Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	University Maternity Hospital Limerick
Healthcare service/Organisation ID:	OSV-0002037
Address of healthcare service:	Ennis Road Limerick Co. Limerick V94 C566
Type of Inspection:	Announced
Date of Inspection:	22/10/2025 and 23/10/2025
Inspection ID:	NS_0167

About the healthcare service

Model of hospital and profile

University Maternity Hospital Limerick is a statutory, standalone maternity hospital under the governance and management of the HSE Mid West health region. The hospital is the only maternity hospital in HSE Mid West, providing healthcare services for an estimated population of 413,000 people. A variety of maternity care pathways are provided at the hospital in line with the *National Maternity Strategy: Creating a Better Future Together 2016-2026*[*] — supportive care[†] assisted care pathway[‡] and specialised care pathway.[§] The hospital's Neonatal Unit is a Level 2 (regional unit)[**] facility, offering comprehensive specialised treatment for critically ill pre and full-term babies over 24 weeks' gestation. There were 3,892 births at the hospital in 2024.

The following information outlines some additional data on the hospital

Number of beds	83 inpatient beds, which include: - 29 antentatal beds - 54 postnatal beds - 7-bedded Delivery Suite - 1 special observation bed. 19 baby cots in the Neonatal Unit (four neonatal intensive care cots; five high dependency cots and 10 special care baby cots).

[*] *National Maternity Strategy: Creating a Better Future Together 2016-2026* sets out a plan for maternity and neonatal care in Ireland, to ensure its safe, standardised, of high quality and offer a better experience and more choice to women and their families.

[†] The supported care pathway is intended for normal-risk women and babies, with midwives leading and delivering care within a multidisciplinary framework. Responsibility for the co-ordination of a woman's care is assigned to a named Clinical Midwife Manager, and care will be delivered by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings. The woman, along with her healthcare professional, can choose where to give birth, in an alongside birth centre in the hospital, or at home.

[‡] 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. Responsibility for the co-ordination of a woman's care is assigned to a named obstetrician, and care is provided by obstetricians and midwives, as part of a multidisciplinary team. Care is provided across both the hospital and community, and births take place within a hospital setting in a specialised birth centre.

[§] The specialised care pathway is for high-risk mothers and babies. It is led by a named obstetrician, and delivered by obstetricians and midwives, as part of a multidisciplinary team. Care, in the main, is provided in the hospital, and births will take place in the hospital, in a Specialised Birth Centre.

** A Level 2 Neonatal Unit provides routine neonatal care to term infants, special care, high dependency care and short-term ventilation to infants over 27 weeks gestation (Model of Care for Neonatal Services in Ireland; 2015.

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 services among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* Version 2 2024 (national standards) as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare services.

To prepare for this inspection, the inspectors reviewed information, which included previous HIQA inspection findings, information submitted by the service provider, unsolicited information and other publicly available information since.

During the inspection, the inspectors:

- spoke with women who used the maternity 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 women who received care and treatment in the hospital
- observed care being delivered, interactions with women 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 clinical practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the nine national standards assessed 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 the 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 and treatment.

A full list of the nine 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)
22/10/2025	09.00 – 17.45hrs	Denise Lawler	Elaine Egan Eileen O' Toole Úna Cahill Sorcha Burns
23/10/2025	08.15 – 15.30hrs	Denise Lawler	Eileen O' Toole Úna Cahill Sorcha Burns

Information about this inspection

This inspection focused on nine national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited the following clinical areas:

- Maternity Emergency Unit
- Early Pregnancy Assessment Unit
- M3 – a ward where pregnant women received care
- Delivery Suite, where women were cared for during labour and birth
- M1 – a ward where women and babies were received care after birth
- Operating Theatre Department
- Neonatal Unit – comprised neonatal intensive care cots, high-dependency cots and special care baby cots.

During this inspection, the inspection team spoke with representatives from the Maternal and Child Health Directorate's executive management team, directorate's quality and patient safety manager, human resource 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 the women using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

[††] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[‡‡] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[§§] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

From what the inspectors heard and observed during the inspection, women and babies were well cared for and supported by staff providing care in the Maternity Emergency Unit, early pregnancy assessment unit (EPAU), M1, Delivery Suite, M3 and the Neonatal Unit. Inspectors met and spoke with women receiving care in these clinical areas. The inspectors observed staff engaging with women in a positive, caring, respectful and pleasant way. Call-bells were observed within women's reach. Staff were observed responding promptly to women's needs and requests. The women who spoke with the inspectors were satisfied and content with the care received and described the midwifery, nursing, medical and support staff as *"very good", "supportive", "helpful", "responsive", "kind" and "super-friendly".* Women felt *'well supported'* and described the care provided as *"excellent" and "exceptional".* Positive feedback was received about the food choices on offer and about the cleanliness of the clinical areas visited. With regard to areas for improvement, women described the space between the beds in multi-occupancy rooms as *"very tight"* and how *"at times trying to speak with a medical consultant was difficult"*. Those who spoke with the inspectors were aware of their plan of care and of the hospital's complaint management processes. Information on the HSE's *'Your Service, Your Say'* and independent advocacy services were not clearly visible in all the clinical areas visited during this inspection.

Overall, the women who spoke with the inspectors were very complimentary about the staff and with the care received in all the clinical areas visited. Their experiences was consistent with what women told inspectors and what inspectors observed during the inspection.

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 were in ensuring that a high-quality and safe service is being provided. It also includes the national standard related to workforce. University Maternity Hospital Limerick was found to be 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) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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 University Maternity Hospital Limerick, there has been significant changes to the way health and social care services are now coordinated, delivered and managed in the Mid West region of Ireland. The hospital now forms part of the HSE Mid West health region. HSE Mid West is one of six health regions under the governance of the Health Service Executive (HSE) Board. The HSE Mid West comprise three areas:

- acute and older people services
- Clare and Limerick county Integrated Healthcare Area (IHA)
- Limerick City and North Tipperary IHA.

Staff who spoke with the inspectors during the inspection were clear and understood that the Chief Executive Officer (CEO) for Mid West Acute and Older Persons Services was the accountable and responsible person for the delivery and the integration of acute and older persons healthcare services in HSE Mid West. The CEO for Mid West Acute and Older Persons Services reported to the Regional Executive Officer (REO). Overall accountability and responsibility for the delivery of healthcare services across HSE Mid West lay with the REO. The REO reported directly to the HSE's CEO. Organisational diagrams provided to the inspectors accurately reflected the governance arrangements at the hospital and health region levels, and were consistent with those described to the inspectors during the inspection.

Inspectors found there was robust oversight and accountability systems in place to ensure and assure the quality, safety and reliability of healthcare services at the University Maternity Hospital Limerick. The hospital's corporate and clinical governance arrangements were well established, integrated and were in keeping with the size, scope and complexity of the service delivered at the hospital.

The Maternal and Child Health Directorate's was the key governance group that governed and oversaw the quality and safety of the healthcare services provided at the hospital. This group was delegated with the executive power, authority and accountability to plan, develop and manage healthcare services at the hospital. The governance group was multidisciplinary comprising a clinical director, general manager, business managers, director of midwifery (DOM) and patient quality and safety manager. The group functioned effectively, in line with its terms of reference. The Maternal and Child Health Directorate's general manager was the accountable officer with overall responsibility and accountability for the governance of healthcare

services provided at the hospital. The general manager was clear and described the defined reporting arrangement to the Chief Operations Officer of Mid West Acute Services, who in turn reported to the CEO for Mid West Acute and Older Persons Services. The directorate's governance group met with the CEO for Mid West Acute and Older Persons Services and executive management team of the Mid West Acute Services monthly. Assurances about the quality and safety of healthcare services at University Maternity Hospital Limerick was provided at this monthly meeting. The hospital's performance and compliance with metrics related to quality, workforce, hospital activity, risks and patient safety incidents, were also presented at this monthly meeting.

