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:	Cavan Monaghan Hospital
Centre ID:	OSV-0001020
Address of healthcare service:	Lisdarn Cavan Co Cavan H12 N889
Type of Inspection:	Unannounced
Date of Inspection:	04/02/2026 and 05/02/2026
Inspection ID:	NS_0184

About the healthcare service

Model of hospital and profile

Cavan Monaghan Hospital is a model 3* public, acute hospital comprising both Cavan General Hospital and Monaghan Hospital sites. This hospital is in the HSE Dublin and North East (DNE) health region. Services provided by the hospital include:

- acute medical in-patient services
- surgical
- emergency care
- obstetrics
- gynaecology
- paediatric
- diagnostic services
- inpatient stepdown
- rehabilitation care
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	242 inpatient beds 51 day case beds 59 inpatient beds at Monaghan Hospital site 20 day case beds

How we inspect

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

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

During the inspection, inspectors:

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

About the inspection report

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

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

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
04/02/2025	*13:00 – 17:20*	Emma Cooke	Aedeen Burns Lorenza Cafolla Jennifer Smyth
05/02/2026	*09:00 – 17:00*	Emma Cooke	Aedeen Burns Lorenza Cafolla Jennifer Smyth

Information about this inspection

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

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

The inspection team visited four clinical areas:

- Emergency Department (ED)
- Meadows Ward (rehabilitation, Monaghan Hospital)
- Medical Ward 2
- Paediatric ward

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

Acknowledgements

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

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

Over the course of the two-day inspection, inspectors spoke with patients and their families who expressed their views on their experience of care received in the hospital. Patients were complimentary about the staff reporting that 'staff are lovely'

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

and 'very nice'. However, others reported that staff are 'very busy' and that there is 'not enough staff.'

Some family members who spoke with inspectors were aware of how to make a complaint while patients said they would speak with staff if they wanted to make a complaint. Staff were observed interacting with patients in kind and respectful manner and checking for consent before proceeding with assistance

Inspectors observed that the paediatric ward was designed in a way that was child friendly with access to age appropriate activities for children.

Capacity and Capability Dimension

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

Cavan and Monaghan Hospital was found to be substantially compliant with three national standard 5.5, 5.8 and 6.1 assessed. Key inspection findings leading to these judgements on compliance are described in the following sections.

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

Effective management arrangements were in place to support the delivery of safe, high-quality and reliable care. Hospital management had monthly Health Service Executive (HSE) Performance meetings with the HSE Dublin North East Integrated Healthcare Area (IHA). Management had established oversight arrangements, including relevant committees, to support the achievement of organisational objectives and to provide assurance in relation to key areas of focus reviewed during this inspection; medication safety, the management of the deteriorating patient, and transitions of care. The hospital had clinical governance committees in place for each directorate to support oversight and governance structures.

Medication safety

The hospital's pharmacy service was led by the pharmacy executive manager. The Drugs and Therapeutics Committee (DTC) was the overarching committee overseeing the quality and safety of pharmacy services and supported medication safety practices in Cavan and Monaghan hospital. The DTC was chaired by a consultant, met at intervals of four to eight weeks in accordance with its terms of reference, and included appropriate multidisciplinary representation. The DTC functioned as a subcommittee of the Quality and Safety Executive Committee (QSEC) and had defined and formalised reporting arrangements to that committee. A number of subcommittees report to the DTC including:

- Medication Safety Committee
- Nurse/Midwife Prescribing Committee
- Thrombosis Committee
- Total Parental Nutrition (TPN) Committee
- Antimicrobial Stewardship Team.

A Medication Safety Strategic Plan was developed by the Medication Safety Committee and approved by the DTC, setting out 12 objectives for 2025. Inspectors reviewed the 2025 Medication Safety Strategic Plan and noted a number of actions had been completed. Inspectors were also informed that outstanding actions would be carried forward to 2026 for completion.

The hospital's antimicrobial stewardship (AMS) team, comprised by 1.5 whole time equivalent (WTE) consultant microbiologists, two antimicrobial pharmacists, an outpatient parenteral antimicrobial therapy (OPAT) clinical nurse specialist, and two surveillance scientists. Meeting minutes reviewed by inspectors demonstrated that the AMS team reported to the Drugs and Therapeutics Committee (DTC) meetings and, more recently, to the Infection Prevention and Control Committee meetings.

Deteriorating patient

The hospital had implemented a Deteriorating Patient Improvement Programme under the leadership of a medical consultant. This programme was to ensure a systematic approach to the recognition, response and management of the deteriorating patient. Governance was provided through the Deteriorating Patient Committee (DPC), chaired by the director of nursing. The DPC met monthly in line with its terms of reference. Membership was multidisciplinary. Several subcommittees reporting into the DPC, included:

- Deteriorating Patient (EWS) Working Group
- Resuscitation

- Sepsis Committee
- End of Life Committee
- Transitions of Care
- Mortality and Morbidity meetings.

A defined and formalised reporting arrangements were in place, with the DPC reporting quarterly to the QSEC meeting. A review of minutes of meetings confirmed attendance by representatives from all subcommittees. Key agenda items included; policy procedures and guidelines, audit results, metric results, incidents, mandatory training status reports, and updates from each subcommittee relating to the deteriorating patient.

Transitions of care

The Transitions of Care Committee (TOCC) had oversight of patient flow across the acute setting, including admissions, transfers between departments, and discharges to secondary and tertiary care sites. The TOCC chaired by the director of operations, met every six to eight weeks in line with its terms of reference. Membership was multidisciplinary and had two subcommittees reporting into the TOCC:

- Unscheduled Care Committee
- SAFER discharge committee[††].

