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:	Rotunda Hospital
Healthcare Service ID:	OSV-0001086
Address of healthcare service:	Parnell Square Dublin 1 DO1 P5W9
Type of Inspection:	Unannounced
Dates of Inspection:	23/07/2025 and 24/07/2025
Inspection ID:	NS_0155

About the healthcare service

Model of hospital and profile

The Rotunda Hospital is the largest public voluntary maternity hospital in Ireland. It was established under Royal Charter in 1756 and is governed by a Board of Governors (the board). The Rotunda Hospital is part of the Health Service Executive's (HSE's) Dublin and North East Health Region* and the Dublin North City and West Integrated Health Area (IHA).† The hospital provides healthcare services on behalf of the HSE under Section 38 of the Health Act 2004.‡ The Rotunda Hospital is one of four tertiary maternity hospitals§ in Ireland. In 2024, there were 8,458 births recorded at the hospital, which was 1,864 more births than those recorded in the next busiest tertiary centre.

The Rotunda Hospital provides maternity care pathways in line with the National Maternity Strategy** (supportive care and community midwifery care pathway,†† assisted care pathway‡‡ and specialist care pathway§§). The hospital also provides a range of other maternity, gynaecology and neonatology services, which include fetal medicine, specialist gynaecology, pathology, maternal medicine and perinatal mental health. The Neonatal Unit at the Rotunda Hospital is a Level 3 tertiary care*** facility, offering comprehensive, specialised treatment for critically ill pre-term and full-term newborns. It accepts infants requiring complex neonatal care from other maternity units within the health region and from across Ireland.

The following information outlines some additional data on the hospital.

Number of beds	199 inpatient and day case beds, including:

* The HSE has created six new health regions. Each region is responsible for providing both hospital and community care for the people in that area.
† An Integrated Healthcare Area (IHA) is a sub-structure within a HSE Health Region, designed to bring together acute and community health services, as well as non-HSE providers, to deliver integrated care.
‡ Section 38 of the Health Act 2004 outlines how the HSE can agree with an organisation to provide a health or social service on its behalf.
§ These hospitals are the Rotunda Hospital, National Maternity Hospital, The Coombe Hospital, and University Maternity Hospital Cork.
** *National Maternity Strategy-Creating a Better Future Together 2016-2026* sets out a plan for maternity and neonatal care in Ireland.
†† The supported care pathway is intended for normal-risk women and babies.
‡‡ The assisted care pathway is intended for women and babies considered to be at medium risk, and for normal risk women who choose an obstetric service.
§§ The specialist care pathway for high-risk women and babies is led by a named obstetrician, and is provided by obstetricians and midwives, as part of a multidisciplinary team.
*** Level 3 (tertiary units) provide the full spectrum of neonatal care to term and pre-term infants who are critically unwell.

	– 26 antenatal beds – 11-bedded Delivery Suite – 76 postnatal beds – 31-bedded gynaecology ward – 39 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 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 that included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since HIQA's last inspection in September 2023.

During the inspection, the 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.

[†††]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.

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 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)
23/07/2025	09:00 – 17.30hrs	Aedeen Burns	Denise Lawler Emma Cooke Eileen O' Toole Lorenza Cafolla
24/07/2025	08.30 – 16.15hrs	Aedeen Burns	Denise Lawler Emma Cooke Eileen O' Toole

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 hospital was inspected last in September 2023, part of the function of this inspection was to assess progress with the compliance plan submitted by the hospital following that inspection. The inspection also focussed 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 and Assessment Service (EAS)
- Early Pregnancy Assessment Unit (EPAU)
- Labour and Delivery Suite
- Ante-natal ward
- Post-natal A ward
- Neonatal Unit
- Operating Theatre Department

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Team, Quality and 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 and families using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the Rotunda Hospital.

[‡‡‡] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[§§§] Deteriorating patient programmes ensure there is a standardised, high quality systematic approach to the recognition, response and management of the deteriorating patient for example through the use of National Early warning Score Systems.
[****] 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.

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

Women and their partners who spoke with inspectors during the inspection all spoke highly of the care they received. A number of women said that staff were "amazing", and they described receiving support with breastfeeding and kangaroo care. While they were not aware of the complaints process, all of the women who spoke with inspectors said that they had nothing to complain about but would feel able to approach staff if they did.

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 Rotunda Hospital was assessed as being compliant with two national standards (5.5 and 5.8), substantially compliant with one national standard (5.2), and partially compliant with one national standard (6.1). Key findings informing these judgments are detailed in the sections below.

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

Since HIQA's last inspection of the Rotunda Hospital in September 2023, a number of changes had occurred at HSE level to facilitate the restructuring of the health services into health regions to support an integrated service delivery model.[‡‡‡‡] The hospital had made changes in its corporate and clinical governance reporting arrangements that aligned with the new Regional Health Area configuration and was now a part of the HSE Dublin and North East health region.

[‡‡‡‡] The integrated service delivery model sets out how health regions and the Integrated Healthcare Areas operate. It includes the structures, ways of working and processes designed to make services easier for people to navigate. It is designed to support integration, accountability and transparency in the HSE.

There was a clearly defined reporting structure in place to the HSE Dublin North East Regional Executive Officer (REO), who held accountability and responsibility for the operational delivery of services within the Dublin North East Health Region. The REO reported directly to the Chief Executive Officer of the HSE. Within this structure, an Integrated Healthcare Area (IHA) manager was responsible for the integration and delivery of services across the region and was accountable to the REO.

As a voluntary hospital, the overarching governance body for the hospital was the Board of Governors. The Board of Governors had overall responsibility for corporate and clinical governance and for strategic development of the hospital. Minutes of meetings of the Board of Governors are made available publicly on the hospital website. Overall responsibility and accountability for the operational delivery of services in the Rotunda lay with the Master. The Master had defined reporting arrangements to the Rotunda Hospital's Board of Governors. Reporting and accountability arrangements to the IHA Manager and upwards to the REO of Dublin North East Health Region were in place. Performance meetings were held with the HSE on a monthly basis, where key performance metrics pertaining to performance and care were reviewed and actions monitored. Through these governance and reporting arrangements there was robust oversight of the quality and safety of maternity services in the hospital.

Clinical governance and leadership at the Rotunda Hospital were overseen by the Master and the hospital's Clinical Director. The Director of Midwifery and Nursing (DOMN) held responsibility for the organisation and management of midwifery and nursing services within the hospital and maintained a working relationship with the Chief Director of Nursing and Midwifery for the health region. The hospital had appointed a Secretary/General Manager who was responsible for the provision of effective non-clinical services and allied health services. The Clinical Director, the DOMN and the Secretary/General Manager were members of the hospital's Executive Management Team (EMT).

The hospital had designated clinical leads in obstetrics, neonatology, and anaesthesiology, radiology, pathology and perinatal mental health. These roles were appointed on a rotational basis and provided clinical leadership within their respective specialties. Each lead was responsible for the organisation and management of healthcare services in their area of expertise.

The hospital had established strategic principles and enablers to which activities and improvement plans were aligned. These related to: delivering a broad range of healthcare services for women, providing outstanding care for mothers and babies, ensuring an excellent patient experience, supporting and developing staff and developing infrastructure. The hospital had developed a strategic plan aligned to these principles to plan for the development of the service from 2022-2026.

Evidence was seen of activities and improvement plans being progressed in line with these principles.

