Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an Inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	University Hospital Waterford
Centre ID:	OSV-0001105
Address of healthcare service:	Dunmore Road Waterford Co Waterford X91 ER8E
Type of Inspection:	Unannounced
Date of Inspection:	07/10/2025 and 08/10/2025
Inspection ID:	NS_0168

About the healthcare service

Model of hospital and profile

University Hospital Waterford Hospital is a model 4* public hospital. It is a member of and is managed by the HSE Dublin and South-East† health region.

Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- critical care
- paediatric care
- maternity, obstetrics and gynaecology care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	511 inpatient beds

* A Model 4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24/7) and an Emergency Department, including a Clinical Decision Unit on site.

† HSE Dublin and South-East health region provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and*

[‡]Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

Capability and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
07/10/2025	*13:00 – 17:35*	Laura Byrne	Rosarie Lynch Bairbre Moynihan Patricia Hughes Emma Cooke
08/10/2025	*08:45 – 16:30*	Laura Byrne	Bairbre Moynihan Patricia Hughes Emma Cooke

Information about this inspection

This was an unannounced, targeted inspection prompted by the receipt of solicited and unsolicited information. The inspection focused on eight national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on two areas of known harm, these being:

- the deteriorating patient[**] (including sepsis)[††]
- transitions of care.[‡‡]

The inspection team visited four clinical areas:

- Medical 1 (Cardiology)
- Medical 3 (Care of the Elderly)
- Medical 7 (Medical)
- the Labour ward.

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Team, Quality and Risk, Human Resources and Clinical Staff.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

What people who use the service told inspectors and what inspectors observed

During the two days of inspection, inspectors spoke with a number of patients and families and in more detail with 12 patients who expressed their views on their experience of care received in the hospital. Patients were complimentary about the staff. Some patients commented that call-bells were answered in a timely manner and that staff were available to help. However, others reported that staff were busy and that it could be difficult at times to get the required assistance. A small number

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[**] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

of patients who required assistance had negative feedback on the quality of care provided particularly in regard to personal care and hygiene and felt that at times their care needs were not being met. While one patient reporting being aware of the plan for their care, two patients told inspectors that they had not been informed or updated. Other patients commented that the "care is good" and "nurses are great, food is excellent". Overall there was significant variance in patient experience across the clinical areas visited.

Patients who spoke with inspectors were not aware of how to make a complaint but none wanted to make a complaint. Staff were observed interacting with patients in kind and respectful manner and checking for consent before proceeding with assistance. A University Hospital Waterford mission statement was on display in Medical 3. A philosophy of care was displayed in ward areas.

A hairdressing salon was located in the hospital that offered services to patients. On Medical 3 ward musicians were playing while an inspector was on the ward. Inspectors were informed that this took place every Tuesday. Inspectors observed that wayfinding signage was not clear for navigating members of the public to their destination in an easily accessible way. Information received following inspection indicated that management were aware of this issue and were planning to address it.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce, use of resources.

University Hospital Waterford was substantially compliant in one national standard (5.2) and partially compliant in two national standards (5.8 and 6.1).

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

Inspectors found that corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised.

Organisational charts detailed the direct reporting arrangements of various governance and oversight committees to hospital management, which aligned with what inspectors were told. Since the last inspection in June 2024, the hospital had transitioned to a new governance structure in line with the establishment of the HSE regional health areas (RHA). The hospital was part of the Dublin and South East regional health area. The CEO was the senior accountable officer with overall responsibility and accountability for the quality and safety of the healthcare services delivered in the hospital. The CEO reported to and was accountable to the integrated health area (IHA) manager for Waterford and Wexford. They in turn were accountable to the regional executive officer (REO) for the Dublin and South East RHA.

Senior management described the arrangements for corporate and clinical governance of the women and infants services in the hospital. After the inspection HIQA wrote to the hospital seeking further clarity on these arrangements and how these were integrated within the RHA structures, including the escalation pathway of issues as required. The response from the service outlined the corporate and clinical governance of the maternity, gynaecological and neonatal services in the hospital, the reporting arrangements for the maternity service and its integration within the RHA structures. Hospital management outlined the arrangements in place for quality and safety in the service, for example, the director of midwifery (DOM) and the clinical lead for maternity services were members of the serious incident management team (SIMT) and the quality and patient safety (QPS) committee.

The hospital's CEO was supported by the Executive Management Board (EMB). This was unchanged since the inspection in June 2024. The EMB oversaw the overall quality and safety of the healthcare services provided in the hospital. Membership included clinical directors from the three clinical directorates, clinical leads for the maternity, paediatric and cancer services, the director of nursing (DON) and the director of midwifery (DOM). All provided an update on their respective areas of responsibilities at quarterly meetings. Meetings followed set agendas, were well attended however actions identified were not time bound.

The QPS committee met quarterly, reported to the EMB and discussed issues relating to patient safety and quality across the hospital. Time-bound actions were

identified at meetings. Several sub-committees reported to this committee and the reporting dates for each were defined and monitored. Although management outlined after the inspection that the clinical lead for maternity was a member of this committee and this was outlined in the terms of reference (TOR), they and the clinical leads for paediatrics and cancer were not in attendance at any of the three most recent meetings held in February, May and August 2025. The director of midwifery was in attendance at two of these meetings. At the one meeting where no representative from the maternity service was in attendance, no quarterly report was presented for the maternity governance group. Inspectors were informed of an initiative known as committee day which was implemented to align meetings to a common day and increase overall attendance at meetings and this initiative was evidenced in meeting minutes.

The quality and patient safety (QPS) department and the risk department functioned as two distinct departments and both were directly accountable to the CEO. Management outlined restructuring plans to incorporate the risk department into the QPS department by changing reporting structures. Management provided assurances that current resources or structures in the department were not impacting on the ability of the service to manage, respond and review patient-safety incidents. Assurances were also provided that actions arising from incident reviews were communicated between the two departments effectively. Both risk and QPS department reports were standing items on the QPS Committee meeting agenda.

The Clinically Deteriorating Patient Committee reported to the EMB via the QPS Committee and evidence was provided of quarterly reports that included meeting dates, work in progress and issues arising. Chaired by an emergency medicine consultant who was the lead for deteriorating patients, the group met quarterly and had oversight of audits and quality improvement plans (QIPs), incidents and regional updates. Minutes reviewed for meetings showed that they mostly followed a set agenda and were meeting at the frequency outlined in the TOR.

Nursing services in the hospital were managed and organised by an interim director of nursing (DON) who was supported in the role by assistant directors of nursing (ADONs). The interim DON had recently commenced in post following the vacancy arising in August 2025. Clinical nurse managers (CNMs) of different grades were responsible for the management and oversight of the clinical areas and were operationally accountable to a CNM3 and upwards to the ADONs. A designated night supervisor had responsibility for the service at night. Nursing management attended a quality, safety and risk (QSR) meeting held every two months which had operational oversight of intentional rounding, audits and QIPs, compliments and complaints, education, and updates from each clinical area. Senior nursing

management meetings were attended by the DON and DOM and discussed items such as intentional rounding and recruitment.