The TOCC had formalised reporting arrangements to the QSEC meetings and had established direct links with the DPC meetings. Key agenda items included; development of a patient information booklet, unscheduled transitions of care, emergency department triage times, key performance indicators, quality improvement plans, ICU transfers, discharge summaries, clinical handover, incident analysis, policies procedures protocols and guidelines, and training all related to transitions of care. The TOCC had four objectives and quality improvement plans (QIPs) for 2025/26 were reviewed by inspectors.

Emergency Department

[††] SAFER is an initiative designed to improve patient flow, reduce unnecessary hospital stays, and ensure safer, timely discharges (**S**- Senior Review, **A** – All Patients, **F**- Flow Team, **E**- Early Discharge, **R**-Review Patients with Longer Stays).

The Emergency Services Clinical Governance Committee were responsible for the effective management and oversight of the emergency department. The committee was chaired by a consultant in emergency medicine and accountable to the QSEC. Terms of reference outlined the committee had four meetings scheduled in 2025, however, due to non-availability of key stakeholders, only three meetings were held in 2025.

The hospital had defined lines of responsibility and accountability for medical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine who was supported by non-consultant hospital doctors (NCHDs).

Inspectors reviewed progress with the implementation of the emergency department referral pathway process relevant to this inspection. Through discussion with medical staff working in the clinical areas and senior management, it was evident that staff were aware of the process in place for the timely and safe transfer of patients from the emergency department setting and that processes were in place, guided by a standing operating procedure, to ensure timely and appropriate clinical ownership of patients. Minutes of meetings that occurred in 2025 from the Emergency Services Clinical Governance Committee outlined that adherence to this process was actively discussed and monitored between the clinical director and general manager with evidence of progress with identified actions. Inspectors also found that staff could access this standard operating procedure in the emergency department.

A standard operating procedure was also in place for admission and safe transfer of paediatric patients from the emergency department to the paediatric assessment unit (PAU) and paediatric ward, however, there was a lack of clarity amongst staff spoken with in the department in terms of this process.

Referral processes and forms including preadmission checklists were in place for patients requiring transfer to Monaghan Hospital and nearby rehabilitation facilities.

Patient flow within the emergency department continued to be monitored on a daily basis through regular daily huddles at various points throughout the day where service demand and inpatient capacity were reviewed such as the emergency department activity, access to diagnostics, delayed transfer of care* (DTOC), predicted discharges and staffing issues. Any issues were escalated to the general manager accordingly.

There was no delayed transfer of patient care at the time of inspection and the average length of stay for medical patients was 4.6 days and for surgical patients was 3.6 days which were both compliant with HSE targets.

The hospitals' multiple hospital admission avoidance pathways continued to be implemented to support efficient patient flow including the AMAU and ASAU pathway, Frailty Intervention Therapy Team[‡‡] (FITT) pathway, access to transitional care beds in Lisdarn Unit and Monaghan Hospital and the local injuries unit in Monaghan Hospital.

Overall, inspectors found that effective management arrangements were in place to support the delivery of quality and safe care. However, areas for improvement were required based on the following findings:

- the Emergency Services Clinical Governance Committee did not meet in line with the frequency set out in its terms of reference for 2025
- there was a lack clarity amongst staff spoken with in the emergency department in relation to the process for transferring paediatric patients from the emergency department to the paediatric assessment unit.

Judgment: Substantially Compliant

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

Cavan Monaghan Hospital had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Information on a range of different clinical data related to the quality and safety of healthcare services was collected and collated by the hospital. Collated performance data on complaints, audit activity, patient-safety incidents, medication incidents, training compliance, risk registers and key performance indicators which included quality and performance metrics from Monaghan Hospital was compiled by the quality and safety department and reviewed at meetings of relevant Clinical Governance Committee (CGC) meetings, QSEC and monthly SMT meetings. Performance reports were also discussed at monthly performance meetings at the integrated healthcare area team from the HSE Dublin and North East region.

There were formalised risk management structures and processes in place to proactively identify, analyse, manage, monitor and escalate identified risks with

[‡‡] The Frailty Intervention Therapy Team (FIT) is a multidisciplinary service operates at the front door in the emergency department to identify frail older patients and prevent unnecessary hospital admissions.

oversight by SMT. Risks pertaining to the key areas of harm which were the focus of this inspection will be discussed further under national standard 3.1.

Incidents

Incidents were logged on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework (IMF). The hospital's Serious Incident Management Forum (SIMF) had oversight of the management of serious reportable events and serious incidents, which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMF was accountable to QSEC and information on reported serious reportable events and serious incidents which was included in the quality and patient safety performance report presented at the monthly performance meeting at regional level. The QSEC monitored the implementation of recommendations arising from the review of serious reportable events and serious incidents with oversight by the SMT and at regional level. This is further discussed under national standard 3.3.

Audit

Governance and oversight of audit was provided by SMT, QSEC and relevant Clinical Governance Committees. The hospital had a clinical lead for audit (a consultant in medicine) and a clinical audit facilitator who supported the coordinated approach to auditing. There was evidence that each Clinical Governance Committee had developed an annual programme plan for audit and clinical audit updates including recommendations were an agenda item for discussion at their committee meetings. There was also evidence that the QSEC monitored the development of audit plans by the Clinical Governance Committees. In addition, the SMT had oversight of audit findings and quality improvement initiatives implemented to address areas that fell below standard.

Medication Safety

Monitoring of medication safety at Cavan Monaghan Hospital was through key performance indicators, audit and Nursing and Midwifery Quality Care-Metrics. Medication safety audits results were monitored at DTC, and QSEC.

