Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	University Hospital Kerry
Centre ID:	OSV-0001036
Address of healthcare service:	Rathass Tralee Co. Kerry V92 NX94
Type of Inspection:	Unannounced
Date of Inspection:	24 and 25 February 2026
Inspection ID:	NS_0189

About the healthcare service

Model of hospital and profile

University Hospital Kerry (UHK) is a model 3* acute teaching hospital providing in-patient, day case and outpatient healthcare services for the population of Kerry and surrounding geographical areas of north Cork and west Limerick. It is a Health Service Executive (HSE) funded hospital managed by the HSE Regional Health Area South West (RHA SW)±. It has close links with the model 4† tertiary referral centre within the region. The hospital is affiliated to University College Cork as its primary academic partner. The hospital provides a range of healthcare services for adults and, these include:

- emergency care
- acute medical inpatient services
- emergency and elective surgery
- critical care
- oncology care
- gynaecological services
- maternity and neonatal care
- paediatric services
- diagnostic services
- outpatient care.

* A model 3 hospital admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine and critical care.

± The Regional Health Area HSE South West provides health and social care services to Cork and Kerry. HSE South West includes all hospital and community healthcare services in the region.

† A model-4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, an Emergency Department, including a Clinical Decision Unit on site.

The following information outlines some additional data on the hospital.

Number of beds	296 inpatient beds 64 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, information submitted by the provider, unsolicited information and other publicly available information since the last inspection.

During the inspection, inspectors:

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

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

About the inspection report

A summary of the findings and a description of how University Hospital Kerry performed in relation to compliance with the nine national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in University Hospital Kerry. 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 services, in University Hospital Kerry, 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 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	Inspector	Role
24/02/2026	09:40 – 18:30	Úna Cahill Marguerite Dooley Mary Flavin Yvonne Young Angela Moynihan	Lead Support Support Support Support
25/02/2026	09:00 – 16:25	Úna Cahill Marguerite Dooley Mary Flavin Yvonne Young	Lead Support Support Support

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 four clinical areas:

- Emergency department
- Ardfert Antenatal Ward
- Sceilig Medical Ward
- Cashel Paediatric Ward.

During the inspection, the inspection team spoke with representatives from:

- the Executive Management Team.

Inspectors also spoke with representatives from the following hospital committees:

- Executive Quality, Risk and Patient Safety
- Infection Prevention and Control
- Drugs and Therapeutics
- Deteriorating Patient.

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.

§ 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.

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

Over the course of the inspection, inspectors visited the emergency department, Ardfert antenatal ward, Sceilig medical ward and Cashel paediatric ward. The emergency department provided care for undifferentiated (all manner of conditions) adult and paediatric patients with acute or urgent illnesses or injuries. Those attending were referred by a general practitioner (GP), had been brought by ambulance or had self-referred. The emergency department had the following capacity:

- a waiting area
- audio-visually separated waiting area for children
- two triage rooms
- one hub room
- nine cubicles for major presentations, including one room for gynaecological assessments
- three cubicles for minor presentations
- a designated plaster room with capacity for one patient
- three paediatric cubicles
- one paediatric single-bed isolation room
- three resuscitation bays
- four respiratory single-bed isolation rooms.

Cashel ward was a 29-bed paediatric ward comprising two six-bed multi-occupancy rooms, one five-bed multi-occupancy room, one two-bed multi-occupancy room and 10 single rooms. At the time of the inspection, one of the six-bed rooms was being used for a paediatric assessment unit to facilitate the assessment of children presenting through the emergency department.

Ardfert antenatal ward was a 16-bed ward, comprising four labouring rooms, a six-bed multi-occupancy room, a four-bed multi-occupancy room and two single rooms that can also be used by Kells ward. At the beginning of the inspection, there were two patients in this area, and during the course of the inspection one patient was admitted and one patient was discharged.

Sceilig ward was a 28-bed medical ward comprising three six-bed multi-occupancy rooms, one four-bed multi-occupancy room, one three-bed multi-occupancy room and three single rooms. On the morning of inspection, the ward was at full capacity with 28 patients, but had no patients on trolleys. However, inspectors were informed the ward can accommodate up to two patients on trolleys if required.

During the inspection, inspectors spoke with a sample of patients and relatives, where present, about their experience of care in the hospital. Comments from patients and

relatives included the nurses and doctors being "kind and attentive", "fantastic, helpful and friendly" and "they explained everything". Despite this, one patient described their experience of having to "wait for someone to pass to call for help" as they did not have a call-bell. Another patient said they were in the emergency department for greater than 24 hours and "the trolley is uncomfortable, I'm waiting for a bed".

The HSE's complaints management policy 'Your Service, Your Say' leaflets and posters were observed and available throughout all clinical areas visited, along with information on patient advocacy services. In the emergency department, patients were asked by inspectors if they knew how to give feedback or make a complaint and one told the inspector "I'd ask a nurse" and another commented "I wouldn't know how to make a complaint".

Overall, patients in the inpatient wards inspected were complimentary about the staff and the care they received, but the experience of patients in the emergency department was different where some patients reported discomfort and frustration. This was consistent with what inspectors observed in each of the clinical areas visited.

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 and use of resources.

University Hospital Kerry was found to be partially compliant with four of the standards (standard 5.2, 5.5, 5.8 and 6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following section.

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

Inspectors found that University Hospital Kerry had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities to support the quality and safety of healthcare services. However,

inspectors found deficiencies with these structures which could lead to significant risks for people using the service over time if not addressed. The senior accountable officer was the hospital manager (described to inspectors as 'head of service' on the day of the inspection). The hospital manager reported to the integrated healthcare area manager (IHAM) for the HSE South West Kerry, and the IHAM subsequently reported to the regional executive officer (REO) of the Regional Health Area South West.