Decision-making, responsibility and accountability for the maternity services was devolved to executive and operational managers who understood and clearly described their respective reporting and accountability arrangements to the Maternal and Child Health Directorate's governance group and onwards to the CEO for Mid West Acute and Older Persons Services. Clinical governance and leadership at the hospital was led by the Maternal and Child Health Directorate's clinical director who reported to the HSE Mid West's chief clinical director. The DOM organised and managed the nursing and midwifery services at the hospital. The DOM reported to the HSE Mid West's chief director of nursing and midwifery. Operational issues, quality metrics, service improvement and staff resourcing were reviewed and discussed at monthly meetings held by the DOM with clinical midwifery managers (CMMs), clinical nurse managers (CNMs) and assistant directors of midwifery. As per the national standards, the hospital had designated clinical leads in the specialties of obstetrics and gynaecology, neonatology and anaesthesiology who provided clinical leadership and were responsible for the organisation and management of healthcare services within their specialty.

A number of subcommittees, described below, provided the Maternal and Child Health Directorate's governance group with assurances about the effectiveness of the systems and processes in place to assure and ensure the quality and safety of healthcare services provided at the hospital. These subcommittees had defined and well established reporting arrangements to the directorate's governance group.

The Quality and Safety Executive Committee (QualSEC) was the overarching structure that provided assurances on the quality and safety of healthcare services provided at the hospital to the CEO for Mid West Acute and Older Persons Services and the executive management team of the Mid West Acute Services. This multidisciplinary committee, chaired by the health region's chief clinical director, met quarterly and functioned in line with its terms of reference. Members of the Maternal and Child Health Directorate's governance group — general manager, DOM and patient quality and safety manager were also members of QualSEC. The Maternal and Child Health

Directorate's governance group disseminated relevant information and updates from QualSEC meetings to staff in University Maternity Hospital Limerick. QualSEC delegated some of its assigned function and responsibilities in the areas of infection prevention and control, medication safety, antimicrobial stewardship and the deteriorating patient to a number of subcommittees. Each of these subcommittee had a defined and formalised reporting arrangement to QualSEC on a quarterly basis. Each subcommittee reported on the quality and performance metrics for their respective function to QualSEC quarterly. Minutes from QualSEC meetings, reviewed by inspectors were comprehensive and showed the committee was action-orientated and had good oversight of the quality and safety of healthcare services provided at the hospital. At the time of inspection, the terms of reference and scope of QualSEC were being reviewed and revised to align with the new health region configuration.

The multidisciplinary Infection Prevention and Control Committee (HICCM) governed and oversaw the continual improvement of infection prevention and control (IPC) practices and hygiene standards at the hospital and other acute hospitals in HSE Mid West. Chaired by a clinical director, the committee comprised relevant membership who met quarterly. The committee functioned in line with its terms of reference. A number of subcommittees of HICCM were assigned with the responsibility for ensuring and providing assurances that University Maternity Hospital Limerick were compliant with best practice IPC standards and guidance. These subcommittees had defined and formalised reporting arrangements to HICCM. Minutes from HICCM meetings, reviewed by inspectors were comprehensive and showed that the committee had effective and robust oversight of the implementation of the HSE Mid West acute hospital's annual IPC programme. The IPC programme set out the specific IPC objectives and actions to be achieved in the hospital in 2025. They showed that the committee was action-orientated and focused on safe IPC practices and quality improvement. HICCM submitted a report with information on the hospital's and other acute hospitals in HSE Mid West compliances with national IPC targets, IPC surveillance, IPC monitoring and staff training to QualSEC quarterly. Information on IPC monitoring and surveillance, along with measures taken to promote IPC practices at the hospital was also reported on in the IPC annual report. At the time of inspection, the terms of reference and scope of HICCM were being reviewed and revised to align with the new health region configuration.

The University Maternity Hospital Limerick Hygiene Working Group was a local hospital based committee that governed and oversaw the hygiene practices and standards at the hospital. It provided the Maternal and Child Health Directorate governance group, the CEO for Mid West Acute and Older Persons Services and executive management team of the Mid West Acute Services with assurances about the hospital's compliance with relevant hygiene national targets, standards and best practice guidance. Minutes of the working group's meetings (dated May, July and

September 2025), reviewed by inspectors, showed that the group had oversight of the hygiene standards and practices at the hospital, but meetings were not held monthly as per the working group's terms of reference.

The multidisciplinary Drug and Therapeutics Committee (DTC) was the overarching committee that promoted and oversaw the safe and appropriate use of medications across all acute hospitals in HSE Mid West, including University Maternity Hospital Limerick. Chaired by the consultant lead for drugs and therapeutics, the committee comprised corporate and clinical representation from across all the acute hospitals in the health region who met monthly. The committee functioned in line with their terms of reference. The committee delegated some of its assigned function and responsibilities in the areas of medication safety, antimicrobial stewardship, formulary development, and prescribing and guidance development to a number of subcommittees. These subcommittees had defined and formalised reporting arrangements to the DTC. The DTC submitted a report with information on the hospital's and other acute hospitals in HSE Mid West compliances with best medicines practices and standards to QualSEC quarterly. Information detailing the measures taken to promote and support the safe use of medicines at the hospital was also included in the medication safety report published annually.

The implementation of the hospital's antimicrobial stewardship programme was governed and overseen by the multidisciplinary Antimicrobial Stewardship Committee, which was a subcommittee of the DTC. Membership of the committee comprised the chief pharmacist, antimicrobial pharmacist and a consultant in infectious diseases. Chaired by a consultant medical microbiologist, the committee met quarterly and functioned in line with its terms of reference. The Antimicrobial Stewardship Committee updated the DTC on the progress in implementing the antimicrobial stewardship programme and this information was also reported in the annual antimicrobial stewardship report.

The multidisciplinary HSE Mid West Acute Services Medication Safety Committee was the overarching committee assigned with responsibility for reducing preventable harm to patients from medicines and to promote best practice in medicines use across the acute hospitals in HSE Mid West. There was a local multidisciplinary Medication Safety Committee in place at University Maternity Hospital Limerick who reported to the HSE Mid West Acute Services Medication Safety Committee and the DTC. The hospital's Mediation Safety Committee and the medication safety officer assigned to University Maternity Hospital Limerick were responsible for progressing the implementation of HSE Mid West acute hospital's medication safety strategy. Chaired by a medical consultant, the hospital's Mediation Safety Committee was, as per its terms of reference, supposed to meet monthly. Minutes of committee meetings (dated February, May, and September 2025), reviewed by inspectors, showed that the

committee was action-orientated and had oversight of the medicines use and practices at the hospital, but committee meetings were not held monthly in line with the committee's terms of reference.

The University Maternity Hospital Limerick Deteriorating Obstetric Patient Committee (UMHL DOPC) governed and oversaw the delivery of care to obstetric patients experiencing clinical deterioration. Chaired by the hospital's clinical lead for sepsis and deteriorating patient, the committee met quarterly and functioned in line with its terms of reference. The committee provided the Maternal and Child Health Directorate's governance group and QualSEC with assurances about the hospital's compliance with national guidelines relation to the deteriorating patient, including compliance with guidance on sepsis management and the escalation protocols for the early warning systems — Irish National Early Warning System (INEWS) for women with gynaecological conditions, Irish Maternity Early Warning System (IMEWS) for pregnant and postnatal women.

University Maternity Hospital Limerick is the only maternity hospital in HSE Mid West so it was a not member of an established clinical maternity network as per the *National Maternity Strategy: Creating a Better Future Together 2016-2026*. Specialist obstetric, fetal-medicine and neonatal care was accessed when needed from Cork University Maternity Hospital, specialist maternity hospitals in Dublin (The National Maternity Hospital, The Coombe Hospital, Rotunda Hospital) and Children's Health Ireland. The arrangements seeking specialist care from clinicians in different health regions were not formally established, they were based on an informal medical consultant to medical consultant referral arrangement, but the inspectors were told these arrangements worked well.

In summary, the inspectors found that there were effective governance arrangements at the hospital to support the delivery of safe, high-quality healthcare services. There was a structured reporting framework that ensured each governance committee provided assurances about the quality and safety of services to the Maternal and Child Health Directorate's governance group and upwards to the CEO of Acute and Older Persons Services and REO. The corporate and clinical governance arrangements were well established and integrated with clearly defined reporting, responsibility and accountability arrangements. Performance and compliance with quality metrics was tracked. The hospital was not of a member of an established clinical maternity network. Specialist obstetric and neonatal care was obtained from maternity and children's hospitals in counties Cork and Dublin when needed. Formalising the arrangements for seeking specialist care from healthcare services outside the HSE Mid West health region will support a structured and standardised process of referral.