The director of midwifery (DOM) had overall midwifery responsibility for the maternity services (including the Domino service, which provides midwife-led maternity services in community-based clinics), gynaecology service, neonatology services, the regional sexual assault trauma unit (SATU) service as well as oversight of the home birth service. They also had responsibility for training and education of midwifery students from both University of Limerick and University College Cork as well as being a member of the EMT, SIMT and a number of other committees. There was no assistant director of midwifery (ADOM) in post. This resulted in the DOM being required to assist in the day-to-day operational running of the service in addition to the strategic operation of the maternity service. Management described recruitment challenges in filling the ADOM post and outlined plans to hire a clinical midwifery manager (CMM) grade three for this role on an interim basis to support the DOM. Clinical midwifery managers of different grades were responsible for the management and oversight of the clinical areas and were operationally accountable to an existing CMM3.

The hospital had three clinical directorates; medical, peri-operative and diagnostics, each with a 0.5 whole time equivalent (WTE) clinical director who reported to the CEO. The maternity, paediatric and cancer services each had a clinical lead and reported directly to the CEO. These services were not under the directorate structure and did not have the same resources. The clinical leads did not have a WTE allocation or administrative support. The clinical lead for maternity services was a consultant obstetrician and gynaecologist who led and oversaw the quality and safety of the service while concurrently completing their clinical role. They were supported in their role by a business manager. The maternity, gynaecology & neonatal service management team met monthly and discussed staffing, infrastructure, quality risk and safety, compliments and complaints. This group was chaired by the clinical lead and attended by the DOM and business manager. However, although updates were provided at the quarterly EMB meetings in 2025, this did not align with the TOR which stated that progress reports would be provided monthly.

A maternity clinical governance group met monthly. The TOR reflect that this meeting was chaired by the DOM but inspectors were informed and meeting minutes reviewed showed that the meeting was chaired by the clinical lead. This group had oversight of items relating to quality, safety and risk in the maternity service for example audit, incidents, complaints and educational updates. Inspectors were informed that minutes of this meeting were provided to the CEO and reporting was to the QPS Committee. There was evidence that a report was provided at February and August 2025 meetings which is not in line with quarterly reporting outlined in

the TOR as discussed previously. The chair of the committee was also a member of the EMB and updates were provided at the EMB meeting. A monthly multidisciplinary team meeting was also held in the maternity service, chaired by the DOM. This meeting followed a set agenda and discussed recruitment, staffing and unit updates.

Overall there were formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. However, the following was identified;

- there was no assistant director of midwifery (ADOM) in post
- attendance at the QPS Committee meetings in 2025 did not align with the TOR membership or the information provided by the hospital after the inspection
- the maternity, gynaecology and neonatal service management team did not provide updates to the EMB monthly as per the TOR
- the maternity, paediatric and cancer services were not under the directorate structure and were not allocated the same resources.

Judgment: Substantially Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring arrangements were in place to continually improve the quality, safety and reliability of healthcare services. However, deficits were identified in relation to the functioning of the SIMT in line with the TOR regarding documentation of immediate actions, review decisions and supporting rationale.

Incident Management

Incidents were logged on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework (IMF). The SIMT had oversight of patient safety incidents. Chaired by the CEO, the SIMT was attended by the clinical directors, DOM, DON and the risk officer. This group met monthly or meetings were convened in response to notification of a serious patient-safety incident as required. However, evidence provided on the days of inspection showed that this was not always within the 72 hours or 5 working days outlined in the TOR for SIMT, which were in draft format. This is not in line with the HSE incident management framework (IMF). Time-bound actions were not documented in response to items discussed at this meeting.

The TOR stated that role of the SIMT was to 'oversee the management of serious safety incidents' and that 'in the instance of a decision not to review provide

adequate rationale for same'. They also stated that the SIMT will 'gain assurance in relation to the immediate actions taken on identification of the incident'. Meeting minutes for the three most recent meetings were reviewed. However, it was found that there was varying levels of detail recorded. For example,

- for some incidents no detail was documented on assurances in relation to immediate actions
- for some incidents no decision in relation to commissioning a review or rationale not to commission a review of incident was documented.

After the inspection hospital management informed HIQA that assurances regarding immediate actions are documented in part A of the Preliminary Assessment Forms (PAF) for all relevant incidents and that decisions and supporting rationale were formally documented in part B. However this is not in line with the TOR for the SIMT. On review of three sample PAFs provided during the inspection, one was not completed in line with the IMF. This is further discussed under national standard 3.3.

Documentation provided to inspectors indicated that one review was commissioned from a total of 14 category one incidents occurring from January to September 2025. In 2024 five reviews had been commissioned from a total of 39 category one incidents. Of the 36 serious reportable events (SREs) year to date in 2025 (12 category one incidents and 24 category two incidents), one internal review was commissioned of a category two incident. There was a lack of consistency in the recording of the decision not to review an incident or the factors on which this decision was made. Overall, the SIMT was not functioning in line with the TOR regarding documentation of immediate actions, review decisions and supporting rationale.

Patient-safety incidents were discussed at EMB and QPS committee. Hospital management reported on the number of clinical incidents reported to NIMS, submitted monthly at performance meetings with the IHA. Evidence was provided that incidents were tracked and trended and this was shared with CNMs. This is further discussed under national standard 3.3. Information provided following inspection outlined the standard operating procedure in place for alerting category one incidents by the SAO to the IHA managers and senior regional person on call for the Dublin and South East Region.

Monitoring Performance

Performance data was discussed at performance meetings between the hospital and IHA manager for Waterford and Wexford. Information on a range of performance indicators and data related to the quality and safety of healthcare services was collected and reported in line with the HSE's reporting requirements. A collated

quality and patient safety performance report was submitted for review at each performance meeting. This included an overview of patient-safety incidents, complaints, and the top five risks on the hospital risk register for example, workforce and recruitment.

Risk Management

Formalised risk management structures and processes were in place to proactively manage and minimise risks at the hospital. Risks in relation to transitions of care, quality and safety, care standards and workforce were recorded on the hospitals' corporate risk register. These are further discussed under national standards 6.1 and 3.1. There was evidence that the risk register was reviewed at the March meeting of the EMB. While existing and additional controls were documented on the risk register, action due dates were not recorded. There was a Maternity, Neonatal and Gynaecology services' risk register that detailed high rated risks relating to the focus of this inspection such as staffing and the maternity patient record. Management outlined that risks arising in the maternity service could be escalated from the maternity risk register to the corporate risk register. However, at the time of the inspection none had been escalated. Inspectors were informed that risks that could not be managed at hospital level could be escalated to the regional IHA risk register but that none had been escalated to this level at the time of inspection.

