Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

17th September, 2021

A special QPS Webinar session for World Patient Safety Day

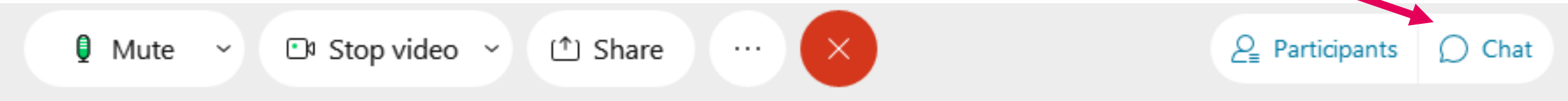
"Safe maternal and new born care"

CHAMPION PARTNER ENABLE DEMONSTRATE www.qualityimprovement.ie @NationalQPS

World Patient Safety Day 17 September 2021

Welcome

- **Sound:** Computer or dial in:
  - **Telephone no: 01-5260058 (Ireland), +44-20-7660-8149 (UK)**
  - **Event number: 174 230 1108#**
- **Chat box function**
  - Comments/Ideas
  - Keep the questions coming!
- **Recording**
- **Engage with the team**
  - **Twitter: @QPSTalktime / #patientsafety / #WorldPatientSafetyDay / #QIreland**
- **Feedback**
  - **Short feedback form after the session, please help us to improve our QPS Webinars**
  - **A window will pop up before logging out**



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To get started … we invite you to

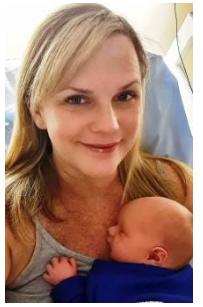
Share using the chat box

- Your name and where you are joining from
- Your one wish for World Patient Safety Day?

Speakers today

Dr Orla Healy, HSE National Clinical Director, Quality and Patient Safety Directorate, Chief Clinical Officer's Office

Kilian McGrane, Director, National Women and Infant Health Programme



Roisin Egenton, mum to Darragh, born January 2021

Angela Dunne, National Lead Mid-wife, National Women and Infant Health Programme

Dr Peter McKenna, Clinical Director, National Women and Infant Health Programme, former Master of the Rotunda who was a practising obstetrician for many years

Dr Carmel Moore, Consultant Neonatologist, National Maternity Hospital, Holles Street

Setting the Scene - Dr Orla Healy

National Clinical Director for Quality and Patient Safety

- Effective Leadership and Governance to improve Patient Safety
- Patient Safety Strategy
- All Patients using our health and social care services will consistently receive the safest care possible.
- Nurture a culture of patient safety, transparency and organisational learning with meaningful involvement of patients and staff

Patient Safety Strategy Commitments:

- Empowering and Engaging Patients to Improve Patient Safety
- Empowering and Engaging Staff to Improve Patient Safety
- Anticipating and Responding to risks to Patient Safety
- Reducing the Common Causes of Harm
- Using Information to Improve Patient Safety
- Providing effective Leadership and Governance to improve Patient Safety

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My experience and reflections – Roisin Egenton

Introducing national women and infants health programme – focus on safety, Kilian McGrane

Origins of NWIHP

- The need for a maternity strategy was recommended by HIQA
- Tragic events surrounding the death of Savita Halappanavar; and the HIQA review into maternity services in Portlaoise
- Maternity services mired in controversy
- Recommendation to develop NMS, and also establish NWIHP
- NWIHP modelled on NCCP, which emerged a decade early following similar controversies in cancer care.

NWIHP approach

- Small team totally dedicated to maternity, gynaecology and neonatology
- Change the profile of maternity – not just a good news story until it isn't
- Improving the safety of our service has required developing governance structure; implementing the Model of Care (MOC); and enhancing the approach to quality and safety
- I'm going to talk to you about the governance and leadership; Angela will talk to you about MOC; and Peter will talk about Quality and Safety
- Our objective is to ensure a consistent delivery of high quality, safe care across our 19 maternity services.