The Executive Management Team (EMT), as identified in the 2023 report, was the hospital's senior executive decision-making body. The EMT had revised terms of reference since the last inspection, dated 2025. The EMT was responsible for governance, clinical risk management, and oversight of the quality and safety of care at the Rotunda Hospital. Membership of the EMT was appropriate, and meetings were well attended and held weekly in line with its terms of reference. Inspectors found the meeting minutes to be comprehensive and action-oriented, with clear evidence of ongoing monitoring of agreed actions. Evidence was seen that the EMT reported on hospital performance against national KPIs to the REO through performance meetings with the IHA Manager. The EMT reported to the Rotunda Hospital Board of Governors via its governance subcommittee. Inspectors found the EMT to be functioning effectively and efficiently in line with its terms of reference.

The hospital had established integrated corporate and clinical governance arrangements to support the delivery of high-quality, safe and reliable healthcare. The Quality Safety and Risk Committee was a subcommittee of the Board of Governors. The Quality and Safety Committee reported to this committee as well as liaising regularly with the EMT. Evidence showed that the Rotunda Hospital's Quality, Safety and Risk Committee met and functioned effectively and efficiently, in line with its terms of reference. Reports reviewed by inspectors, which were produced for presentation to the Quality Safety and Risk Committee, were comprehensive and showed that the committee had effective oversight of the quality of healthcare services and the management of clinical risks in the hospital.

Organisational diagrams provided to HIQA accurately reflected governance structures to Board level but did not depict relationships to the IHA and REO.

The Rotunda Hospital had maintained the clinical maternity network structures and relationships that were established when the hospital was part of the Royal College of Surgeons (RCSI) hospital group.[§§§§]Since restructuring of the HSE, maternity hospitals in this network were now spread across three IHAs. There was an Associate Clinical Director for Women's and Children's Services for the Dublin North East Health Region, who reported to both the Master of the Rotunda Hospital and the Clinical Director of the Dublin North East Health Region. The DOMN met monthly with the Regional Director of Nursing and Midwifery. There was evidence of networking, for example:

- joint appointment or sessional commitments for obstetricians and neonatologists across sites

- formalised care pathways for women and babies requiring transfer from other maternity units to the Rotunda Hospital for specialised obstetric and neonatal care
- formalised arrangements for the repatriation of mothers and babies to neonatal units within the network when specialist services at the Rotunda Hospital were no longer needed
- a joint Women and Children's Serious Incident Management Forum (SIMF) for review of maternity services serious incidents across the network
- specialist pathology services for the hospitals in the network were provided in the Rotunda Hospital.

The hospital had established a mechanism for the performance and reporting of quality and safety walk-rounds.*****Terms of reference indicated that a Quality and Safety Walk-Rounds Group was appointed annually, that it comprised at least four board members and was chaired by the Chair of the Quality, Safety and Risk Committee. Evidence reviewed by inspectors showed that quality and safety walk-rounds were being conducted, which enabled board members, senior managers and frontline staff to address local issues and to prevent, detect and mitigate risks to patient safety. There was also evidence that actions were taken as a direct result of these discussions.

At the time of inspection, the hospital had formed committees and subcommittees relating to two of the four areas of known harm that were the focus of this inspection. These covered the same areas that were identified at the time of the last inspection: infection prevention and control and medication safety.

Hospital activity, including admissions, discharges and transfers, continued to be monitored daily at safety huddles and operational meetings. Oversight of this activity was monitored by the EMT, the Board, and IHA managers.

The hospital did not have a deteriorating patient committee. Inspectors were informed that the hospital was in the process of convening one. The hospital had working groups and processes in place to coordinate and monitor response to certain sudden deteriorations in condition of women and babies (this is discussed further under National Standard 3.1). Sepsis was a standing agenda item at the Infection Prevention and Control Committee (IPCC), and reports were submitted to this committee relating to this item. However, terms of reference of the IPCC did not

§§§§ The RCSI group was one of six hospital groups in Ireland. These were stood down as part of the transition to a new governance mode land the implementation of Integrated Health Areas (IHAs), and Regional Health Areas (RHAs).

***** A quality and safety walk round is a structured process to bring senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent, detect and mitigate patient/staff harm.

reflect its responsibility for the governance of a standardised approach to the management of sepsis in the hospital. Inspectors were informed that this would fall under the remit of the deteriorating patient committee when it is convened. The hospital should progress plans to convene this committee.

The IPCC was responsible for the review and oversight of infection prevention and control processes and for ensuring that the hospital was compliant with national standards for the prevention and control of healthcare-associated infections. Inspectors found the IPCC to be functioning effectively and efficiently within its stated terms of reference.

The Drugs and Therapeutics Committee was responsible for ensuring that medicines were used safely and effectively based on the best available evidence. As part of its responsibilities, this committee governed all policies relating to medications, reviewed medication safety incidents, coordinated the hospital's antimicrobial stewardship programme, and had oversight over all decisions related to medication use throughout the hospital. The Drugs and Therapeutics Committee had four sub committees: the Adult Medication Safety Committee, Neonatal Medication Safety Committee, Antimicrobial Stewardship Team and the Venous Thromboembolism Committee. A review of the terms of reference for the Drugs and Therapeutics, and Neonatal Medication Safety Committee provided evidence that these two committees, with responsibility for medication safety, were operating in line with their respective terms of reference. These committees met at the required frequency, maintained time-bound, action-oriented minutes with clearly assigned responsibilities, and demonstrated effective communication and oversight. There was documented evidence of reporting both to and from these committees, ensuring alignment with relevant governance structures and oversight of their delegated responsibilities. Minutes of meetings supplied to HIQA for the Adult Medication Safety Committee suggested that this committee did not meet in 2024 but had met once in 2025. Terms of reference required this committee to meet at least twice per year.

In summary, the hospital had established and maintained integrated corporate and clinical governance arrangements that clearly defined roles, accountability, and responsibilities throughout the service. Governance structures provided assurance that the quality and safety of outcomes for people using the service were prioritised. Inspectors saw evidence of public reporting by those governing the service, which contributed to transparency and accountability in relation to the quality and safety of care provided. Governance arrangements to support current processes for ensuring a standardised, systematic approach to the recognition, response and management of the deteriorating patient, including patients with sepsis, should be progressed and implemented. The Adult Medication Safety Committee should ensure that meetings occur with the frequency outlined in its terms of reference. Organisational charts

should be updated to reflect new reporting arrangements to the IHA and REO. This is consistent with the judgment following the inspection in 2023.

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. The Emergency Assessment Service (EAS) at the Rotunda Hospital operated on a 24-hour basis, seven days a week. It served as the primary access point to the hospital for pregnant and postnatal women, women presenting with gynaecological emergencies, and babies up to two weeks old requiring unscheduled or emergency care. Inspectors found that the hospital had established appropriate systems and processes to support the effective operation of the EAS and to respond to the demand for emergency care. Responsibility for the operational governance and oversight of the EAS, both during and outside of core working hours, rested with the on-call consultant obstetrician and gynaecologist. Electronic status boards facilitated at a glance data regarding activity in the department. At the time of inspection, the EAS was functioning effectively, providing timely triage, medical review, and assessment for women and babies presenting for unscheduled and emergency care.

There was an operational Assistant Director of Midwifery (ADOM) on duty and available via a bleep 24/7-365 days a year. This ADOM, with the Master and consultant on-call, was responsible for coordinating the management of patient flow and midwifery staffing on a day-to-day basis. Despite the high levels of activity and complexity inherent in the maternity service, inspectors found that the Executive Management Team maintained clear oversight of operational processes. This enabled the service to manage patient flow safely and effectively, while maintaining a focus on quality outcomes. Transitions of care into and out of the hospital were underpinned by clear policy and protocols and standardised documentation.

