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:	National Maternity Hospital
Healthcare service/Organisation ID:	OSV-0001082
Address of healthcare service:	Holles Street Dublin 2 D02 YH21
Type of inspection:	Unannounced
Date(s) of inspection:	15/07/2025 and 16/07/2025
Inspection ID:	NS_0153

About the healthcare service

Model of hospital and profile

The National Maternity Hospital is a public voluntary hospital, managed by a Board of Governors (the board). The hospital is a member of the Health Service Executive (HSE) Dublin and South-East health region (HSE DSE)* providing healthcare services on behalf of the HSE.

The National Maternity Hospital is the tertiary maternity hospital in HSE DSE region providing a range of maternity, gynaecology and neonatology services.

The following information outlines some additional data on the hospital.

Number of beds	117 inpatient beds 14-bedded Labour and Birthing Unit 35 baby cots in the Neonatal Unit

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 of 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, information submitted by the provider, unsolicited information and other publicly available information since HIQA's last inspection in May 2023.

* The 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.

†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*.

During the inspection, the inspectors:

- spoke with women who used the maternity services to ascertain their experiences of receiving care
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to women and babies who received maternity care and treatment at the hospital
- observed care being delivered in the hospital, interactions with women who were receiving care and other activities to see if it reflected what women told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what women told inspectors during 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 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 women and babies 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)
15/07/2025	09:00 – 17:45hrs	Danielle Bracken	Patricia Hughes Denise Lawler Bairbre Moynihan
16/07/2025	09:00 – 15:45hrs	Danielle Bracken	Patricia Hughes Denise Lawler Bairbre Moynihan

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes[‡] of the *National Standards for Safer Better Healthcare Version 2* (2024). The inspection focused in particular, on four key areas of known harm, these being:

- infection prevention and control
- medication safety
- the deteriorating patient[§] (including sepsis)[**]
- transitions of care.[††]

The inspection team visited the following clinical areas:

- Emergency Room
- Antenatal Ward (Unit 3) where pregnant women received care
  - which included the Day Assessment Unit
- Labour and Birthing Unit where women were cared for during labour and birth
- Holles Wing, a postnatal ward where women and babies were cared for after birth
- Operating Theatre department and High Dependency Unit (HDU)

[‡] 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 improves 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.

- Neonatal Unit (NNU) also known as Unit 8, where premature or unwell newborn babies received care. The NNU comprised a Neonatal Intensive Care Unit (NICU 1), a step-down (NICU 3) for high-dependency babies, and the Special Care Baby Unit (SCBU).

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Team, Quality, Risk and Patient Safety department, Human Resources team 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 women who spoke with inspectors about their experiences of the care they, and where relevant their babies, received in the National Maternity Hospital.

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

Inspectors spoke with a number of women throughout the two days of inspection about their experience of receiving care in the hospital. Overall, there was consistency between women's experience of care received and what inspectors observed in the clinical areas visited.

Women were satisfied with the care received and stated they felt that they and their babies were "well looked after". A number of women expressed that they felt informed about procedures, and that staff "explain everything". Inspectors were informed that information was provided to women on discharge. This included phone numbers to ring if support was needed when discharged home. Staff were described as "supportive", "excellent", "amazing", and that they "really care".

The hospital food was complimented by a number of women who described it as "lovely" and "very good". Women gave the following feedback to inspectors: "refreshments could be made available in the Day Assessment Unit" — this was escalated to senior management, and that it was difficult to rest in multi-occupancy rooms in the ward.

Capacity and Capability Dimension

This section describes the themes and national standards relevant to the dimension of capacity and capability. It outlines the national 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 national standard related to workforce. The National Maternity Hospital was compliant with two national standards (5.5, 5.8), substantially compliant with one national standard (5.2) and partially compliant with one national standard (6.1).

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

Inspectors found integrated corporate and clinical governance arrangements, with clearly defined responsibilities and accountability arrangements. Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management. New reporting structures to the Integrated Healthcare Area (IHA) manager and upwards to the Regional Executive Officer (REO) of HSE Dublin and South-East (HSE DSE) health region had been implemented since the last inspection in May 2023. Organisational charts had not yet been updated to reflect these new reporting arrangements.

HIQA identified risks on this inspection relating to the workforce. Risks identified included:

- the sustainability of current Operating Theatre department staffing to support the unplanned utilisation of a second operating theatre outside normal working hours
- a resourcing deficit in nursing staff to support the level of acuity and occupancy in the Neonatal Unit in line with British Association of Perinatal Medicine (BAPM) guidelines.

These risks were discussed with senior management who were aware of both risks and had escalated resourcing deficits to HSE Dublin and South-East. Additionally, workforce risks were documented on the hospital's corporate risk register with existing and additional controls in place. Immediately following this inspection, inspectors sent a high-risk letter to the hospital's Master. The Master, in response, provided assurances in relation to how these risks were being managed, and the additional actions required. This is discussed further in national standard 6.1.

Progress had been made since the previous inspection in implementing a Women and Neonatal Health Network in line with the National Maternity Strategy 2016-2026. The network[‡‡] was now aligned with new reporting structures within the HSE Dublin and South-East health region and included all of the maternity units in the region. A governance plan for the network had been developed and a copy of this was given to inspectors. The leadership team for the network included the National Maternity Hospital's Master and the Director of Quality, Risk and Patient Safety (QRPS) as the joint clinical directors for the network.

The Master was the senior accountable officer with overall oversight of the effective management of the hospital, and was supported in this role by the Clinical Director, and the Director of Midwifery and Nursing (DOMN). The Executive Management Team (EMT), whose members included the Master, DOMN, and Director of QRPS met weekly in line with the terms of reference. Inspectors reviewed a sample of minutes from this meeting and observed that there were no time-bound assigned actions arising. However, progress with some actions were discussed from meeting to meeting, for example, staffing. The EMT reported to the hospital board through the QRPS subcommittee of the board. Inspectors reviewed a sample of minutes of this committee, and observed that a report from the Director of QRPS was submitted for discussion at each of these meetings. This report included updates on the corporate risk register, patient-safety incidents and feedback from those using the service.

The Clinical Governance Executive Committee (CGEC) was the main committee tasked with oversight of the quality and safety of the services at the hospital. The CGEC reported to the EMT and upwards to the QRPS subcommittee of the hospital's board. The committee had oversight of corporate risks, patient-safety incidents, performance data, education and training, and feedback from those using the service. Ten care groups reported into CGEC, these included antenatal, labour and delivery, operating theatre, postnatal and neonatal care. Inspectors reviewed agendas and a sample of minutes for the CGEC, which showed that it received regular updates from the care groups.

Committees relevant to this inspection that reported to CGEC included:

- Infection Prevention and Control
- Drugs and Therapeutics, of which Medication Safety was a subcommittee

[‡‡] The HSE Dublin and South-East Women and Neonatal Health Network consists of the National Maternity Hospital, and maternity units in the following hospitals: University Hospital Waterford, St Luke's General Hospital Kilkenny, Tipperary University Hospital, and Wexford General Hospital.