Safe Maternity Care - Angela Dunne

Safe Maternal and New Born Care

- The National Maternity Strategy 2016-2026 outlines that women should have access to safe, high quality, nationally consistent women-centred care
- It is vital that we all of us working in maternity services constantly strive to ensure woman and babies can access the best maternity care. Everyone involved in providing maternity services in the ROI wants the same outcome “the safe delivery of a healthy baby and a healthier mother.

Directors of Midwifery – Strong Leadership

- One of this biggest drivers of safe maternity care over the last five years has been the recruitment of a Director of Midwifery for each maternity unit. The DOM sit at the executive table and are strong advocate for women and babies
- Strong focus:
  - On multi-displinary team working together
  - Learning and best practice
  - Driver of continuous change
  - Innovation and accelerating improvements
  - Data – enable benchmarking.

Continuing Need to Effectively Measure The Experience of Women

- Ireland's first ever survey of maternity services took place in early 2020, A joint initiative by HIQA, the HSE and the DOH
- The National Maternity Survey asked women who have recently given birth about their experiences of Ireland's maternity services
- In response to the finding the HSE developed and have implemented quality improvement plans at national, regional and local levels This is an ongoing piece of work
- The results also inform national policy.

Drivers of Safe Evidence Based High Quality Care

- Over 20 Advanced Midwifery/Nurse Practitioners
  - 86 CMS/CNS
  - 66 RM
  - 6 Quality and Safety posts
- The establishment of an All Ireland Midwifery Network
- Project leads to drive:
  - The implementation of the HSE National Standards for Antenatal Care
  - Fetal Monitoring/Obstetric Emergencies
  - Neonatal Resuscitation

Women and their partners deserve maternity care that supports safe outcomes for mother and baby.

Safe Delivery - Dr Peter McKenna

Annual Maternal Mortality Rates 1880- 1980

FIGURE 1.

Open in new tab Download slide

Annual maternal mortality rates in England and Wales, 1880–1980. Data from references 1–3.