The hospital had a multidisciplinary infection prevention and control (IPC) team. This team included consultant microbiologists, specialist midwives at ADOM and CMMII (Clinical Midwife Manager 2) grades, a decontamination coordinator, an antimicrobial pharmacist and a surveillance scientist. The consultants had joint commitments to Children's Health Ireland. The nurses also had joint commitments to roles such as

tissue viability and operational ADOM. Members of this team were key members of the IPCC described under Standard 5.2. The hospital had developed an IPC service plan for 2025, which aligned with the hospital's infection and prevention strategic priorities. Inspectors saw evidence of ongoing quality improvement initiatives which aligned to this plan, and were being progressed with oversight at IPCC and EMT levels.

While a formal overarching governance structure for the deteriorating patient was still under development – also a finding in the report of 2023 – interim arrangements were in place through condition-specific working groups, such as those for women with postpartum haemorrhage. These working groups reported directly at EMT level. The hospital had structures and processes in place to ensure a standardised, systematic approach to the recognition, response and management of the deteriorating patient, including patients with sepsis. Relevant early warning systems such as Maternity Early Warning Score (IMEWS) and the Irish National Early Warning Systems (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 management of medication safety in the hospital was governed through the committees outlined under Standard 5.2. A medication safety programme was in place and overseen by the medication safety committee, reporting to the drugs and therapeutics committees. Evidence was provided of multiple ongoing continuous quality improvement initiatives and research activities aligned with this strategy, aimed at enhancing safety and protecting service users from the risk of harm associated with medication management.

There had been a reduction in the percentage deficit in pharmacy staffing since 2023. A formalised prioritisation tool was used to identify women requiring clinical pharmacy review, ensuring that resources were targeted effectively. Pharmacist-led medication reconciliation was performed for women with pre-existing medical conditions, those attending the maternal medicine service, and other complex cases as outlined in policy documents. The clinical pharmacy service was delivered in accordance with the hospital's clinical pharmacy services guidelines. Quality improvements to expand the availability of medication reconciliation to more patient cohorts were being advanced based on clinical priority.

Inspectors found that the hospital had effective management arrangements to support the delivery of safe and reliable care, including in relation to the four known areas of harm. These arrangements were well established within operational procedures, supported by multidisciplinary teams, and aligned with strategic priorities. While governance arrangements were still in development for the deteriorating patient, interim structures were in place and functioning. Pharmacy led medicines reconciliation was still not in place for all women in all clinical areas, however quality improvement initiatives were underway to extend medication

reconciliation to additional patient cohorts, and this was prioritised based on clinical need. The hospital demonstrated an improvement in compliance in this standard, from substantially compliant in 2023 to compliant in 2025.

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 in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital used multiple sources including incident reports, complaints, audit findings and clinical outcomes to inform risk management. There were formal risk management structures and processes in place to proactively identify, assess and minimise risk. This included the identification, documentation, monitoring and analysis of patient-safety incidents. The risks and the effectiveness of mitigating actions were reviewed regularly by the Quality and Safety and Quality Safety and Risk Committees, with oversight provided by the Board.

Performance monitoring arrangements and risk management arrangements included regular reporting to the Board and onward reporting to the Regional Executive Officer (REO) via the Integrated Hospital Area (IHA) manager as described under Standard 5.2.

As in the previous inspection report of 2023, the hospital continued to monitor key patient-safety indicators and their associated outcomes. This data provided assurances to the Board on the standard of care provided in the Rotunda. The hospital actively contributed data to national and international quality and safety databases and audits, including to the Irish Maternity Indicator Systems, National Perinatal Epidemiology Centre (NPEC), the National Perinatal Reporting System (NPRS), and the Vermont Oxford Network audit of very low birth weight (VLBW) infants.[†††††]This data informed quality improvement programmes and supported benchmarking against peer institutions. The hospital publicly reported on its outcomes through mechanisms such as the Maternity Safety Statements published on its website. Collection, collation and sharing of this data facilitated shared

[†††††] The Vermont Oxford Network is a voluntary collaborative group of health professionals committed to improving the effectiveness and efficiency of medical care for new-born infants and their families through a coordinated programme of research, education, and quality improvement projects.

learning within and across services in the hospital and across the network and promoted transparency for service users.

As in the previous HIQA inspection report of 2023, the hospital had a dedicated clinical audit team and a structured approach to auditing clinical practices. This activity was coordinated by the Clinical Audit Committee, which reported to the Quality and Safety Committee.

Structures were in place to provide effective oversight and management of patient-safety incidents occurring in the hospital, including serious reportable events (SREs) and notifiable incidents.[‡‡‡‡‡] This is discussed further under Standard 3.3.

Feedback from women using the service was monitored and oversight of the management of this feedback was provided at EMT level and reported onwards to the IHA at performance meetings this is discussed further under Standard 1.8.

Evidence was provided of a proactive approach to learning from the findings and recommendations of audits and investigations as well as national and international reviews. Resulting changes were communicated to staff in a structured and systematic way to support service-wide learning and continuous improvement.

The hospital's electronic patient record system facilitated the collection and collation of clinical data to support patient safety in the four areas of harm, particularly in the area of medication safety, through improved prescribing, administration and traceability.

Processes were in place to ensure appropriate monitoring, reporting and action on issues relating to infection prevention and control such as surveillance, screening and water safety.

Overall, the hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. This included structured risk management processes, evidence of learning from patient-safety incidents and data collected through audit, and the implementation of quality and safety programmes. This was supported by regular performance reporting through governance structures. This is consistent with the judgment following the inspection in 2023.

Judgment: Compliant

[‡‡‡‡‡] 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.

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

At the time of the inspection, the hospital employed 56.8 whole-time equivalent (WTE) consultant hospital doctors across all specialities and reported no vacant posts. As previously mentioned, some of these posts included joint appointments or sessional commitments to other hospitals in the clinical maternity network and within the Regional Health Area (RHA). Inspectors were informed by the Executive Management Team that all consultants were on the appropriate section of the specialist register with the Irish Medical Council. Furthermore, there was evidence that arrangements were in place for consultant cover either on site or on call 24/7 every day of the year for all clinical specialties. Staff who spoke with inspectors reported prompt responses when consultation or attendance was required. All non-consultant hospital doctor (NCHD) posts were filled at the time of inspection. There were also corresponding arrangements to ensure appropriate levels of NCHD cover at all times.

Despite an increase in midwifery WTE since the inspection in 2023, inspectors noted deficits in midwifery-staffing; this was evident in data submitted by the hospital to HIQA during and following the inspection. It was also reported by staff who spoke with inspectors on the days of inspection.

Based on information provided to HIQA by the hospital, the birth-to-midwife ratio was 1:37.5 in November 2024. The HSE recommends a ratio of 1:35, as outlined in its *Midwifery Workforce Planning Project Final Report* (2016). As outlined in the compliance plan submitted following the 2023 HIQA inspection, the hospital had continued to advocate for an increase in funded baseline midwife headcount with the HSE (based on the birth rate and complexity of the Rotunda patient population). At the time of this 2025 inspection, the hospital had recently received approval to recruit an additional 17.5 WTE midwives. Filling of these posts was expected by the hospital to bring staffing into line with the recommended HSE ratio of 1:35. Midwives in the clinical areas visited on inspection by HIQA inspectors were supported by approximately 30 maternity care assistants.

While the overall midwifery-staffing deficit was estimated by inspectors to be 12.6% (based on figures submitted by the hospital), higher shortfalls were identified in key clinical areas such as the Delivery Suite and the Antenatal Ward, where deficits reached up to 20% in both. Hospital management described a proactive approach to staffing, with daily oversight of rosters, redeployment of staff, and use of internal 'bank' (sourced from Rotunda midwives) and agency shifts to address gaps. Inspectors were informed that staffing levels were reviewed regularly throughout each day to respond to service pressures and prioritise safe care delivery. However,

staff in clinical areas who spoke with inspectors reported that gaps in midwife rosters were not always filled. At the time of inspection, the Delivery Suite was operating with a 20% deficit in whole-time equivalent (WTE) registered midwives. This figure excludes preregistration midwives on placement, who remain under the supervision of a registered nurse or midwife with ultimate legal and professional accountability for patient care. This meant that the Delivery Suite frequently did not have its full complement of staff, however hospital management outlined contingency arrangements in place to address this and all women admitted to the delivery suite at the time of the inspection received one to one care from a registered midwife.