Audit

The service was completing regular audits in a number of areas related to the focus of this inspection including early warning score and sepsis audits. There was evidence that committees had oversight of audit results relevant to their area of focus, for example sepsis and early warning score audits results were reviewed at the clinically deteriorating patient committee. QIPs were developed in response to audit findings, for example a QIP to guide the implementation of the sepsis management guidelines in the maternity service. Wards received feedback about their performance in metrics and audits through a monthly quality, safety and risk report and a sample of these were reviewed.

Audits of the Irish National Early Warning System (INEWS) were completed quarterly and each quarter the audit varied between ward and audit types. An INEWS documentation audit for quarter one 2025 showed compliance of 94.1% which was improved from 91.4% in 2024 and 85.5% in 2023. The INEWS escalation and response audit had an overall score of 90.1% for Q2 2025 which had improved from 83.2% in 2024. Medical 1 was included in this audit and had 89.7% compliance. Time-bound actions were identified on INEWS audit samples reviewed by inspectors. Evidence was provided of a QIP that had been developed after an INEWS escalation and response audit in June 2024 in Medical 7 which showed 78.9% compliance and

included actions, for example staff training and education. This result improved to 86.3% in a repeat audit in September 2024 and maintained at this in September 2025. High compliance was recorded in the frequency of observations however an area of low compliance identified on this audit was the adjustment of INEWS scores or parameters. The utilisation of the INEWS protocol was also tracked as part of intentional rounding. This was reported monthly and in a report compiled for the cancer and medicine services for 2025 it was found that there were opportunities to improve on 22% -77% occasions.

There was evidence that Irish National Maternity Early Warning Score (IMEWS) chart audits were completed in the maternity service. Partogram charts were in use on the Labour ward as a tool to monitor the progress of labour and the wellbeing of both the mother and the baby. Audits of the partogram were completed in the Labour ward. A sample of these from September 2025 was reviewed. Overall compliance was 72% and the audit report outlined the key strengths and gaps to be addressed. An action plan with assigned responsible persons was developed and recommendations were set out for immediate and long term timeframes with an aim of over 95% compliance by Q2 2026. Although the audit found consistent use of the partogram, varying compliance with recording key monitoring data and escalation standards was identified.

An Identify, Situation, Background, Assessment and Recommendation, Read-back Risk ($ISBAR_3$) communication tool for inter-departmental handover audit was completed in the maternity service in July 2025. This included charts from the Labour ward. This audit did not have an overall compliance calculation but showed high compliance in staff and patient identification and low compliance in areas such as documentation, background information and the inclusion of a safety pause. A time-bound action plan was developed which included training and revised handover templates. During the inspection HIQA were informed that audits of the ISBAR tool were not taking place. ISBAR audits were requested during inspection and not provided for the adult medical wards visited. This was also a finding on the inspection in 2024 and had not been actioned. Management outlined that this was a plan for quarter two 2026.

Nursing quality care metrics were completed in each ward visited. Medical 7 and Medical 3 showed good compliance of over 95% for the three months prior to the inspection. Medical 1 had overall compliance of 90.7% in August 2025 and 92.3% in September however some individual sections such as care planning had compliance of 76.5% in September 2025 compared to 100% on Medical 7 and 93.6% on Medical 3. This varying compliance with care planning was also a finding on the inspection and this is discussed under national standard 2.2.

Quality Improvement

A QIP was developed by the hospital in response to findings from the 2024 National Inpatient Experience Survey (NIES). Actions included to improve the process to ensure all patients receive a patient information booklet with complaints information and to increase the number of complaints posters on display. However, staff in the wards were unaware of any booklet containing complaints information and the posters were not observed by inspectors in the ward areas. Another action from the QIP was to commence a patient satisfaction survey in quarter one 2025 however management confirmed this had not been actioned at the time of the inspection. A separate QIP planned by the service in relation to coloured placemats to identify patients who required assistance at mealtimes had been delayed and was not yet in place.

Overall, there was evidence of monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services relevant to the size and scope of the hospital. However,

- the SIMT was not functioning in line with the TOR regarding documentation of immediate actions, review decisions and supporting rationale
- QIPs planned by the service in response to the NIES had not been implemented
- audits of the ISBAR tool were requested and not provided for the adult medical wards.

Judgment: Partially Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

While workforce arrangements in the general hospital were planned, organised and managed to provide high-quality, safe and reliable services, staffing gaps were identified in the maternity service which had the potential to impact on the quality and safety of care. The ADOM position was vacant as previously discussed under national standard 5.2.

Inspectors were informed that the required staffing on day shift on the labour ward was five staff midwives. However, on the day of inspection, although four midwives had been rostered for day duty on the Labour ward there were only three midwives on duty. On the day of inspection, staff reported that midwives were redeployed from the Domino scheme to the Labour ward to ensure one-to-one midwifery care.

A review of recent rosters showed that in the month of September, 21 out of the 30 day shifts had four out of the five required midwives rostered. Assistance was provided by the Domino scheme staff, by registered nurses who had been upskilled to support the operating theatre and via agency cover. Management outlined that two midwives were recently recruited and one would be commencing two weeks after the inspection however, a deficit remained. Staffing was a risk recorded on the Maternity, Neonatal & Gynaecology services' risk register. Staffing was also an item on the corporate risk register, however no specific controls were documented in relation to midwifery staffing. The total midwife funded complement was 80 whole time equivalent (WTE). At the time of inspection, 10.8 WTE (12%) of these posts were vacant. There was a deficit of 7.8 WTE (20%) staff midwives from a total funded complement of 39 WTE.

Inspectors identified that there were minimal gaps in nursing staffing in the adult medical wards visited on the days of inspection. However there were 24 WTE permanent vacancies representing a vacancy rate of 2.0% and temporary vacancies due to statutory leave of 48.92 WTE which was a rate of 4.1%. The hospital was working with a deficit of 58 WTE permanent vacancies in healthcare assistant (HCA) posts from a total funded WTE of 158.24. This represented a 36.7% deficit and this was similar to the figure at the time of the last inspection. Management outlined that HCA recruitment was ongoing and that current staffing was supplemented with the use of agency staff to reduce this deficit. Following the inspection, hospital management provided additional information that at the time of inspection the hospital was operating with 142 HCA staff, resulting in an 11% deficit vs safer staffing requirements. In the adult wards visited there were a total of 6.6 WTE HCA vacancies from a total of 21.88 posts with the highest vacancy on Medical 3 which had 3.47 WTE vacancies. On the day of inspection, Medical 3 was fully staffed with agency HCA staff.

Hospital management confirmed that medical and surgical consultants were on the relevant specialist division of the specialist register with the Irish Medical Council (IMC) with minimal exceptions. The clinical director had oversight of consultants not on the specialist register. Consultants were supported by non-consultant hospital doctors (NCHDs). There was a deficit of two registrars in the maternity service roster. Management outlined that the service was managing with the existing team through rostering and that recruitment was underway for these posts. No deficit in medical staffing on the Labour ward was noted on the day of inspection.