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.

The inspectors found the hospital had effective management arrangements in place to support the delivery of safe, high-quality and reliable healthcare services. It was evident that there were clear and defined lines of responsibility and accountability, devolved autonomy and decision-making to support the effective and efficient management of healthcare services at the hospital. The Maternal and Child Health Directorate governance group were responsive and reactive. They had good control and oversight of the operational processes that support the delivery of safe care.

Operational responsibility for implementing the hospital's IPC programme was assigned to the multidisciplinary IPC team. The IPC team, based in University Hospital Limerick, actively supported staff in University Maternity Hospital Limerick to implement best IPC practices and standards. The IPC team reported quarterly on the progress in implementing the IPC programme, information on IPC surveillance and IPC monitoring in University Maternity Hospital Limerick to the Maternal and Child Health Directorate's governance group, HICCM and QualSEC. This information was also reported in the annual IPC report.

The pharmacy service at the hospital was led by a chief pharmacist from the pharmacy department in University Hospital Limerick. The chief pharmacist provided leadership and oversight of maternity and neonatal pharmaceutical services at the hospital. This included leading on measures to support the medication management element of the electronic healthcare record. Medication safety and antimicrobial stewardship pharmacists from University Hospital Limerick supported safe medicines practices in University Maternity Hospital Limerick. Measures to support medication safety were set out in the medication safety strategy for the HSE Mid West acute hospitals. A medication safety officer was assigned to the hospital who, along with the pharmacist, was responsible for implementing the medication strategy. The medication safety officer updated on the progress in implementing the medication strategy to the hospital's medication safety committee, HSE Mid West Acute Services Medication Safety Committee, the DTC and QualSEC quarterly. This information was also reported in the annual medication safety report.

There was a focus on improving care for women and babies experiencing clinical deterioration. The national early warning systems for the various cohorts of women — IMEWS INEWS and the Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool were used by staff to monitor pregnant and postnatal women and to detect, escalate and manage clinical deterioration in a timely way. Hospital management had introduced a hospital specific

neonatal assessment track-and-trigger (NATT) tool to be used for babies on the postnatal wards who were deemed to be at risk of clinical deterioration. A modified version of the Birmingham Symptom-Specific Obstetric Triage System, was used in the Maternity Emergency Unit to standardise the maternity triage process and prioritise women for review to ensure they received timely and appropriate care. The UMHL DOPC and QualSEC oversaw the effectiveness of arrangements in place to recognise and efficiently manage the women and babies experiencing clinical deterioration.

Transitions of care incorporates internal transfers, shift and interdepartmental handovers, and the transfer and discharge of women and babies from the University Maternity Hospital Limerick. Internal transitions of care in the hospital included the transfer of women and or babies to and from the different care pathways as per the woman's risk categorisation (supported, assisted or specialist pathways), transfers to the delivery suite, postnatal wards and Neonatal Unit. External transitions of care included the transfer of pregnant and or postnatal women to a Model 4 hospital (University Hospital Limerick) for critical care services and babies to a tertiary referral (level 3) Neonatal Unit.*** The number of transfers from the hospital were reported monthly on the Irish Maternity Indicator System (IMIS) and in Maternity Safety Statements (MSS), as part of the HSE's reporting requirements.

In summary, there were defined, responsive and reactive management arrangements in place at the hospital to manage and support the delivery of high-quality, safe and reliable healthcare services.

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 arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services at the hospital were systematic and functioning. The hospital's electronic patient record system facilitated the collection and collation of clinical information. Information from the electronic patient record system and other sources was collected, collated and published in line with the HSE's reporting requirements — Maternity Safety Statements (MSS) and Irish Maternity Indicator System (IMIS). Performance data on clinical outcomes for women and babies was also submitted to the National Perinatal Epidemiology Centre (NPEC)

*** Level 3 Neonatal Units (tertiary units) provide the full spectrum of neonatal care to term and pre-term infants who are critically unwell.

and Vermont Oxford Network. This information provided assurances about the quality and safety of healthcare services provided at the hospital to the Maternal and Child Health Directorate's governance group and different governance committees. The hospital's performance data and compliance with quality metrics was presented at the monthly performance meetings with the CEO for the Acute and Older Persons Services. This information facilitated the comparison with other maternity services with similar acuity and complexity and informed the quality improvement prioritises and service development plans at the hospital. Documentation reviewed by the inspectors showed the hospital's performance data and clinical outcomes were comparable with other maternity services with similar acuity and complexity.

Actual and potential risks to patient safety were well managed. The hospital had an overarching risk management framework with formalised structures and processes to enable a structured, consistent and proactive approach to identify, analyse, manage and minimise risks to women and babies. The risks and the effectiveness of actions applied to manage the risks were reviewed regularly by the Maternal and Child Health Directorate's governance group. Serious risks were escalated appropriately to the Maternal and Child Health Directorate's governance group and documented on the directorate's risk register. There was evidence the directorate's risk register and mitigations was reviewed regularly by the Maternal and Child Health Directorate's governance group.

There was a comprehensive and structured approach to the auditing of clinical practice at the hospital. Clinical audits were planned to align with identified priorities and were agreed by the Maternal and Child Health Directorate's governance group. Clinical audit activity was coordinated at health region level by the Clinical Audit Committee who had a formalised reporting arrangement to QualSEC. Audit was a standard agenda item for meetings of a number of governance committees — HICCM, DTC, the hospital's Medication Safety Committee and UMHL DOPC. Quality improvement projects were aligned to the opportunities identified for improvement through the monitoring and evaluation of care and services at the hospital. The progress in implementing quality improvement plans and service improvements developed following clinical audit activities was tracked by the Maternal and Child Health Directorate's governance group.

There was a robust structure in place at the hospital that governed and oversaw the effective management of patient safety incidents, including serious reportable events (SREs) and notifiable incidents. Patient safety incidents were managed at directorate level. The Maternal and Child Health Directorate's serious incident management team (SIMT) oversaw the management of Category 1 and 2 patient safety incidents and the hospital's compliance with the HSE's National Incident Management Framework. The SIMT, chaired by the Maternal and Child health Directorate's clinical director, met

weekly or more frequently, if needed. The numbers and categories of patient-safety incidents were tracked and trended by risk advisors and the collated information was presented at monthly meetings of the Maternal and Child Health Directorate's governance group and quarterly meetings of QualSEC. A comprehensive incident management report detailing the hospital's compliance with incident management performance indicators was submitted to the Maternal and Child Health Directorate's governance group and QualSEC quarterly and annually. The implementation of recommendations and quality improvements arising from the review of patient safety incidents were actively tracked by the Maternal and Child Health Directorate's governance group and QualSEC.

There was a formalised process to monitor and act on feedback from women who received care at the hospital. Feedback on the maternity services, including the hospital's findings from the National Maternity Experience Survey and National Maternity Bereavement Survey was shared at meetings of the Maternal and Child Health Directorate's governance group and QualSEC. At the time of inspection, there was evidence that a number of quality improvement initiatives were being implemented to improve the delivery of healthcare services. The Maternal and Child Health Directorate's governance group and QualSEC tracked the progress in implementing the service improvements. Multidisciplinary perinatal mortality and morbidity meetings were held monthly. This meeting was a forum where the hospital's compliance with defined quality and safety indicators and clinical outcomes were reviewed, discussed and compared with maternity services with similar acuity and complexity.

Overall, the monitoring arrangements in place at the hospital to identify and act on opportunities to improve the quality, safety and reliability of healthcare services were systematic and functional. The systems and processes in place to identify, manage and minimise risks to women and babies using the healthcare services were robust. There were also robust arrangements in place to review and act on feedback from women and their families and improve healthcare services for women and babies.

Judgment: Compliant

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

The allocation of workforce for University Maternity Hospital Limerick was managed centrally by the HSE Mid West acute services. A business partner from the HSE Mid West acute services' human resource department was assigned to the hospital. This business partner supported the Maternal and Child Health Directorate's general

manager, business managers and wider governance group to manage and plan the workforce to achieve the service's objectives and deliver high-quality, safe and reliable health care. The business partner provided an update on workforce at monthly meetings of the Maternal and Child Health Directorate's governance group. Information on workforce was also included in the human resource report submitted to the CEO of Acute and Older Persons Services monthly. At the time of the inspection, the hospital had an approved complement of:

- Eighteen whole-time equivalent (WTE) consultant obstetricians and gynaecologists. Seventeen WTE (94%) consultant obstetricians and gynaecologists positions were filled and hospital management were actively recruiting to fill the remaining position, which was a new post.
- Seven WTE consultant neonatologists. All these positions were filled.