Medication safety and medication storage and custody was monitored in clinical areas monthly as part of the nursing quality care metrics. Medication safety audit results reviewed for the clinical areas inspected demonstrated good compliance overall with the majority of results reported at over 90% for January 2025 to December 2025. There was evidence that quality improvement plans were developed when medication standards fell below acceptable levels for medication audits. For example, a quality improvement plan was in place for some of the clinical

areas inspected in response to non-compliance with medication fridge audit criteria. Inspectors found similar findings during the inspection of some of the clinical areas whereby medication fridges were not always locked and routine monitoring of temperature was not consistently completed. There was evidence that quality improvement plans implemented in response to emergency department medication prescribing and safety audit reports had resulted in improved compliance.

Inspectors were informed that due to the limited clinical pharmacy resources at the hospital, medication reconciliation was prioritised for high-risk patients. A medication reconciliation audit report completed in 2025 found that 22.6% of admitted adult patients (excluding maternity) had a medicines reconciliation completed by a clinical pharmacist. The audit also found variation in how medicines reconciliation was requested, undertaken, and documented, with implications for patient safety and service efficiency. The audit identified a number of recommendations, however, a quality improvement plan had yet to be developed in response to the audit findings.

Compliance with antimicrobial stewardship KPIs was monitored quarterly for each clinical governance group at the hospital. Documentary evidence reviewed of performance against set targets for AMS for quarter one of 2025 indicated good compliance overall with opportunities for improvement against set targets noted within the surgical governance group. Follow-up results for quarter two to quarter four were not recorded.

Deteriorating patient

The hospital was using national early warning systems for the relevant cohorts of patients to support the recognition, response and management of a deteriorating patient – the Irish National Early Warning Systems (INEWS), the Maternity Early Warning Score (IMEWS) and the Irish Paediatric Warning System (IPEWS). EMEWS was also implemented in the emergency department. Audits of the Irish National Early Warning System (INEWS) were completed monthly through the nursing quality care metrics and quarterly through a hospital-wide audit. Audit reports reviewed by inspectors for INEWS and patient monitoring and surveillance compliance outlined an overall compliance of 97.6% within the hospital from January 2025 to January 2026. Notwithstanding this, quarterly audit results reviewed for January to March 2025 fell below the acceptable parameter of 90% with clinical areas scoring from 82% - 89%. Where compliance in clinical areas fell below 90%, time-bound quality improvement plans were implemented, with assigned responsibility for action completion and re-audit.

A follow-up audit for April 2025 to June 2025 found an overall improvement with compliance of 91.5% achieved. Audits results for Q3 and Q4 achieved compliance of 91.4% and 93.7% respectively.

Compliance with IPEWS was audited monthly in the paediatric ward. Audit results reviewed showed that the ward fell below the acceptable parameter of 90% for four consecutive months from January 2025 to April 2025 with compliance levels ranging from 78% to 89%. A time-bound quality improvement plan was developed in April 2025 in response to consistent non-compliances which resulted in audit results improving following this, with the exception of one month (August 87%), for the months up to October 2025 with improved compliance ranging from 90-95%.

Compliance with EMEWS was audited in March 2025 and October 2025. Overall compliance with EMEWS from January 2025 to January 2026 was 87.2% with detection of deteriorating patient response to escalation being identified as an area which required improvement. A quality improvement plan in response to these audit results was developed and was ongoing at the time of inspection with plans to re-audit by end of Q1 2026.

There was evidence that audit results were reviewed at the relevant oversight committees within the hospital. The Deteriorating Patient Committee (DPC) also developed an audit plan for 2026 outlining the frequency of audits for the relevant early warning scores in use at the hospital.

A baseline audit was completed at the hospital to assess compliance with the National Clinical Guideline (NCG) No. 26, Sepsis management for adults (including maternity). A prospective audit was carried out in July 2025 on all inpatient departments, reviewing patient data over the previous 72 hours. As a follow-up to the July audit, a sepsis re-audit was carried out to reassess compliance in November 2025. The audit identified a number of recommendations which resulted in the development of a quality improvement plan. While there was evidence that progress with the quality improvement plan was discussed at the sepsis working group, a re-audit was scheduled for March and April 2026.

Compliance with sepsis guideline in the paediatric ward was identified as an area which required improvement. A sample of monthly audit reports reviewed by inspectors identified poor compliance overall with results ranging from 48% to 80% from April 2025 to December 2025. Furthermore, a national sepsis clinical audit completed by the HSE Dublin and North East region in November 2025 for paediatric sepsis found that sepsis management for paediatric sepsis in Cavan Monaghan Hospital required improvement across a number of areas including completion of sepsis screening forms and following the sepsis six protocol. A quality improvement plan was developed in response to these audit findings with oversight for the implementation of actions with the paediatric services clinical governance committee.

Transitions of care

In October 2025, Cavan Monaghan hospital paediatric services undertook an audit examining inter-hospital communication for shared-care paediatric patients. The purpose of this audit was to review current practice on communication with tertiary paediatric services and to follow-up on recommendations arising from a review. The audit found that 80% of unwell shared-care paediatric patients had appropriate communication with the tertiary unit. Rationale was recorded in patients' healthcare records as to why other patients were not discussed. The audit resulted in the development of a time-bound quality improvement plan with actions assigned to individuals for implementation by quarter one of 2026. Compliance with issuing clinical discharge summaries by the hospital was monitored and reported monthly. Records reviewed showed that the percentage of patients who were issued with a clinical discharge summary within a week ranged from 70% to 85%. Meeting minutes reviewed by inspectors documented discussion regarding the implementation of a new electronic discharge system as a potential improvement to support timely completion of discharge documentation.