At the time of inspection, the hospital was still transitioning to a clinical directorate structure representing the different types of care provided. Inspectors were told that five directorates were in place: peri-operative, paediatrics, medicine and integrated care, diagnostics and women and infants. However, the clinical director for the peri-operative directorate (in most cases this describes care before, during and after surgery) was due to commence in post in the coming weeks, and the development of the paediatrics directorate was still progressing. Two of the directorates had a clinical director (a senior doctor in a management role) in post and two directorates had a clinical lead (also a senior doctor managing services) in post. Each directorate also had an assistant director of nursing, a business manager and a health and social care professional lead, with the exception of the women and infants directorate where the director of midwifery was in place instead of an assistant director of nursing.

Each of the clinical directors and the clinical leads reported to the executive clinical director (ECD) who provided clinical oversight for the consultants and non-consultant hospital doctors working in the hospital. The executive clinical director reported clinically to the regional clinical director (RCD) and operationally to the hospital manager.

The director of nursing (DON) and the director of midwifery (DOM) were responsible for the organisation and management of the nursing and midwifery services respectively within the hospital. They both reported professionally to the regional director of nursing and midwifery and operationally to the hospital manager.

The terms of reference for the Executive Management Team (EMT) stated that it had responsibility to provide clear governance, leadership and direction for the hospital, its staff and service users to ensure a high-quality of care in the hospital. It met monthly in line with the terms of reference. This was a change since HIQA's previous inspection when previously the executive management team had met fortnightly, this change followed the introduction of an EMT clinical operations group. The executive management team meetings were chaired by the hospital manager and membership included the executive clinical director, the director of nursing, the director of midwifery, the finance, HR and quality and patient safety managers, the health and

social care professionals (HSCPs) lead and the clinical director for three of the directorates: peri-operative (when in post), medicine and integrated care, and diagnostics. Agenda items for discussion included: monthly and quarterly reports or presentations from hospital teams or services, directorate updates, unscheduled and emergency care along with updates from the operational management team.

However, at the time of inspection the clinical leads for the remaining two directorates were not members of the executive management team (EMT) and, therefore, were not being provided with the same opportunity to provide formal and structured input. Nonetheless, the clinical leads presented updates every three months. Hospital management confirmed that this was in line with the framework agreed. A sample of meeting minutes reviewed by inspectors showed meetings followed a structured agenda and progress in implementing actions were time orientated, person specific and monitored from meeting to meeting. Inspectors saw evidence that demands on the hospital were dominating some executive management team meetings. In one set of meeting minutes reviewed the increased patient demand in the hospital in the period of time preceding the inspection meant that some agenda items had not been discussed. Unscheduled care and the management of very high patient activity took priority during this particular meeting and matters not discussed were carried over accordingly to the next convening of the EMT.

Members of the executive management team attended the Integrated Healthcare Area Kerry-UHK performance meeting monthly, having submitted a performance report in advance. These meetings were in line with the HSE's Performance and Accountability Framework 2025. The terms of reference provided to inspectors for this meeting were not signed or dated. Minutes provided for review showed a structured agenda giving the integrated healthcare area manager a comprehensive oversight of healthcare services in University Hospital Kerry.

Inspectors also received meeting minutes demonstrating that members of the Women and Infants Directorate attended the Ireland South Women and Infants Network meeting weekly. In line with National Maternity Strategy 2016-2026 this meeting acted as a forum for communication and collective decision making in respect of maternity, neonatal and gynaecology services among the four maternity units in the Network. This included clinical referral and transfer pathways for women and neonates and shared policies. The terms of reference for this Network meeting were dated 2017.

The Executive Quality, Risk and Patient Safety Committee was chaired by the executive clinical director and had multidisciplinary membership that represented the executive management team and a variety of hospital departments. The

committee's terms of reference outlined that it reported to the hospital manager via the executive management team and aimed to provide assurances to the executive management team regarding appropriate and effective clinical, quality, risk management and patient safety systems in place in the hospital. The committee also had oversight of all complaints received by the hospital. In line with its terms of reference the committee was scheduled to meet monthly; however, on review of minutes provided to HIQA, it was noted that this committee met on just seven occasions in 2025. The terms of reference were last reviewed in April 2025 and extended at that time until January 2026 as a review of quality risk and patient safety functions were awaited within the directorate structure. This review was being conducted by an external company. From the review of minutes, it was evident that the meetings followed a structured agenda and actions were assigned to a designated member of the committee. However, while actions were monitored from meeting to meeting, inspectors observed that these actions did not have associated timelines.

Inspectors were told that there was no annual quality, risk and patient safety programme in place at the time of inspection. Inspectors were informed that oversight of the quality and patient safety function would be based on the quality and patient safety framework being developed in line with the directorate structure. However, this process had yet to be fully embedded in the hospital. Inspectors were told that much clinician time was being diverted to committee work in the hospital without adequately clear goals for the benefit of patients and in the absence of a structured annual programme. Inspectors reviewed meeting minutes that showed the quality risk and patient safety department had performed due diligence of the patient safety committees in the hospital and this demonstrated sub optimal performance. According to the clinical governance structure organisational chart provided to HIQA, 22 committees or user groups reported formally to the executive quality risk and patient safety committee. These included infection prevention and control, drugs and therapeutics, deteriorating patient and 12 clinical governance committees.

