciplinary skill drills. While it was indicated that skill drills took place on a monthly basis, the review team only saw evidence of four to five a year. The review team concluded from the evidence presented that dissemination of learning and action points could be strengthened by linkage with risk management and audit.

Recommendation 6: The results of skill drills should be shared not only with those directly involved in the drill, but with all staff as appropriate.

Staff interviewed by the review team indicated that there were difficulties in securing time out from clinical duties to attend the labour ward forum which was seen as a key forum at which

[1] Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health.

discussion on effective team working practice was held. It was noted that labour ward forum meetings were not formally minuted.

It was also noted that the maternity service team worked collaboratively to produce a range of policies, protocols, guidelines and audits.

Improvement of the effectiveness of current models of service provision

In their self assessment response the Trust indicated that a Delivery Suite Manager had been appointed. Furthermore, as a result of the Review of Public Administration there had been changes in the maternity services structure to meet changing service needs including the appointment of an Assistant Director for Healthcare and a Head of Midwifery. The Trust advised that a recruitment process was underway to appoint a Lead Midwife for each maternity unit.

During the review visit, the review team met with the Assistant Director of Healthcare who outlined the vision for the service and the specific roles and functions of the Head of Midwifery, Lead Midwife, Practice Development Midwife and the Risk Management Midwives. The Head of Midwifery and the Practice Development Midwife, based in Altnagelvin, were both in post and the recruitment process for the appointment of two Lead Midwives and two Risk Management Midwives was continuing.

The review team noted that although the newly formed Trust had been in place for one year, the senior team responsible for Obstetrics had only recently been appointed. Therefore the emerging structures were still in their infancy. Despite this, the review team saw considerable progress in audit, training activity and policy development and noted progress on the recruitment of a more robust management infrastructure with clear lines of accountability.

Registrar shift working

The review team found that shift working was established. All medical staff interviewed reported this was working well, providing the required cover to meet service needs. In discussion with staff the review team was assured that registrars had now adapted to the shift work pattern and no difficulties were expressed. Following review of some recent rotas the review team concluded that they met the needs of the service.

Midwifery prescribing

The review team established that this recommendation was a misinterpretation. The recommendation should have been based on the ability of midwives to administer, not prescribe, the first dose of IV antibiotics. Midwifery staff reported that training had taken place and that midwives can now administer first dose antibiotics. There is a Trust prescribing policy for nurses and midwives in line with regional policy.

Risk management capability

The review team were informed that the Trust was in the process of recruiting two Risk Management Midwives with a clear intention to link the Directorate risk management strategy to the Trust's governance and risk management system. The post-holder would develop initiatives to see incorporated in the improvement plan. This was confirmed upon review of the job description for this post. It was noted that there still was a considerable delay in progression of this appointment given the time that had elapsed since the original external review (September 2006) and the agreed improvement plan (July 2007).

Formal handovers

In discussion with Trust staff, the review team established that a handover system was in place, however this was not formally documented. The review team was assured that a formal handover arrangement had been designed and would be implemented from Monday 14 April 2008, which was to include high risk patients on the maternity wards. In the absence of a dedicated Consultant presence handovers were led by a middle grade doctor. The review team noted the significant time delay in implementing this recommendation given that it was a key recommendation of the original external review. The Trust gave absolute assurance to the review team that this would be implemented by the date specified above. Upon subsequent enquiry with the Labour Ward Manager, the RQIA were assured that the documented formal handover system had been implemented from the agreed date.

The review team noted that 40 hour dedicated prospective cover was not in place on the labour ward. However the Trust assured the team that 40 hour cover was in place albeit with some overlap with antenatal clinic cover. At the time of the review, the Trust was in the process of recruiting a seventh Consultant and has planned to recruit an eighth Consultant in 2009. The review team were satisfied this would ensure 40 hour prospective cover for the delivery suite and achievement of the required standard. No firm timeframe was provided by the Trust as to when this would be in place.

Communication and Documentation

Training specifically arranged by the Trust in record keeping had recently been provided, led by a barrister with a nursing background. The review team were advised that approximately 90% of midwives had attended this training. Medical staff interviewed by the review team also reported having completed this training.