The quality and patient safety department was staffed by one WTE QPS manager and 2.6 WTE quality, audit and improvement managers. One grade V post was vacant with a recruitment process underway. The QPS department also included one WTE patient services manager, one deputy patient services manager and 1.45 WTE patient services officers of which 0.45 WTE was shared with another department.

The risk department comprised an acting grade VII risk manager, and one grade III. One grade VI post was vacant. A permanent grade VII risk manager was appointed and due to commence soon after the inspection. Management informed inspectors that business cases had been submitted for additional resources in the complaints function but reported no progress had been made with this.

The human resource department tracked staff absenteeism rates. This was reported as 5.84% at the time of inspection which was above the HSE target of 4% or less. Figures reviewed for year to date 2025 showed that the rate was above 5% monthly. Management stated that back-to-work interviews were conducted with staff on return from unplanned leave in line with the HSE Managing Attendance Policy. Occupational health supports were available to staff onsite, and staff had access to an employee assistance programme (EAP) if required.

The human resources department had oversight of mandatory training and liaised with ward managers who had oversight in their clinical areas. Training compliance varied across staff disciplines. For example, compliance with annual mandatory INEWS training was 99% for nurses and 61% for doctors. Other areas with low compliance levels included basic life support (BLS) which was 54% for doctors and 14% for HCAs. Following the inspection, the hospital provided further clarification on figures pertaining to HCA training and clarified that the 14% figure represented HCAs who had undergone internal training by UHW. The figure for total compliance was provided as 44% for surgical in-patient wards and 73% for medical services. This was also a finding on the previous inspection. Hospital management outlined initiatives aimed at improving mandatory training compliance such as additional computer availability and giving staff time to complete online training from home.

A review of training records provided in the clinical areas showed good compliance levels in some areas such as INEWS which was 100% for nurses in all three wards visited. Midwives on the Labour ward had 100% training compliance in the IMEWS and 90.1% for Fetal Heart Monitoring. Management reported that the figure for Fetal Heart Monitoring was not at 100% due to staff on statutory leave. BLS training for nurses had compliance rates of, for example, 93.5% on Medical 3 and 100% on Medical 7. However, BLS training compliance by midwives was 60.5% in the Labour ward and for HCAs in the wards ranged from 100% on Medical 3 to 50% on Medical 1. Following the inspection, management reported that the figure provided did not capture all training and HIQA were informed that 78% of midwives in the Labour ward had completed BLS training. This remains below the service's target of 100% compliance.

Overall while the service had workforce arrangements in place in the general hospital, the following was identified;

- there was a 20% vacancy rate among staff midwifes with associated deficits observed on the day of inspection
- there was a deficit in HCA staffing in the adult medical wards
- compliance with attendance at mandatory training in some areas was low, for example BLS training
- vacancies existed in both the QPS and risk departments.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

University Hospital Waterford was substantially compliant in one national standard (1.6) and partially compliant in four national standards (1.8, 2.2, 3.1 and 3.3).

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

All single rooms and multi-occupancy bays in the clinical areas visited in the general hospital had en-suite toilet and shower facilities with the exception of one which had a toilet only. Patients were cared for in single gender bays with the exception of the high observation bays on each ward which were mixed gender and utilised based on clinical need for observation. Inspectors were informed that a risk assessment for this placement was carried out by staff in the emergency department. Single rooms were available for patients requiring isolation for infection control purposes or for those requiring end-of-life care. One family commented that they were happy with the privacy provided by the single room. The Labour ward was a nine-bedded ward consisting of four single occupancy labouring rooms, two of which had en-suite shower and toilet facilities. There were also two single admission rooms, and one three-bedded multi occupancy bay which had an en-suite shower and toilet facilities.

Curtains were in use in multi-occupancy bays to maintain privacy. Patient information was kept in a secure manner in many instances. For example, a whiteboard in Medical 7 with patient details was situated in a manner to protect privacy and patient's healthcare records were stored appropriately. However, on the Labour ward patients' healthcare records were open and unattended in an area near the midwives' station. This was brought to the attention of staff on the ward. Healthcare records were included as part of a ward assessment audit completed in September 2025 and the Labour ward had 81% overall compliance in this section with 100% compliance with the storage of records in a secure private area.

Inspectors observed some examples where patients' dignity was not promoted and maintained and this was highlighted to ward management. A small number of patients on Medical 1 told inspectors about negative experiences with continence care and management. This included experiences of infrequency of continence wear changes or the use of incontinence products for a continent patient. Inspectors observed that patient dignity and privacy was not maintained in two instances on Medical 1, for example where appropriate covering or clothing was not in place for patients in bed.

A family room was available on Medical 1 which included a couch, tea and coffee making facilities, and a television. A "This Is ME" record was in use on Medical 3 which detailed issues of importance for patients and documented for example, activities patients may need assistance with. There was evidence that the service took into account individual needs and preferences at meal times. Catering staff were observed checking information on dietary requirements prior to providing meals and staff were observed providing assistance to those requiring it at mealtimes in line with their care plan.

There were examples of good practice in relation to the hospital promoting autonomy, such as the use of the "End PJ Paralysis" initiative on Medical 3 and Medical 7, and a number of patients were observed dressed in their own clothes.

Overall, on the days of inspection, service users' dignity, privacy and autonomy was respected and promoted. However, the following was identified,

- some patients had negative feedback about their continence care needs not being met appropriately and some patients were observed to not be appropriately clothed or covered which impacted on their dignity.

Judgment: Substantially Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

The hospital had systems in place to respond effectively to complaints. The hospital had a designated complaints officer assigned with responsibility for managing complaints. Formal complaints received by hospital management were managed in line with the HSE's complaints management policy '*Your Service Your Say*[§§].

As discussed under national standard 5.8, complaints information was not clearly displayed in the wards visited. In Medical 7 ward, the number for the patient services' office was on display at the nurses' station but overall, inspectors did not find that complaints information was clearly on display throughout the hospital. Complaints information on a large pop up board was noted at the main entrance however this was not located in a high visibility area. There were no information leaflets available on how to make a complaint.

Inspectors were provided with evidence of complaints logging by the patient services office that included the outcome of each complaint and a tracker for any actions. Complaints were categorised into themes for example safe and effective care, and dignity and respect. Complaints were discussed at the EMB and the nursing QSR meetings. In the maternity service, complaints and compliments feedback was discussed at clinical governance meetings and at the management team meetings. Complaints and compliments were included in the quality safety and risk reports that were compiled for each directorate. Inspectors were informed that actions were taken in response to individual complaints but that no QIPs had been developed in response to an identified trend in complaints and that this was planned for future development. Clinical nurse managers reported that they did not receive complaints trending reports for their individual clinical areas.

The number of complaints received were reported monthly to the IHA Waterford Wexford as part of the QPS performance report. The hospital was tracking their compliance with the HSE KPI of percentage of complaints investigated within 30 working days of being acknowledged by the complaints officer and this was reported as 48% from January to September 2025 which was below the HSE target of 75%. This had improved from 24% at the time of the last inspection in June 2024 and a QIP had been developed in July 2025 to address this.