Anaesthesiologists were not recruited and employed directly to University Maternity Hospital Limerick. They were recruited and appointed to the HSE Mid West acute hospital's department of anaesthesiology. Anaesthesiology services to the hospital were provided from the composite acute hospital's schedule. The HSE Mid West acute hospital's department of anaesthesiology had an approved complement of 28 WTE consultant anaesthesiologists. At the time of inspection, 96% (27 WTE) consultant anaesthesiologist positions were filled. The inspectors were informed that all medical consultants were on the appropriate section of the specialist register with the Irish Medical Council.

Medical consultants in University Maternity hospital Limerick were supported by non-consultant hospital doctors (NCHDs) in the specialty of obstetrics and gynaecology, neonatology and anaesthesiology. The hospital had an approved complement of:

- Thirty-one WTE NCHD positions in obstetrics and gynaecology at intern, senior house officer (SHO) and registrar grades.
- Seven WTE NCHDs in gynaecology at registrar grades.
- Eighteen WTE NCHDs in neonatology at SHO and registrar grades.
- Forty-six WTE NCHD positions in anaesthesiology at SHO, registrar and other grades, providing an anaesthesiology services across the acute hospitals in HSE Mid West.

At time of inspection, 94% (29 WTE) NCHD positions in obstetrics were filled. All NCHD positions in gynaecology, neonatology and anaesthesiology were filled. Arrangements were in place to ensure consultant and NCHD medical cover 24/7, 365 days of the year for obstetrics, gynaecology, neonatology and anaesthesiology. A dedicated consultant obstetrician was assigned to the Delivery Suite and provided

clinical oversight of the care there 24/7, 365 days of the year. A consultant obstetrician and gynaecologist was rostered on call usually one in every seven nights. A consultant anaesthesiologist was rostered on site at the hospital during core working hours. Three consultant anaesthesiologists were rostered to cover the on call schedule (6pm to 8am) for the acute hospitals in HSE Mid West. Staff who spoke with inspectors reported prompt responses when women or babies needed medical review.

The hospital had an approved complement of 221.49 WTE midwives and nurses (inclusive of management and other grades). This complement was to be further increased by an additional 11.9 WTE positions allocated in late 2025 for new service developments. Eventually, when these new positions are filled, they will bring the hospital's total complement of midwives and nurses to 233.39 WTE. Midwifery and nursing staffing numbers at the hospital had changed following the application of the HSE's pay and numbers strategy in 2024. This strategy sets the hospital's staffing ceilings, recruitment targets and pay spend limits. Before the HSE's pay and numbers strategy was applied, the hospital's approved complement of midwives and nurses was 258.23 WTE. The application of the HSE's pay and numbers strategy resulted in a variance of 36.74 WTE (14%) when compared to the hospital's pre strategy approved complement of midwives and nurses.

During the inspection, 4% (8.31 WTE) of the 221.49 WTE positions in midwifery and nursing were unfilled. The midwife-to-birth ratio was 1:34, greater than the hospital's Birthrate Plus ratio of 1:29.5.[†††] The shortfall in midwives and nurses was most evident in the Delivery Suite (10% - 3.54 WTE) and the Neonatal Unit (13% - 5.19 WTE). This shortfall in midwives and nurses was further exacerbated by the hospital's high absenteeism rate (9.5%), which was double the HSE's target of less than or equal to 4%. Measures were in place to manage the absenteeism rate, including the conduct of return to work interviews, staff access to occupational health and access to employee assistance programmes.

Adequate staffing of the Delivery Suite was prioritised to ensure a one-to-one midwife to woman ratio during labour and birth. Midwives were redeployed to the Delivery Suite from other clinical areas, impacting midwifery and nursing staffing levels in those areas. To further support and ensure the safe delivery of care, the shift leader rostered on each shift in the clinical areas visited took a casehold when needed, they were not always supernumerary. Clinical midwifery managers (CMMs), clinical nurse managers (CNMs) and assistant directors of midwifery reviewed and oversaw staffing rosters daily. Staff redeployment, staff working additional hours or overtime and agency staffing was used to fill gaps in midwifery and or nurse staffing. Midwifery and

[†††] Birthrate plus" is an internationally recognised tool for calculating midwifery staffing levels, while a "midwife-to-birth ratio" is a metric used to measure and plan how many midwives are needed per birth. The tool helps determine how many midwives are required to care for the number of births the hospital expects by analysing activity data for each birth and converting it into a score.

nursing staff in the hospital were supported by healthcare assistants. During this inspection, 24.60 WTE (93%) of the 26.36 WTE healthcare assistant positions were filled.

Staffing and workforce was a documented high rated risk that was managed through the hospital's risk management process. The risk had been escalated to health region level. A range of mitigating actions were applied to manage the risk. This included the development of a three-year workforce strategy and implementation plan that planned and forecasted the workforce requirements needed to support the delivery of safe, sustainable healthcare services up to 2028. Other mitigating actions included ongoing recruitment campaigns (nationally and internationally) staff rotation and redeployment within University Maternity Hospital Limerick, and support for staff to undertake post graduate education. The effectiveness of these mitigating actions was tracked monthly by the Maternal and Child Health Directorate's governance group.

It was evident from staff training records reviewed by the inspectors that clinical staff had clearly defined mandatory training requirements. Staff undertook multidisciplinary team training appropriate to their scope of practice at a minimum every two years. Staff were required to complete mandatory and essential training in obstetric emergencies. Staff were also required to complete mandatory and essential training in infection prevention and control, medication safety and the early warning system on the HSE's online learning and training portal (HSELanD). Obstetric emergencies were practiced through live skills and drills (simulation training) which were held monthly in the Delivery Suite. Midwives rotated internally through the different clinical areas to maintain their competence and skills. Midwifery, nursing, medical and support staff who spoke with the inspectors confirmed they had received a formal corporate and clinical induction on commencement of employment at the hospital. Midwifery clinical skills facilitators provided induction training and supported midwives and nursing staff to maintain their clinical skills and competence. CMMs and the assistant directors of midwifery oversaw and tracked the uptake of training by midwives, nurses and healthcare assistants. The level of uptake of staff training was reported at meetings of the Maternal and Child Health Directorate governance group and QualSEC. Training records from M1, M3 and the Delivery Suite, reviewed by the inspectors showed that improvement was needed in the staff uptake of training in multidisciplinary obstetric emergencies, basic life support, neonatal resuscitation, early warning systems, fetal heart rate monitoring and cardiotocography interpretation, hand hygiene and sepsis management.

Hospital management proactively managed staffing (midwives and nurses) challenges on a day-to-day basis to ensure and support the delivery of high quality, safe and reliable healthcare. Activity and acuity levels across the hospital were tracked and

managed, with staff resources re-allocated as needed to areas of high activity and acuity. Notwithstanding this, during this inspection:

- there were midwifery and nursing staff shortfalls in the Delivery Suite and the Neonatal Unit
- the staff absenteeism rate was greater than the HSE's target
- a range of measures were applied to manage the risk arising from midwifery and nursing shortfalls, but some of these (staff working additional hours or overtime and agency staff) were not sustainable in the long-term
- CMMs and CNMs were not supernumerary
- mitigating actions applied to manage the risk to patient safety arising from midwifery and nursing staff shortfalls, had resulted in staffing challenges in other clinical areas
- improvement was required to ensure staff undertook essential and mandatory training, appropriate to their scope of practice at a minimum every two years.

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 healthcare services and if this care and support is safe, effective and person centred. University Maternity Hospital Limerick was found to be compliant with one national standard (1.8), substantially compliant with two standards (3.1 and 3.3), partially compliant with one national standard (1.6) and non-compliant with one standard (2.7) assessed. Key inspection findings leading to the judgment of compliance with these five national standards are described in the following sections.