Hospital management identified and recorded a workforce-related risk on its corporate risk register, this was assessed as a moderate risk for the hospital. It related to the risk of staffing shortages, retention challenges, and succession planning. These risks reflect wider national and international difficulties in recruiting healthcare professionals, particularly in urban areas. In response, the hospital had implemented a range of mitigating measures, including ongoing recruitment (nationally and internationally), staff rotation, skill-mix reviews, redeployment, and support for staff education. The hospital reported it was also exploring accommodation-related solutions to support recruitment and retention. It was evident that the hospital had escalated staffing deficit concerns as inspectors were provided with evidence of ongoing engagement with the HSE regarding staffing levels.

During the inspection of the Neonatal Unit, including the Neonatal Intensive Care Unit (NICU) and Special Care Baby Unit (SCBU), staff in the unit were caring for between 27 and 30 infants with varying levels of complexity. Inspectors observed that care was being delivered in a calm, professional and compassionate manner. However, inspectors were informed that the unit was not using the British Association of Perinatal Medicine (BAPM) guidelines for nurse staffing of neonatal units, which is included in the HSE's national model of care for neonatal services in Ireland (2015). Following the inspection, and a further review of evidence gathered during the on-site inspection, HIQA had concerns about the sustainability of contingency arrangements for nurse staffing levels to meet the acuity, complexity and occupancy levels and demands on the unit. As a result, HIQA issued correspondence to the hospital seeking assurances regarding staffing levels in the Neonatal Unit. In the hospital's response, the Master of the hospital outlined a number of measures related to workforce planning and risk mitigation strategies to ensure that the Neonatal Unit was being appropriately staffed to meet service demands. These included targeted recruitment of staff, support for specialist training, active clinical oversight, and hourly staffing level review and management.

The Master also reported that resources were reallocated as needed to maintain safe staffing levels.

Staff training throughout the hospital was monitored through line managers and through clinical directorate structures. There was regular oversight of training compliance by the Master, as training compliance was reported at the Quality Safety and Risk Committee. At the time of inspection, figures submitted to HIQA indicated that while 86% of relevant midwives and 92% of NCHDs had completed multidisciplinary obstetric emergency training, only 54% of consultants had completed this training in the previous two years. Neonatal resuscitation training was completed by 99% of midwives and 100% of medical staff. Similarly, 99% of midwives and over 90% of medical staff had completed training in fetal heart rate monitoring and cardiotocography (CTG) interpretation.

With regard to training for hand hygiene, midwives, housekeeping staff, and health and social care professionals all had training levels above the 90% key performance indicator (KPI) set by the HSE. The percentage of doctors trained was reported to be 69% and it was 81% for healthcare assistants. Records provided to HIQA regarding training in infection prevention measures, including standard and transmission-based precautions, showed 89% compliance among health and social care professionals and 81% among midwives, but only 27% among doctors. Basic life support training was completed by 87% of midwives and 91% of healthcare assistants, and figures for doctors were not provided. Early warning system training for adult and maternity patients showed compliance of 77% for midwives trained in INEWS and 76% in IMEWS, while 67% of NCHDs and 63% of consultants had completed INEWS training.

Absenteeism was reported to be between 4% and 5% for the year-to-date across the hospital, compared to the HSE KPI of less than or equal to 4%. Absenteeism was being actively managed at ward level and staff had access to occupational health and employee assistance programmes.

The hospital demonstrated a planned and responsive approach to workforce management. This included recruiting staff with appropriate skills, supporting ongoing training, and actively managing staffing levels to meet the needs of service users. Activity and acuity levels were monitored and managed across the hospital, with resources reallocated as needed to ensure safe staffing and responsiveness to demand.

While it was evident that progress had been made since the last inspection to address staffing deficits at the hospital and that hospital management continued to proactively manage staffing challenges on a day-to-day basis, considerable staffing gaps in some clinical areas persisted. These gaps, while being actively managed on a daily basis by hospital management, remain a concern for HIQA in the context of

the sustainability of contingency arrangements for midwifery and nursing staffing levels in some clinical areas. Furthermore, risks associated with staffing levels had been identified by the hospital itself as a moderate risk. Continued focus on workforce planning is required to further mitigate the risks associated with staffing levels. In addition, training compliance with some mandatory and essential training, as described above, remained below expected levels. There was a similar finding in the 2023 inspection report.

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 hospital was found to be compliant with three national standards (1.7, 1.8, and 3.3), substantially compliant with three standards (1.6, 2.8 and 3.1) and non-compliant with one standard (2.7).

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

It was evident that staff in the Rotunda Hospital were committed to promoting a person-centred approach to care and were observed by inspectors to be respectful and responsive to the women's individual needs. Women who spoke with inspectors on the day reaffirmed this.

Inspectors found that women were supported in autonomous decisions such as those related to birthing choices and infant feeding.

Staff were observed to be diligent in their efforts to provide privacy, and inspectors were informed that women with particular needs (including after suffering bereavement) were prioritised for single rooms. However, most of the care was being delivered in multi-occupancy areas, where up to 11 women were receiving care with only privacy curtains between them. The limited availability of private spaces did not support the delivery of care in a consistently private and dignified manner. This was especially the case during the provision of personal care or sensitive procedures.

Hospital management was aware of the constraints to the provision of privacy caused by multi-occupancy rooms, and efforts were being made to ensure that communication was carried out in a way that supported service users' privacy and dignity. Women's personal information was protected and stored appropriately in the clinical areas visited. However, inspectors found that within the context of multi-occupancy rooms, privacy curtains, or portable screens for breastfeeding mothers did not fully support confidentiality and privacy when discussing individualised care and treatment with women and parents of babies in the clinical areas inspected, in particular the Neonatal Unit.

In the areas of the hospital visited by inspectors, care was seen to be provided in line with the FREDA principles (fairness, respect, equality, dignity and autonomy). This was consistent with the human rights-based approach to health and social care promoted by HIQA. Service users' dignity, privacy and autonomy were respected and promoted at the time of inspection. However, ongoing limitations in the physical environment continued to hinder the consistent delivery of private and confidential care resulting in the judgment of substantially compliant being unchanged since the HIQA inspection of 2023.

Judgment: Substantially Compliant

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

Inspectors observed staff to be respectful, kind and caring towards women and babies in the clinical areas visited. Staff were observed to listen to and communicate with women in an open and sensitive manner, in line with their expressed needs and preferences. This was confirmed by women who spoke positively about their interactions with staff in the clinical areas visited. Feedback from women using the service and their partners reflected positive experiences of kindness and respect.

The hospital had established specialist clinics for vulnerable groups, in response to feedback, some of these were renamed to reduce stigma and enhance clarity. Additionally, special pathways were developed for families experiencing pregnancy loss and bereavement, including tailored appointment scheduling and access to dedicated support staff. Specialised supports and initiatives were also in place for families with babies in the Neonatal Unit.

There was evidence that the views, values and preferences of people using the service were actively sought, respected and taken into account in the provision of their care.

Overall, inspectors saw evidence that hospital management and staff promoted a culture of kindness, consideration and respect for women and infants and families receiving care at the hospital. Specialist supports were in place to meet the needs of vulnerable groups. This is consistent with the judgment following the inspection in 2023.

Judgment: 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.