[§§] Health Service Executive. Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf

A patient partnership forum that had previously been in place was re-established in 2025 and this was noted in minutes of the EMB and QPS committees. No signage was observed in the wards with information on access to an advocacy service.

Overall, there was evidence that while the hospital had systems and processes in place to respond to complaints and concerns raised by people using the service however the following deficits were identified;

- compliance with the HSE KPI for complaints investigated within 30 working days of being acknowledged by the complaints officer was below the target of 75%
- with the exception of the large pop up board referenced above, information on making a complaint was not clearly visible or available throughout the hospital.

Judgment: Partially Compliant

Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.

While there were many examples where care was planned and delivered in line with patients' assessed needs, there was significant variance in how care was planned and delivered across the clinical areas visited. In particular, there were gaps in ongoing assessment and updating of care plans in line with changing needs of patients during the course of their admission.

Clinical nurse managers (CNMs) and nursing executive management had oversight of care planning activity. Intentional rounding was completed daily on a sample of patients by members of the nursing executive team. This had been maintained since the last inspection. The intentional rounding process included a review of care planning documentation, bed spaces and equipment. CNMs also completed daily intentional rounding of a sample of six patients in their ward area and the ADON had oversight of these results. The service was monitoring and tracking compliance with care planning and care bundles monthly as part of the intentional rounding process. For care planning the number of wards with non-compliances ranged from 30% to 55% for January to August 2025 in the cancer and medicine services. For care bundles this range was 50% to 77%. This aligns to inspectors findings. Although individual items were addressed through the intentional rounding process and trending of results completed, no QIP or action plan was in place to address the trended findings.

Patients' care needs and goals were identified by using a nursing assessment on admission followed by commencement of a number of nursing care plans. A variety of assessments were in use for the evaluation and planning of patients care needs, for example the Waterlow score, malnutrition universal screening tool (MUST), frailty score and falls risk assessment tool (FRAT). Hospital management had identified that improvement was required in the area of nursing care planning records to ensure they were individualised to each patients' needs and goals. Inspectors were shown a sample of a new patient nursing record that was due to be introduced in the hospital and a time-bound QIP which outlined a planned introduction date of October 2025.

There were some examples of good practice in relation to care assessment and planning. For example, records showed weekly reviews for FRAT and MUST and daily completion of core care records, skin care plans and personal care plans. There was evidence of appropriate care plans being commenced and maintained for patients, for example a diet sheet in response to noted weight loss was in place, maintained and up to date, a pressure relieving mattresses was in place for a patient identified in need of one and a behavioural monitoring chart, where there was evidence of staff completing 30 minute checks. However, there were also examples where care was not assessed or delivered relevant to a patient's needs. Examples included the absence of a bowel monitoring chart for a frail patient on Medical 1 and the absence of falls, nutrition and hydration, or skin care plans for patients identified as at risk on Medical 7. In some cases gaps were noted in the records reviewed by inspectors. For example, for one patient a fluid balance chart was not accurately recorded or totalled on three separate days, a bowel chart for another patient had not been updated in a week and a section for continence was not filled out on a care plan.

There were some instances where assessment and care planning were not responsive to an individual's changing needs. For example, a Waterlow assessment planned for weekly review had two reviews in the month of September and another patient's continence needs had not been updated in line with their changed status. In other examples, a falls risk assessment and discharge plan was not updated after a patient had a fall and another patient's care plans had not been updated following a significant change in their clinical condition and were not reflective of their current mobility status and associated care needs at the time of the inspection. Overall, there was evidence that care plans were not always implemented, regularly reviewed and revised to ensure effectiveness and this impacted on the ability of the service to deliver care in a timely and appropriate manner according to the patient's ongoing assessed healthcare needs.

Inspectors were informed that relevant referrals were made to health and social care professional (HSCP) staff and there was evidence of review by physiotherapy,

speech and language, dietetics and medical social workers. There was evidence that care plans were not always aligned to advice from relevant HSCPs. For example, a patient's nutrition plan was not updated and fluid output was not being accurately recorded on a stoma output record chart in line with instructions from the dietician.

Inspectors were informed that patients and families were included in the care planning process for example via family meetings. The family of one patient commented on how they felt that care provided was meeting the patient's needs appropriately. However, a small number of patients outlined that they were not made aware of their care plan. One patient told inspectors that they had not received a falls booklet although this was included in their care plan.

Care needs were identified on the ward whiteboard using symbols for example falls risk or patents required enhanced one-to-one care. Staff confirmed that information regarding falls risk or mealtime assistance was communicated via huddles.

A QIP with an action due date of quarter one 2025 developed in response to findings from the 2024 National Inpatient Experience survey stated that a patient with any impairment or communication issues would be highlighted in the nursing care plan. However, on the day of inspection, inspectors found evidence that no communication care plan was completed for a patient who required one.

Women referred to the maternity services were assessed at referral for inclusion on one of the three pathways of care available; supported, assisted and specialist. One woman commented positively on her experience with care delivered on her chosen pathway. Women were assessed for risk factors and these were documented on their healthcare record. Care planning and care delivery audits were requested and not provided for the Labour ward. The Labour ward had a poster displayed with patient safety strategy top tips which included involving patients in the design, planning and delivery of care and communicating clearly with patients about their care.

Training for staff on care planning and assessment was provided by clinical facilitators on induction. The hospital ran regular clinical safety update training which covered topics including pressure area care, nutrition and hydration, and falls and this was mandatory every three years.

Overall while there were examples of good practice in relation to care planning and delivery, there were also examples of gaps in care planning, assessment, documentation and re-evaluation. Nursing executive and clinical nurse managers had oversight of care planning however significant variance in standards remained across the clinical areas. The following was identified;

- there was evidence that care plans were not regularly reviewed and revised to ensure care could be guided effectively, including alignment with advice from relevant HSCPs
- there were examples where care was not assessed relevant to a patient's individual needs
- non-compliances with care planning recorded as part of the intentional rounding process was noted to range from 30% to 55% for January to August 2025 in the cancer and medicine services
- some patients outlined that they were not made aware of their care plan.

Judgment: Partially Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services

The service had systems in place to protect service users from the risk of harm however, some risks identified by inspectors had not been fully managed. Risks were recorded on the local maternity risk register and hospital risk register as previously discussed. The risk identified in the maternity service due to midwifery staffing deficits has been discussed under national standard 6.1.

The service had recorded a risk in relation to challenges in achieving optimal discharge pathways affecting patient flow. Actions listed included optimal discharge planning and multidisciplinary meetings. Inspectors observed tracking and planning for discharges was completed with the use of a colour coded system on the ward whiteboard and staff were familiar with the discharge process. Details on upcoming discharges and planned discharge location were recorded at handovers. Discharge entries were documented in the patient's healthcare record and discharge summaries were completed. A large sticker with a discharge checklist had been developed which placed on the outside of the discharge documentation envelope, assisted staff to ensure correct process was followed. Nurses were utilising a handover sheet to document handover to other services for example for patients discharging to nursing homes. An intra-hospital transfer sheet was in use and contained details of care bundles in place, nursing assessments and INEWS scores.