Perinatal Mortality in Ireland

- 1950 → 2020
  - 40 per 1,000 births
  - ↓
  - 6 per 1,000 births

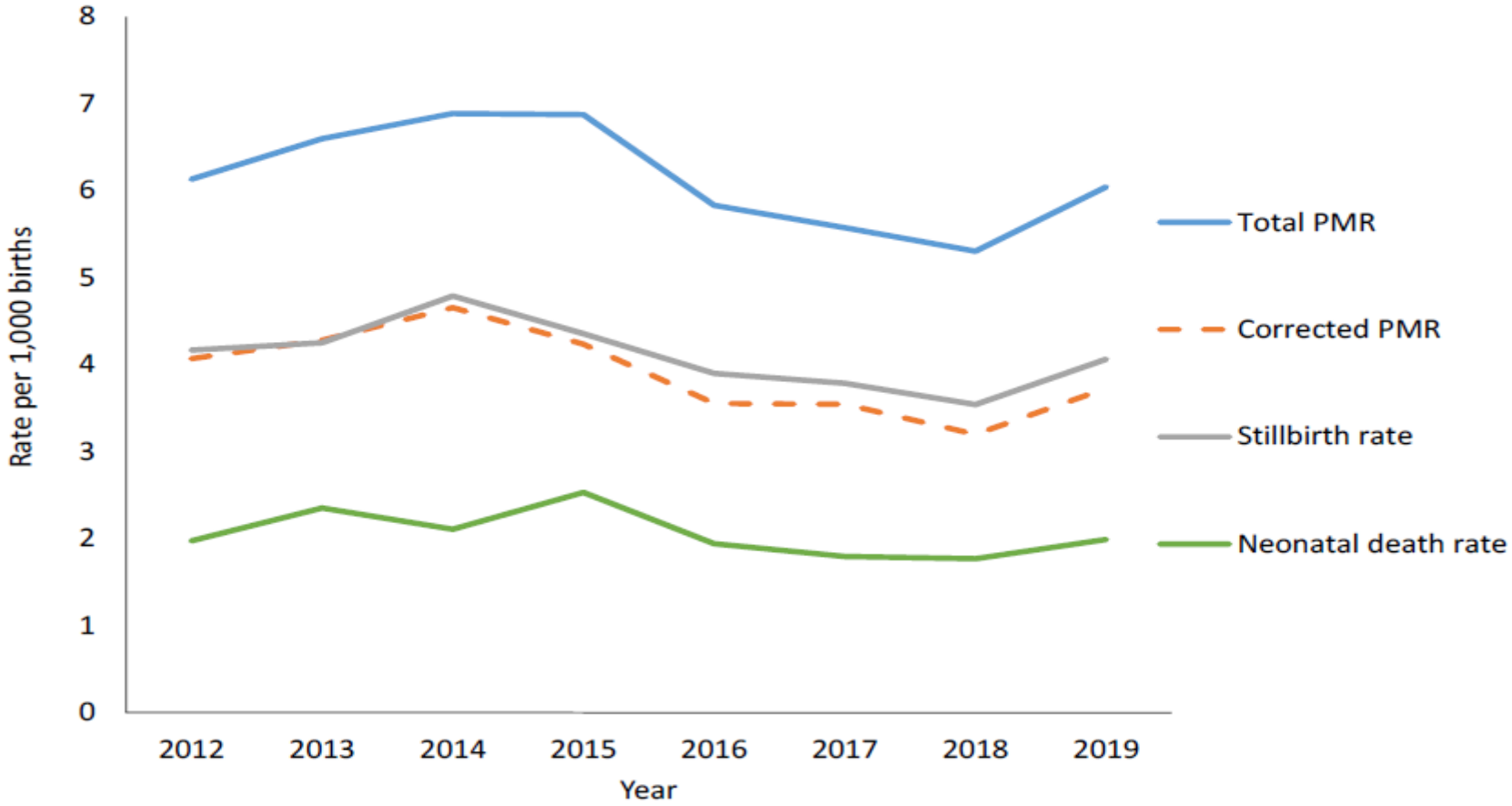
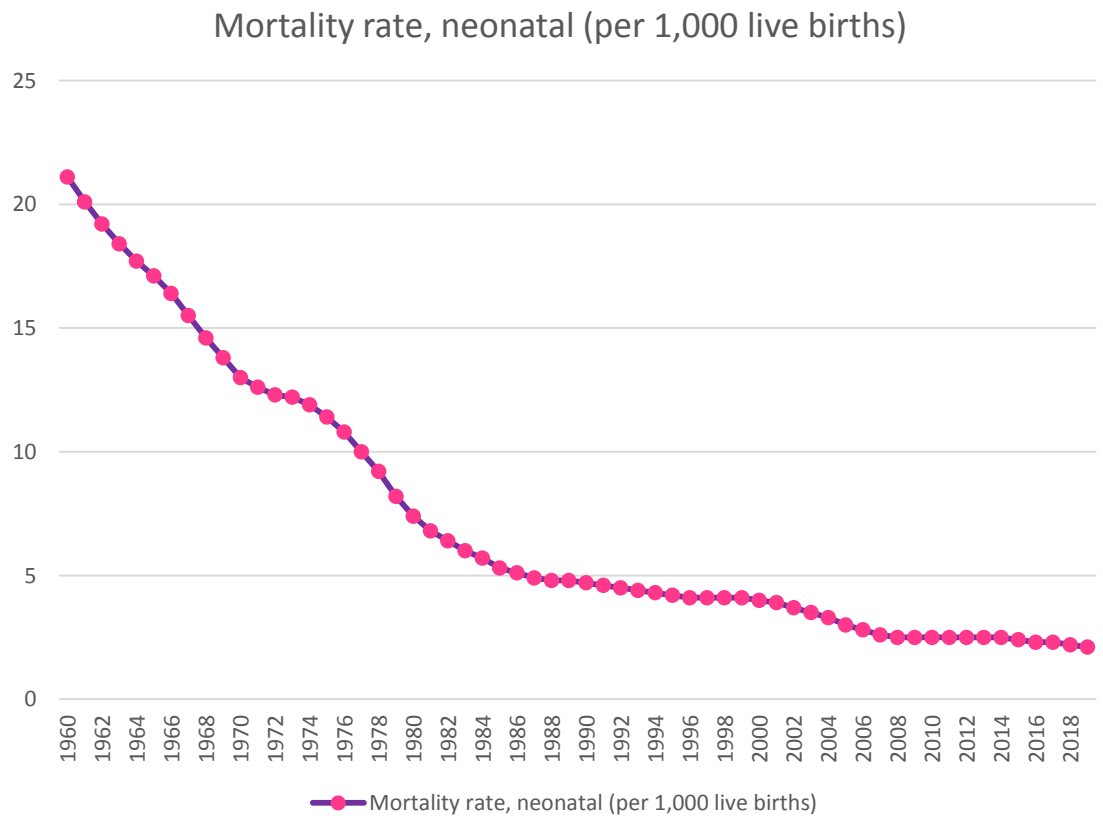