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

Staff in the hospital were committed to promoting a person-centred approach to care and a culture of kindness, consideration and respect for women and families. Inspectors observed staff communicating in a pleasant, respectful, compassionate and kind way. Staff were observed actively engaging with and listening to women. Inspectors observed staff in the clinical areas being responsive and attentive to the

woman's individual needs and requests. Staff were also observed assisting with, supporting and advising on personal and baby care and infant feeding. Despite the staff's best attempts, the infrastructure and design of the Maternity Emergency Unit, M1 and M3 did not facilitate and enable the promotion of the woman's privacy, dignity and confidentiality. Privacy curtains were used when women were receiving care in multi-occupancy rooms. However, within the context of large rooms and a shared environment, privacy curtains did not support the effective promotion of confidentiality and privacy for individualised care and treatment. This was not in line with the human rights-based approach to care promoted by HIQA. Parents with babies in the Neonatal Unit described the facilities in the unit for parents as *"very, very, good"*. A number of person-centred, quality improvement measures, supported women to make decisions autonomously. These measures included the:

- availability of different care pathways aligned with those in the *National Maternity Strategy: Creating a Better Future Together 2016-2026*
- availability of water immersion used as a method of pain management during
- availability of birthing balls and peanut balls to support women's comfort during labour
- availability of mobile epidural used as a method of pain management for women during labour
- opportunity to use the Labour Hopscotch Framework – an active birth tool to guide women through labour
- opportunity to have Kangaroo care – a method of skin-to-skin contact for babies in the Neonatal Unit
- supports available to women and families experiencing pregnancy loss and bereavement.

Electronic healthcare records were introduced in the hospital earlier this year (July 2025), but at the time of inspection:

- some hard copy healthcare records were still in use. The inspectors found some of these records on trolleys in public areas that were easily accessible to clinicians and to others, including other women and visitors. This practice was
- not in line with general data protection and regulation legislation and was
- brought to the attention of the CMM during inspection for immediate remedy
- the infrastructure and design of the three clinical areas inspected did not support the effective promotion of confidentiality and privacy for women receiving care.

Judgment: Partially 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.

There were systems and processes in place at the hospital to respond to complaints and concerns received from women and their families. The process was formalised and underpinned by an up-to-date policy that aligned with the HSE's complaints management policy 'Your Service Your Say'. A business manager from the Maternal and Child Health Directorate was the hospital's designated complaints officer and the principal point of contact for women and or families who wanted to make a complaint or raise a concern about their care. The business manager was supported in their role by the Maternal and Child Health Directorate's patient quality and safety manager and the patient advocacy and liaison services (PALS) team based in University Hospital Limerick. Staff who spoke with inspectors were knowledgeable about the hospital's complaints management processes. Complaints were logged onto a healthcare management system. Point of contact complaint resolution occurred in line with national guidance. Verbal complaints were managed at local clinical area level by clinical midwife managers (CMMs) and the assistant directors of midwifery. Written complaints were managed by the Maternal and Child Health Directorate's business manager, with input from CMMs, assistant directors of midwifery, midwives, nurse and clinicians, as appropriate. Complaints were tracked and trended by the Maternal and Child Health Directorate's patient quality and safety manager and there was a standardised system in place to share information from this process with staff in the clinical areas.

Feedback, complaints and compliments from women who used the healthcare services was a standard agenda item at monthly meeting of the Maternal and Child Health Directorate governance group and quarterly meetings of QualSEC. All complaints were acknowledged within 5 days of receipt and at the time of inspection, the hospital was compliant with the HSE's target that 75% of complaints be investigated within 30 working days of being acknowledged by the complaints officer. The Maternal and Child Health Directorate's governance group tracked the implementation of recommendations and service improvements from complaints.

Overall, the inspection found evidence of an effective, coordinated process in place to respond to complaints and concerns raised by women who used the healthcare services and or their families. The hospital was compliant with the HSE's 30 day timeframe for investigation of complaints. Learnings from the complaints resolution process was shared with staff. Hospital management tracked the implementation of recommendations and service improvements from the complaints resolution process.

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.

With the exception of the Neonatal Unit, the current infrastructure and design of University Maternity Hospital Limerick was outdated and did not meet recommended specifications and international best practice standards for maternity services. The infrastructure presented many challenges and risks to patient safety. Hospital management had a comprehensive plan to improve the physical environment and infrastructure, which involved the commission and completion of a number of capital projects, which included a new Early Pregnancy Assessment Unit (EPAU). The Neonatal Unit had recently been refurbished to a high standard and specification. Infrastructure-related risks and corresponding mitigation actions were acknowledged risks documented on the Woman and Child Health Directorate's risk register.

The seven-bay Maternity Emergency Unit was located on the ground floor of the hospital and was clearly signposted. The unit comprised an ultrasound scanning room that doubled as the EPAU, Monday to Friday from 13.30pm to 5pm. The open plan nature of the Maternity Emergency Unit and location of the EPAU did not support the delivery of optimal care to women, especially those who had experienced a pregnancy loss. The Maternity Emergency Unit did not have a clearly defined inclusion and exclusion criteria that outlined the profile of pregnant and postnatal women to attend the unit for emergency and urgent care. During the inspection, women requiring emergency and urgent care and those requiring scheduled care were reviewed in the unit. A clearly defined inclusion and exclusion criteria will enhance patient safety by ensuring that only suitable pregnant and postnatal women attend the unit and receive appropriate emergency and urgent care. The Maternity Emergency Unit did not have a dedicated clinical room (clean utility room) where sterile supplies could be stored and or the sterile materials prepared. It did not have a dedicated designated room (dirty utility room) or area for the safe and hygienic processing of contaminated items. The absence of both rooms posed an infection risk and was not in keeping with best practice standards and guidelines.

M3 was the antenatal ward where pregnant women received care. It comprised 28 beds configured as multi-occupancy and single rooms. M1 was the postnatal ward where women and babies were cared for after birth. It comprised 27 beds configured as multi-occupancy and single rooms. Storage space was a challenge in the antenatal and postnatal wards visited. Patient equipment and supplies were stored on corridors, which posed a risk to patient safety.

The Delivery Suite had seven delivery rooms and one special observation bay that was equipped for women who required close monitoring and observation during

pregnancy or after birth. One of the delivery rooms had a birthing pool to support women with low risk pregnancies who wanted to use immersion in water as a method of pain management in labour. This room had an ensuite toilet and shower. The remaining delivery rooms did not have ensuite toilet or shower facilities. Storage space was a challenge in the Delivery Suite, consequently patient equipment and supplies were stored on the corridors, this was a risk to patient safety.

The Operating Theatre Department comprised two operating theatres located on the same floor as and adjacent to the Delivery Suite. Access to the operating theatre was through the Delivery Suite, which was ideal and supported the timely intervention when needed during an emergency. However, having to pass through Delivery Suite to get to an operating theatre could potentially intensify the distress felt by women experiencing a pregnancy loss who may need surgery.

The Neonatal Unit was a self-contained spacious, newly refurbished unit to a high specification with 19 cots, which comprised four intensive care cots, five high dependency cots and 10 special care baby cots. The unit had isolation facilities. During the inspection, the unit was in escalation and the surge capacity (additional seven cots) was accommodated well.

There was no laboratory onsite at the hospital to process blood samples or to provide blood products for women and babies who may require them. All samples that required laboratory testing were sent to the laboratories at University Hospital Limerick. The lack of laboratory services onsite was an acknowledged risk documented on the Maternal and Child Health Directorate's risk register. Measures were applied to manage the risk and to ensure rapid access to blood and blood products for women and infants when needed. The hospital:

- maintained a supply of four units of Type O negative blood on site for emergency use at all times
- maintained a supply of fibrinogen on site for the management of obstetric haemorrhage at all times
- had an automated haemobank blood bank system on site that could store and dispense units of blood
- had a haemovigilance officer on site who is responsible for monitoring the safety of blood and blood products
- had a direct, dedicated emergency phone line to the haematology laboratory in University Hospital Limerick
- had arrangements in place to transfer women at higher risk of bleeding to University Hospital Limerick for delivery of the baby.

The physical space in the clinical areas visited, especially the larger multi-occupancy

rooms was constrained, which made it difficult to maintain adequate physical spacing between beds and posed an infection risk.