Management outlined how they managed delayed transfers of care via daily patient flow huddles. The delayed discharge forum was an operational forum, attended by the DON, held weekly to review patients with delayed transfers of care and any patients who were identified as having complex discharge plans. The agenda was consistent and structured. The service was tracking delayed transfers of care and monitoring 30 and 100 day KPIs. Huddles and safety pauses were held daily at ward

level and discussed updates on each patient's status, patients for discharge and INEWS scores.

The ISBAR communication tool was used for the escalation of the care of the deteriorating patient, at handover and on transfer of patients. ISBAR information was on display beside the phone in Medical 3 and Medical 7. On the Labour ward, a whiteboard was used for multidisciplinary team handover which was in ISBAR format. It was not evident from healthcare records reviewed that ISBAR was being used for communication of deteriorating patients in the Labour ward. Management outlined plans for a maternity specific ISBAR tool to be introduced in 2026.

Emergency equipment was available in each clinical area and there was evidence of appropriate checks. Oxygen and suction equipment were available at each bedside. Emergency call response system information was on display. A critical care outreach service was in place 8am to 8pm Monday to Friday with specific review criteria. A new sepsis form was being implemented and training was ongoing by sepsis link nurses. Implementation of the National Clinical Guideline No. 26 Sepsis Management for Adults (including maternity) was ongoing and inspectors were provided with a log which was tracking the hospital's progress with this implementation and which contained actions with identified responsible persons.

Inspectors were informed that the hospital was following national guidelines for INEWS, IMEWS and Paediatric Early Warning System (PEWS). All staff in the general hospital spoken with were knowledgeable about the INEWS and response protocol to ensure timely management of patients with a raised early warning score. Inspectors reviewed a sample of INEWS charts. It was observed that, while the majority of INEWS entries were appropriately recorded and adhered to the required frequency there was some variance in compliance with INEWS modified escalation and response protocols in the clinical area. For example, on Medical 7 one record showed appropriate documentation of a modified escalation protocol. However a record on Medical 1 for a patient with a raised INEWS did not show that escalation was in line with INEWS escalation protocol.

In the Labour ward staff outlined the use of the IMEWS from admission for women presenting to the unit. Inspectors reviewed a sample of charts and found that in two cases, repeat observation frequency was not in line with the protocol for patients with a raised IMEWS score nor was a plan of care after the escalation protocol triggered clearly documented. This is not in line with National Clinical Guideline No. 4, Irish Maternity Early Warning System (IMEWS) V2.

Partogram charts were used for monitoring of women in established labour. However, this document was reviewed by inspectors who identified a number of gaps. For example, there was no designated area or prompt on the chart to record

abdominal palpations or respiratory rate and there was a lack of sufficient space for recording details in the narrative section. This documentation did not support the recording of essential midwifery care. The service had not adopted the national maternity healthcare record and cited that various challenges had been halting progression of this issue. This was recorded on the Maternity, Neonatal & Gynaecology services' risk register.

The hospital had a number of policies, procedures, protocols and guidelines (PPPGs) in place to guide staff which were up to date with the exception of the restraint policy which was in draft format. Staff in the clinical area were aware of how to find policies on the hospital's information technology system in most cases.

Overall while the service had systems in place to protect service users from the risk of harm, the following was identified.

- significant gaps were identified in the partogram document in use and the labour ward had not yet adopted the national maternity healthcare record. This documentation did not support the recording of essential midwifery care
- there were some examples amongst the charts reviewed where INEWS and IMEWS national guidelines were not being followed with regard to modified escalation and response protocols and frequency of observations.

Judgment: Partially Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

Systems were in place in University Hospital Waterford to identify, manage, respond to and report patient-safety incidents, in line with national legislation, standards, policy and guidelines. All patient-safety incidents were notified to the risk manager, using the National Incident Report Form (NIRF). Arrangements for the Serious Incident Management Team (SIMT) are discussed under national standard 5.2.

Staff outlined the most common patient-safety incidents reported in their clinical areas. Clinical nurse managers received information on the type and number of incidents for their respective areas via email. There was evidence on Medical 1 and Medical 3 that incident reporting was discussed at staff meetings and staff in the ward confirmed that incidents were discussed at huddles and staff meetings.

Ward managers had access to incident data that provided a break-down of the number and type of incidents in their clinical areas. A sample of a quality, safety and risk report compiled for individual services was reviewed for July and August 2025 for the cancer and medicine services. In this report incidents were categorised into

medication errors, falls, skin, violence and aggression and 'other' and numbers of each category tracked monthly. An annual risk management report was compiled which detailed the number and type of incidents for the year including categorisation of incidents by type. For example, the location and person involved. Trends identified from incidents in the management of deteriorating patients were discussed at the Clinically Deteriorating Patient Committee.

A trend had been identified by hospital management in relation to incidents resulting from falls and some trending of witnessed and unwitnessed falls and associated time of occurrence had been carried out. On review of documentation provided, inspectors identified that no reviews had been carried out on any incidents in this trend using the IMF framework and or the Falls Concise Review Tool. Management described initiatives such as the purchase of specialised low height beds. However, beds or environmental factors were not identified as contributory factors in the falls trending carried out. Furthermore, as no comprehensive, concise or aggregate reviews were completed in 2024 or 2025 despite 35 falls categorised as category one, the service had not identified any contributory factors to the falls. Therefore, hospital management could not identify shared learnings from the falls incidents and no recommendations were identified.

A review of a sample of preliminary assessment forms (PAF) showed that while the service was completing the forms, gaps were identified in the information documented as part of the decision making process. For example, a section relating to environment and equipment had not been completed in one record. In another record the assessment was missing key data such as the selection of the review type, level of independence of the review team and three of the four relevant items in one section were not completed.

External patient-safety reviews carried out in response to serious incidents were not completed in line with the HSE key performance indicator (KPI) of 125 days. Management informed inspectors that external reviews were reliant on a small number of available reviewers and that this impacted on the timelines for completion. This was also a finding on the previous inspection.

Staff who spoke with inspectors were knowledgeable about the systems in place and their role in reporting and managing patient-safety incidents. There was evidence that recommendations from the review of patient-safety incidents were implemented. However, the following was identified;

- incident reviews were not carried out in the timeframe in line with the HSE KPI
- a review of incidents in response to an identified trend was limited to time of day of the incidents and did not account for any other possible causative

factors. No concise, comprehensive or aggregate review was completed of these incidents to identify findings, learnings and recommendations
- gaps were identified in the documentation of the decision making process for incident reviews.

