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IT'S ARCHHAIC

● Nine maternity hospitals rely solely on paper records ● The rest use computers that do not link up ● Plan to overhaul the system has been stalled for SIX years ● HSE will not tell us how much it's costing

By Niamh Griffin

HEALTH CORRESPONDENT

A €17M project to update and centralise patient records in maternity hospitals has taken over six years and is still only in the planning stages.

Freedom of Information documents released to the Irish Mail on Sunday reveal repeated delays, project management issues and missed deadlines since the project was conceived in 2008.

But the system will not be ready for pilot tests until next year at the earliest.

In the meantime, 10 maternity hospitals use five different software systems that cannot communicate with each other.

The remaining nine out of a total 19 maternity hospitals nationwide are still dependent exclusively on paper charts to record patient treatment.

The new system is intended to create electronic patient charts for pregnant women that can be accessed by any medical staff, including their GPs. Crucially, all 19 hospitals will have the same system.

But despite an estimate in 2011 of a total project cost of €17.2m, the HSE and the Department of Health this week declined to reveal how much the ongoing project has cost taxpayers so far.

Delays have been compounded by the

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FIRST LOOK: Holly Sweeney with her son Max

PICTURE EXCLUSIVE

Holly's gorgeous baby boy Max

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Mother: I'll sue TD over 'hit and run'

By Gerry Hand

A MOTHER plans to sue Meath West TD Ray Butler for injuries she says she sustained after being hit by his car at a protest outside his constituency office in February.

Anti-eviction protester Fiona Lloyd was hospitalised after the incident and has been on crutches for the past six weeks.

She was part of a protest outside Mr Butler's home which moved to his office when protesters realised he was not in the house. The incident, which is disputed by the TD, happened as he drove away from his office.

FULL STORY See Page 4 >>

Maternity record

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project team having no chairman for most of 2014. One source described the project board as '110% committed' but hampered by a lack of allocated resources.

A patient advocate said the software was needed as women often used more than one maternity hospital in their lifetime. But a senior obstetrician warned that without enough funding for staff training, the system could cause harm.

Over 75,000 babies a year are born in our 19 maternity hospitals. Cork Maternity Hospital, chosen as the pilot hospital for the digital project, has 9,000 births annually.

One mother who gave birth last month in a large Dublin hospital said: 'My charts were all hand-written. It's a bit archaic.'

'My mother had me in the same hospital. When she read my notes, she said they were the same as in her day. She recognised the attendance cards and everything. Nothing had changed in 30-odd years. The midwife was brilliant but she spent most of the time writing continuously. There has to be an easier way.'

A Post-it saying she had an allergy to one type of medication was stuck

'There was a very bad experience with PPARS'

to the front of her chart. Documents released under FoI show the software plan was first sent for approval from health chiefs in July 2008. It took six years before a contract was signed with US multinational IT company Cerner Corp to begin building the system.

Minutes of meetings show that the HSE had not provided the project team with a budget as recently as May 2014.

Delays were also caused by having to advertise some key roles on the project team twice. This happened after the original adverts only ran in parts of Ireland instead of nationally. As a result, no one applied.

In 2010, vital paperwork was not signed for weeks because those submitting the paperwork did not know that staff were on holidays. Documents had to be cleared through the Department of Health and various HSE departments.

A note reads: '[We sent] a number of queries to try to find out what was happening.'

It took four years before a questionnaire was sent to all the maternity hospitals assessing their needs. Costings done in 2011 show an estimated cost of €17.2m with just over €4m to come from the hospitals themselves.

The report says: 'The cost will be dependent on the number of hospitals, quality, standard and functionality of the system selected.'

In the FoI request, the MoS asked for the estimated cost of the project, including the fees paid to Cerner Corporation to install the project, salaries for seconded HSE staff and the cost of buying equipment. Both the HSE and the Department of Health refused to

HOSPITALS THAT RELY ON DIGITAL SYSTEMS

HOSPITAL	SOFTWARE NAME (INSTALLED)	STATUS
Our Lady of Lourdes, Drogheda	iSoft (2007)	Relatively modern system
Cavan General, Cavan	iSoft (2007)	Relatively modern system
Holles St, Dublin	McKesson (1996)	Replacement required
Rotunda, Dublin	McKesson (1996)	Replacement required
Coombe, Dublin	Euroking (1986)	Replacement required
UCHG, Galway	Euroking (1988)	Replacement required
Sligo General	Euroking (N/a)	Replacement required
Letterkenny General	Euroking (N/a)	Replacement required
Portiuncula Hospital, Ballinasloe	Keogh Software (2004)	Limited functionality
Mayo General Hospital, Castlebar	Cardiac Services (N/a)	Replacement required

HOSPITALS THAT RELY ON PAPER-BASED RECORDS

Cork University Maternity Hospital, Cork	South Tipperary General Hospital, Clonmel
Kerry General Hospital, Tralee	St. Luke's General Hospital, Kilkenny
Limerick Regional Maternity Hospital	Waterford Regional Hospital, Waterford
Midland Regional Hospital, Mullingar	Wexford General Hospital, Wexford
Midland Regional Hospital, Portlaoise	

release this information, saying it was commercially sensitive.