Overall, there was evidence of monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services relevant to the size and scope of the hospital. Areas for improvement were identified based on the following findings:

- compliance with sepsis guidelines at the hospital required improvement
- a quality improvement plan in response to the recommendations for improvement from a medication reconciliation audit conducted in 2025 had not yet been developed
- compliance with issuing clinical discharge summaries required improvement.

Judgment: Substantially Compliant

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

Hospital management had effective arrangements in place to plan, organise and oversee staffing levels to support the delivery of high-quality, safe healthcare. However, compliance with mandatory training in the paediatric ward and in the paediatric assessment unit is required.

Hospital management reported an approved complement of 47.6 whole-time equivalent (WTE) medical consultant posts. At the time of inspection, 46.6 WTE consultants were in post, with the remaining 1 WTE vacancy being covered by a locum consultant. A small number of consultants were not registered on the relevant

specialist division of the Irish Medical Council register; however, management advised that appropriate supports were in place in line with Health Service Executive (HSE) guidance.

Medical consultants were supported by 140.4 WTE non-consultant hospital doctors (NCHDs) against an approved complement of 142.7 WTE. The resulting deficit of 2.7 WTE, primarily within medicine, was being mitigated through the employment of locum NCHDs.

The emergency department had an approved complement of 6 WTE consultants in emergency medicine. At the time of inspection, 4 WTE permanent consultants were in post, with the remaining 1 WTE position filled by a locum consultant. A consultant in emergency medicine was available on-call 24 hours a day, seven days a week.

Consultants in emergency medicine were supported by an approved complement of 13 WTE registrar posts. At the time of inspection, 2 WTE registrar posts were vacant; which were being addressed through the use of locum registrars. The hospital also had an approved complement of 13 WTE senior house officer posts; however, 16 WTE were in place at the time of inspection.

The hospital had an approved complement of 650.6 WTE nursing and midwifery posts, inclusive of management and other grades. At the time of inspection, 642.2 WTE posts were filled, with 7.6 WTE nursing vacancies. Hospital management advised that nine nurses were scheduled to commence employment in March 2026.

Nursing staff were supported by 120.7 WTE healthcare assistants (HCAs). The approved complement was 207.4 WTE, with 6.7 WTE positions vacant at the time of inspection. Hospital management advised that 12 HCAs were at the on boarding stage of recruitment.

On the days of inspection, three of the four clinical areas visited had their full complement of nursing and HCA staff, including the emergency department, paediatric ward and Medical 2 ward. Meadow ward (Monaghan) did not have a clinical nurse manager (CNM) on duty however, a CNM 2 was redeployed from another ward on the day, and no impact on care delivery was identified. Inspectors were informed that overtime and agency staff were utilised to address nursing staffing shortfalls as they arose. This was evidenced by the rosters reviewed during the inspection.

The hospital was approved for 18.3 WTE pharmacists and 13.1 WTE pharmacy technicians. At the time of inspection, 0.4 WTE pharmacist posts and 0.5 WTE technician posts were vacant. In addition, 5 WTE staff members were on statutory leave at the time of the inspection. Inspectors were informed that the hospital had received approval in November 2025 for a Chief II Pharmacist and two WTE senior

pharmacists for adult medicine and that recruitment for these posts was in progress at the time of inspection.

Medical staffing arrangements for Monaghan Hospital during working hours comprised one registrar and one senior house officer. Out-of-hours cover included one register assigned to a twilight shift from 04.00pm to 12.00am, and a further register on duty from 08.30pm until 09.00am. Inspectors were informed that occasionally Monaghan Hospital did not have the required medical staffing arrangements in place. Records received following the inspection outlined that for the month of December 2025 and January 2026, there were nine shifts where Monaghan Hospital did not have the required medical staffing arrangements on duty.

At the time of inspection, the paediatric ward was approved for 15.63 WTE nurses of which there were 12 WTE nurses in place resulting in a deficit of 3.6 WTE. Hospital management informed inspectors that recruitment panels were established and in use. However, it was acknowledged that some staffing deficits were attributable to statutory leave. Inspectors were informed that overtime and agency staff were utilised to address nursing staffing shortfalls as they arose. This was evidenced by the rosters reviewed during the inspection. Documentation reviewed by inspectors showed an overall increasing trend in paediatric inpatient, day case and paediatric assessment unit (PAU) activity at the hospital in the last five years, however, no changes in the approved complement of paediatric nursing had occurred in response to the overall increase in activity in the PAU. Paediatric nursing staffing levels was recorded as a risk on the paediatric departmental risk register and the emergency department risk register. Minutes of paediatric governance meetings reviewed outlined that a business case was updated for nursing staff for the Paediatric Assessment Unit (PAU). This was discussed with hospital management on the days of inspection and will be discussed further under national standard 3.1.

Compliance with the uptake of mandatory training in the paediatric ward and PAU required significant improvement. Compliance with sepsis training in the PAU was 60% and 52 % in the paediatric ward. Records reviewed for the uptake of mandatory training across the two units in basic life support indicated that only 47% of staff were up to date with this training. This was discussed with senior management at the time of inspection and inspectors were informed that current records available may not be accurate at the time of inspection as it was believed that compliance levels were higher. Following the inspection, hospital management submitted updated training records demonstrating that, at the time of the inspection, compliance with training in the recognition and management of sepsis in children was 58% in the PAU and 68% in the paediatric ward. Compliance with basic

life support training was 62% among staff across the PAU and paediatric ward combined at the time of the inspection.