The Serious Incident Management Team (SIMT) met weekly in the hospital in line with its terms of reference and this meeting was chaired by the hospital manager. The terms of reference stated that its purpose was to ensure a robust process was in place for accountability, communication and consultation in relation to the management of incidents. A sample of agendas and meeting minutes demonstrated the team had oversight of incidents and reviews ongoing within the hospital and received regular updates. However, the terms of reference reviewed by inspectors were not signed and were missing a review date.

The Infection Prevention and Control (IPC) Committee reported directly to the executive quality risk and patient safety committee and by extension to the executive management team. It provided assurance on the governance and accountability framework for infection prevention and control in the hospital. Chaired by a consultant microbiologist, this committee had an appropriate membership, including a surveillance scientist, an antimicrobial pharmacist, hygiene services representatives and IPC nurses. The members met every three months in line with the terms of reference which were reviewed and agreed upon in August 2025. At the time of inspection, representatives of the IPC committee informed inspectors that the annual work programme and three-year strategy were ready for approval at their next meeting scheduled for March 2026. The committee provided a summary report twice a year and an annual report to the executive quality risk and patient safety committee. The committee received reports from the following subcommittees – decontamination, hygiene services, antimicrobial stewardship, environmental and waste, IPC team, and outbreak committee (this committee was convened as required). It was evident from minutes reviewed by inspectors that there was good oversight of compliance in the hospital with IPC key performance indicators, relevant audit findings and IPC risks being discussed. IPC committee representatives informed inspectors that changes would be occurring within the directorate structure once established. At the time of inspection, the IPC committee had no links with any regional HSE committees, but inspectors were told there were close links with the relevant regional Model 4 hospital.

Inspectors found the Drugs and Therapeutics Committee (DTC) function lacked effective strategic direction and designated administrative support at the time of inspection. The committee's terms of reference stated that it was an advisory committee that was responsible for the expert governance oversight and review of the service, in order to ensure safe and effective medication usage in the hospital. In line with the terms of reference, it aimed to meet eight times per year and had the following subcommittees report into it – Antimicrobial Stewardship (AMS) Team, Inpatient Palliative Care Services, Venous Thromboembolism (VTE) Committee and Medication Incident Review Team (MIRT). On review of minutes of this committee provided after the inspection, it was evident that the committee met five times in 2025. Chaired by a medical consultant and with appropriate membership, the drugs and therapeutics committee reported to the executive quality risk and patient safety committee, providing reports twice per year and also had a direct reporting line to the hospital manager and the executive clinical director. Meetings followed a structured agenda, with actions being assigned to a designated person; however, there was no evidence that these actions were time bound.

Inspectors were advised that the drugs and therapeutics committee strategy plan for 2025 remained in draft form at the time of inspection and had not been approved, despite this forming part of the compliance plan submitted by the hospital to HIQA following the previous HIQA inspection in early 2025. There was no drugs and therapeutics plan in place for 2026. Nonetheless, the committee did provide an annual report to the executive quality risk and patient safety committee for 2025. The terms of reference for the committee reviewed by inspectors were last approved in February 2024 and representatives of the committee informed inspectors during this current inspection that updated draft terms of reference had been circulated to members for review and approval at its next meeting. Inspectors were also told that the drugs and therapeutics committee was in a transition phase and the medication incident review team had been disbanded. It was noted by inspectors in other meeting minutes provided to HIQA, that a Medication Safety Committee had been 'stood up'. It was unclear from meeting minutes provided to inspectors if the Medication Safety Committee would have responsibility for medication incidents in the future, however hospital management confirmed that medication incidents would be discussed at directorate local incident management meetings. The drugs and therapeutics committee was also without dedicated administrative support and this was presenting a resource challenge for the committee.

Patient deterioration was formally discussed every month under the umbrella of a Deteriorating Patient Committee. The terms of reference of the Deteriorating Patient Committee (DPC) in the hospital outlined that it provided integrated leadership and governance over systems introduced for recognising and managing the deteriorating patient. On review of its terms of reference, the committee was chaired by the consultant clinical lead for the Deteriorating Patient Improvement Programme and it had multiprofessional clinical representation from the hospital as well as regional representation. It reported directly to the executive quality risk and patient safety committee and provided it with a report twice a year. However, the terms of reference were dated June 2024 with no evidence that they had been reviewed in June 2025 as set out in the terms of reference. Hospital management advised that this was due to a review of quality risk and patient safety functions that was underway at the time of inspection. The terms of reference stated that the deteriorating patient committee met monthly and this was reiterated by the deteriorating patient committee representatives when they met with inspectors.

Each meeting on a rolling basis appeared to focus on the work of three other separate sub-groups associated with this committee called the Early Warning Systems Group (EWSG), the Sepsis Group (SG) and the Resuscitation Committee (RC). Inspectors received three sets of minutes for each of the three sub-groups.

All minutes of these sub-groups provided to HIQA for review following the inspection were from 2025, and none were made available from 2026 at the time of the HIQA information request in February 2026 as they were in draft form. Documentation reviewed indicated that each sub-group met once every three months to discuss patient deterioration, with the EWSG meeting the first month, the SG meeting the next month and the RC meeting the third month. Terms of reference were not provided for two of the sub groups (EWSG and SG). In addition to the deteriorating patient committee, inspectors were told a Deteriorating Patient Steering Group was a nursing group in place that supported the implementation of actions arising from the committee, this group reported directly to the director of nursing.

Terms of reference for the Early Warning System Group (EWSG) were not available to inspectors. The group was chaired by a consultant physician and met every three months. Minutes provided to HIQA demonstrated a structured agenda was followed and actions were assigned to a designated person but were not time bound.