- Sepsis, Irish Maternity Early Warning System (IMEWS), Irish National Early Warning System (INEWS)
- Quality, Risk, Health and Safety, of which hygiene was a subcommittee.

Scheduled and unscheduled care activity was discussed as a standing agenda item at performance meetings with HSE DSE. From a review of meeting minutes, inspectors found that this scheduled and unscheduled activity data was not discussed routinely or as part of the agenda at EMT or CGEC. Inspectors were told that bed, cot, and operating theatre capacity, admissions, and discharges were discussed daily at the 8am handover huddle. The Assistant Director of Midwifery and Nursing (ADOMN) on site duty had oversight in relation to this activity. Inspectors were told that any concerns or issues were escalated to the hospital's Master.

Committee governance structures in the hospital were unchanged since HIQA's previous inspection in 2023. The committee governance organisational chart in the terms of reference for the Drugs and Therapeutics committee was not up to date. Terms of reference for all committees reviewed by inspectors were up to date. Committees were meeting at the frequency set out in these, with one exception. Although no frequency of meetings was set out in the terms of reference for the Sepsis, IMEWS, INEWS committee, in practice, this committee was meeting on a quarterly basis. From a review of meeting minutes and from speaking with lead representatives it was clear that committees had effective oversight of the areas within their remit. Updates from committees reporting into CGEC as listed above were not agenda items. However, there was evidence of relevant discussion taking place. Furthermore, committee chairpersons attended CGEC, and could escalate issues if needed. The exception to this was the chairperson for the Sepsis, IMEWS, INEWS committee who was not a member of CGEC. Discussions at CGEC included the infection prevention and control annual report, high-risk medicines, and training related to medical and obstetric emergencies. PROMPT[§§] training was discussed, however, inspectors found no evidence that issues with compliance for this training had been escalated to CGEC. This is discussed further in national standard 6.1. With the exception of the Medication Safety committee, actions arising from these committees were not time-bound or routinely followed up from meeting to meeting.

Overall, while there were formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare at the hospital, the following was identified:

§§ The Practical Obstetric Multi-Professional Training (PROMPT) course is an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies.

- there was no evidence that issues and concerns arising from the Sepsis, IMEWS, INEWS committee were escalated to the CGEC, for example, poor compliance with PROMPT training
- organisational charts did not reflect the new formalised reporting arrangements to the HSE DSE
- actions arising from the majority of committees relevant to the focus of this inspection were not time-bound, or routinely followed up from meeting to meeting.

Judgment: Substantially Compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Effective management arrangements were in place to support the delivery of safe, high-quality and reliable healthcare services in the hospital.

Designated leads for obstetrics, neonatology, and anaesthesiology had oversight of the services within their speciality, and reported to the Master. Organisation and management of nursing and midwifery services was overseen by the DOMN, supported by Assistant Directors of Midwifery and Nursing (ADOMN).

Operational oversight of the day-to-day running of the Emergency Room, the Labour and Birthing Unit, and the Operating Theatre department was the responsibility of the relevant Clinical Midwife Manager 3 (CMM3) in each area and the Consultant Obstetrician and Gynaecologist on duty. The postnatal and antenatal wards, Neonatal Unit (NNU), and Day Assessment Unit were overseen by CMMs and Clinical Nurse Managers (CNMs) of different grades who were operationally accountable to the relevant CMM3 or CNM3, and ADOMN for that area.

The hospital's infection prevention and control (IPC) team was multidisciplinary. The composition of the team was unchanged since the last inspection. A microbiologist was available for advice 24/7. The IPC team provided support to staff in the clinical areas inspected, and were responsible for the implementation of the hospital's IPC work plan, which is discussed further under national standard 5.8.

The pharmacy executive manager oversaw all aspects of the pharmacy service. A medication safety strategy for 2024-2028 outlined the hospital's approach to medication safety. The strategy was implemented through an accompanying work plan which is discussed further under national standard 5.8.

The hospital had a consultant lead for the deteriorating patient, including sepsis. Relevant early warning systems such as the IMEWS and the INEWS were used on the appropriate cohorts of women attending the hospital. Additionally, national guidance for sepsis and for fetal heart rate monitoring were implemented in the hospital.

The Master, as supported by consultants on-call and the ADOMN on duty for the site, had operational oversight on a day-to-day basis of hospital activity, demand and capacity for beds and cots, and transfers into, out of, and within the hospital. The Emergency Room (ER) Escalation Guideline, outlined the clinical and management processes initiated in the event of excess demand or a surge in capacity in the ER to ensure patient flow was managed appropriately. This included a patient flow chart for unplanned presentations to stream women to the correct location, for example, to the Labour and Birthing Unit where appropriate.

Judgment: 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.

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

A range of hospital performance data was collated and published, in line with the HSE's reporting requirements including Irish Maternity Indicator System (IMIS) data, and Maternity Safety Statements (MSS). These were published on the hospital's website. MSS and IMIS reports were discussed at meetings of CGEC, these included the numbers of transfers into and from the hospital which were reported on a monthly basis. Neonatal outcomes were benchmarked and performance data was submitted to the National Perinatal Epidemiology Centre (NPEC),[***] and Vermont Oxford Network.[†††] Annual reports were published on the hospital's website. Inspectors reviewed a copy of the annual report for 2024 which contained performance and activity data in relation to neonatal and obstetric services, including information on morbidity and mortality.

[***] The National Perinatal Epidemiology Centre conducts ongoing national audits of perinatal mortality, maternal morbidity and home births in Ireland.
[†††] The Vermont Oxford Network is a voluntary collaborative group of health professionals committed to improving the effectiveness and efficiency of medical care for newborn infants and their families through a coordinated programme of research, education, and quality improvement projects.

Hospital performance was discussed at monthly meetings of the CGEC, which included MSS and NPEC data, patient-safety incidents, and education and training. Performance data was submitted to managers in the HSE Dublin and South-East health region using a standardised reporting template and discussed at monthly performance meetings with HSE DSE managers. This included data and information on patient-safety incidents, and audits.

The majority of risks in the hospital, both clinical and non-clinical, were managed through the operational risk register and recorded on an electronic risk management system. This system allowed staff to filter risks based on which department they related to. Risks that could not be managed at an operational level were escalated to the corporate risk register. Inspectors reviewed risks on the corporate risk register relevant to the areas of focus of this inspection, which provided evidence of regular review of documented risks, and that existing and additional controls were being used to mitigate risk. This was consistent with what inspectors were told by representatives from the Quality, Risk and Patient Safety (QRPS) department. From a review of meeting minutes, inspectors found evidence that the operational risk register and or the corporate risk register were reviewed at CGEC, EMT, the QRPS subcommittee of the hospital board, and at the Quality, Risk, Health and Safety committee. The number of risks on the operational risk register that were mitigated and closed was reported through the QRPS report to the QRPS subcommittee of the board. The top five risks on the corporate risk register were escalated at each performance meeting with the HSE DSE. For example, in May 2025, two risks escalated to HSE DSE included recruitment challenges, and the rising complexity of obstetric patients.