Figure 1.2: Trend in perinatal mortality rates in Ireland, 2012-2019

Note: Rates per 1,000 births; PMR = perinatal mortality rate; Corrected PMR excludes deaths due to a congenital malformation.

Safe Neonatal Care – Dr Carmel Moore

Neonatal Mortality Rate: Death before 28 days



- For every 1,000 babies born in Ireland 998 babies go home
- Safe maternity and delivery care vital
- Care immediately post delivery very important

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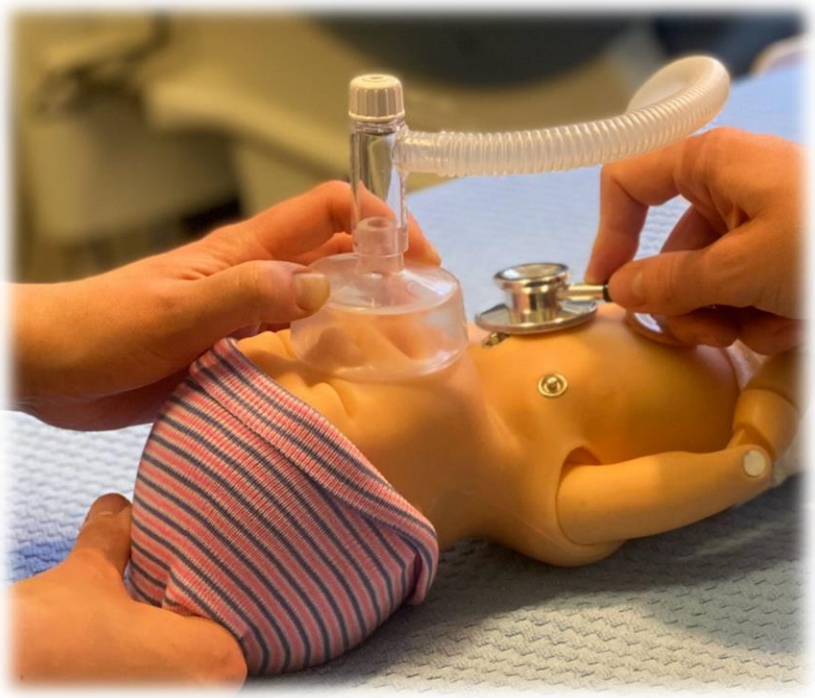
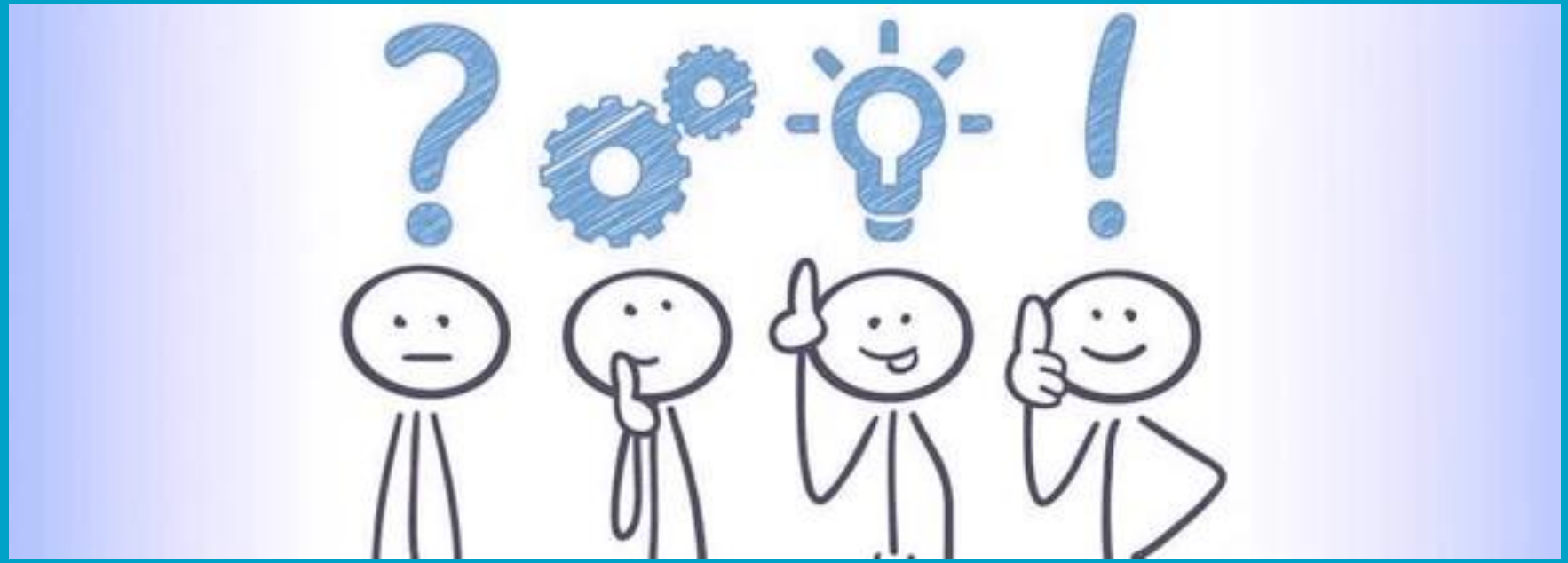
Neonatal Stabilisation and Resuscitation



- 10% babies require some resuscitation to begin breathing after birth
- <1% babies require more extensive resuscitation
- International priority
- Training essential
- Teaching and learning programs highlight importance of communication
- Important to have program suitable for working environment
- NRP 8thEd: recent refocus on QI with mask ventilation.

Safety in the Neonatal Unit and beyond…

- Range in size - <500g to >5kg
- Range in complexity
- Important to be safe on the postnatal wards and in the community
- Neonates expected to live the longest with consequences of unsafe or low-quality care



TIME FOR QUESTIONS AND DISCUSSION

Let us know how we did today ….

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS Webinars by sharing your feedback

We really appreciate your time, thank you

Upcoming Webinars: Dates for your diary ….

Dates	Topics	Speakers
21 September	A conversation with Dr A Shah, Forensic psychiatrist & Chief Quality Officer at East London NHS Foundation Trust (ELFT).	Dr Amar Shan and Dr John Fitzsimons
12 October	Clinical Decision Support and Quality Improvement - the Challenge of Comorbidities	Dr Kieran Walsh, BMJ and Aoife Lawton, HSE

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