Recommendation 7: In order to comply with the Quality Standard for Health and Social Care 5.3.1(f) (iv) recording of care given, the Trust must ensure regular audit and review of record keeping standards. In response, the Trust must continue to ensure that all medical, midwifery and nursing staff have access to training/update in relation to documentation and record keeping as required. The frequency of training required should be established, to reflect the outcome of audit, and adhered to by the Trust

Switchboard management of an obstetric emergency

Staff interviewed reported that the baton bleep system was in place, operating effectively and that there had been no breakdown in communication since its introduction. The Trust assured the review team that the system was subject to a recent audit.

5.0 Summary of Recommendations

Recommendation 1: The Trust should formalise the process of policy development and review within the Directorate.

Recommendation 2: The Trust should strengthen the processes for dissemination of action required and feedback from audits. Audit reports should be monitored by the Obstetric Directorate Risk Management Committee presented to divisional meetings and lessons learned being communicated to staff.

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Section 6 - Declaration of Self Assessment

Regulation and Quality Improvement Authority
Clinical and Social Care Governance Review of Health and Social Care Trusts (2007/2008)

Name of Trust	**WESTERN HEALTH & SOCIAL CARE TRUST**
Address	**TRUST HEADQUARTERS, MDEC BUILDING, ALTNAGELVIN HOSPITAL SITE, GLENSHANE ROAD, LONDONDERRY, BT47 6SB**
Chief Executive's Name	**ELAINE WAY**
Chief Executive's Contact Details (Telephone and Email)	**TEL: 028 71 345171 – EXTN 3601** **EMAIL: ELAINE.WAY@WESTERNTRUST.HSCNI.NET**
Chairperson's Name	**MR GERARD GUCKIAN**
Chairperson's Contact Details (Telephone and Email)	**TEL: 028 71 345171 – EXTN 3601** **EMAIL: GERARD.GUCKIAN@WESTERNTRUST.HSCNI.NET**
Date Self Assessment Form was Completed	**31ST JANUARY 2008**

In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this Trust.

Signature of Chief Executive:	Date:	Signature of Chairperson	Date:
Elaine Way	31.1.08	Gerard Guckian	31/01/08

Appendix (ii): Review Team Membership

Date of Review:	8 & 9 April 2008
Project Manager:	Helen Hamilton

Peer Reviewer	Dr David Boyle Consultant	Belfast HSC Trust
Peer Reviewer	Margaret Gordon Assistant Director Women's and Children's Health (Obstetrics/Gynaecology)	Northern HSC Trust
Peer Reviewer	Ruth Clarke Maternity Services Manager and Head of Midwifery	Belfast HSC Trust

Appendix (iii): Glossary of Terms and Abbreviations

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
Clinical and Social Care Governance (CSCG)	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Consultant	Medical or dental practitioner who works independently without supervision.
CTG Cardio Toco-graph	The machine that is used in delivery suite to measure contractions and baby's heart rate over a period of time.
DHSSPS	Acronym for Department of Health Social Services and Public Safety.
Governance	The system by which an organisation directs and controls its functions and relates to its stakeholders.
Neonatal Encephalopathy	A clinically defined syndrome of disturbed neurological function in the earliest days of life in the term infant, manifested by difficulty with initiating and maintaining respiration, depression of tone and reflexes, sub normal level of consciousness and often seizures.
Organisational structure	A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.
Patient records	The record of all aspects of the patient's treatment, otherwise known as the patients notes.
Peer Review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review.

Policy	An operational statement of intent in a given situation.
Procedure	The steps taken to fulfil a policy.
Professional staff	Includes all medical, nursing and allied health professional staff.
Records	Information held in all media e.g. paper, video, photographic or electronic.
Review of Public Administration	Review of the existing arrangements for the accountability, development, administration and delivery of public services in Northern Ireland, bringing forward options for reform which are consistent with the arrangements and principles of the Belfast Agreement, within an appropriate framework of political and financial accountability.
Risk Assessment	The identification and analysis of risks relevant to the achievement of objectives.
Risk Management	He culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
Stakeholder	A person, group or organisation who affects or can be affected by an organisation's actions.

The **Regulation** and **Quality Improvement** Authority

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