From a review of documentation and speaking with staff it was clear to inspectors that the governance structures in place had effective oversight of the management of patient-safety incidents that occurred in the hospital, including serious reportable events (SREs), and notifiable incidents.[‡‡‡] These included the CGEC and the QRPS subcommittee of the board. The hospital's Women and Neonate Serious Incident Management Forum (WaN-SIMF), and HSE DSE's Women and Neonatal Health Network SIMF (HSE DSE WaN-SIMF) had oversight of the management of serious incidents (Category 1 and SRE). The hospital's Clinical Incident Review Group (CIRG), had oversight of the management of less serious incidents (Category 2). Management of patient-safety incidents is discussed in more detail under national standard 3.3.

[‡‡‡] Where a health services provider is satisfied that a notifiable incident under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 has occurred in the course of the provision of a health service to a patient, it shall notify HIQA as soon as practicable, and no later than seven days from the day the provider was satisfied the incident had occurred.

The WaN-SIMF, which was chaired by the Master and met monthly, was operationally accountable to the CGEC and reported through it to the EMT and QRPS committee of the board, with the submission of a quarterly report. The WaN-SIMF reported monthly to the HSE DSE WaN-SIMF. The CIRG, which reported to the CGEC, met on a monthly basis. A review of meeting minutes of the CIRG showed that Category 2 incidents were discussed in detail, with evidence of oversight of recommendations and actions arising. In addition, multidisciplinary perinatal mortality and morbidity meetings were held in the hospital where incidents and other cases of relevance were discussed in order to share learning.

Feedback from women using the maternity services was discussed at meetings of the CGEC, the QRPS subcommittee of the board, and performance meetings with HSE DSE. The CGEC had oversight in relation to National Maternity Experience Survey responses, and quality improvements arising from in-house Maternity Experience Surveys. The hospital had a Patient Voice Group. There was evidence that posters advertising the group were displayed in clinical areas visited. The Group consisted of previous users of the hospital's services and members of the hospital team where quality initiatives are suggested and discussed. Inspectors were informed, and documentation confirmed that this group reported to management in the QRPS department.

Relevant governance committees — the Infection Prevention and Control (IPC) committee, the Drugs and Therapeutics and Medication Safety committees, and the Sepsis, IMEWS, INEWS committee had oversight of findings from relevant metrics and clinical audits.

The IPC team had oversight of the hospital's progress against the IPC work plan 2025, which included an ongoing programme of audit and monitoring and surveillance of infection rates, which were publically reported. An antimicrobial stewardship report was submitted for discussion at each IPC committee meeting. A detailed IPC annual report had been produced for 2024, which included performance in relation to surveillance of infection, audit and antimicrobial stewardship.

A medication safety strategy for 2024-2028 outlined the hospital's approach to medication safety. The strategy was implemented through an accompanying Medication Safety Workplan 2025 which was overseen by the Medication Safety committee. The plan included oversight in relation to medication-related patient-safety incidents and audit.

Judgment: Compliant

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

Overall, while all areas inspected were fully staffed with one exception on the days of inspection, inspectors identified deficits in workforce arrangements in the Operating Theatre department and the Neonatal Unit (NNU). In addition, as part of the compliance plan submitted to HIQA to address the findings of an inspection of the service in May 2023, hospital management had committed to increasing compliance with PROMPT training. On this inspection, deficits remained in compliance with this training.

As discussed under national standard 5.2, following the inspection, a high-risk letter was sent to hospital management. Risks identified in the letter included:

- the sustainability of current Operating Theatre department staffing to support the unplanned utilisation of a second operating theatre outside normal working hours
- a resourcing deficit in nursing staff to support the level of acuity and occupancy in the NNU in line with British Association of Perinatal Medicine (BAPM) guidelines.

Risk assessments and assurances were sought around the contingencies in place, or planned, to ensure that Operating Theatre department and NNU were safely staffed. In the hospital response, the Master submitted risk assessments, relating to the Operating Theatre and NNU staffing to support safe care. Assurances were provided in relation to how these risks were being managed, and the additional actions required. In the response it was indicated that concerns with staffing levels were discussed at hospital performance meetings with the integrated health area (IHA) manager, and Regional Director of Nursing and Midwifery (RDONM) for HSE Dublin and South-East.

Inspectors found that while there was an arrangement for staffing of an emergency operating theatre outside of core hours, this did not extend to the requirement for the use of a second operating theatre for a back-to-back emergency. In this instance the second operating theatre was staffed through redeployment of staff from other areas of the hospital including the site duty manager (ADOMN). Hospital management were aware of this risk. Inspectors were informed and reviewed evidence of the increasing frequency and regularity of the need to open a second operating theatre for back-to-back emergencies in 2025 when compared to 2024. This posed an ongoing and increasing risk to safety in the absence of appropriate planning for an ongoing requirement.

The NNU was approved for a total of 84 whole-time equivalent (WTE)[§§§] neonatal nurses, with 86 WTE in place and one CNM2 vacancy. On the day of inspection all ventilated babies were receiving 1:1 care in line with BAPM. However, inspectors were informed of challenges in maintaining staffing in line with these guidelines. Data was recorded morning (day duty) and evening (night duty) to give an overview of unit activity. This included the percentage occupancy, patient complexity, nurses on duty versus recommended over the preceding 12 hours. Data provided for April, May and June 2025 indicated that on five days and nine nights, when the unit was over 100% capacity there was a deficit in nursing staff based on complexity. For example, in May 2025 the unit was over capacity on eight nights and was short staffed by between two to 10 staff on those occasions.

There were three high-rated risks on the hospital's corporate risk register relating to workforce, the risk posed by 'sub-optimal' staffing, workforce shortages, and staff capacity, retention and succession planning. Controls and additional controls were in place with a documented review date.

At the time of inspection, three vacant consultant posts were filled on a locum basis with recruitment to fill these positions progressing. All non-consultant hospital doctor (NCHD) positions were filled. Shortfalls in approved midwifery and nursing staff positions (excluding management positions) were identified in the Labour and Birthing Unit (12.6%), Antenatal Ward (16.7%) and the Emergency Room (10%). Shortfalls identified in Holles Wing (32.9%) were higher when compared to shortfalls for this area (6.6%) identified on inspection in 2023. Hospital management were addressing this through recruitment, and had escalated shortfalls to HSE Dublin and South-East. No impact was found in relation to these shortfalls on the days of inspection. Managers who met with inspectors stated that staff were regularly rotated to maintain skill-mix and that redeployment was used to address staff shortages on a day-to-day basis. Midwives who spoke with inspectors confirmed that they rotated between the Labour and Birthing unit, antenatal and postnatal wards to maintain skills. An information technology application to assess real-time midwifery and nursing staffing needs for women and babies based on acuity was used in the hospital.