Inspectors found that the hospital had a formal complaints management process in place, supported by a current policy that aligned with the HSE's complaints management framework. A designated complaints officer was responsible for receiving and managing complaints and acted as the main point of contact for women and families wishing to make a complaint. There was oversight of complaints at both EMT and Integrated Health Area (IHA) level. In the year-to-date to July 2025, the hospital had received 93 complaints and 890 compliments. All complaints were addressed within the policy's defined timeframes, indicating effective oversight and responsiveness to service user feedback.

Hospital management promoted early resolution of complaints at the point of contact, in line with national guidance. Verbal complaints were managed locally within clinical areas and escalated to more senior managers if unresolved. Written complaints were managed by the senior nurse or midwife manager for the relevant area, with assistance from the complaints officer and input from other clinical staff where appropriate. Inspectors were provided with evidence that complaints were tracked and trended to identify emerging themes, categories and departments involved. However, not all managers from the clinical areas inspected who spoke with inspectors confirmed that they received feedback or learning from this process for their area. Training records submitted to HIQA demonstrated that 75% of midwives, 25% of doctors and 70% of HSCPs had received training on the management of complaints.

There was evidence that quality improvement initiatives were developed and implemented as a result of complaints received. For example, staff described an initiative to improve early discharge to facilitate better access to beds early in the day thus reducing waiting times for booked patients.

While information on how to make a complaint and access independent advocacy services was available on the hospital's website, it was not displayed in all the

clinical areas visited during the inspection. This limited visibility may reduce opportunities for women and families to raise concerns while attending the service.

Overall, inspectors found that the hospital had systems and processes in place to respond to complaints and concerns in a timely, open and effective manner. As outlined in the HIQA report of 2023, information on how to make a complaint and how to access independent advocacy services should be displayed for patients in the clinical areas visited during the inspection. Training attendance for doctors in complaints management requires improvement. This is consistent with the judgment following the inspection in 2023.

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'.

As outlined in the 2023 HIQA inspection report, the Rotunda Hospital faces unique challenges when delivering 21st century obstetric, gynaecological and neonatal care in an 18th century listed building. At that time and since then, hospital management had comprehensive and ongoing strategic plans for both major and minor capital projects. In addition, there were ongoing plans for maintenance works and further sourcing additional capacity to enhance and expand the physical environment in which care was delivered. This included the development of a new critical care facility which is a multiannual project, and which was at the time of this 2025 inspection advancing through the planning process.

Infrastructure-related risks and their impact on infection prevention and control (IPC) were recognised by management and entered onto the corporate risk register.

Evidence was seen that the mitigating actions described in the risk register were being taken. As outlined in the compliance plan submitted by the hospital following the inspection in 2023, some elements of the plan will take up to five years to complete. Notwithstanding the proactive management of the hospital environment, this 2025 inspection found that risks seen on the inspection in 2023 persisted relating to current infrastructural constraints.

Refurbished areas such as the Delivery Suite and Emergency Assessment Service (EAS) were modern, clean at the time of inspection and well maintained. In some older clinical areas, while they appeared clean at the time of inspection, there was evidence of chipped and scuffed surfaces which did not facilitate effective cleaning.

Cleaning arrangements in the hospital were unchanged since the last inspection and managers in clinical areas reported satisfaction with the availability and standard of the service, both inside and outside core working hours. Oversight of cleaning was the responsibility of the clinical midwife managers (CMM) or the household supervisors – depending on the equipment involved. Systems were in place to identify clinical equipment that was clean and ready for use; however, these systems were not consistently used in all areas visited by inspectors.

While linen storage cupboards were available for clean linen, some clean linen was inappropriately stored, uncovered, on trollies on the corridor of the antenatal ward. Inspectors saw that waste and hazardous materials were being segregated and stored securely. However, a lack of storage space led to inappropriate storage of supplies and emergency care equipment on public corridors which potentially posed a risk to patient safety.

The hospital had processes in place to prioritise and manage the placement of women and or babies requiring transmission-based precautions (these are extra measures to help prevent the spread of certain infectious agents) during their stay in hospital. This placement was overseen by the hospital's infection prevention and control team. The hospital had a total of 19 single-occupancy en-suite rooms, which represented approximately 10% of its beds. When demand for single rooms exceeded the number of patients requiring isolation, patients with resistant organisms were placed together in multi-occupancy rooms (which was in line with national guidance). However, inspectors found that the physical infrastructure of multi-occupancy wards and units did not support the service's ability to maintain best infection prevention and control practices in line with national clinical guidelines relating to healthcare-associated infections (HCAI). There was evidence that extensive cleaning and disinfection protocols were in place. Despite mitigation measures, the physical environment did not always support women and babies being effectively segregated and infection control risks being managed effectively.

The ability to move women from some multi-occupancy rooms on a bed was restricted due to the physical infrastructure. For example, inspectors were informed in the Antenatal Ward that beds could not be removed from some rooms. The hospital had put procedures in place to partially mitigate these risks.

Multi-occupancy rooms did not all include individual toilet and shower facilities for the sole use of the women occupying the room. Not all showers were found to be operational on the day of inspection, staff who spoke with inspectors reported that in some cases this was a long-standing issue. This resulted in limited bathroom facilities for the women on these wards.

Not all sinks in clinical areas conformed to national standards for hand hygiene in Irish healthcare settings,§§§§§ thereby hindering effective infection prevention and control. Hand hygiene signage was not clearly displayed throughout all the clinical areas visited. However, good practice was supported by the presence of wall-mounted alcohol-based hand sanitiser dispensers being readily available for staff and visitors.

Inspectors found that the physical environment, particularly the design of multi-occupancy wards, compromised the privacy and dignity of women and families. While staff were observed to be diligent in their efforts to provide privacy, the limited availability of private spaces did not support the delivery of care in a consistently private and dignified manner, especially during personal care or sensitive procedures.

Special arrangements for particular physical and sensory needs of people using the service, such as labouring women or families experiencing bereavement, were evident. For example, the use of dimmable lighting and sound systems were in place for women in the Delivery Suite, and there were allocated bereavement or counselling suites in other areas. Progress with actions in the compliance plan submitted following the HIQA inspection of 2023 was evident. The service had implemented a range of good practices and demonstrated a proactive approach to developing the campus and managing the risk related to the ageing infrastructure. Nonetheless, the limitations of the existing physical environment negatively impact its ability to fully comply with key features of this national standard and, the risk to women and their babies persisted. In particular, the infrastructural challenges continued to limit the hospital's ability to effectively manage healthcare-associated infection risks and compromised the rights of people using the service to privacy and dignity. Specific issues on this inspection included:

- the physical environment did not always support the best practice around the segregation of people to support the effective management of infection control risks
- the ability to move women from some multi-occupancy rooms on a bed was restricted
- chipped and scuffed surfaces in some areas observed by inspectors did not facilitate effective cleaning
- systems in place to identify equipment being clean and ready for use were not consistently used in all areas visited
- lack of storage space led to inappropriate placement of supplies and equipment on public corridors
- multi-occupancy rooms did not all include toilet and shower facilities for the sole use of the people occupying the room

§§§§§ As per Guidelines for hand hygiene in Irish healthcare settings clinical hand wash sinks should (amongst other things) conform to HBN 00-10 Part C Sanitary Assemblies described in Health Building Note 00-10 Part C Sanitary assemblies DOH UK 2013

- bathroom facilities as outlined above on the Antenatal ward and General Postnatal A ward were out of order for a prolonged period prior to the inspection leaving limited facilities for women on those wards
- many sinks in clinical areas viewed by inspectors did not conform to national standards for hand hygiene in Irish healthcare settings
- multi-occupancy spaces throughout the hospital did not support the delivery of care in a private and dignified manner, especially during personal or sensitive interactions.