The Sepsis Group was chaired by the assistant director of nursing (ADON) for critical care and had wide representation from across the hospital. It met every three months and meeting minutes reviewed by inspectors demonstrated that meetings followed a structured agenda. Actions from these meetings were assigned to a designated person but were not time-bound, this was a similar finding in HIQA's previous inspection in January 2025. Terms of reference for this group were not provided to inspectors.

The Resuscitation Committee (RC) had a cardiology consultant as chairperson and an emergency medicine consultant as interim chairperson. This group met every three months and meeting minutes reviewed by inspectors demonstrated a structured agenda was being followed and actions were assigned to a designated person but were not time bound. Some actions remaining open across three quarterly meetings. Terms of reference were provided to HIQA for this committee.

There was no formal committee in University Hospital Kerry for transitions of care, even though this had been recorded on the hospital's corporate risk register (updated in December 2025) as being in place as an existing control measure. Limited documentation in relation to transitions of care was available as part of this inspection. Nevertheless, inspectors were informed that oversight for transitions of care lay with the executive clinical director through the executive quality risk and patient safety committee. Inspectors met with staff that work in the area of transitions of care and were informed of a number of status meetings where

transitions of care were routinely discussed locally within the hospital and also regionally.

In summary, the hospital had defined corporate and clinical governance arrangements in place. Despite this, HIQA found that these arrangements required strengthening. The efficiency of the executive management team was challenged by frequent high volume demand on services. A number of committees had not met as frequently as set out in their terms of reference or had not produced annual plans. There was a need for improved clarity around the reporting arrangements in relation to deteriorating patient structures. HIQA acknowledges the transition process discussed by representatives outlining what will happen once the clinical directorate structure is fully in place. Nonetheless, in the interim, there is a need to assess and review committee structures to identify and support their role. Areas for focus include:

- not all clinical directorates were embedded
- committee terms of reference not in date and/or signed
- a number of committees are not meeting in line with their terms of reference
- lack of administrative support for committees in line with their terms of reference.

Judgment: Partially 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 hospital had management arrangements in place to support the delivery of healthcare services in relation to the four areas of known harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. There were management arrangements in place to manage patient flow throughout the emergency department, the hospital and on to the community. However, these operational arrangements were not fully effective in supporting patient flow through the hospital, as a significant difference between demand for services and availability of beds was evident. At the time of inspection, this resulted in many admitted patients being accommodated on trolleys either in the emergency department or in hospital inpatient wards, along with delayed transfers of care from the hospital out to the community.

The infection control team followed the IPC annual work programme to ensure safe and reliable IPC practices in the hospital. They were also responsible for providing updates on the progress of its implementation. At the time of inspection this

programme was awaiting approval at the next scheduled meeting of the IPCC. The team had recently commenced using ICNet, a National Clinical Surveillance Infection Control System (NCSICS) that provides better tools for monitoring, tracking and responding to infection risks and continued to use the Integrated Patient Management System (iPIMS) for placing alerts to support the correct accommodation of patients. The hospital also had two consultant microbiologists available 24/7.

The clinical pharmacy service provision in the hospital was led by the executive pharmacist manager. Areas that were provided with a clinical service included oncology, maternity, psychiatry, palliative care, the emergency department and the medical wards. A service was also provided to three community hospitals. Hospital pharmacy services were available onsite during core working hours and for two hours on Sundays, outside of these times nursing administration had access to pharmacy stock. The hospital had two dedicated anti-microbial pharmacists who worked across all departments.

There were recognised processes in place to support the identification, escalation and management of a deteriorating patient. The national early warning systems (EWS) were in use in all clinical areas visited by inspectors and for their appropriate patient groups. Staff were aware of the $ISBAR_3$ tool, but clinical records reviewed showed the $ISBAR_3$ tool was not always used to ensure clear and structured handover. $ISBAR_3$ was used for clinical handover in the emergency department each morning and this was documented in a clinical handover book seen by inspectors. Inspectors were told there was a nominated consultant lead for each early warning system in the hospital and a clinical nurse manager 2 (CNM2) for the Deteriorating Patient Improvement Programme (DPIP). A critical care outreach team is also in place, inspectors were told this team review patients discharged from critical care to the wards, attend medical emergencies and are an important link between the intensive care unit and the ward teams. A resuscitation officer was also employed by the hospital to ensure compliance with national resuscitation guidelines.

Transitions of care were managed through the bed management and patient flow team that consisted of two clinical nurse manager 3s (CNM 3s), three clinical nurse managers 2s (CNM 2s) and three discharge coordinators. There were also three operations directors that ensured 7/7 coordination for capacity and site management. There were local and regional status meetings held weekly that were attended by one of the CNM3s and a daily meeting to discuss complex cases of delayed transitions of care (DTOC). On the first and second day of the inspection the number of DTOC was 19 and 14 respectively. A review of data on delayed transitions of care for the months preceding the inspection was undertaken by inspectors and

this showed the number range from 14 to 44, all of which exceeded the threshold set by the HSE of 10 for the hospital.

Over the course of the inspection, inspectors were made aware of a number of measures undertaken by hospital management to assist patient flow. Within the emergency department a hospital operational huddle was being held daily at 08.15hrs, attended by members of the executive management team and the operations director on duty each day. A number of admission avoidance pathways were in place with an acute trauma service (for minor injuries), a geriatric emergency medicine service (GEMS) and an acute medical assessment unit operating. A paediatric pathway directing some children to the paediatric assessment unit from the emergency department was also in place. Despite these measures, on the first day of the inspection, a total of 14 admitted patients remained in the emergency department awaiting a bed. Inpatient beds were available to hospital management for suitable medical and cardiology patients in a nearby private hospital and transfer of care was from consultant to consultant. Additional beds were also available to support access to scheduled care for orthopaedic cases. Inspectors were told that management were working through the process at the time of inspection to ensure that discharge communication for these patients was more consistent.