The Emergency Room was short one midwife on day one of inspection, and this had been escalated to the ADOMN responsible for the area. No impact was found at the time of inspection in relation to this shortage. Inspectors were informed by staff that one to one midwifery support was provided to women in labour.

Hospital management submitted a compliance plan to address findings from a previous inspection in May 2023 related to the workforce, which included addressing

[§§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

staff vacancies. There was evidence that actions had been undertaken to address these findings. For example, the 'careers' page on the hospital's website was redeveloped to include current vacancies.

Deficits in training compliance rates in relation to hand hygiene, obstetric emergencies including sepsis management (PROMPT), and neonatal resuscitation were identified during HIQA's previous inspection of the service in 2023. In the compliance plan submitted following that inspection, hospital management had committed to addressing this. Sepsis training compliance rates were now above 95% in the areas inspected. However, during this inspection deficits remained in training compliance for hand hygiene, neonatal resuscitation, and PROMPT. Hand hygiene compliance levels for midwives and nurses ranged from 63% in the Emergency Room to 97% in Holles Wing, and for healthcare assistants ranged from 71% in the Labour and Birthing unit to 100% in the NNU. Neonatal resuscitation compliance levels for midwives and nurses ranged from 37% in the Antenatal ward to 75% in the Labour and Birthing Unit, and 86.7% in NNU. Data supplied to inspectors showed that PROMPT training compliance rates varied, with compliance of 22.2% in the Antenatal Ward, 67.4% in the Operating Theatre, and 98% in the Labour and Birthing Unit. This was discussed with senior management who informed inspectors of upcoming PROMPT training dates. Additionally, on this inspection, it was found that compliance with standard and transmission-based precaution training also varied between areas with compliance ranging from 67.4% in the Operating Theatre department to 88.9% in the Antenatal Ward.

Mandatory training in the hospital was recorded in an online training platform and inspectors were told that managers in clinical areas received a message when training for staff needed to be updated. Inspectors were shown the training room in the Labour and Birthing Unit which was used to facilitate scenario-based training for cardiac arrest and obstetric emergencies. Inspectors were informed by a number of staff that a skills day was planned on the Labour and Birthing Unit the week following inspection and this would cover obstetric emergencies such as postpartum haemorrhage.

In summary, the workforce arrangements did fully support and promote the delivery of high-quality, safe and reliable healthcare with the following identified:

- risks were identified on inspection regarding the sustainability of current Operating Theatre department staffing outside normal working hours when use of a second operating theatre was required
- a resourcing deficit in nursing staff to support the level of acuity and occupancy rate in the NNU in line with BAPM guidelines

- training compliance in relation to hand hygiene, neonatal resuscitation, and obstetric emergencies (PROMPT) identified on a previous inspection of the service in May 2023, remained an issue.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and national standards relevant to the dimension of quality and safety. It outlines the national 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.

The National Maternity Hospital was compliant with five national standards (1.6, 1.7, 1.8, 3.1, 3.3), and substantially compliant with two national standards (2.7, 2.8).

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

Staff who spoke with inspectors were aware of the need to respect and promote the dignity, privacy and autonomy of women when providing care. Inspectors observed staff communicating with women and their support persons, and providing care to women in a manner that respected their privacy and dignity.

Women received care in single cubicles in the Emergency Room and in individual rooms in the Labour and Birthing Unit. Privacy curtains were used in multi-occupancy areas in the antenatal and postnatal wards. Women who spoke with inspectors did not highlight any concerns regarding privacy and dignity in clinical areas. Personal information was stored in electronic healthcare records and was protected.

A designated bereavement suite in the Labour and Birthing Unit, provided privacy for bereaved parents. The Antenatal Ward had a designated quiet room where difficult conversations could take place privately. There were two entrances to the Operating Theatre department to allow for more privacy for women attending for obstetric and gynaecological procedures. In the NNU, privacy screens were available for use around cots when providing care at end of life. A parents' room was available for private conversations, and families wore earphones during ward rounds. Two breastfeeding rooms were available for use.

Inspectors observed person-centred initiatives to support choice and decision making for women in the hospital. Initiatives included the Labour Hopscotch[****] birthing tool and access to a hydrotherapy birthing pool that was used for water birth and to manage pain during labour. Women who spoke with inspectors confirmed they had received information, which helped to support their autonomy. Women received information related to health and wellbeing, infant feeding, baby care, and physiotherapy supports.

Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Inspectors observed kind and considerate interactions between staff, women, and babies in the clinical areas visited.

Women who spoke with inspectors about their experience were positive about their interactions with staff. Women felt that there were enough staff, responses to call bells were prompt, and that staff were "attentive", "approachable", "responsive", and "busy, but always willing to help".

Evidence of a culture of kindness and consideration included team names displayed in the Emergency Room, numerous thank-you cards on display in the Labour and Birthing Unit, and the provision of light refreshments outside of mealtimes in the Postnatal ward. In the NICU there was a designated room where parents could sleep, and designated quiet time for the babies being cared for where the lights were dimmed to create a calm and restful environment.

Birth reflections service — for women who had a complicated labour and or delivery, and bereavement services provided by designated staff in the hospital were described to inspectors.

Judgment: Compliant

[****] Labour Hopscotch is a visual birthing tool designed to aid women in active labour and birth. Providing structured guidance by outlining 20-minute rotating "steps" to perform during labour. These include keeping mobile by walking sideways on a stairs, or sitting on a stool while being massaged.

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

Systems to respond promptly, openly and effectively to complaints and concerns about the healthcare service were in place.

The hospital's quality manager was the designated complaints officer. Two patient advocacy officers were available to assist women and their families to make complaints and to provide support in accessing independent advocacy services.

The complaints management process was outlined in the hospital's 'Feedback Management Policy', which was aligned with the HSE's 'Your Service, Your Say' policy. The complaints resolution process was audited against the hospital's Feedback Management Policy every six months. Results from July to December 2024 showed conformity of 95.4% to 100%.

The CGEC and the QRPS subcommittee of the hospital's board had oversight of complaints data. Complaints were discussed as a standing agenda item at monthly performance meetings with the Dublin and South-East health region, which had oversight of performance in relation to complaints timelines. Year to date, 98.4% of complaints in the hospital had been resolved within 30 working days (target 75%).