Judgment: Non-compliant

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

The hospital had a coordinated programme of ongoing quality improvement plans for 2025, aligned with its strategic principles as outlined under Standard 5.2. Inspectors were provided with evidence of a large number of active quality improvement plans, which included initiatives targeting each of the four recognised areas of harm. Ownership of these initiatives was devolved to departmental level, with oversight and support provided by the Quality and Safety Department. These plans reflected a structured approach to monitoring and continuously improving the effectiveness of care. The hospital used information from a range of sources such as: audits against key performance indicators, patient-safety incident reviews, and the tracking and trending of complaints to monitor and evaluate the quality of care provided. This information was used to benchmark performance and inform the development of quality improvement plans, supporting a continuous cycle of improvement across the service. Specific monitoring relating to the four areas of known harm was also in place.

Compliance with adherence to World Health Organisation *5 Moments for Hand Hygiene*[******]and with hand hygiene training was monitored by the infection prevention and control team. For all wards, compliance with performance of hand hygiene was reported to be between 93.2% and 94.2% in quarter two of 2025.

Women attending the Rotunda Hospital were routinely screened for multi-drug resistant organisms (MDROs) and immunity to common childhood illnesses at the time of their booking appointment. Screening was in line with national guidance and babies admitted to the Neonatal Unit were also screened for relevant organisms. Compliance with this screening for MDROs was monitored by the infection prevention and control team, with 100% compliance reported year to date (July). Rates of hospital-acquired infections were reported at local and regional level and

[******] The World Health Organization (WHO) "Five Moments for Hand Hygiene" is a framework that guides healthcare workers on the critical times to clean their hands to prevent the spread of infections.

published on the HSE safety and quality of care dashboard and were consistently within the values targeted in key performance indicators.

Readmissions related to surgical and other relevant infections were monitored, and quality improvement initiatives were initiated in reaction to results of the monitoring. Audits of peripheral and central venous catheter care were completed monthly with compliance levels consistently over 90%.

A medication safety programme was in place and overseen by the Medication Safety and Drugs and Therapeutics committees. Evidence was provided of multiple ongoing audits, continuous quality improvement initiatives and research activities aligned with this strategy, aimed at enhancing safety and protecting service users from the risk of harm associated with medication management. The presence of an electronic patient record, accompanied by automation of pharmacy processes, facilitated efficient monitoring of medication safety practices. Evidence was provided of multiple high-level quality improvements related to medication safety. However, although the hospital reported using some modules of the *National Nursing and Midwifery Quality Care-Metrics* [††††††]programme, hospital-wide metrics relating to medication safety and medication storage and custody were not provided to HIQA, and practices relating to medication storage were not optimal in all areas on the days of inspection, as discussed under Standard 3.1.

The electronic patient record incorporated early warning scores and the Introduction, Situation, Background, Assessment, Recommendation read-back/risk [‡‡‡‡‡‡] (ISBAR[3]) structure for the handover of information.

This facilitated efficient use and monitoring of compliance with use of IMEWS and ISBAR. The hospital conducted regular audits and recorded 99.4%-100% compliance with the use of early warning scores where they were relevant. In one of the clinical areas inspected, there was one instance where compliance fell below the required target of 90% and QIP was put in place. When re-audited the unit was back in compliance. The hospital reported that a hospital-wide audit on the use of the sepsis protocol, performed in June 2025 had an overall compliance rate of 97.5%.

Evidence provided to HIQA reflected a structured approach to monitoring and continuously improving the quality and effectiveness of care. There were opportunities for improvement in the routine audit of medication storage and custody. This judgment was unchanged since 2023.

Judgment: Substantially Compliant

[††††††] National Nursing and Midwifery Quality Care-Metrics (QCM) are a set of agreed-upon, evidence-based indicators used in Ireland by the HSE Office of Nursing and Midwifery Services Director (ONMSD) to measure, monitor, and improve the quality of fundamental nursing and midwifery care.

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

Inspectors found there were arrangements in place in the Rotunda Hospital to proactively identify, analyse, evaluate and manage immediate and potential risks to women and babies. Inspectors saw evidence of the proactive identification of and response to emergent and existing risks associated with the design and delivery of healthcare services.

Risk registers were maintained at board and executive hospital management level. Risks associated with the four areas of known harm that were the focus of this inspection were documented on these risk registers. Details of existing controls and additional actions required to mitigate these risks were documented, and inspectors saw evidence of active and ongoing management of these risks, with updates and progress on mitigation measures recorded within the risk register. Lead representatives who spoke with inspectors were aware of risks pertaining to their areas that had been entered on the executive or corporate risk registers. The hospital reported that it was managing risk in line with the HSE Enterprise Risk Management Policy and Procedures 2023. Clinical managers who spoke with inspectors escalated risks through management structures. Formal risk assessments of local risks were not kept at ward level and local managers were not aware of the risks for their areas that had been escalated to the executive or corporate registers. Incident reports were also used to report incidents and escalate concerns.

The IPC team were involved early in capital projects that involved building works, and managed these processes to ensure the protection of vulnerable women and babies. At the time of inspection, inspectors saw responsive management of an emergent public health issue related to Listeria which had IPC implications for the hospital. The hospital had put policies, procedures and guidelines for the management of these patients in place and staff had been made aware of these new risks and how to manage them.

Staff had access to microbiologist expertise 24 hours per day 365 days per year, and the IPC team provided a suite of policies, procedures and guidelines (PPGs) to guide practice in the hospital to minimise IPC risks associated with the design and delivery of the healthcare service. These PPGs were readily accessible for staff, and updated to reflect ongoing and emergent risks. Staff who spoke with inspectors were familiar with these policies.

To reduce risks associated with infection prevention and control, women attending the Rotunda Hospital for care were routinely screened for multi-drug resistant organisms

‡‡‡‡‡‡ The ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework, provides a standardised approach to communication, as endorsed by the World Health Organisation, it is promoted by the HSE as part of National Clinical Guideline No.1 INEWS, and Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11

(MDROs) and immunity to some common childhood illnesses as per guidelines, at the time of their booking appointment. Babies who were admitted to the Neonatal Unit were also screened for appropriate organisms. Those requiring transmission based precautions were isolated or cohorted within 24 hours where possible as described under Standard 2.7.

There was one high-rated risk related to IPC on the board risk register and one on the executive risk register, both were related to hospital infrastructure. Controls to address these risks were implemented as described under Standard 2.7. Controls were reviewed regularly to determine how effective they were in reducing the risk. Bed management was responsive to minimise the risks of HCAI associated with the dated infrastructure.

The hospital reported three outbreaks of methicillin-resistant *Staphylococcus aureus* (MRSA) in 2025 year to date (July). It was evident to inspectors that the management of these outbreaks was proactive and responsive. Documentation reviewed demonstrated that a multidisciplinary outbreak team was convened to oversee the response and the hospital had acted promptly on the findings of the outbreak investigation report. The hospital's infection prevention and control team worked collaboratively with clinical and household staff to implement the recommended control measures. Inspectors saw evidence of changes to local policies and practices that had been instigated following the outbreak, including enhanced surveillance protocols and revised cleaning schedules to ensure sustained improvement and reduce the risk of recurrence.

Medication safety was enhanced by the integration of medication administration records into the electronic patient record, facilitating extra controls on medication safety. Pharmacists in the Rotunda were involved in the design of this tool and forcing functions and alerts relevant to the service were built into the system to enhance the safety of medication administration, particularly in relation to high-risk medications. The hospital also had lists of high-risk medications tailored to the service displayed in clinical areas, and extra labelling to alert staff when administering sound alike look alike drugs (SALADS).