- Compliance with mandatory training in the paediatric unit (sepsis and basic life support) required significant improvement.

Judgment: Substantially Compliant

Quality and Safety Dimension

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

Cavan Monaghan Hospital was found to be substantially compliant with one national standard (3.3) and partially compliant with two national standards (1.6 and 3.1) assessed. Key inspection findings informing judgments on compliance with these three national standards are described in the following sections.

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

From discussions with staff, it was clear that they were aware of the need to respect and promote the dignity, privacy and autonomy of the people using the service. However, there were instances where patient privacy and dignity were at risk of not been fully maintained or protected.

Privacy curtains were used in clinical areas to support privacy while patients received care. However, the physical environment did not always ensure that patients' dignity, privacy and autonomy was respected, particularly in the emergency department. While privacy and dignity were upheld for patients accommodated in individual cubicles and bays within the department, this was not the case for patients accommodated on trolleys in the corridor of the emergency department. Staff informed inspectors that if a patient on a trolley required assessment, they would be moved into a cubicle to ensure privacy during the provision of care. However, there was a risk that others (patients, visitors and staff) could overhear patient-clinician conversations and personal information exchanged between patients, medical and nursing staff when communicating and interacting with patients being cared for on

trolleys outside cubicles. Patients in the emergency department had no access to shower facilities and had to go to another ward (Medical 2) to shower, which impacted their privacy and dignity and potentially that of other patients, and meant they were also outside the direct supervision of emergency department staff. This was consistent with findings from the previous inspection in 2024.

Patients were familiar with their immediate surroundings and understood how to use their call-bell to request assistance in all clinical wards visited. However, not all patients had access to call-bells in the emergency department. Patients accommodated on trolleys in the corridor had no way of calling for assistance with personal care needs.

Although patient information was protected in emergency department, patient's personal information in Meadow's ward, the Paediatric ward and Medical 2 ward was observed not to be protected which was not in line good practice guidelines. Patients' medical records were accessible in a trolley with a broken lock in the Paediatric ward and in an unlocked trolley in Meadow's ward. This was brought to the attention of the clinical nurse manager (CNM) in the clinical areas visited to ensure appropriate corrective action was taken. Hospital management informed inspectors that new lockable trolleys had been requested through corporate business manager, and this was confirmed by staff in Meadow's ward. However, there was no timeframe for this. On Medical 2 there was a white board available with a security screen, however inspectors observed on two occasions the whiteboard left uncovered. This was addressed with the CNM on both day one and day two of inspection.

Overall, while there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this was consistent with the human rights-based approach to care promoted by HIQA. However, the following findings impacted on patients' dignity and privacy:

- patient-clinician conversations were overheard by accommodating patients on trolleys in the emergency department corridor
- patients in the emergency department had no access to shower facilities within the department
- patients on trolleys in the corridor in the emergency department had no access to a call-bell to alert staff for assistance
- patient information was not consistently protected in clinical areas inspected.

Judgment: Partially Compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service.

The hospital's Senior Management Team (SMT) was assigned with responsibility to review and manage risks that impacted the quality and safety of healthcare services. Risks relevant to the areas of harm which were the focus of this inspection were recorded on the corporate risk register with existing controls and additional actions required to manage and reduce these risks. Each directorate was responsible for their own risk register. Risks were escalated to the corporate risk register and were reviewed at monthly SMT meetings. Risks that were rated high or where the required controls fell outside the direct control of the risk owner were escalated for discussion at monthly HSE performance meetings with HSE Dublin North East Integrated Healthcare Area.

Inspectors reviewed local risk registers in place for the clinical areas inspected including the emergency department and paediatric ward and medical services. There was evidence that risks identified at departmental level were escalated to the corporate risk register. CNMs and assistant directors of nursing, with support from the risk manager assessed, analysed and managed any actual and potential risks to patients in their clinical areas. There was evidence that local risk assessments were completed in response to identified risks within some of the clinical areas inspected.

Medication Safety

Medication safety risks recorded on the risk register included a lack of clinical pharmacists on wards. Similar to findings from previous inspections of this service, HIQA found that the clinical pharmacy service provision was limited at the hospital and was not standardised across wards. A dedicated clinical pharmacy service was not in place for high-risk clinical areas which were inspected such as the emergency department, and the paediatric ward. A clinical pharmacist formed part of the Frailty Intervention Therapy Team (FITT) in the emergency department and reviewed patients on the FITT pathway. There was a very limited clinical pharmacist service available in Monaghan Hospital. Staff could access clinical pharmacist advice via telephone, as required. A pharmacy technician visited the wards to monitor medication stock levels. Actions outlined by hospital management to address the risk of a limited clinical pharmacy service at the hospital included the recent approval of additional pharmacy posts in November 2025 as discussed under national standard 6.1.

The impact to patient safety when medication reconciliation was not completed at the time of admission, discharge or transfer was also recorded as a risk on the hospital's corporate risk register. As outlined in national standard 5.8, 22% of patients were receiving medication reconciliation at the hospital. Controls in place to mitigate this risk included the provision of a clinical pharmacy service in some high-risk areas and a clinical pharmacist review of consultant clinical handover documents to highlight patients requiring medication reconciliation for high-risk medicines.

The hospital had a sound-alike-look-alike drug (SALAD) list and a list of high-risk medications.

Under reporting of medication incidents was also recorded on a number of departmental risk registers reviewed in the clinical areas inspected and will be discussed further under national standard 3.3.