Complaints data for the hospital was trended. Year to date in 2025, 61 formal (stage 2) complaints had been received. Common themes included waiting times in the Emergency Room, communication, and the provision of information. The quality manager stated that complaints data was submitted each quarter to the HSE's National Complaints Governance Learning Team (NCGLT). A database was used by the quality manager to track implementation of recommendations arising from complaints. Quality improvement plans provided to inspectors to address complaints included the development of information leaflets in relation to early pregnancy loss and chemical pregnancy.

Staff who spoke with inspectors were knowledgeable about the complaints management process and focused on resolving complaints locally. Staff told inspectors that they were given feedback on complaints, with some getting feedback at safety huddles and others at departmental meetings. A number of women had been given information about how to provide feedback, although not all women who spoke with inspectors knew how to make a complaint. Inspectors observed the hospital's complaints process displayed on a screen on the ground floor of the hospital. Inspectors also observed information on how to make a complaint available in clinical and public areas. This included information displayed on noticeboards such as the e-mail address for feedback, the complaints officer contact details, information on the Patient Voice Group and information on patient advocacy

services. Feedback forms and feedback boxes were available. Information on how to provide feedback was also available on the hospital's website.

Judgment: Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

The infrastructure and age of the hospital building presented ongoing challenges in relation to infection prevention and control. This was particularly apparent in Holles Wing (a postnatal ward) and the Antenatal Ward (Unit 3). Despite these infrastructural challenges, inspectors found that the clinical areas visited were well-maintained and clean, with few exceptions. Hospital management were aware of these issues and submitted a compliance plan to HIQA in response to findings relating to the physical environment as part of a previous inspection of the service in May 2023. The plan outlined submissions to HSE estates for clinically necessary projects, and that the solution to the physical environment issues was to move to a new purpose-built modern facility. At the time of this inspection, the plan to relocate the hospital to the campus of St Vincent's University Hospital was progressing, however, this would take a number of years, with building works set to commence in 2026.

The design and infrastructure of the building was a medium-rated risk on the hospital's risk register. Existing controls to minimise the risk to patient safety included planned preventative maintenance and regular surveillance and audits by the Infection Prevention and Control (IPC) team. Additional controls included funding for interim refurbishment works, including a lift upgrade. The IPC team outlined some of the works that had taken place since the last inspection, these included refurbished sanitary ware on a postnatal ward, and stair and flooring repairs. Inspectors observed in the Labour and Birthing Unit that flooring in the corridor had recently been repaired. Refurbishment of a lift to accommodate patient transfers remained outstanding since the last inspection. Inspectors were told by the IPC team that this was planned for quarter four 2025.

Some refurbishment of the Neonatal Unit (NNU) had taken place in 2025. The Labour and Birthing Unit and Operating Theatre department which had been refurbished prior to the previous inspection remained well-maintained. The Antenatal Ward had a 14-bedded room with two toilets. This large multi-occupancy room presented an infection prevention and control risk, however as discussed earlier, management were challenged by the ageing infrastructure. Inspectors observed some general wear and tear of wall and floor surfaces, and in bathrooms, that did

not facilitate effective cleaning in Holles Wing and the Antenatal ward. Staff who spoke with inspectors told them about the system to submit maintenance requests. Inspectors were shown a maintenance request to repair the floor in the Emergency Room.

Not all clinical hand wash sinks conformed to the required specifications,[††††] this included sinks on Holles Wing and the Antenatal Ward. Inspectors were informed by the Infection Prevention and Control team that this was being managed through a sink replacement programme. Inspectors observed that hand-washing technique posters were displayed and alcohol-based hand gel was readily available. Point of care risk assessment posters for personal protective equipment (PPE) were displayed and PPE was available.

Isolation facilities were available in the clinical areas visited, including five negative pressure rooms in the Labour and Birthing Unit, three rooms with a total of nine cots in the NNU, and one neutral pressure room in the High Dependency Unit that could be switched to negative pressure when required to isolate those with transmissible infection. Positive pressure was in place in the Neonatal Intensive Care Unit (NICU 1) to protect babies vulnerable to infection.

CMMs and CNMs who spoke with inspectors had oversight of the level of cleanliness in their areas and were satisfied with cleaning resources. Each area had a cleaning team assigned. Cleaning checklists reviewed by inspectors were up to date to evidence that cleaning had been carried out. A system to tag equipment, such as drip stands, was used to evidence that it had been cleaned. Equipment cleaning checklists reviewed by inspectors were up to date.

Linen and hazardous waste were segregated and stored appropriately in the areas inspected with few exceptions. Inspectors on the Antenatal ward observed inappropriate storage of items which included personal belongings of staff stored in the linen room. Trays for three sharps boxes had not been cleaned after use. The sluice room door and treatment room door were open on day one of inspection. This was brought to the attention of management. On day two an inspector observed that both doors remained opened. The inspector was informed that the lock was broken on the treatment room which prevented it from remaining closed and locked. Inspectors found medicines in this room that were not secured and unlocked presses containing antibiotics. The unlocked door presented a risk of inadvertent access of medicines by women and the general public. Inspectors were informed that the broken door lock was escalated to maintenance for repair on day one of inspection.

[††††] Infection Prevention and Control (IPC) National Clinical Guideline No. 30, Department of Health (2023). NCEC National Clinical Guideline No. 30 Infection Prevention and Control Volume 1. Available at: http://health.gov.ie/national-patient-safety-office/ncec/

Inspectors observed a three-bedded room with limited space for resuscitation trolleys in the event of an emergency due to tight bed spacing in Holles Wing. Staff were aware of this risk and outlined the controls to minimise it, however, a documented risk assessment was not available at the time of inspection. Inspectors requested a risk assessment in relation to this, which was submitted to HIQA following inspection. The risk was rated as a medium risk. Existing controls to minimise the risk included:

- the room was mainly used for low risk mothers whose babies were either in the NNU or at home
- use of the room was avoided for mothers with limited mobility
- new staff on induction were made aware of the limited spacing on orientation.

In summary, the physical environment did not fully support the delivery of high-quality, safe, reliable care with the following identified:

- a number of issues were identified on the Antenatal Ward including an open sluice room door and a broken lock on a treatment room door, which were found on both days of inspection, inappropriate storage of items, and cleanliness of sharp box trays.

Judgment: Substantially Compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

The systems to systematically monitor and evaluate the service in order to continuously improve quality and safety were not fully effective in addressing compliance with hand hygiene and sepsis form filling. This is discussed in more detail below.

Results of hand hygiene audits from November 2024 to July 2025 reviewed by inspectors showed that the Neonatal Unit (NNU) and the Emergency Room had not reached the HSE target of 90%, with both having average scores of 80%. All other areas inspected achieved the target. Barriers to hand hygiene (such as wearing hand and wrist jewellery, wrist watch, nail varnish, and long sleeves) were also audited in June 2025. Three clinical areas inspected, the Antenatal Ward (74%), Holles Wing (81%), and the Emergency Room (73%) did not achieve the target of 90%. Recommendations were made to improve compliance when targets were not met for hand hygiene and barriers to hand hygiene, although these were not time-bound.