The risk of medication error was recognised and entered on the executive risk register. Inspectors saw that mitigating actions to minimise risks associated with the administration of medications were employed as described. Evidence was seen of proactive monitoring of risks and formulation of policy to protect mothers and babies from harm. For instance, a quality improvement that protected babies from risks associated with commonly used medications in the Neonatal Unit. Responses and alerts, issued by the pharmacy department, to clinical staff based on internationally reported emergent risks were also evident, with appropriate risk reduction strategies employed in response.

The pharmacy department was responsible for the provision of clinical pharmacy services and antimicrobial stewardship across all hospital areas, in accordance with

hospital policy. Medicines reconciliation was conducted for women and babies based on a predefined risk stratification. This included all women with pre-existing medical conditions or polypharmacy, and all neonates admitted to the Neonatal Unit. Plans to expand the service of medicines reconciliation to other patient populations were evident and innovative processes to improve medication safety through inclusion of over the counter or previously prescribed medications on the electronic patient record prior to admission were also seen.

Inspectors found that the Drugs and Therapeutics Committee had developed local policies, procedures and guidelines (PPGs) to support safe medication practices, and these were readily accessible to staff, including at the point of preparation and administration. However, policy was not consistently followed in relation to medication storage and self-administration by patients. For example, hospital policy stated that all medications must be stored securely, in either a locked cupboard or a locked room. However, inspectors observed that this was not the case for all medications in the Neonatal Unit and the Antenatal Ward. Self-administration of medications was not being carried out in accordance with hospital policy, and secure storage was not provided for this practice. These findings were brought to the attention of hospital managers during inspection. Immediate corrective actions were taken to address some of the issues identified. Management committed to resolving documentation and storage concerns related to self-administration of medications, including insulin which is a high-risk medication.

As in the report of 2023, the hospital was using national early warning systems for the relevant cohorts of patients to support the recognition, response and management of a deteriorating patient, i.e. Maternity Early Warning Score (IMEWS) and the Irish National Early Warning Systems. The Sepsis 6 care bundle and the ISBAR framework were used for the escalation of the care of the deteriorating patient. All of these tools were built into the patients' electronic health record. Policies and procedures were in place to support the early warning systems and staff were knowledgeable about escalation and response protocols. Access to critical care was recorded as a risk on the executive risk register and mitigating actions to minimise risk were described to inspectors as outlined in the risk register. Hospital management was assured that these measures were sufficient to mitigate this risk. The hospital had established pathways and referrals for pregnant and postnatal women with complex medical conditions. There was formalised access to medical and surgical consultant specialists if needed. There were arrangements in place to support the safe and timely transfer of women to a Model 4 hospital if needed.

Mechanisms for initiating a prompt response by the appropriate emergency response team to the most common causes for deterioration in women and babies had been devised to ensure that the correct resources arrived on scene in a prompt manner in the event of an emergency. These processes had been reconfigured since the inspection of

2023. Inspectors observed these processes in action and found staff to be familiar with them and responses prompt. Staff reported that these responses worked well and operated 24 hours per day every day of the year. Regular training was offered to staff to enhance response to emergency situations.

There was access to operating theatres on a 24/7 basis. A defined process was in place for accessing and staffing an operating theatre for emergency surgery both during and outside core working hours. Emergency procedures such as caesarean sections could be carried out in a designated obstetric operating theatre located within the Delivery Suite. Procedures also supported the rapid transfer of pregnant or postnatal women to the main operating theatre when required. Arrangements were in place to manage simultaneous obstetric emergencies (including out of hours), and to ensure that emergency caesarean sections could be performed within essential clinical timeframes. Audits were carried out to monitor the timing of category 1 caesarean sections, with the aim of ensuring these procedures were performed within 30 minutes of the decision to operate. Staff reported that these systems worked well and there were no safety incidents relating to a lack of availability of theatres or staff.

Emergency equipment was standardised across clinical areas, and checklists were formulated to be performed daily or weekly depending on the equipment in question. Inspectors found that these checks were not being done with the prescribed frequency in all areas visited on inspection.

All aspects of the electronic patient record were available simultaneously to all staff at all times (including off-site consultants), this contributed greatly to enhanced safety at transitions of care. This, accompanied by the inclusion of Introduction, Situation, Background, Assessment, Recommendation read-back/risk (ISBAR[3]) framework in the hospital's electronic patient record supported good communication and information transfer at transitions of care.

Formalised arrangements were in place to support the safe and effective transfer of women and babies into and out of the hospital, including inter-facility transfers in the event of critical illness. These arrangements were supported by clear protocols. Standardised documentation had been developed for this purpose as not all sites transferring patients to or from the hospital had access to the electronic patient record. There was active communication between services to plan such transfers. There was a designated discharge coordinator who facilitated safe transitions of care for babies transferring from the neonatal unit. Inspectors saw evidence of formalised and well-established arrangements with referring and receiving hospitals to support safe transitions of care for patients with complex needs requiring input from multiple specialties; as mentioned under Standard 5.2, this was up to and including cross-site appointment of consultants.

The hospital provided a suite of local and national up-to-date policies, procedures and guidelines to support safe practice. These were readily available to staff at all times on a document controlled and mobile platform.

Overall, the hospital demonstrated a strong commitment to the provision of quality and safe care to women and babies. While systems and processes were largely effective, some improvements were necessary to achieve full compliance with the standard meaning that the judgment remains substantially compliant, as in the HIQA report of 2023.

- local managers in the clinical areas inspected were not aware of the risks for their areas that had been escalated to the executive or corporate registers
- not all medications were stored securely in accordance with hospital policy in clinical areas inspected
- procedures for self-administration of medications outlined in policy (including safe storage) were not followed
- checks on emergency equipment were not being done with the prescribed frequency in all areas visited on inspection.

Judgment: Substantially Compliant

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

The hospital had a Clinical Risk and Patient Safety department that was responsible for the administration and coordination of the hospital's response to patient-safety incidents, including serious incidents (SI), serious reportable events (SRE) and specified notifiable incidents reportable in line with the Patient Safety Act (PSA). This department also monitored the progress of implementation of recommendations from patient-safety incident reviews.

Patient-safety incidents were reported on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework, the hospital's local incident management policy and national legislation.

Local serious incident management teams (SIMT) and regional serious incident management forums (SIMF) were convened appropriately and in response to patient-safety incidents at local and regional level. Patient-safety incidents were discussed at weekly meetings of the EMT, and data was compiled to facilitate the detection of trends in incidents. The EMT escalated adverse clinical events to the regional SIMF. The Integrated Health Area (IHA) manager and clinicians from the Rotunda sat on the local SIMT and the regional SIMF. The regional SIMF comprised hospitals from three IHAs. A summary report of all patient-safety incidents was included as part of the Master's quality and safety report for the Quality, Safety and Risk subcommittee of the Board. A summary of all serious

patient-safety incidents was also supplied to the IHA manager at monthly performance meetings.

Staff who spoke with inspectors demonstrated a clear understanding of the procedures for reporting, managing and responding to patient-safety incidents. Staff also confirmed that debriefings with both service users and staff were carried out following incidents to support learning, support patients and drive service improvement.

The hospital recorded and reported on clinical patient-safety incidents. Formal reviews were commissioned appropriately and indicated a proactive and open culture for the reporting and investigation of patient-safety incidents. There was a structured approach to shared learning from patient-safety incidents at the hospital. A multidisciplinary Adverse Clinical Event (ACE) Review Team meeting was held monthly to disseminate learnings from completed reviews following SI or SRE investigations. Terms of reference indicated that the function of this team was to ensure that recommendations approved by EMT were disseminated to midwifery managers and midwifery staff. In addition, this meeting reviewed incidents that did not fall within the criteria of an SI or SRE but which were classified above negligible, to determine whether policy and safety standards were followed, what actions, if any, could have prevented the incident and whether new measures should be considered by the hospital in light of the incident. These meetings were not recorded as the incidents discussed at the meeting were recorded elsewhere, but attendance records showed good attendance from across the hospital and many of the staff who spoke with inspectors attended it regularly and spoke of the learning shared at the meeting. Huddles and communication books were also seen in use as mechanisms to share patient-safety information. Pharmacy also issued bulletins for learning in response to medication safety incidents which were seen disseminated at ward level.