HSE acute hospitals use a colour scheme to describe hospital activity levels based on risk. These colours are black, red, amber and green, black being the highest level of activity. On the first morning of the inspection, inspectors were told that the hospital was in red escalation due to high levels of activity. There were a total of 57 patients registered in the emergency department at 11am. Fourteen patients were admitted and had been awaiting an inpatient bed for greater than 24 hours, two of whom were over 75 years of age. These patients were waiting on a trolley either in a cubicle in the emergency department or on a corridor adjacent to the department.

Patients in the emergency department were triaged on presentation using the Manchester Triage System. At 11am on the first day of inspection there was a total of 57 patients registered in the emergency department. Thirty five percent (35%) had been referred by a GP, 24% had arrived by ambulance and 41% had self-referred. The mean waiting times were as follows:

- 22 minutes from registration to triage (HSE time to triage = 15 minutes)
- 4 hours and 46 minutes from triage to medical assessment
- 25 hours and 18 minutes from decision to admit to admission to an inpatient bed

Data provided to inspectors for those aged 75 years and over showed:

- 16.7% of patients aged 75 years and over were admitted to a hospital bed or discharged within six hours after registration (*HSE 2026 target 95* %)
- 33.3% of patients aged 75 years and over were admitted to a hospital bed or discharged within nine hours after registration (*HSE 2026 target 99%)*
- 33.3% of patients aged 75 years and over were admitted to a hospital bed or discharged within twenty four hours after registration (*HSE 2026 target 100%).*

Scheduled and unscheduled care was overseen by the clinical operations group (COG) who updated the executive management team on activity within the hospital. Average length of stay (AvLOS) for patients was measured per ward and per consultant. Inspectors were advised on the first day of inspection that the AvLOS for medical patients was 15 days and for surgical patients 13 days. These figures were significantly higher than targets set out in the HSE's National Service Plan 2026. Increased length of stay is associated with poorer patient outcomes. Figures reviewed by inspectors for 2025 showed that the overall AvLOS for medical and surgical patients was 5.1 days and 7.1 days respectively which were closer to the targets set by the HSE. In minutes reviewed by inspectors, it was evident that the 30-day readmission rate to the hospital had increased to 16.8%, this was above the HSE target of less than or equal to 11%. Members of the executive management team advised inspectors that this was being examined further by hospital management. Challenges experienced by the hospital in relation to patient flow were discussed with inspectors and these included a greater demand than availability of inpatient capacity, an increase in emergency department attendances, a lack of community beds and appropriate home care packages, along with an ageing demographic.

In summary, the hospital had management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services but in relation to pharmacy arrangements these were not consistent in every clinical area and the use of $ISBAR_3$ was not imbedded. It was evident to inspectors that the executive management team reacted and responded to challenges experienced by the hospital but the significant difference between demand for services and availability of beds continued to negatively impact patient flow with staff dedicating significant time and resources to balancing and mitigating the associated risks. Areas for focus include:

- clinical pharmacy service provision not available in all clinical areas
- delayed transitions of care
- emergency department PETs, particularly for those aged 75 years and over, were not in line with HSE targets

- AvLOS greater than HSE targets.

Judgment: Partially 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.

University Hospital Kerry had systematic monitoring arrangements in place at the time of inspection to identify and act on opportunities to improve the quality, safety and reliability of healthcare services. However, inspectors found there was scope for improving clinical risk management in relation to the care being provided and enhancing clinical audit activity within the hospital to help ensure the safety and reliability of services.

The hospital collected and collated data relating to complaints and compliments, patient safety incidents, national key performance indicators (KPIs) associated with the quality and safety of services provided and workforce measures in line with HSE reporting requirements. This data was being reviewed monthly by the executive management team and at the Integrated Healthcare Area Kerry-UHK Performance meetings. The Executive Quality Risk and Patient Safety Committee had formal oversight of risk management in the hospital. Clinical governance groups had oversight of risks within their clinical service and reported to the Executive Quality Risk and Patient Safety Committee. In meeting minutes of the Emergency Department Governance Committee, reviewed by inspectors, the identification and review of risk had been noted in the minutes. Minutes from the Women and Infants Clinical Governance Meeting demonstrated risk oversight; however, in minutes from early February 2026 reviewed by inspectors a risk was identified and was to be put on the corporate risk register (a function of the executive management team) but this was not in place on this register at the time of the inspection in late February. Nonetheless, executive management team meeting minutes showed that risks for patients associated with the delivery of healthcare at the hospital were being discussed on a regular basis.

Evidence reviewed by inspectors indicated that the hospital was monitoring healthcare-associated infection prevalence and other data in the hospital. Rates of healthcare-associated infection were reported to the HSE's Business Information Unit on a monthly basis. Inspectors received meeting minutes that showed the Staphylococcus aureus rate is UHK 0.7 per 10,000 bed days used (BDU), the HSE national target is less than 0.7/10,000 BDU. Clostridium Difficile was also reported as

being 3.4/10,000 BDU, which is above the HSE target of less than 2.0/10,000 BDU. Inspectors also reviewed maternity-specific data collected by the hospital for 2025, this data, while in draft form at the time of inspection, contributes to the Irish Maternity Indicator System (IMIS) report published annually by the National Women and Infants Health Programme (NWIHP). The data demonstrated that maternity performance indicators, including therapeutic hypothermia and maternal sepsis rates, were in line with national rates previously published in 2024. The women and infants governance meeting also scheduled presentations for discussion and review and this presentation was provided to inspectors for review.