The physical environment in the clinical areas visited was clean and well maintained. There were a few exceptions, for example, the bathroom facilities in M3, which were brought to the attention of the clinical midwife manager (CMM) and remedied during the inspection. General wear and tear observed on woodwork and floor surfaces did not facilitate effective cleaning and posed an infection risk. CMMs who spoke with inspectors were satisfied with the level of cleaning resources available during core and outside core working hours. CMMs and household supervisors had oversight of the standard of cleaning and cleaning schedules for their respective clinical areas. The cleaning of patient equipment was assigned to healthcare assistants and midwives with oversight by the CMM. There was no formal system in place to clearly identify patient equipment that was clean and ready for use. The inspectors found it difficult to distinguish between cleaned equipment and equipment to be cleaned. There was inadequate storage space in all the clinical areas visited. Patient equipment and supplies were stored on public corridors, which was inappropriate and posed a risk to patient safety. The inspectors observed hazardous material and waste stored safely and securely, and linen segregated appropriately.

Environmental, patient equipment and hand hygiene standards were audited monthly by the household supervisor, CMMs, midwives and nurses and or the IPC team using a standardised approach. Environmental, patient equipment and hand hygiene audits carried out in the months preceding the inspection showed a variance in compliance rates with best hygiene practices and standards. Environmental hygiene standards in the clinical areas visited ranged from 63% (Maternity Emergency Unit) to 98% (Delivery Suite). Patient equipment hygiene standards in the clinical areas visited ranged from 64% (Maternity Emergency Unit) to 100% (Neonatal Unit).

Improvements were needed to bring the hospital into compliance with the HSE's hand hygiene audit target of 90%. Audit findings of hand hygiene practices and standards in the clinical areas visited ranged from 80% (M3) to 93% (Maternity Emergency Unit). The hospital's overall hand hygiene compliance rate was 65% in August 2025. Time bound quality improvement plans were not always developed to improve compliance with best environmental, patient equipment and hand hygiene practices and standards.

Signage on hand hygiene and transmission-based precautions was displayed in all clinical areas visited. Wall-mounted alcohol-based hand sanitiser dispensers and personal protective equipment were readily available for staff and visitors use. Hand hygiene sinks in the clinical areas visited did not all conform to the specified standards

and requirements, which compromised hand hygiene practices and increased the risk of infection. A hand hygiene sink replacement project was ongoing at the time of inspection. Women and or babies requiring transmission-based precautions were placed in single rooms, when available. Their placement was prioritised and managed with advice and support from the IPC team to ensure alignment with national guidance. If there were no single rooms available, women and or babies requiring transmission-based precautions, were placed together in multi-occupancy rooms in line with national guidance. Multi-occupancy rooms did not support the delivery of optimal infection prevention and control practices.

Emergency equipment and supplies including relevant medications to manage obstetric and neonatal emergencies were readily available and accessible. Emergency equipment was checked and serviced regularly in line with hospital policy. The postnatal ward (M1) did not have neonatal resusciataires. This was acknowledged and documented as a risk on the Maternal and Child Health Directorate's risk register. Staff who spoke with the inspectors knew and described the mitigating action applied to support the timely resuscitation of a baby in M1 when needed. A baby requiring support and resuscitation were taken to the Delivery Suite, the operating theatre or Neonatal Unit where neonatal resusciataires and appropriately skilled staff were available to intervene. Piped oxygen was not available in all clinical areas. The risk to patient safety was managed by the provision of portable oxygen cylinders. Full portable oxygen cylinders that were checked regularly were observed by the inspectors in the clinical areas visited during the inspection.

Finally, it is noted that it is government policy to co-locate the maternity services with University Hospital Limerick but, at the time of inspection, there was no definitive timeframe or plan for the relocation. HIQA's recently published independent review of urgent and emergency healthcare services in HSE Mid West presented the Minister of Health with three options to increase inpatient bed capacity across the health region. The relocation of maternity services was included in these options. The age and current footprint of the hospital's physical environment presented many challenges that did not support the delivery of high-quality, safe healthcare services. Specific issues identified during this inspection included:

- with the exception of the Neonatal Unit, the physical environment did not meet relevant legislative requirements or best practice guidelines
- there was no process to clearly identify clean patient equipment
- lack of storage space led to inappropriate placement of supplies and equipment
- many hand hygiene sinks did not conform to specific standards and requirements
- neonatal resusciataires was not available in all postnatal wards
- piped oxygen was not available in all clinical areas

- time bound quality improvement plans were not always developed to support improvement in compliance with best hygiene practices and standards.

Judgment: Non Compliant

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

There were arrangements in place at the hospital to proactively identify, analyse, evaluate and manage immediate and potential risks to women and babies. The Maternal and Child Health Directorate's governance group managed the risks documented on the directorate's risk register. A risk and patient safety advisor supported the directorate's governance group to manage the risks in line with the HSE's integrated risk management policy. Risks identified in the clinical areas were documented on local risk registers. The clinical midwife managers (CMMs), clinical nurse managers (CNMs) and assistant directors of midwifery identified the mitigating actions applied to manage any potential and actual risks to patient safety. CMMs and CNMs oversaw the implementation of the mitigating actions and monitored the effectiveness of these actions in reducing the risk to patient safety. More serious risks were escalated to the Maternal and Child Health Directorate's governance group and serious incident management team (SIMT), and were documented on the directorate's risk register where appropriate. High-rated risks that could not be managed at hospital level were escalated to the CEO of Acute and Older Person's Services. The Maternal and Child Health Directorate's and clinical area's risk registers reviewed by inspectors were up to date, mitigating actions were applied and named persons were assigned to implement and monitor the effectiveness of the actions. At the time of inspection, 29 risks and mitigating actions related to infection prevention and control, medication safety, the deteriorating patient and transition of care were documented on the directorate's risk register. Documented risks included risks related to the hospital's infrastructure and physical environment, healthcare-associated infections, medication safety, capacity and workforce.

There was a comprehensive approach to clinical audit at the hospital. The Maternal and Child Health Directorate's governance group defined and approved clinical audits to be carried out at the hospital. There was some evidence that action plans were developed to address non-compliances, to support quality improvement and service developments, but the practice was not consistent across all clinical areas. When this was discussed with hospital management, the inspectors were told that the implementation of the electronic healthcare record had been resource intensive.

Resources were diverted to support the implementation of the electronic healthcare

record, but this had impacted on other operational functions, such as clinical audit activity. The Maternal and Child Health Directorate's governance group and QualSEC tracked the progress in implementing action plans to improve healthcare services. Learnings from audit activity and service improvements were shared with staff in clinical areas via staff meetings, huddles and other mechanisms such as communication books and learning memos (Big 4). Audit findings were also discussed at monthly clinical midwifery senior management meetings and Maternal and Child Health Directorate's governance group meetings.

Women attending the hospital were routinely screened at their first antenatal appointment (booking appointment) for multi-drug resistant organisms (MDROs) and immunity to childhood illnesses in line with good practice standards. This included screening for *Methicillin-Resistant Staphylococcus aureus* (MRSA), *Carbapenemase-Producing Enterobacterales* (CPE) *Group B Streptococcus* (GBS) and *Vancomycin-Resistant Enterococcus* (VRE) infection. Babies admitted to the Neonatal Unit were also routinely screened for a variety of organisms, including *Extended spectrum beta lactamase (ESBL) -producing Enterobacterales,* MRSA and CPE. Relevant alerts were flagged on the electronic healthcare record and patient information administration system. Compliance with MRSA, CPE and GBS screening was audited by the IPC team. Compliance with CPE screening for women admitted to the hospital required improvement, as the hospital was 66% compliant with CPE screening for these women in August 2025. Clinical staff had access to microbiologist expertise 24/7, 365 days of the year.

A full clinical pharmacy service was provided to the Neonatal Unit. Clinical pharmacy services in other clinical areas was prioritised for women and babies categorised as high priority, women with complex medical needs, women on multiple medications and those on high-alert medications. Medication reconciliation was carried out by the pharmacist and non-consultant hospital doctors (NCHDs) on admission and discharge for women categorised with a high risk pregnancy. There were formalised arrangements in place to ensure medicines were available outside core working hours. Pharmacy technicians carried out medication stock control in all clinical areas visited. Staff were observed using risk-reduction strategies to support the safe use of high-risk medicines. The hospital had a list of high-risk medications tailored to the maternity service and a list of sound-alike look-alike drugs (SALADs). The hospital's medication formulary, prescribing guidelines, antimicrobial guidelines and medication information were readily available and accessible to staff electronically at the point of care. Clinical staff also accessed medicines information and guidance on an application for smartphones, this further supported safe medication practices.