Judgment: Partially Compliant

Conclusion

HIQA carried out a targeted unannounced inspection of University Hospital Waterford following the receipt of solicited and unsolicited information to assess compliance with the *National Standards for Safer Better Healthcare.*

This inspection focused on two areas of known harm; the deteriorating patient and transitions of care. This inspection incorporated national standard 2.2 to monitor that care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.

Capacity and Capability

The hospital had defined accountability and reporting arrangements for the senior management team, however the representation of the maternity service at the QPS committee was not aligned with the information provided and the ADOM position was vacant. Senior management organised their workforce however, the maternity service was functioning with an ongoing deficit in midwifery staffing with deficits identified on the day of inspection. While for some staffing disciplines mandatory training had high compliance, some had low levels of compliance such as BLS. The hospital had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services with regard to audit and performance monitoring, however, deficiencies were identified in the serious incident management team, QIPs had not been actioned as planned and no audits of the ISBAR tool were taking place.

Quality and Safety

Through observation and discussions with staff members it was evident that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Patients who spoke with inspectors had mixed views about their experience of receiving care in the hospital and inspectors found deficits in the identification, assessment and planning for care needs across ward areas.

Systems were in place to identify potential risk of harm however, not all risks identified by inspectors had been fully managed by the service. The hospital had a number up-to-date of policies, procedures, protocols and guidelines (PPPGs) in place to guide staff. Complaints management processes were in place however the service was not meeting the HSE KPI for complaints management and complaints information was not clearly on display throughout the hospital. Staff identified, recorded and responded to patient-safety incidents. There was evidence that QIPs were developed in response to incidents. However incidents were not reviewed in line with the IMF and there were missed opportunities for learning from an identified incident trend. Incident reviews were not completed within the HSE KPI timeframe.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing actions to bring the hospital into full compliance with the national standards assessed during inspection.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant
Theme 2: Effective Care and Support	
Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance Plan for University Hospital Waterford

Inspection ID: NS-0168

Date of inspection: 7 and 8 October 2025

Compliance plan provider's response:

Standard	Judgment
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Outline how you are going to improve compliance with this national standard 1. A retrospective review of the previous six months of SIMT documentation is currently underway. This review will assess completeness of immediate actions (Part A), review decisions and rationale (Part B) and Evidence of follow-up. The hospital will implement a revised and standardised Serious Incident Management Team minutes template to strengthen governance, documentation and oversight of incident management processes to ensure full compliance with the HSE Incident Management Framework and to ensure the Serious Incident Management Team operates fully in line with its Terms of Reference. The revised template will incorporate a structured approach to SIMT decision - making and action tracking to include a time bound action record, clearly documenting all actions arising from SIMT review, with assigned responsible persons, defined completion dates and recorded status updates to record progression and completion. All SIMT decisions will be clearly documented. Where a decision not to proceed to a comprehensive review is made, a clear comprehensive rationale will be recorded. All actions, decisions and associated timelines will be formally recorded within SIMT minutes. At each SIMT meeting, a review of previous actions assigned will take place as a standing agenda. A standardised SIMT checklist will be implemented to ensure compliance. All immediate actions will be recorded in Part A, and all review decisions and rationale will be documented in Part B of every preliminary assessment complemented. This will provide standardisation and verification undertaken by the Risk Manager at each SIMT, which will have oversight by the QPS Committee where all SIMT decisions and recommendations will be reported as a standing agenda. Where a decision not to	

commission a review is made, a clear and comprehensive documented rationale will be provided to the QPS Committee.
A SIMT log tracker and review record has been implemented to ensure clear visibility of all decisions and actions from the point of the incident to final closure. Routine monthly review by the Risk Manager will take place to ensure completeness and quality of SIMT documentation.
Compliance with the revised SIMT documentation will be subject to ongoing audit (Q3) , with findings used to inform continuous improvement.

2. QIPs planned by the service in response to the NIES had not been implemented
-Since the HIQA inspection the successful rollout of coloured trays was introduced on the 18th March 2026 in the main concourse of UHW, with the Dunmore wing to follow (alternative tray required due to catering process). Audits to evaluate its effectiveness will take place at six months and twelve months post implementation in each area. The first audit for the main concourse is due in October with the second scheduled for April. Any finding and recommendations will be progressed via the Nutrition and Hydration Committee.
-The Patient Information Booklet is completed and provided on entry to all inpatient wards.
-While UHW had aimed to complete a patient satisfaction survey in Q1 2025, UHW prioritised the other infrastructure and patient care needs identified in the survey of 2024. With the pending National Inpatient Experience Survey due to commence in May 2026, UHW will review the findings of this survey and implement QIP's accordingly.

3. Audits of the ISBAR tool were requested and not provided for the adult medical wards.
-In addition to conducting monthly audits of ISBAR for INEWS escalation as part of QCMs, UHW will conduct additional audits to demonstrate written use of ISBAR through use of an ISBAR sticker.
Timescale:
Q1 2026: Amend local INEWS policy to include recording of ISBAR on an ISBAR sticker for INEWS escalations. Status: Complete√
Q2 & Q3 2026: To provide education on recording ISBAR on ISBAR sticker to ≥ 85% of nurses in adult in-patient wards. Status: In progress
Q3 2026: To audit written evidence of ISBAR for INEWS escalations through use of ISBAR sticker. Status: To complete

Timescale:
Retrospective review: underway and completed within 4 weeks.
Revision of SIMT minute template to include time-based actions and detailed rationale of review decision section. Implemented 1st May 2026
SIMT documentation checklist: Implemented 1st May 2026

SIMT incident log tracker and review as a standing agenda at SIMT to review previous actions at SIMT. Implemented 1st May 2026
Full compliance: within 4 weeks

Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant

Outline how you are going to improve compliance with this national standard

1. There was a 20% vacancy rate among staff midwifes with associated deficits observed on the day of inspection

-UHW acknowledges the vacancy rate at the time of the inspection. The current vacancy rate is 12% (3.5 WTE) with ongoing recruitment to fill these vacancies.

2. There was a deficit in HCA staffing in the adult medical wards

-In line with safe staffing framework the HCA approval is 158 WTE. On the day of audit UHW had 107 WTE's in post, with 40 WTE outstanding posts backfilled by agency HCA's.

Since the HIQA review;
*20 WTE agency conversion posts have been approved, interviews are complete and candidates are currently being processed.
*A business case is being formulated to approve the further 20 WTE's currently being filled by agency HCA's.
*There is ongoing robust recruitment processes in place to fill the remaining HCA posts.
*Business case prepared for the variance of 11 WTE HCA's to comply with Safe Staffing

3. Compliance with attendance at mandatory training in some areas was low, for example BLS training

-BLS training for the labour ward staff in October 2025 was 78%. It is currently at 82%.(A 95% target is set for end of Q2. 2026 with on-going and continuous training for all staff)
-UHW currently has 0.5 WTE's CNM2 Resuscitation Officer approval. Additionally, there is 0.5 S/N post approved to support this role. On the day of the HIQA inspection the Medical and Surgical HCA's BLS mandatory training compliance was 58.5%.