All births which took place outside of the delivery suite or operating theatre were reported as patient-safety incidents, incident forms were reviewed and data was maintained for tracking and trending. This number has been diminishing year on year since 2021. The majority of incidents related to precipitous labour,§§§§§§where it became unsafe to move the mother. A smaller number of cases related to capacity issues and one in the past two years related to staffing levels. Births on the Antenatal Ward attributed to capacity issues will be down significantly this year if current trend persists. As noted in Standard 5.5 there was responsive management of capacity across departments to mitigate this risk.

The hospital's infection prevention and control team was informed of and reviewed patient-safety incidents related to infection control, recommending corrective measures to prevent reoccurrence. The effectiveness of these measures was then overseen by the Infection Prevention and Control Committee (IPCC).

The Drugs and Therapeutics Committee and Medication Safety Committees reviewed all medication errors in the hospital. Incidents were formally categorised using the National

Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)******* classification to inform the implementation of corrective actions, which were then monitored by the committees to ensure that actions were effective.

Overall, there were effective management systems in place at the Rotunda Hospital to identify, report, manage and respond to patient-safety incidents in line with national guidance and legislation. This is consistent with the judgment following the inspection in 2023.

Judgment: Compliant

Conclusion

An unannounced inspection of the Rotunda 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. The inspection also focused on progress the hospital made with its compliance plan since the previous inspection.

There was evidence that hospital management was progressing with actions in the compliance plan submitted to HIQA following the last inspection of the service in 2023. The judgments of compliance were similar to those in the 2023 report with an improvement from substantially compliant to compliant noted in standard 5.5.

Capacity and Capability Dimension

The hospital had formalised governance arrangements in place to assure the delivery of high-quality, safe and reliable healthcare. This was coupled with effective management arrangements that supported and promoted this objective across the service. While governance arrangements for the deteriorating patient were still in development, interim structures were in place and functioning effectively.

Workforce planning and management arrangements were responsive and actively monitored. While staffing levels had improved, shortfalls in midwifery and nursing staffing persisted. These were recognised by hospital management and recorded as a moderate risk. Following the inspection, HIQA sought assurances from the hospital regarding the sustainability of nurse staffing levels in the Neonatal Unit, relevant to the

§§§§§§ Precipitous labour is a very rapid and short labour, typically defined as delivery occurring less than three hours after the start of regular contractions.

******* The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) error classification, known as the Medication Error Index, categorizes errors based on their potential for harm, whether they reached the patient, and the severity of the outcome, if any.

acuity, complexity and occupancy levels. In response, the hospital Master provided assurances on contingency measures, including responsive resource reallocation, to maintain safe staffing levels in the unit. Continued focus on workforce planning and training compliance is required to ensure that the service can plan, organise and manage its workforce to achieve its objectives for high-quality, safe and reliable healthcare.

Systematic monitoring arrangements were evident, enabling the hospital to identify and act on opportunities to continually improve the quality, safety and reliability of care. There was evidence of a proactive approach to learning and improvement, supported by structured risk management processes, audit findings, and the implementation of quality and safety programmes. Hospital management and staff promoted a culture of kindness, consideration and respect for women, infants and families receiving care. Specialist supports were in place to meet the needs of vulnerable groups, and service user feedback reflected positive experiences of compassionate and person-centred care.

A structured and responsive complaints management process was in place, supported by governance oversight and evidence of quality improvement.

Quality and Safety Dimension

Inspectors found that care was delivered in line with the principles of fairness, respect, equality, dignity and autonomy, consistent with a human rights-based approach. Service users' dignity, privacy and autonomy were respected and promoted. However, limitations in the physical environment impacted the consistent delivery of private and confidential care.

While the hospital had implemented good practices and demonstrated a proactive approach to managing infrastructural risks, limitations in the physical environment continued to impact effective infection prevention and control, privacy and dignity. These constraints affected the hospital's ability to fully meet the requirements for a safe and appropriate physical environment.

The hospital had a structured and coordinated approach to monitoring and improving the effectiveness of care, supported by robust governance, targeted audits and high compliance rates. There was evidence of a proactive approach to learning and improvement. Opportunities for improvement were identified in the routine audit and management of medication storage and custody.

Systems and processes were in place to support the safe design and delivery of care, including structured governance, proactive risk management, effective infection prevention and control, and comprehensive medication safety practices. While overall compliance was achieved, improvements are required in local risk awareness, medication storage, self-administration procedures and emergency equipment checks.

Inspectors found that the hospital had effective systems in place to identify, report, manage and learn from patient-safety incidents. These systems were aligned with national legislation and guidance, supported by strong governance structures, and established mechanisms for shared learning and continuous improvement.

HIQA will, through the compliance plan submitted by hospital management, continue to monitor the progress in implementing the actions identified bring the hospital into full compliance with National Standards.

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.	Substantially 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 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Non Compliant

quality, safe, reliable care and protects the health and welfare of service users'.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially 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.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

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

1. **Details of interim actions and measures to mitigate risks associated with non-compliance with standards:**

- As outlined in our response in 2024 we have offered all the graduates from both programmes, the higher diploma programme and the undergraduate programme a permanent position. In addition we are continuing to monitor activity and service needs with proactive oversight of rosters to ensure optimal and safe staffing levels- offering overtime, Bank shifts and use of Agency resources as required
- As per our return in 2024 we continue with operational ADOM 24/7 monitoring of activity via regular rounds and attendance at safety huddles and deployment of resources as required
- We have 20 students who have started the H Dip programme in March 2024 who have now joined our workforce.

2. **Long-term plans requiring investment to achieve compliance with this standard:**
   As detailed in the 2024 reply we continue to pursue

- Ongoing active recruitment including attending recruitment fairs in Ireland and overseas
- Engaging with recruitment agencies to look at oversea recruitment campaigns within the ethical framework defined by WHO
- Progressing provision of an adaptation programme to recruit candidates with NMBI decision letters
- Continue to work with NWIHP to develop a framework for safe staffing in maternity services.
- Continue to advocate for an increase in funded baseline headcount with our IHA manager Mellany McLoone. The fact that NWIHP have not published there activity based assessment of midwifery numbers is regrettable. The Rotunda Hospital, based on the number and complexity of our population should be entitled to a significant uplift in our midwifery numbers.

Timescale: There is no particular timescale for improvement as this is an ongoing challenge but short term is 1-2 years, long term is 4-5 years

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'.	Not Compliant

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

Interim plan over the next 3-4 years. Ongoing maintenance of the facilities in our postnatal accommodation. Early recognition of events that result in curtailed access to the limited shower and bathroom facilities. As a result of a further increase in our delivery numbers we frequently are at 100% bed capacity. When we are below capacity we prioritise the use of other beds within the hospital and therefore reduce the need to accommodate 10/12 postnatal women in wards in Postnatal A&B.

Medium Term Plan:

We plan to have our Critical Care Wing built over the next 4-5 years. This will allow us remodel our current facilities, subject to planning permission and reduce the hospitals reliance on 18th Century infrastructure. We are currently in the appeals process with the planning commission. Next year we will start the enabling works and hope to have the Critical Care Wing completed by 2029.

Timescale: As above