A previous effort to reform HSE digital salary-systems, called PPARS, was ultimately dumped having cost more than €200m instead of the expected €9m.

This week, former health minister Mary Harney, in her first interview since leaving politics, told the Irish Medical Independent: 'There was a very bad experience with PPARS. The costs ran away and that made everybody, including me, nervous of going down this road again.'

'There are organisations not ready to change'

In February 2012, HSE regional directors were told the software would be rolled out at the end of that year in four pilot hospitals. But the tender process only finished in November 2012.

In June 2012, the directors were told the roll-out would take place between April and June 2013.

In October 2012 Savita Halapannavar died in Galway University Hospital while miscarrying. Her inquest recommended changes in how hospital records were kept and communicated.

By January 2013 a 'revised' plan was circulated to managers, including staff training in mid-2013 and roll-out by the end of the year.

Top medical staff were seconded on to the project board, with a plan

for a midwife in each hospital to take charge of training locally.

One senior obstetrician, who is not on the board, said: 'I'd love to see this resourced well. We have staff who finger-type; how is that going to work in a busy hospital? This has been going on for years but Savita's death gave it impetus. If they rush into this now, it will put patients in harm's way.'

By January 2014 briefing documents for managers and consultants show the HSE planned to finish building and testing the system by early 2015.

The HSE planned to have the first pilot scheme live in Cork by the end of this year. This was to be followed by the Rotunda, Holles Street and Kerry General.

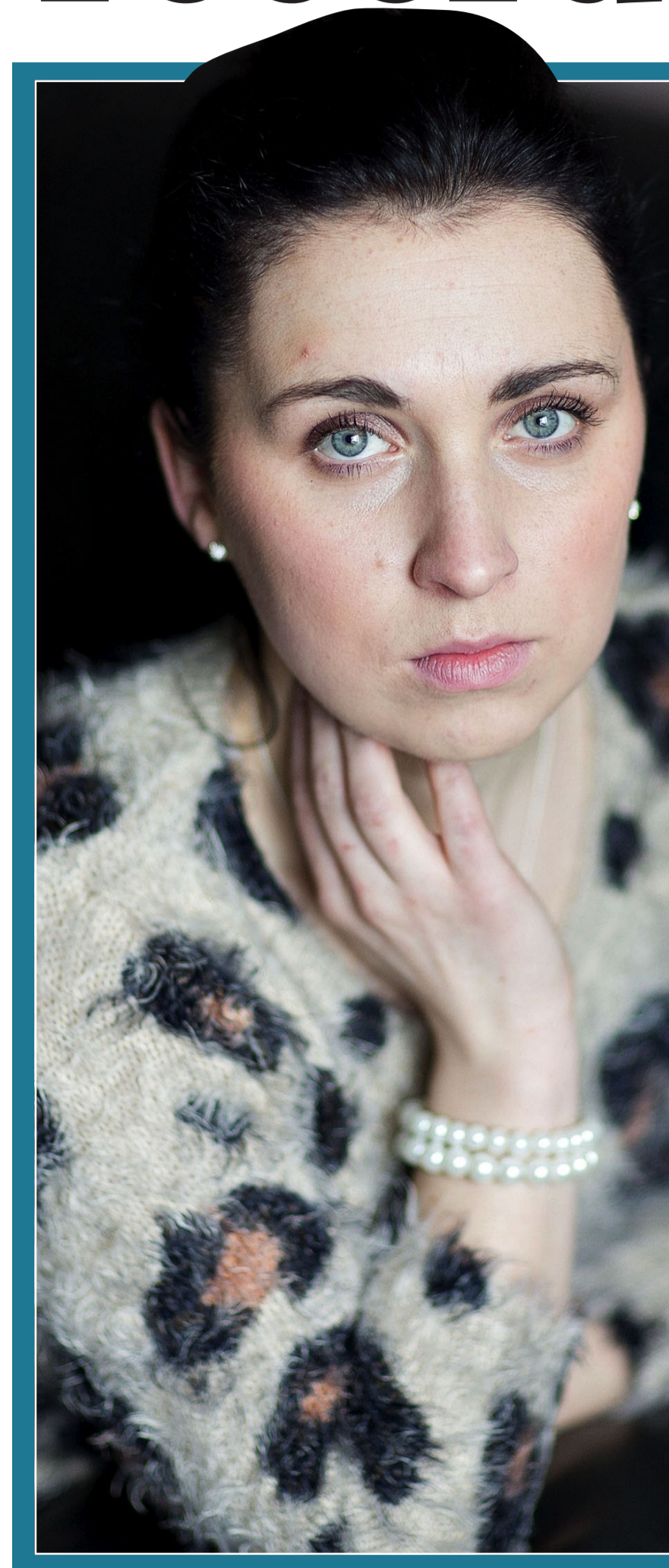
However, minutes of meetings show board members continuing to highlight basic problems including a lack of IT staff.