Despite a number of audit initiatives ongoing in the hospital, at the time of inspection there was no centralised governance or oversight in place for managing hospital audit findings, actions or recommendations, and as a result audit activity was being conducted in isolation within clinical areas and also by respective representative committees. Each committee managed its own audits and reported to the Executive Quality Risk and Patient Safety Committee, with the responsibility to implement recommendations resting with the approver of the audit. Inspectors saw in meeting minutes from the executive quality risk and patient safety committee that assurance on clinical audit could not be provided. Inspectors were told that the hospital had submitted a business case for a clinical audit facilitator to support development and oversight of the hospital's clinical audit function but this had not been approved. The lack of central coordination limited the hospital's Executive Quality Risk and Patient Safety Committee's ability to ensure the implementation of audit recommendations.

Patient safety incidents were reviewed in two ways within University Hospital Kerry as the hospital transitions to a clinical directorate structure. Category 2 incidents were reviewed by local incident management teams (LIMTs) where directorates were established and by the Serious Incident Management Team (SIMT) where the directorate was still progressing. More serious Category 1 incidents were reviewed by SIMT. The quality, risk and patient safety department kept a local referencing system for tracking and trending of incidents and this was reported to the executive management team and at the Integrated Healthcare Area Kerry-UHK performance meeting monthly. Since HIQA's previous inspection in 2025 education had been delivered to staff on incident management and on incident reporting through the electronic point of entry (ePOE) for the National Incident Management System (NIMS) and this was evident in discussions with staff in the clinical areas. Staff that spoke with inspectors acknowledged that more training and education was needed in particular with medical staff.

Unscheduled and emergency care (UEC) was monitored daily within the hospital by members of the executive management team and regionally at a daily UEC dial in.

Scheduled and unscheduled care activity data was reviewed monthly at the executive management team meeting and at the Integrated Healthcare Area Kerry-UHK performance meeting. Inspectors were made aware of a suite of exceptional surge measures implemented to respond to a surge in UEC presentations to the hospital prior to the inspection, and these remained in place at the time of inspection. Inspectors had been informed of the accommodation of medical inpatients in the postnatal ward as a surge measure, and were shown a completed risk assessment associated with this measure. In correspondence with hospital management following the inspection, HIQA highlighted the risk associated with this patient placement and were advised of additional measures implemented to militate risks to patient safety.

In summary, the hospital had some established systematic monitoring arrangements at department level to identify and act on opportunities to improve the quality, reliability and safety of care. However, improvements in the centralised oversight and governance of audit would assist in prioritising audits and ensure the implementation of associated audit recommendations. Further progression of the clinical directorate structure is required to promote greater local governance and oversight of risks. The full rollout of local incident management teams within each clinical directorate would enhance incident review and management at both department and hospital level. Areas for focus include:

- appropriateness of surge patient placement
- inconsistent review and validation of the corporate risk register
- no centralised oversight of audit activity
- implementation of quality improvements arising from audit
- continued education and training in incident reporting.

Judgment: Partially Compliant

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

Workforce arrangements in University Hospital Kerry were reviewed by inspectors to assess that they were planned, organised and managed with the objective of ensuring the delivery of high-quality, safe and reliable healthcare services. Inspectors reviewed meeting minutes where 178.53 WTE positions were reported as vacant with several key positions particularly across medical and health and social care disciplines unfilled. These vacancies had the potential to disrupt the hospital consistently meeting the needs of its patient. The shortfalls, along with the mitigation measures in place, were recorded in five workforce related risks on the corporate risk register. Workforce was discussed at the monthly executive management team meetings and workforce issues

were escalated to regional management at the monthly Integrated Healthcare Area Kerry-UHK performance meeting.

Data provided to HIQA after the inspection showed that almost 1 in 5 consultant posts (19.5%) in the hospital were vacant, with the bulk of the vacancies occurring in the specialty of medicine. Given that UHK is a Model 3 hospital providing acute medical care, inspectors viewed this as a significant shortfall in the consultant staffing complement. However, the documents also showed that vacancies were covered by locum consultants, and that funding had been approved for many of these posts. In documents provided to HIQA following the inspection, inspectors saw that there were 70.45 whole-time equivalent (WTE) consultant posts approved for the hospital. In the specialties of emergency medicine, obstetrics and gynaecology, microbiology and paediatrics all approved consultant posts had been filled. Eight consultants in post were not on the Irish Medical Council Specialist Division of the Register, and this was being managed in the hospital by the executive clinical director and hospital manager, in line with HSE processes. WTE deficits were as follows:

- medicine — 11 WTE vacant (8 of these 11 posts were at approval stage)
- radiology — 1.8 WTE vacant
- surgery — 1 WTE vacant.

In contrast, most non-consultant hospital doctor (NCHD) positions in the hospital had been filled; however, existing NCHD vacancies were at higher grades of experience. Inspectors were informed that consultant staff were supported by NCHDs across the four medical grades of specialist registrar, registrar, senior house officer (SHO) and intern, to provide 24/7 medical cover in the hospital. The hospital had approved funding for 212 NCHD WTEs, with 200 WTEs in post, leaving 12 WTEs vacant across registrar (9 WTE) and senior house officer (3 WTE) grade.

Most approved nursing and midwifery posts had been filled, but almost 15% of healthcare assistant posts were vacant. The number of approved nursing and midwifery posts in the hospital was 614.42 and 109.57 WTEs respectively, inclusive of all grades including nursing and midwifery management. At the time of inspection, 3.7% of nursing posts and 4.5% of midwifery posts were unfilled. Nursing and midwifery staff were being supported by healthcare assistants. Of the 111.78 WTE healthcare assistant positions approved, 95.14 WTE positons were filled, leaving a deficit of 16.64 WTEs healthcare assistants at the time of inspection.