Structures were in place to support a prompt response when a woman and or baby's

clinical condition deteriorated. Staff in the clinical areas visited were knowledgeable about the early warning system's escalation process, the Sepsis 6 care bundle and policies, procedures, procedures and guidelines (PPPGs) related to obstetric emergencies. Rapid response teams for obstetric, maternal, and neonatal emergencies were in place. Staff confirmed that the ISBAR$_3$ communication tool was used when requesting medical review for a woman with a triggered early warning system. The early warning system and ISBAR$_3$ communication tool were integrated in the electronic healthcare record. Compliance with the early warning system's escalation process, medication safety, fetal heart monitoring guidelines, obstetric emergencies and neonatal resuscitation related PPPGs was audited regularly, with good levels of compliance found in the months preceding the inspection. Findings from audit activity and compliance with nursing and midwifery quality care-metrics were shared with staff in the clinical areas via multidisciplinary huddles, staff meetings, learning memos, quality and safety walkarounds.

There was access to designated obstetric operating theatres 24/7, 365 days of the year and there was an agreed process to access and staff an operating theatre for emergency surgery during and outside core working hours. Women requiring a higher level of observation and care were transferred to the observation bay in the Delivery Suite. The hospital did not have a Level 3 Intensive Care Unit onsite. Critically ill pregnant and or postnatal women requiring intensive care facilities were transferred by the National Ambulance Service, using Protocol 37 to University Hospital Limerick. This arrangement was formalised and underpinned by an inter-hospital transfer policy. The National Ambulance Service or national neonatal transport programme team transferred babies when needed.

Arrangements were in place to support the safe and effective transfer of women and babies within and from the hospital. A formalised policy supported the transfer process. The operational assistant director of midwifery coordinated the safe transition of care for pregnant or postnatal women. The designated discharge coordinator and operational assistant director of midwifery coordinated the safe transition of care for babies transferred from the Neonatal Unit. Clinical staff had 24-hour access to clinical advice from consultants in other specialties including cardiology, endocrinology, haematology, specialist vascular surgeons and mental health services. The inspectors saw evidence of formalised and well-established clinical pathways for referring pregnant and postnatal women with complex needs who require specialist medical review and care to University Hospital Limerick. When required, women were referred to medical and surgical specialists based in Cork University Maternity Hospital and or specialist maternity hospitals in Dublin. Babies who may require specialist medical or surgical care were referred to Children Health Ireland. Anomaly scanning was offered to all eligible women at 20-22 weeks'

gestation.

Day-to-day operational issues and measures to mitigate the impact of any potential harm to women and babies were discussed at the multidisciplinary safety huddles. Multidisciplinary safety huddles were held in the Delivery Suite multiple times a day with representation from all clinical areas — antenatal areas, postnatal areas, Neonatal Unit, the operating theatre department, the Maternity Emergency Unit and input from senior executive and clinical managers.

The delivery of high-quality, safe care was underpinned by a range of national and service specific policies, procedures, protocols and guidelines (PPPGs). Staff could access a range of PPPGs on standard and transmission-based precautions, infection outbreak management, obstetric and neonatal emergencies. Staff could also access a range of medication PPPGs and National Clinical Effectiveness Committee (NCEC) based guidelines, including sepsis management, clinical handover, IMEWS and INEWS. The majority of PPPGs reviewed by inspectors were up-to-date. PPPGs relating to medication management at ward level and guidance in relation to after action reviews were not updated in line with the HSE's recommended three year review and update of PPPGs. Staff could access the PPPGs via a computerised document management system.

In summary, there were effective systems in place to identify, manage and protect women and babies receiving care in the hospital from risk of harm. However,

- some PPPGs needed to be reviewed and updated, if needed in line with the recommended three year timeline
- a full clinical pharmacy service was not provided to all clinical areas, but was provided in areas where there was a perceived high risk such as the Neonatal Unit, ensuring there was targeted and efficient use of pharmacy staff and resources.

Judgment: Substantially Compliant

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

There was an effective system in place at the hospital to identify, report, manage and respond to patient-safety incidents and this was in line with national guidance. Patient safety incidents and serious reportable events (SREs) that occurred at the hospital were uploaded to a local document management system, they were then reviewed by

the Health and Child Health Directorate's patient quality and safety manager and

appropriate incidents were reported to the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework. The electronic point of entry function of the National Incident Management System was not available at the time of inspection. The number of clinical incidents were also reported to the HSE as part requirement of the monthly reporting arrangements for the Maternity Safety Statement. The Maternal and Child Health Directorate's serious incident management team (SIMT) oversaw the management of Category 1 and 2 patient safety incidents.

Staff who spoke with the inspectors were knowledgeable about the types of patient safety incidents and SREs to be reported, how to report them and how to manage different types of patient safety incidents. Relevant patient safety incidents were discussed at perinatal morbidity and mortality meetings. Staff confirmed that debriefing and after action reviews were carried out to identify learnings and service improvements after serious patient safety incidents and obstetric emergencies.

Patient-safety incidents were tracked and trended by the risk, quality and patient safety department. The IPC team reviewed all IPC related patient-safety incidents and proposed corrective actions were needed. Medication patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. A report with details on the number and type of medication related patient-safety incidents was compiled monthly by the medication safety officer and submitted to the hospital's Medication Safety Committee, the HSE Acute Services' Medication Safety Committee and DTC. Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not tracked or trended at the hospital. The hospital was compliant with the HSE's target of 3.0 medication incidents as reported to NIMS per 1,000 bed days used.

Collated information on the number, type, location and categories of patient safety incidents and SREs reported at the hospital was presented at the weekly meetings of the Maternal and Child Health Directorate's SIMT, the monthly meetings of the directorate's governance group and quarterly meetings of QualSEC. There was structured processes in place to ensure the learning from patient safety incidents was shared with staff in the clinical areas. Information relating to and feedback about patient safety incidents and SREs were shared by clinical midwife managers (CMMs) and clinical nurse managers (CNMs) at clinical handover and at multidisciplinary safety huddles. Quality improvement plans were developed to ensure service improvements occurred and practice changes were implemented following a patient safety incidents.

The Maternal and Child Health Directorate's governance group and QualSEC tracked and oversaw the implementation of recommendations and service improvements from reviews of patient-safety incidents and SREs. Updates on the progress of

implementation of the recommendations and service improvements were included in the Maternal and Child Health Directorate's quarterly report to QualSEC. The hospital was not compliant with the HSE's target that 70% of external reviews commissioned following category 1 SREs be completed within the 125 days from the date the service was notified of the incident. This impacted on the timeliness of the open disclosure process, on the learnings from patient safety incidents and on the implementation of service improvements.

Overall, the inspection found evidence of a robust system to manage patient safety incidents. Learnings from patient-safety reviews was shared with staff and the implementation of any recommendations and service improvements was tracked. The hospital was not compliant with the HSE's target that 70% of commissioned external reviews for category 1 SREs be completed within 125 days.

Judgment: Substantially Compliant

Conclusion

The two-day announced inspection of University Maternity Hospital Limerick was carried out to assess compliance with the *National Standards for Safer Better Healthcare*. The hospital was judged to be compliant with three national standards (5.5, 5.8 and 1.8), substantially compliant with three nationals standards (5.2, 3.1 and 3.3), partially complaint with two national standards (1.6 and 6.1) and non-compliant with one national standard (2.7) assessed.

Capacity and Capability Dimension

There was good compliance with the three national standards assessed in the governance, leadership and management theme. The hospital was partially compliant with the national standard assessed in the workforce theme. There were well established, formalised governance arrangements in place at the hospital and regional health levels to ensure and assure the delivery of high-quality, safe and reliable healthcare. Healthcare services at the hospital were managed by the Maternal and Child Health Directorate's governance group. This group had good operational grip and oversight of the quality and safety of healthcare services provided at the hospital. Several governance committees provided the directorate's governance group with assurances about the quality and safety of the healthcare services. The hospital was the only maternity hospital in HSE Mid West, therefore it was not a member of an established clinical maternity network. Specialist obstetric, fetal-medicine and neonatal care was obtained from outside the HSE Mid West health region, from maternity and children's hospitals in counties Cork and Dublin. The referral process

seeking specialist care from other hospitals outside the HSE Mid West health region was informal. The monitoring arrangements to identify risks and act on opportunities to improve the quality, safety and reliability of healthcare services were systematic, robust and effective.