Last year, one doctor resigned from the board temporarily as money had not been allocated to cover his hours at a busy maternity hospital. This would have left his department short-staffed. He was not available for comment this week.

For most of last year the board did not have a chair, although minutes show this was repeatedly raised with hospitals director Dr O'Connell and senior executives Angela Fitzgerald and Gerry O'Dwyer. A chair was finally appointed in October.

Amanda Green, spokeswoman for Cerner Ireland, said the software would now begin its pilot run early next year.

She said: 'The vast majority of



Irish maternity systems are based on paper. It is challenging.

'Observations and vital sign measurements are on bits of papers and clipboards at the end of your bed, so this is a massive change process.'

'There are organisations which

are not ready to make changes. That is hard.'

Although Cerner Corp is recognised as one of the top e-health companies globally it has faced controversy over similar installations in Britain. In one tragic case,

The VERY slow progress in introducing an IT system for maternity

July 2008
Business plan submitted

2008 - 2011
Funding application reviewed

March 2011
Cost projected at €17.2m

Throughout 2011
Questionnaires sent to hospitals

February 2012
Roll-out set for year's end

June 2012
Roll-out delayed to April-June 2013

November 2012
Contract awarded to Cerner Corporation

s in the dark ages

ANSWERS:

Natasha Molyneaux, main picture; her baby Nathan, inset below in Natasha's arms, died six days after being born in Portlaoise Hospital

The hospital didn't tell me for five years why my baby died. I wondered what I'd done wrong

By Niamh Griffin

EVERY July, Natasha Molyneaux visits her son Nathan's grave for his birthday, bringing balloons, toys and cake. The little boy died just six days after being born at Portlaoise Hospital in 2008.

With a catch in her throat, she describes sitting on the ground with her other two children, thinking of their elder brother. Even though the two children and her partner, Alan, never met Nathan, he is a large presence in their family.

Natasha says she has let hatred go but desperately wants to finish with the endless rounds of reports. She simply wants the HSE to fully explain what happened and then improve the maternity services.

Only weeks ago it emerged that a HIQA report into infant deaths at the hospital was being challenged by the HSE. It's understood that this report, unlike a Department of Health report in February 2014, includes criticism of HSE executives.

This week it was revealed that only one in six complaints in Portlaoise Hospital was dealt with within the recommended 30 days.

Natasha said: 'I was shocked to hear all this. The families should be heard. We should be the priority.'

'HIQA is just doing its job. I don't think the HSE should be standing in its way. We know about 80 families talked to HIQA - that is so upsetting to me.'

'The HSE are putting their own necks before the patients'

A HIQA spokesman said: 'We can understand the legitimate concerns of the families. We just have to conclude the full process now. It will be published soon after Easter, within the next few weeks.'

A senior source in the department said: 'One thing the department is p****d about is that the HSE are putting their own necks before anyone else. They should be putting the patients first.'

Róisín Molloy, whose son Mark died in the hospital in January 2012, said she met senior HSE executives that year to warn them of the risks.

'We met senior managers, people right at the top. We knew that when baby Mary Kate Kelly died in 2013, she died after we told the head directors that another baby was going to die here.'

In February 2012, the Molloys wrote to Portlaoise Hospital asking for an investigation, copying a senior HSE manager at national level.

Meetings with hospital management followed, and then with senior people at regional and national HSE level in October, November and December 2012.

Amy Delahunt and Oliver Kelly lost their daughter Mary Kate in May 2013, following some similar errors.

Natasha was 19 years old when she went into Portlaoise Hospital. She describes the day as 'horrible' and remembers begging for a caesarean section after hours of labour.

She said: 'I know Nathan would be here if I'd had that caesarean. That child went through so much stress.'

Nathan was rushed to the Coombe Hospital. But Natasha was not told lack of oxygen linked to the high dose of Syntocinon she

was given caused his brain damage. A hospital report on his death was only given to her more than five years later.

'I blamed myself, I wondered what I did wrong. I'm thankful for the days I had with him. He passed away in my arms,' she said.

NO HEED: Mark and Róisín Molloy warned senior execs



three-year-old Samuel Starr died when Bristol Royal Children's Hospital's new Cerner Millennium computer system failed to allocate a follow-up scan until

almost two years after his heart surgery in 2010.

The scan showed he needed urgent open-heart surgery and he died of a stroke during the operation. A coroner ruled the delay contributed to his death.

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COMMENT Page 19

January 2013
Roll-out delayed to end of 2013

January 2014
Roll-out delayed to end 2015

February 2014
Cerner Corp signs contract with HSE

April 2015
Pilot tests set for early 2016

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