Over one in five health and social care professional posts were vacant, with particular shortfalls in the areas of physiotherapy and dietetics. The hospital had approved funding for 130.8 WTE health and social care professionals across the

professions of physiotherapy, occupational therapy, social work, dietetics and radiography. There were 103.97 WTE posts filled with vacancies in each of the disciplines — physiotherapy (11 WTE deficit out of 44.13 approved WTEs), dietetics (4.65 WTE deficit out of 11.75 approved WTEs), occupational therapy (1.86 WTE deficit), hospital social work (1.6 WTE deficit) and radiography (7 WTE deficit).

The emergency department (ED) medical staffing had been increased since HIQA's previous inspection in January 2025. The department operated with four consultants present in the department Monday to Friday, two of whom were rostered until 8pm, and also provided a 24/7 on-call service. There were 16 NCHDs rostered daily over a 24-hour period in the department. Nursing management for the ED comprised of one WTE assistant director of nursing (ADON), one WTE clinical nurse manager 3 (CNM 3), 8.3 WTE CNM 2s and 7 WTE CNM 1s with a total of 58.9 WTE registered general nurses. There were no vacant nursing posts in the ED; however, staff who spoke with inspectors said that this nurse staffing complement was for ED attendances only and did not include staffing for admitted patients awaiting a bed, which on the first day of the inspection was 14 patients. Inspectors were also made aware of gaps in nursing cover for the paediatrics bays in the ED, and this is discussed further under national standard 3.1. Nurses were being supported by 7.2 WTE healthcare assistants which was 0.8 WTE short of their approved 8 WTE. Seven WTE advanced nurse practitioners (ANPs) and 2 WTE candidate advanced nurse practitioners (cANPs) were also working within the department. There was one WTE hospital social worker funded for the department and this post was filled with 0.8 WTE.

Cashel paediatric ward had five consultants who were supported by 16 NCHDs. The ward had an advanced nurse practitioner in paediatrics and a clinical nurse specialist in life-limiting conditions. The ward was managed by a CNM 2 and a CNM 1 with oversight from an ADON. There were 23 out of the approved 26.62 RGNs in post, 13 of whom had formal paediatric training. They were supported by 1.6 healthcare assistants in the ward. This ward also had support from a hospital social worker — 0.5 WTE, a speech and language therapist — 0.25 WTE and two WTE administrative staff, with one assigned to the ward and one to the paediatric assessment unit.

Ardfert antenatal ward had one WTE clinical midwife manager 3 (CMM 3), 5.76 WTE CMM 2 and oversight from one WTE assistant director of midwifery (ADOM) to manage the midwifery activities within the department. There were 21.32 WTE midwives that were supported by 2 WTE HCAs, with no vacancies in this ward. There were six WTE consultant posts funded in the Women and Infants Directorate within the hospital and all posts were filled.

Sceilig medical ward had an allocation of one WTE CNM 2 and one WTE CNM 1 to

manage nursing activities. They had 27.5 WTE RGNs who were supported by 10 HCAs and one multi-task attendant. There were no vacancies on this ward.

The pharmacy department WTE had an improvement in its funded positions since HIQA's last inspection in January 2025 but were still carrying a significant deficit. The approved posts were 19.6 WTE across pharmacy manager, senior and staff pharmacists, and pharmacy technician grades. A deficit of 4.1 WTE at senior pharmacist grade was noted by inspectors (a medication safety pharmacist had been recruited but was not in post at the time of inspection) and discussed with members of the drugs and therapeutics committee where the negative impact on service delivery and expansion was outlined.

There were two WTE consultant microbiologists in the hospital, one permanent and one temporary. However, they did not have any NCHD support at the time of inspection and these consultants provided 24/7 cover to the hospital across the year. The infection prevention and control team comprised of one WTE ADON and three WTE CNM 2 to manage the infection prevention and control activities across the hospital Monday to Saturday.

The average absenteeism rate in the hospital for 2025 was 6.99% representing a decrease since HIQA's previous inspection. However, this remained above the rate of less than 4% set out in the HSE's National Service Plan 2026. Nursing back-to-work interviews were monitored by the nursing human resources (HR) lead and training was being rolled out for managing attendance at work. Ongoing supports such as occupational health and an employee assistance program were also available to staff. Absenteeism was reported at the Integrated Healthcare Area Kerry-UHK performance meeting and targets had been set for further improvements in 2026.

CNMs, CMMs and clinical skills facilitators had oversight of nursing and midwifery staff attendance and completion of mandatory and essential training within their clinical areas of the hospital. A central repository had been set up immediately before the inspection to capture nursing mandatory and site-specific training records. Essential and mandatory training for NCHDs was recorded on the National Employment Record (NER) system and for consultants it was via the appraisal process. Training records, of staff who had attended training over the past 24 months, provided to inspectors following the inspection showed compliance with mandatory and essential training to be lower than expected. For standard- and transmission-based precautions training compliance for nurses was 50%, midwives 100%, healthcare assistants (HCAs) 78%, HCAs working in the maternity directorate 100%, doctors 0% and for health and social care professionals it ranged from 38–50% depending on profession group. Standard precautions are routine infection prevention and control practices and measures that should be used for all people at

all times. Transmission-based precautions are extra measures to help prevent the transmission of certain infectious agents. Mandatory sepsis training compliance was 42% for nurses, 72% for doctors and 100% for midwives. Compliance for the Irish National Early Warning System training was 56% for nurses and 26% for doctors and for Basic Life Support training it was 54% for nurses, 85% for midwives, 25% for HCAs, 100% for HCAs working in the maternity directorate, 66% for doctors and ranging from 11–87.5% for HSCPs. For the Irish Maternity Early Warning System training 48% of nurses were trained along with 100% of midwives and 72% of doctors.