Inspectors were informed by the Infection Prevention and Control team that re-audits and face-to-face training was carried out to improve compliance.

Findings from environmental audits in 2025 reviewed by inspectors showed compliance scores ranging from 93.6% to 98.3% in inspected areas. Actions arising from audits were tracked with dates of completion documented.

Infection prevention and control screening compliance was measured for Methicillin-resistant *Staphylococcus aureus* (MRSA), Carbapenemase-Producing *Enterobacterales* (CPE) and Group B *Streptococcus* (GBS) infection. Percentage compliance for GBS screening had improved in quarter one of 2025 compared to quarter four of 2024. MRSA screening compliance in quarter one of 2025 was 88.2%, which was slightly below the local target of 90%, but an improvement on quarter four of 2024 (81.5%). CPE screening compliance in quarter one of 2025 was 90%. Although this was a slight decrease on quarter four 2024 (93%), it was an improvement on the same quarter the previous year (66%).

Medication safety audit and metric findings were discussed as a standing item at the Medication Safety committee. This included metric findings in relation to medication storage and custody for April 2025 with compliance of over 90% achieved for each item measured. An antimicrobial register provided oversight of antibiotic use for the babies in NNU.

Audit findings for maternal sepsis, the Irish Maternity Early Warning System (IMEWS), fetal monitoring, and clinical handover were submitted to inspectors following inspection. Inspectors reviewed reports of two maternal sepsis audits, from November 2024 and April 2025. Non-compliance with sepsis form completion was a finding on both audits. Quality improvement plans had been developed in response to findings which included education on sepsis and promoting the use of the sepsis form. Compliance with sepsis form filling had been discussed at meetings of the hospital's Sepsis, IMEWS, INEWS committee in November 2024 and May 2025. An electronic healthcare record was used in the hospital. Lead representatives from the committee who met with inspectors stated that one barrier to documentation was that the form was electronic, and that they planned on trialling a new sepsis form that was more obstetrics and gynaecology focused. Lead non-consultant hospital doctors (NCHDs) who met with inspectors told them that sepsis form completion was an area of focus in the hospital.

An audit of IMEWS escalation and response, which included the use of the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool, from quarter one of 2025 across three audit periods showed variable overall compliance levels. A time-bound quality improvement plan developed to address findings included reinforcing the importance of recording and documentation of

observations (vital signs). IMEWS metrics carried out in April, May and June 2025, which included Antenatal ward and Holles Wing showed compliance of 89.5% to 100% with measured parameters on nursing and midwifery quality care-metrics. Documentation of urinalysis had improved from 67.6% in May to 95% in June 2025.

Compliance with fetal heart rate monitoring and cardiotocography (CTG)[‡‡‡‡] interpretation was measured at the hospital. Compliance with CTG interpretation during pre-labour and induction of labour was over 90% in quarter one of 2025.

Fetal heart rate monitoring compliance in quarter one of 2025 in the Antenatal Ward was 100% and in the second stage of labour in July 2025 was 93%.

Audits of clinical handover had been carried out in a number of clinical areas in June and July 2025, including the Emergency Room, Operating Theatre, Labour and Birthing Unit and the NNU. Findings, which varied across the areas visited, were addressed through time-bound quality improvement plans. Recommendations included providing education on clinical handover. Staff in NNU told inspectors about the introduction of a clinical handover sheet to improve communication, and inspector's observed a copy.

The Emergency Room was functioning well on the day that it was inspected. Real-time visualisation of patient flow, including discharge was facilitated in the Emergency Room through an electronic dashboard which was demonstrated to inspectors. The dashboard also showed levels of acuity across the antenatal and postnatal wards, and the Labour and Birthing Unit. Hospital activity dashboards were updated monthly and these showed total births, mode of delivery, caesarean-section rate, numbers of induction of labour and reason for induction, and percentage of infants breastfeeding. An ADOMN had oversight of records of internal and external transfers of women and babies.

Audit and metric results were displayed on noticeboards in the areas visited. Examples of audit results displayed in the Labour and Birthing Unit included audits of the numbers of caesarean-sections, postpartum haemorrhages, and third degree tears. Feedback from women using the service was displayed in the Labour and Birthing Unit on a 'what our patients say about us board'. Inspectors were told that staff were given feedback and discussed quality improvement plans (QIPs) in relation to audits and metrics at safety pauses.

Overall, the hospital had systems to systematically monitor and evaluate the service in order to continuously improve practice and the quality and safety of the service. However, the following was identified:

[‡‡‡‡] Cardiotocography (CTG) uses ultrasound to monitor a fetus's heart rate and uterine contractions during pregnancy and labour.

- hand hygiene compliance levels in the NNU and the Emergency Room had not reached the HSE target of 90%
- non-compliance with sepsis form filling, identified by hospital audits in 2024, had not been adequately addressed, as this remained an issue identified by audit in 2025.

Judgment: Substantially Compliant

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

As discussed under national standard 5.8, hospital management had oversight of the corporate and operational risk registers. Staff in clinical areas recorded local risks using the hospital's electronic risk management system, which could be filtered by department. Clinical midwife and clinical nurse managers had oversight of risks in their areas. Risks that could not be managed at local level were escalated to the operational risk register in the first instance, and from there could be further escalated to the corporate risk register.

Safety pauses and or huddles, as a means to share information and learning, took place at least once a day in all clinical areas inspected. This included twice daily safety pauses in the Antenatal ward and Holles Wing, and twice daily huddles in the Labour and Birthing Unit, which were attended by staff from the Operating Theatre department and CMMs from the postnatal wards. Inspectors attended the Emergency Room huddle at 10.25am on day one of inspection. Patient priority level, completed and outstanding tasks, including imaging and laboratory tests, were discussed. Communication books were observed on the Antenatal Ward, and Holles Wing, which were used to share important information with staff.

Inspectors were told that women's history of infection was taken at the antenatal booking visit, and relevant alerts entered into the patient information administration system. Screening for multi-drug resistant organisms (MDROs) was carried out in line with national guidance. This included screening for MRSA, CPE and Vancomycin-Resistant *Enterococcus* (VRE). In addition, women were screened for GBS history, and babies in the NNU were screened for *Extended-Spectrum Beta-Lactamase* (ESBL). As discussed under national standard 2.8 compliance with MRSA, CPE and GBS screening was audited by the Infection Prevention and Control team. A review of healthcare records provided evidence that women and babies were assessed on admission for MDROs.

Women and babies requiring transmission-based precautions were isolated in line with national guidance. Signage was in place on the doors to isolation rooms to alert staff and visitors to contact unit/ward manager or midwife in charge before entering. Inspectors observed one instance in the NNU where no signage was placed on the door of an isolation room. This was not in line with local policy and was brought to the attention of management.