Deteriorating patient

The hospital identified the lack of paediatric trained nurses in the emergency department as risk and recorded the requirement for each emergency department shift to have a paediatric trained nurse on the hospital's risk register. Senior hospital management reported that this requirement can no longer be achieved due to a number of paediatric nurses moving to new roles and that the risk required review to reflect this. Records provided following the inspection outlined that the emergency department had five paediatrics nurses in place at the time of inspection. Controls in place to mitigate the risk included having the PAU operational 24/7 and paediatric staff from the PAU holding a bleep and coming to the emergency department when required. Hospital management were satisfied that the current controls in place to mitigate this risk were effective but reported that the risk required review and updating to reflect the current situation in the emergency department. However, paediatric nurse staffing deficits for the PAU and paediatric ward were also recorded as a risk on the paediatric services risk register. Controls in place included the redeployment of staff, use of agency nursing staff and healthcare assistants, reduction of bed numbers, deferral of dental services and alteration of activity. The hospital should review current staffing arrangements in place for paediatric services at the hospital to ensure that current staffing arrangements are appropriate to meet the size, activity and scope of paediatric services provided by the hospital.

Escalation of the deteriorating patient in a timely manner was also reported by staff and hospital management as a risk, however, it was noted that this was not recorded on the hospital's corporate risk register. Additional controls implemented in July 2025 to address this risk included the appointment of second registrar from 5.00pm to 12.00pm to assist with timely response to the management of the deteriorating patient. Staff spoken with reported that this was having a positive impact on the

ability to escalate and respond to the deteriorating patient in a timely manner. A critical care outreach team from the intensive care unit (ICU) were available to provide support to staff when required when a patient's condition deteriorated and plans were in place to expand the operational hours of this team at the hospital.

The hospital was following national guidelines for INEWS, IMEWS and Paediatric Early Warning System (IPEWS). All staff in the general hospital spoken with were knowledgeable about the INEWS and response protocol to ensure timely management of patients with a raised early warning score. Inspectors reviewed a sample of INEWS charts. It was observed that, while the majority of INEWS entries were appropriately recorded and adhered to the required frequency there was some variance in compliance with INEWS modified escalation and response protocols in the clinical area. For example, there were some examples among healthcare records reviewed where INEWS and IPEWS national guidelines were not being followed with regard to response protocols and frequency of observations.

Systems and processes for the deteriorating patient were in place at Monaghan Hospital. During core working hours the onsite medical registrar and the SHO responded to concerns about the deteriorating patient. During out of hours, if a patient's condition deteriorated, staff communicated with the medical registrar on-call in Cavan General Hospital using the Identify, Situation, Background, Assessment, Recommendation/Read Back/ Risk (ISBAR3) [§§] communication tool and if required, the patient was transferred to the emergency department in Cavan General Hospital using Protocol 37[***]. The ISBAR communication tool was in use in the clinical areas inspected.

Transitions of care

Risks pertaining to transitions of care recorded at departmental level risk registers included lack of compliance with clinical handover. Controls in place to mitigate this risk included daily handover processes in place to include nursing and NCHD handover and safety pauses. Since HIQA's previous inspection the hospital introduced a consultants daily meeting identifying deteriorating patients and liaising with anaesthetics.

The ISBAR communication template was not formally used for shift handover or interdepartmental handover. At the time of the inspection, a quality improvement initiative aimed at improving interdepartmental handover was being piloted in Medical 1 ward. Hospital management informed inspectors that the initiative was scheduled

[§§]Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk (ISBAR3) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

[***] Protocol 37: has been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

for hospital-wide implementation the following week. There was evidence that multidisciplinary team clinical handover meetings occurred and consultants from all specialities attended these meetings with the advanced nurse practitioner (ANP) for critical care outreach.

Monaghan Hospital tracked and trended the numbers of patient transfers back from Monaghan to Cavan Hospital which was reported to be 19% of all patient transfers. This was discussed further with hospital management who were satisfied that patients were being transferred appropriately but had identified a trend in number of patients being transferred back in receipt of palliative care which required review.

Emergency Department

Inspectors visited the emergency department on the second day of inspection. At 11.00am, there were 33 patients registered in the emergency department, including three admitted patients awaiting an in-patient bed. On the day of inspection, the hospital was operating at amber escalation level. The escalation plan was activated with evidence of implementation of escalation actions, such as the use of surge beds. Surge capacity was utilised in the AMAU, the ASAU and the hospital's day services unit.

Data on emergency department Patient Experience Times (PETs) collected at 11.00am on the second day of inspection, showed that the hospital was not compliant with two of the HSE's targets. At 11.00am:

- 9% (3 out of 33) patients were in the department for more than six hours after registration — this was in line with the HSE's target of 70%
- 39% (13 out of 33) patients were in the department for more than nine hours after registration — this was not in line with the HSE's target of 85%
- no patient was in the emergency department for more than 24 hours after registration
- 24% (8 out of 33) patients aged 75 years or over were in the department for more than nine hours after registration - this was not in line with the HSE's target of 99%
- all attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration in the department which was compliant with the HSE national target.

All adult patients were triaged and prioritised in line with the Manchester Triage System.[†††] Staff could view the status of all patients in the department on the

[†††] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

hospital's electronic information system — their prioritisation category levels and waiting times.

On the second day of inspection the patient wait time from registration to triage ranged from two minutes to 50 minutes, with an average triage time of 25 minutes. This exceeded the 15-minute target recommended by the HSE's emergency medicine programme.

Continuous and effective flow of patients within the hospital and delayed discharges of care were the keys risks associated with transitions of care that were being actively managed by the Unscheduled Care Committee.

The hospital reported the percentage of patients attending the emergency department who were admitted (conversion rate) was 22% of total emergency department admissions (8,015) in 2025 which was a slight improvement from the previous inspection year of 34% (13,687) of total emergency department admissions in 2024.