Since the HIQA review;

*A business case has been completed and submitted for approval for an initial additional 2 Resuscitation Officers which would still not be in line with other Model 4 hospitals.

*Local arrangements have been put in place to complete HCA BLS training. The AIM By quarter 4, HCA BLS training will be <85%.

3. Vacancies existed in both the QPS and risk departments.

-Assistant Risk Manager post-recruitment in progress-successful candidate has interviewed.

- Since the inspection, the Grade V QPS post is now filled.

Timescale: In progress

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

1. Compliance with the HSE KPI for complaints investigated within 30 working days of being acknowledged by the complaints officer was below the target of 75%

- At the time of inspection, the KPI was 48%. As of Q1 2026, the KPI is currently at 69%. The Patient Services Office are committed to continuing to improve this percentage with ongoing staff engagement, MDT response meetings and education. The KPI will continue to be monitored through reporting to the QPS Committee.

2. With the exception of the large pop-up board referenced above, information on making a complaint was not clearly visible or available throughout the hospital.

- Since the inspection, the below is now in place:

*YSYS posters, feedback leaflets, Patient Advocacy leaflets and Patient Information booklets on display on entry to the wards.

*A patient information board at the main entrance which displays information in relation to providing compliments, complaints and feedback and the Patient Advocacy Service.

* UHW has increased the number of feedback boxes in the hospital including high footfall areas such as the main entrance and all lifts. There are feedback leaflets included, which will give service users the opportunity to provide their feedback easily.

*A poster with information on how to provide feedback is displayed in all wards and on the information board at the main entrance.

Timescale: In progress

Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

1. There was evidence that care plans were not regularly reviewed and revised to ensure care could be guided effectively, including alignment with advice from relevant HSCPs

- As discussed with HIQA, a new Patient Nursing Record was introduced on 03.11.25 to support individualised, person-centred care, along with comprehensive assessment and ongoing review of care. A follow-up compliance audit was conducted on 25% of all adult in-patient wards. Result 87.86%. Status: Complete

2. There were examples where care was not assessed relevant to a patient's individual Needs

- To maintain and enhance compliance, refresher education to be provided to ≥ 85% nurses in adult in-patient wards. Education sessions will be informed by documentation audit results and HIQA findings, including where possible patients to be included and informed about their care plan. Status: In progress

3. Non-compliances with care planning recorded as part of the intentional rounding process was noted to range from 30% to 55% for January to August 2025 in the cancer and medicine services some patients outlined that they were not made aware of their care plan.

-To track and trend compliance with nursing documentation through intentional-rounding and implement QIPs as required. Status: To complete Q3 2026

4. Some patients outlined that they were not made aware of their care plan

-To conduct follow-up audit on 25% of adult in-patient wards. Status: To complete Q4 2026

Timescale: In progress

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

1. Significant gaps were identified in the partogram document in use and the labour ward had not yet adopted the national maternity healthcare record. This documentation did not support the recording of essential midwifery care

-A committee for the implementation of the National Maternity Chart was established in November 2025. A draft version of a bespoke chart for UHW is in progress with the committee. The partogram within the national maternity chart will ensure prompts for escalation and will also ensure recording of essential midwifery care in a uniformed manner.

Timescale: Aim to roll out the new chart in Q3. 2026 with adequate training and supports for all staff.

2. There were some examples amongst the charts reviewed where INEWS and IMEWS national guidelines were not being followed with regard to modified escalation and response protocols and frequency of observations.

(IMEWS)

-Will continue to adhere to the National IMEWS KPIs for numbers of staff educated and number of audits undertaken (National Clinical Guideline No 4)

Timescale:
Q1 2026: Completed audit on the maternity ward (30 charts). Results: Completion Standards 90%, Escalation & Response, 65%. Status: Complete

Q2 & Q3 2026: To implement QIPs as required from the Q1 audit. To complete escalation and response audits on the maternity ward. To provide refresher IMEWS education to midwifery staff in relation to audit results & HIQA report findings. Status: In progress.

Q4 2026: Conduct IMEWS escalation & response audit of 25% of IMEWS charts in the maternity ward. Status: To complete

(INEWS)

-Will continue to exceed National INEWS KPIs for numbers of staff educated and number of audits undertaken (National Clinical Guideline No 1 p.113).

Timescale:

Q1 2026: Completed audits on two medical and two surgical wards (40 charts). Results: Documentation Standards 91.6%, Escalation & Response, 85.8%. Status: Complete

Q2 2026: To complete escalation and response audits on two medical and two surgical wards (20 charts). To provide refresher INEWS education to ≥ 85% of nursing staff in relation to audit results & HIQA report findings. Status: In progress.

Q3 2026: Conduct INEWS escalation & response audit of 25% of INEWS charts in all adult in-patient areas. Status: To complete

Timescale: In progress

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

UHW has established systems to identify, monitor and respond to falls incidents by formal governance oversight through the falls Committee. Aggregate and trend based analysis of falls data will continue to be provided by the Risk department and reviewed at multidisciplinary falls committee meetings with feedback to the QPS Committee.

Documentation in relation to the review decision to be completed on all falls incidents. Rationale relating to no review decision to be recorded on part B of the IMF document and also on NIMS in line with IMF guidance. This rationale will also now be recorded on the SIMT meeting minutes. Part C of the review decision record will be completed if a review has been commissioned.

All immediate actions will be recorded in Part A and all review decisions and rationale in Part B. A newly introduced SIMT minute record revised template will incorporate a structured approach to SIMT decision -making and action tracking to include a time bound action record, clearly documenting all actions arising from SIMT review, with assigned responsible persons, defined completion dates and recorded status updates to record progression and completion.

Detailed rationale for review decisions will be clearly documented in SIMT minutes.

A SIMT review log and action tracker will be created with named responsible persons to track all decisions and progress. This will ensure SIMT processes align with the ToR and will provide clarity of roles and responsibilities from the time of the incident through SIMT to the review decision.

All decisions and recommendations will be reported to the QPS Committee for oversight. This will ensure effective communication and implementation of learning

across departments. At all QPS meetings, risk reports will include incident trends and actions arising from reviews.

A retrospective review of SIMT documentation for the last 6 months will be undertaken. A structured standardised SIMT checklist will be implemented to ensure documentation compliance with SIMT Terms of Reference.

Timescale:
Retrospective review of all current SIMT documentation is underway and will be completed within 4 weeks.

Immediate and ongoing documentation surveillance at each SIMT by Risk Manager to ensure SIMT documentation oversight with a newly introduced checklist to be completed following each SIMT by the Risk Manager to ensure review decisions are clearly documented. Implemented 1st May 2026

QPS Committee report from risk will be provided at scheduled meetings as a standing agenda at QPS meetings to include all recommendations from SIMT. Ongoing action.

Full compliance: within 4 weeks