An example of a recent outbreak of infection was provided to inspectors. The outbreak report outlined that risk factors that had contributed to the outbreak. Actions in response to the outbreak included increased screening and environmental swabbing.

A full clinical pharmacy service[§§§§] overseen by the pharmacist executive manager, was provided for the NNU on a five day a week basis. The clinical pharmacy service for babies other than those in the NNU and for adults, was provided on a prioritised basis. This was unchanged from a previous inspection in May 2023. The hospital's 'Clinical Pharmacy Prioritisation Tool' set out the criteria for those classified as high priority, which included those on high-alert medications, complex medications, and restricted or semi-restricted antibiotics. The maternal medicines pharmacist and antimicrobial stewardship (AMS) pharmacist facilitated review of these patients. Pharmacy technicians carried out medication stock control in all clinical areas inspected.

Medicines in the Operating Theatre department were stored in an automatic medicines dispensing machine, which maintained records of medicines dispensed. Posters on high-risk medicines and sound-alike look-alike medicines were not displayed in the Operating Theatre department and adjacent High Dependency Unit (HDU), and the NNU. Staff in NNU told inspectors that a pharmacist checked the dosing of all medicines. Pharmacy sent monthly medication safety memos and alerts to clinical areas. For example, an alert that was sent out in June 2025 alerted staff to the fact that a medicine to treat nausea in pregnant women was being replaced with an alternative medicine that month. Pharmacy staff facilitated a drug safety huddle 'Druggle' each month in a clinical area, the purpose of which was to foster communication and learning in relation to medication safety. There was evidence that progress with this initiative had been discussed at the medication safety committee.

Inspectors observed rapid response phone numbers for obstetric emergencies, maternal cardiac arrest, and neonatal emergencies displayed as relevant in clinical areas. In Holles Wing, the emergency number was available in a folder and not visibly displayed, this was highlighted to the CMM. Inspectors observed pre-

[§§§§] Clinical pharmacy service – is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

prepared equipment, supplies, and medicines to respond to maternal emergencies including preeclampsia,[*****] post-partum haemorrhage and hypoglycaemia.[†††††] Daily and weekly checklists on equipment and supplies including resuscitation trolleys for women and babies were up to date. One exception to this was the hypoglycaemia box in the Labour and Birthing Unit, which was highlighted to the CMM, who addressed this.

Relevant early warning systems (IMEWS and INEWS), sepsis, and fetal monitoring guidelines were implemented in the hospital. Associated forms and observation charts, including the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool for escalating care were built in to the electronic healthcare record. Staff who spoke with inspectors were knowledgeable in relation to the early warning systems and the escalation process. Mothers and babies were continuously monitored during labour, and in the Operating Theatre department. Rapid response teams for obstetric, maternal, and neonatal emergencies were in place. Inspectors observed whiteboards in clinical areas, for example, the Labour and Birthing Unit where on-call staff were listed in the event that they needed to be contacted. Women and babies requiring a higher level of care and monitoring were transferred to the hospital's HDU or NNU as relevant. Inspectors were informed that the emergency bleep system was tested daily at 2.30pm.

The hospital did not have access to a level 3 ICU[‡‡‡‡‡] onsite, this was a risk recorded on the corporate risk register. Critically ill women were transferred via Protocol 37[§§§§§] to St Vincent's University Hospital, as outlined in the hospital's Critical Care Inter-Hospital Transfer policy. Other transfers out of the hospital to access specialised care including treatment and diagnostic tests, were recorded on a form in the electronic patient record. As a tertiary referral hospital, transfers into the hospital included women and babies from other maternity units. The process for safe transfers into the hospital were explained to inspectors by an ADOMN, this included an accompanying referral letter sent by the referring hospital.

The Operating Theatre department and HDU had criteria for discharge, with a computerised checklist undertaken by two staff members prior to discharge. Internal transfers were handed over verbally. The process in the Antenatal ward for clinical handover at change of shift was described to inspectors. This process was in line with ISBAR. Handover forms in the electronic patient record were used and

[*****] Preeclampsia is high blood pressure and signs of liver or kidney damage that occur in women after the 20th week of pregnancy.
[†††††] Hypoglycaemia is a medical emergency where the blood sugar (glucose) level is lower than the standard range.
[‡‡‡‡‡] Level 3 critical care is the level of care required for patients who need advanced respiratory support (mechanical ventilation) alone or basic respiratory support along with support of at least one additional organ.
[§§§§§] Protocol 37 is an emergency inter-hospital transfer policy, designed to prioritise time-critical patient transfers between hospitals.

demonstrated to an inspector. Staff in NNU used a handover communication tool to facilitate effective handover of information, a copy of this was provided to inspectors. A discharge summary for women and babies discharged from the Holles Wing was given to each woman and forwarded to their public health nurse and general practitioner.

Staff could readily access policies, procedures, protocols and guidelines (PPPGs) electronically on computers in clinical areas as demonstrated to inspectors. Medicines information and antimicrobial guidelines could be accessed at the point of prescribing through a software application on electronic devices. All PPPGs reviewed by inspectors related to the four areas of focus of this inspection were up to date.

Judgment: Compliant

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

Systems were implemented at the hospital to identify, report, manage and respond effectively to patient-safety incidents. As discussed under national standard 5.8, the governance structures had oversight in relation to patient-safety incidents occurring in the hospital. Patient-safety incidents were reported by staff directly on to the hospital's risk management and incident reporting platform. An incident prompt list was in place to facilitate staff with categorising incidents. Staff in the quality, risk and patient safety department entered incidents from this platform onto the National Incident Management System (NIMS), where incidents were classified by severity. This process was outlined in the hospital's Clinical Incident Management Policy.

Documentation reviewed by inspectors showed that the HSE target of 70% for incidents created in NIMS within 30 days of date notified, had been achieved from quarter two of 2024 to quarter one of 2025, with compliance levels of over 99% in each quarter. The HSE target of 70% for serious incidents requiring review completed within 125 days of date notified had been achieved in the hospital over a 12 month period from March 2024 to February 2025.

Inspectors found evidence in meeting minutes reviewed that medication-related patient-safety incidents were discussed as an agenda item at the Drugs and Therapeutics committee and the Medication Safety committee. Analysis of incidents included point of occurrence, type of incident, and type of medicine involved. Members of the Infection Prevention and Control team stated that hospital-acquired infections were reported as incidents and were reviewed in line with national

guidelines. There was evidence of discussion of hospital-acquired infections in minutes of the Infection Prevention and Control committee reviewed by inspectors.

Staff who spoke with inspectors were knowledgeable about the incident reporting systems and processes in the hospital. CMMs and CNMs outlined that they attended the multidisciplinary Clinical Incident Review Group (CIRG). Relevant incidents were discussed at perinatal morbidity and mortality meetings. A number of staff informed inspectors that an After Action Review[******] took place following serious incidents and obstetric emergencies. Feedback on incident trends, and learning from patient-safety incidents was shared with clinical staff at handover and safety huddles. Staff stated that feedback was also given from the quality, risk and patient safety department. Examples of initiatives that had been introduced in response to incidents included swab counting bags in the Labour and Birthing Unit, and safe skin to skin practice in Holles Wing.