Policies, procedures, protocols and guidelines

The hospital also had a range of national policies, procedures, protocols and guidelines related to the clinical deteriorating of patients. The hospital had a range of local medication safety policies, procedures, protocols and guidelines. However, inspectors found that staff in the clinical areas inspected did not have access to up-to-date policies, procedures and guidelines at the point of care This was identified as a risk in the paediatric ward and placed on the paediatric risk register however, it was not on the hospital's overall risk register. A number of policies, procedures and guidelines in the paediatric ward were found to be out of date, and staff did not have access at the point of care. However, hospital management stated that staff could access current guidelines via a shared folder located on the paediatric drive on computers.

Overall, while the service had systems in place to protect service users from the risk of harm, further action was required based on the following findings.

- there were some examples in the healthcare records reviewed where INEWS and IPEWS national guidelines were not being followed with regard to response protocols and frequency of observations
- staff did not have access to up-to-date policies, procedures and guidelines in some of the clinical areas inspected
- the ED did not always have sufficient paediatric staffing to provide a paediatric nurse on every shift as identified as a requirement of the risk register
- there were a limited medication reconciliation service and improvements identified in the 2025 audit had yet to be implemented
- the hospital was not compliant with two of the HSE's targets relating to emergency department patient experience times.

Judgment: Partially Compliant

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

The hospital had systems in place to effectively identify, manage, respond to and report on patient-safety incidents.

As outlined in national standard 5.5, arrangements for the Serious Incident Management Team were in place at the hospital with governance and oversight of patient-safety incidents provided by the SMT, QSEC, and CGCs and at regional level.

Staff in the clinical areas inspected were knowledgeable about how to report and manage a patient-safety incident and were aware of the most common patient-safety incidents reported. The hospital used electronic point of entry reporting and the CNM 2s had oversight of all clinical incidents reported. These incidents were escalated to the CNM 3s and the relevant assistant director of nursing (ADON) for review before being sent to the quality and patient safety manager. Learning and feedback from incidents were shared at safety huddles and staff meetings.

The QSEC and SIMF were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework.

A monthly quality and patient safety analysis report was submitted to the SMT, QSEC and presented at monthly performance meetings with the IHA. The quality and safety analysis report provided information on the number of serious reportable events and serious incidents, incident trend analysis, compliance with complaints KPIs, incident reviews in progress, staff complaints training compliance rates, open disclosure metrics, the implementation of recommendations from reviews and the hospital's risk register. A SIMF annual report was also completed for 2025 detailing number of SIMF meetings held, number of cases presented, case review outcomes, categories for escalated patients, themes arising from and status of recommendations arising from reviews.

Inspectors followed up on patient-safety reviews that were the focus of this inspection including progress with the implementation of recommendations arising from such reviews. Inspectors found that limited progress was made with recommendations made in 2024 regarding medication safety. Target dates for the completion of recommendations were set for Q4 2025 and Q1 2026; however, no recommendation had been fully implemented at the time of this inspection. Inspectors were informed that recommendations arising from patient-safety reviews associated with the requirement to have a medication reconciliation service in all clinical areas could not be implemented due to limited clinical pharmacy resources, which is also discussed under national standards 6.1 and 3.1.

There was evidence of progress with the implementation of recommendations arising from patient-safety incidents associated with the deteriorating patient that were the focus of this inspection. For example, inspectors noted that policies and guidelines aligned to recommendations were developed and staff were knowledgeable of such policies and could access these in the clinical areas inspected. Clinical and medical staff who spoke with inspectors described education received as part of recommendations arising from patient-safety reviews. Notwithstanding this, training records were not available on the day of inspection or provided following the inspection to reflect that a recommendation was implemented for all relevant staff to receive training on the recognition and management of peritonitis. Hospital management advised inspectors that a surgical study day, which included a presentation on peritonitis, was held twice annually. The most recent session took place in December 2025, and two further sessions were scheduled for 2026. This was identified as a recommendation arising from a long-standing patient-safety review and while documentation reviewed outlined that this had been implemented, training records were not available to demonstrate that this was implemented.

For recommendations that involved other hospitals, there was evidence that the hospital was escalating any issues or delays with implementing recommendations at senior level and continuing to engage with the relevant hospital to ensure recommendations were being followed up on to prevent a similar incident happening again.

There was evidence that patient-safety reviews were completed in line with relevant local and national guidelines. Inspectors found that for the majority of patient-safety reviews that were the focus of this inspection, time-bound action plans and quality improvement plans with persons responsible for the implementation of recommendations were developed, with the exception of one report reviewed by inspectors which did not identify persons responsible for the implementation of recommendations.

Patient-safety incidents were tracked and trended. Medication safety incidents were tracked and trended and reviewed as part of an incident analysis summary report at CGCs quarterly meetings. In addition, the number of medication safety incidents reported on the National Incident Management System (NIMS) was reviewed at each CGC and monitored at QSEC meetings.

Overall, the hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents. Further action was required based on the following findings:

- Recommendations arising from patient-safety reviews associated with the requirement to have a medication reconciliation service in all clinical areas could not be implemented due to limited clinical pharmacy resources.

Judgment: Substantially Compliant

Conclusion

HIQA carried out a targeted unannounced inspection of Cavan Monaghan Hospital following the receipt of information to assess compliance with the *National Standards for Safer Better Healthcare.*

This inspection focused on three areas of known harm; the deteriorating patient, medication safety and transitions of care.