The hospital had its full complement of approved medical consultants and non-consultant hospital doctors, but the midwifery and nursing staff shortfalls in the Delivery Suite and the Neonatal Unit did present a risk to patient safety. The shortfall in midwifery and nursing staff was compounded by a high staff absenteeism rate. Hospital management proactively managed the staffing challenges on a day-to-day basis to ensure the safe delivery of care. Staff resources were re-allocated when needed to areas of high activity and acuity. A range of measures were applied to mitigate the risk arising from the midwifery and nursing staff shortfalls but some of these measures (staff redeployment, staff working additional hours or overtime and agency staffing) were not sustainable in the long-term. Staff uptake of essential and mandatory training required improvement. A continued focus on workforce planning and compliance with staff uptake of essential and mandatory training is needed to ensure the workforce can be can planned, organised and managed to deliver high-quality healthcare.

Quality and Safety Dimension

There was good compliance with the national standard related to the management of complaints and concerns. There was also good compliance with the two national standards assessed in the safe care and support theme related to risk management and the management of patient safety incidents. Care was delivered in a kind, respectful and compassionate way. The hospital's Neonatal Unit was newly refurbished to a very high standard and specification. The new, refurbished unit supported the delivery of safe, high-quality care to babies. Hospital management demonstrated a proactive approach to managing the infrastructural risks arising from the age, current footprint and physical design of the hospital, but limitations in the physical environment continued to impact on the delivery of high-quality, safe healthcare services. Despite the staff's best attempts, the infrastructure and hospital design did not facilitate or enable the promotion of a woman's privacy, dignity and confidentiality. This was not in line with a human rights-based approach to care promoted by HIQA.

There were effective systems in place to protect women and babies receiving care in the hospital from the risk of harm, but the evidence and guidance informing the delivery of safe, high-quality care should be up to date. There was a robust system at the hospital to identify, report and manage patient safety incidents. There was also structured processes to ensure the learning from patient safety incidents was shared with staff in the clinical areas. The hospital was not compliant with the HSE's target

that 70% of the external reviews commissioned following SREs be completed within the 125 days.

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 was 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.	Partially 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 quality, safe, reliable care and protects the health and welfare of service users.	Non Compliant

Dimension: Quality and Safety	
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.	Substantially Compliant

Compliance Plan for University Maternity Hospital Limerick

Inspection ID: NS_0167

Date of inspection: 22 and 23 October 2025

Introduction

This document sets out a compliance plan for healthcare service providers to outline action(s) completed or intended to be completed following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare* Version 2 (2024).

Any substantially compliant judgments indicate that some action is required to bring the service into full compliance. These actions should be addressed locally and do not form part of this compliance plan.

This compliance plan only relates to:

- national standards that were deemed **partially compliant or non-compliant** by HIQA.

The compliance plan should be completed and authorised by a representative of the service provider with responsibility to act on behalf of the service, for example the service's Chief Executive Officer, Chief Officer, or other relevant designated manager.

It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the national standards.

Instructions for use

The healthcare service provider must complete this plan by:

- outlining how the service is going to come into compliance with the relevant national standard(s)
- outlining timescales to achieve compliance.

The provider's compliance plan should be SMART in nature:

- **Specific** to the non-compliance identified with the national standard(s).
- **Measurable** so that progress towards compliance can be monitored.
- **Achievable.**

- **Relevant.**
- **Time bound** – The proposed actions outlined in the compliance plan should be accompanied by clear delivery dates and key milestones (where appropriate).

Healthcare Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems that they have, or will put, in place to ensure compliance with a particular national standard, under which a partially compliant or non-compliant judgment has been made.
- Service providers should change their systems as necessary to bring them into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the national standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent actions and plans for improvement related to urgent risks already identified by HIQA during the inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Continued non-compliance

Continued non-compliance with the national standards resulting from a failure by a service provider to put in place appropriate action(s) to address the areas of risk previously identified by HIQA may result in increased monitoring activity including further inspection activity, seeking compliance plans and assurance reports from the provider. It may also result in further escalation to the relevant accountable person(s) in line with HIQA's policy.

Long-term and medium-term work to meet compliance with the standards

HIQA recognises that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium- and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the

service provider plans to improve the level of compliance with the relevant national standard.

HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on medium and long-term mitigation measures to manage risks and improve the level of compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance plan provider's response:

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

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

Absenteeism

To continue with monthly on-site workshop to support line managers and staff with return-to-work plans.

To ensure that Performance achievement has commenced for all staff in each department level by the 1st of March 2026

To continue with the referral of staff to EAP & the Occupational Health Department as required.

Monthly HR reports are being provided to line managers.

HR has completed an audit of line manager awareness of the absenteeism management policy on 12th December 2025.

DOM to engage with Health and Well-being department to consider programmes to support staff well-being within Nursing & Midwifery by February end 2026.

HR to complete audits on the managers compliance with absenteeism documentation and supports.

To complete the recruitment campaigns for the various departments by March end 2026.

Staff vacancies

To complete the Midwifery Recruitment campaign which has closed. Interviews to be arranged in early January 2026

HR to complete the recruitment process for the neonatal vacancies. Interviews completed panel in place. March end 2026

Student midwife interns will be on placement since the 29th of December 2025

To continue with the practice of daily monitoring of rosters with the redeployment of staff to the areas of greatest need.

To continue with the use of agency staff which equates to 6 WTE per week until vacancies are filled.

Staff training

Actions completed

CTG training is delivered on an ongoing basis with monthly monitoring, and a 100% compliance is achieved each year by December end 2025 (Has been the case for the last number of years)

Within the neonatal department - Neonatal resuscitation training is 100% compliant.

PROMPT (Practical Obstetric Multi Professional Training) which includes all obstetric emergencies and was held in November 2025. Going forward, this will be held on a quarterly basis in 2026.

Maternal collapse drill was held in November 2025

CTG & K2 training – 100% compliant by December end 2025

Additional actions

M1, M3 & labour ward to be 100% compliant in sepsis training by the 1st of March 2026

To roll out BLS training in January 2026. January 2026

To introduce the new national sepsis form with the necessary training by February end 2026

To raise awareness amongst the maternity site staff of the HIQA findings in relation to mothers' concerns regarding the difficulty of private conversations in multi occupancy rooms. Two rooms are available for sensitive conversations/ breaking bad news. January end 2026

Timescale:

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

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

Short-term actions:

All hardcopy health care records were removed from the patient bedside during the inspection.

Medical records are only being used for read-only purposes and not for documentation and are available in a secure trolley at the nurse's station.

To relocate the EPAU service from the MEU to a refurbished unit by the end of June 2026

Long-term actions

To divide the service provision within the MEU for this aged <16 and over 16 with the renovation of the MEU into two single rooms. September end 2027

New Maternity Hospital build has been included as part of the wider capacity provision and infrastructural developments, announced by the Minister for Health

Timescale:

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.	Non Compliant

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

Update

Current hand hygiene compliance stands at 93% (please refer to feedback document)

Education by the hygiene service supervisor has been completed. The identification process for clean patient equipment is in place (I am clean sticker in use)

M3 room (previously an inpatient space) Rm 25 is currently being converted into a non-clinical storage area.

Actions

Audit of compliance with the tagging of clean equipment to be completed January end 2026

Review of the clinical wash hand basins to be undertaken by January end 2026

To complete clinical wash hand basin replacement programme by December end 2026 To secure Neonatal resuscitaires for the various wards by December end 2026 Piped oxygen for the clinical areas- design &costings being progressed. To complete by the end of June 2026.
Timescale:

Service Provider Use	
Service Provider Univerity Maternity Hospital Limerick	
CEO/ General Manager/ Master, Designated Manager Signature	
Date	06.01.2026

HIQA Official Use	
Date Reviewed	19.01.2026
Authorised Person(s)	**Denise Lawler**
Signature