Judgment: Compliant

Conclusion

An unannounced inspection of the National Maternity Hospital was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2* (2024). The inspection focused in particular, on four key areas of known harm, these being infection prevention and control, medication safety, the deteriorating patient and safe transitions of care.

Overall, the hospital was found to be compliant in seven national standards (1.6, 1.7, 1.8, 3.1, 3.3, 5.5, 5.8), substantially compliant in three national standards (2.7, 2.8, 5.2) and partially compliant in one national standards (6.1).

Capacity and capability

Following the inspection, a high-risk letter was sent to hospital management. Risks in relation to the workforce identified on this inspection included:

- the sustainability of current Operating Theatre department staffing outside normal working hours
- a resourcing deficit in nursing staff to support the level of acuity and occupancy in the Neonatal Unit (NNU) in line with international guidance.

[******] A structured, facilitated multidisciplinary discussion / review of an event, the outcome of which enables the individuals involved in the event to understand why the outcome differed from that which was expected and what learning can be identified to assist improvement.

Risk assessments and assurances were sought around the contingencies in place, or planned, to ensure that the Operating Theatre department and the NNU were safely staffed. In the hospital's response, the Master provided assurances around staffing contingencies in both areas and submitted risk assessments outlining the controls to minimise these risks.

Formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare were in place. Organisational charts did not reflect new reporting arrangements to the HSE Dublin and South-East health region. The management arrangements supported the day-to-day running of the hospital and promoted the delivery of safe, high-quality healthcare services. There were systematic monitoring arrangements in the hospital to identify areas for improvement, with oversight of performance by relevant committees. Deficits in training compliance were identified in a number of areas. There was no evidence that issues and concerns arising from the Sepsis, IMEWS, INEWS committee were escalated to the CGEC, for example, poor compliance with PROMPT training.

Quality and Safety

Management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of women and babies being cared for in the hospital, and promoted a culture of kindness, consideration, and respect. Women spoke positively about their experience in the hospital.

The hospital had systems and processes to respond openly and effectively to complaints and feedback raised by those using the service. The physical environment in which care was provided did not fully support the delivery of high-quality, safe, reliable care. This was also a finding on a previous inspection of the service in May 2023 as discussed under national standard 2.7. Notwithstanding this, hospital management were ensuring that clinical areas were well-maintained while awaiting a permanent move to a new purpose-built facility on the campus of St Vincent's University Hospital.

Assurance systems were in place to monitor, evaluate and continuously improve the healthcare services in the hospital. Performance in relation to hand hygiene and sepsis form filling were areas identified for improvement by the hospital with quality improvement plans in place. There were effective systems at the hospital to proactively identify, manage and minimise the potential risk of harm to women and babies in the four areas of focus of the inspection. Systems were in place in the hospital to identify, manage, respond to and report patient-safety incidents.

HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with areas identified under national standard 6.1.

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 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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.	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.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	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.	Compliant
Theme 2: Effective Care and Support	

Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Standard	**Judgment**
Dimension: Capacity and Capability	
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.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for the National Maternity Hospital

Inspection ID: NS_0153

Date of inspection: 15 and 16 July 2025

Compliance plan provider's response:

Standard	Judgment
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.	

ISSUE:

Risks were identified on inspection regarding the sustainability of current Operating Theatre department staffing outside normal working hours when use of a second operating theatre was required

RESPONSE:

Operating Theatre staffing out of hours:

The risk identified for opening a second theatre out of hours is being addressed. A recruitment process for an additional CMM2 on the night shift has commenced. This will ensure that there is adequate senior staffing to cover the possibility of requiring a second theatre to be opened out of hours. It will ensure that the night shift ADOM will remain available to the rest of the hospital. The Executive Management Team would like to reiterate that no evidence has been found that patient care has been

negatively affected to date. This is all the more significant in view of the time critical requirement in managing obstetric emergencies.

Timescale: Ongoing

ISSUE:

A resourcing deficit in nursing staff to support the level of acuity and occupancy rate in the NNU in line with BAPM guidelines.

RESPONSE:

Neonatal Unit (NNU) staffing:

We rely on overseas recruitment of experienced staff to provide safe staffing. We are also competing for new graduates from HDip Children's nursing programmes. The recognised standard of Neonatal staffing levels is the British Association of Perinatal Medicine (BAPM) guideline. These guidelines are a professional consensus.

On the day of the HIQA visit the standard was achieved in NICU 1. We have identified a NICU staffing deficit as a priority on the Unit Risk register. We are constantly and actively recruiting staff for our NICU. We are currently in the process of recruiting 15 NICU trained nurses, as approved by HSE Dublin and South East RHA REO, from overseas. This process takes six plus months to complete.

Timescale: Ongoing

ISSUE:

Training compliance in relation to hand hygiene, neonatal resuscitation, and obstetric emergencies (PROMPT) identified on a previous inspection of the service in July, remained an issue.

RESPONSE:

Training records:

We acknowledge that the proportion of staff from the Antenatal Ward who have completed the Neonatal Resuscitation Programme (NRP) is lower than that of other clinical areas. The NRP is a resource-intensive training model, structured on a ratio of one trainer to three participants. In addition, the hospital currently has one dedicated NRP Officer. All other NRP trainers are clinical staff who must be released from their ward duties to deliver training, which further constrains capacity. This limits the number of available places per session and requires careful prioritisation of staff allocation.

Priority for training places has been given to staff in the Labour and Birthing Unit, Postnatal Wards, Theatre, Neonatal Intensive Care Unit (NICU) and Community, where neonatal resuscitation skills are most frequently required in practice. For the current year, 44 NRP training sessions have been planned. We continue to monitor NRP training compliance across all areas on an ongoing basis to ensure timely access to training and to maintain patient safety standards.

Since the HIQA site visit in July there has being a huge drive to ensure all staff attend Obstetric Emergencies/PROMPT training. To increase our compliance, since July there has being 8 PROMPT and 12 ward based training sessions. To date 100% of our consultants are trained, operating theatre compliance has gone from 67.4% to 93% and antenatal ward from 22.2% to 44%.

There has also being a drive to increase our hand hygiene compliance. The names of staff who have not completed same have being sent to their line manager and the rates are now over 85% in most areas and as high as 95% in others. Again this will be monitored on an ongoing basis.

All training records are kept on a Learning Management System. Reports are now sent monthly rather than quarterly to the managers in relation to compliance on their ward/unit for mandatory training. This is to be able to identify staff who need to undertake training and ensure that compliance remains high.

Timescale: Ongoing