Capacity and Capability

There was evidence of responsive management arrangements in place to address the demand for healthcare services and alleviate overcrowding in the emergency department.

The hospital had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services with regard to audit and performance monitoring.

Hospital management had effective arrangements in place to plan, organise and oversee staffing levels to support the delivery of high-quality, safe healthcare.

However, compliance with the uptake of mandatory training in the paediatric unit and in the paediatric assessment unit is required.

Quality and Safety

There was evidence of effective systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service. However, further action was required to improve the quality and safety of care across the hospital sites including improving compliance with sepsis guidelines, increasing medication incident reporting rates, and improving medication reconciliation rates.

There were systems in place to effectively identify, manage and report patient-safety incidents. Hospital management must ensure that recommendations and quality improvement plans arising from audits and incidents are fully implemented in a timely manner.

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

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially 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	Substantially 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
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for: Cavan Monaghan Hospital

Inspection ID: NS_0184

Date of inspection: 4 and 5 February 2026

Compliance plan provider's response:

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

Item 1: Clinician-patient interactions in the Emergency Department (ED)

Actions	**Timescale**
Current controls: Where possible, patients on corridor trolleys are moved to side-rooms for sensitive clinician-patient interactions.	
Interim actions: A room has been secured within the Emergency Department for sensitive clinician-patient interactions.	Completed
Long-term plans: Construction of a new ED building with 56 single rooms to ensure total privacy and confidentiality has commenced.	Expected completion date is 2028

Item 2: Shower facilities in the Emergency Department (ED)

Actions	**Timescale**
Current controls: Continue to facilitate ED patients to use shower facilities on Medical 2.	
Interim actions: A review of the current footprint has identified a potential area for a shower facility within the ED; scoping work is in progress.	Q4 2026
Long-term plans: Provision of integrated patient hygiene facilities within the new ED building.	Expected completion date is 2028

Item 3: Call-bells in Emergency Department (ED) corridor

Actions	**Timescale**
Current controls: Regular rounds by healthcare staff depending on assessed needs.	
Interim actions: A project is underway to install call-bells at each trolley station to ensure patients can alert staff for assistance.	Q1 2027
Long-term plans: Integration of permanent, fixed call-bell systems at every patient station in the new ED building.	Expected completion date is 2028

Item 4: Patient information (Trolleys and Whiteboards)

Actions	**Timescale**
Current controls: Broken trolley locks replaced immediately following the inspection. A Quality Improvement Plan (QIP) is in place since May 2026 to protect patient information on the "Patient Status at a Glance" whiteboards.	
Interim actions: One new lockable trolley has been ordered.	Q3 2026
Long-term plans: Ongoing audit.	Ongoing

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

Item 5: Irish National Early Warning System (INEWS) and IPEWS (Irish Paediatric Early Warning System) Guidelines (Response and frequency)

Actions	**Timescale**
Current controls: Monthly Quality Care Metrics are conducted in all clinical areas. In-depth bespoke EWS audits are conducted quarterly. Results are reviewed and QIPs are developed by the ADON and CNM of the relevant ward during their monthly 1:1 meeting. QIPs are shared at the CNM forum, team meetings. Oversight of EWS Compliance is provided by the Clinical Governance Committees and the Deteriorating Patient Committee (DPC).	
Interim actions: Review existing controls and QIP at the DPC.	Q3 2026
Long-term plans: Progress with QIP.	Ongoing

Item 6: Access to up-to-date Policies, Procedures, Pathways and Guidelines (PPPGs)

Actions	**Timescale**
Current controls: Cavan Monaghan Hospital (CMH) PPPG Database available on all desktops in the clinical areas. PPPG database is also available on the CMH Webpage. "How to access PPPGs" infographic has been circulated. CMH Guideline for developing and approving PPPGs is operational and training has been delivered. All Clinical Governance Committees have oversight of their own PPPG database to monitor PPPGs.	
Interim actions: "How to access PPPGs" infographic will be re-circulated.	Q3 2026
Long-term plans: CMH are currently exploring procurement of an external PPPG management system.	Q1 2027

Item 7: Paediatric nurse staffing in the Emergency Department (ED)

Actions	**Timescale**
Current controls: The Paediatric Assessment Unit (PAU) is operational 24/7. The paediatric staff in PAU hold a bleep and attend ED when required.	
Interim actions: Review the ED and Paediatric risk registers to assess the current risk.	Q3 2026
Long-term plans: The PAU will be incorporated into the new ED Building.	Expected completion date is 2028

Item 8: Limited medication reconciliation.

Actions	**Timescale**
Current controls: Staff can access clinical pharmacists for advice as required. Clinical pharmacy services are in place in some high-risk areas. Patients on high-risk medicines requiring medication reconciliation are highlighted at clinical handover. Lack of clinical pharmacy is on corporate risk register.	
Interim actions: Expedite the recruitment of the three senior pharmacist positions approved in November 2025 to expand clinical pharmacy services and backfill of staff on statutory leave. Develop and implement a formal Quality Improvement Plan (QIP) addressing the findings of the 2025 medication reconciliation audit.	Q3 2026 Q4 2026
Long-term plans: Await approval of business case submitted as part of Estimates 2026 and further business cases to be developed/submitted for clinical pharmacy to support hospital wide medication reconciliation in particular high-risk areas.	Q1 2027

Item 9: Patient Experience Times (PET)

Actions	**Timescale**
Current controls: This is closely monitored daily as part of the Patient Flow Strategy. It is reported and monitored via the monthly performance report.	
Interim actions: We will establish a PET Working Group and QIP to improve compliance with HSE targets.	Q3 2026
Long-term plans: Progress QIP.	Ongoing