In summary, several key positions across various disciplines remained unfilled at the time of the inspection, and this had a notable impact on service delivery. Recruitment efforts were ongoing but inspectors were told that the process was lengthy and hospital management faced challenges with recruitment. Mandatory and essential training requires considerable focus to ensure an increase in compliance. Areas for focus include:

- vacancies of medical consultants, health and social care professionals and healthcare assistants identified
- absenteeism rate greater than HSE target
- sub-optimal compliance with mandatory and essential training.

Judgment: Partially Compliant

Quality and Safety Dimension

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

University Hospital Kerry was found to be substantially compliant with two national standards (1.6 and 1.8), partially compliant with two national standards (2.7, 3.3) and non-compliant with one national standard (3.1).

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

Inspectors noted through observation in the clinical areas and through discussions with staff and management in the hospital the importance of promoting dignity,

privacy and autonomy for all service users. While inspectors observed many examples of good practice being promoted by staff, some improvements to enhance the privacy of interactions with patients were required in and around the emergency department, notwithstanding the challenging physical layout of some areas inside and adjacent to this department.

Findings in relation to the Emergency Department

On the first morning of the inspection, inspectors noted there to be 57 patients registered in the department at 11.00am, and inspectors were told that the hospital was in red escalation. Staff were observed to be kind and caring when interacting with patients within the department and were responsive to their needs. Measures had been put in place by the hospital to promote the privacy and dignity of patients, and inspectors were shown a dedicated family room, a mental health assessment room and a gynaecological assessment room. Patients accommodated in individual cubicles had their privacy and dignity supported. Staff told inspectors that maintaining privacy and dignity was a challenge in escalation times when patients were accommodated on trolleys and chairs in the overcrowding corridors within the department. Where possible staff would bring patients to a quieter room, in particular for examinations or by night to promote privacy and dignity. While in the department, inspectors observed patient-clinician conversations and examinations occurring on the corridor, where other members of the public were present. In this setting it was impossible to maintain privacy and dignity for the patient and this was brought to the attention of the CNM at the time.

This was also documented as an issue in meeting minutes reviewed by inspectors and was addressed in September 2025 by emergency department management. This practice is not consistent with a human-rights based approach to healthcare promoted and supported by HIQA. When inspectors spoke with patients in the department they received mixed responses, some positive including "so kind and explained everything", "everyone is kind and attentive" and less positive feedback including "I have to wait for someone to pass to call for help, I have no call-bell".

During discussions with hospital management inspectors were informed of volunteers available to assist patients, to make phone calls or to access food or beverages during their wait in the emergency department. Inspectors also noted patient advocacy information on display in the department.

Findings in relation to other clinical areas

Staff in the inpatient clinical areas visited during this inspection were observed by inspectors to be respectful, promoting the dignity, privacy and autonomy of patients. Patient details were not seen on whiteboards, electronic healthcare records used in

one clinical area were password protected and privacy curtains were drawn when providing care. The physical environment in these clinical areas was more conducive to promoting privacy and dignity with single rooms being used for end-of-life care when required. Patients were accommodated in mixed gender rooms but the patients that inspectors spoke with were not concerned about this and a risk assessment had been completed by staff identifying any possible risks and outlining measures to mitigate against them.

Staff were observed assisting patients with mobility, at meal-times and with medicines, and promoting patient dignity, for example, through the use of appropriate communication. However, it was noted by inspectors that privacy curtains did not always provide adequate privacy for patient-clinician conversations particularly in the antenatal assessment area. In the paediatric ward children were encouraged to dress in day clothes while inpatients and parents were also assisted by staff.

In some clinical areas information was available to patients on the ward routine, mealtimes and staff on duty and in all clinical areas visited there was information available on advocacy services available in the hospital. A volunteer's desk, to support patients and their families, was also noted in the reception of the hospital and this was operated Monday to Friday.

In summary, staff promoted privacy, dignity and autonomy in University Hospital Kerry however, any meaningful efforts particularly in the emergency department were negated by the department's physical environment and the challenges experienced by the hospital when it was in escalation. An area for focus:

- episodes of care where privacy, dignity and autonomy are not promoted by all in the emergency department.

Judgment: Substantially Compliant

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

There were systems and processes in place in the hospital to respond to and manage complaints both at a local ward level and at a wider hospital level. Nonetheless, some improvements were required to further promote staff knowledge and visibility for patients of the full range of complaint mechanisms within the hospital. The complaints coordinator worked within the Quality, Risk and Patient Safety Department and provided reports on complaints to:

- the executive quality risk and patient safety committee
- the executive management team
- the integrated healthcare area manager at the Integrated Healthcare Area Kerry-UHK performance meetings.

Inspectors were provided with meeting agendas and minutes that showed complaints were discussed at each of these forums. Inspectors were told that once the clinical directorates have been fully established, complaints will be discussed at clinical directorate level. Evidence of this already occurring was provided to inspectors as complaints were being discussed at the Women and Infants Clinical Governance meeting, the longest established clinical directorate at the time of inspection.

The hospital used the HSE's complaints management policy 'Your Service Your Say' (YSYS), and posters promoting this were on display throughout the hospital. Leaflets were also provided along with a Quick Reference (QR) code that took service users directly to the YSYS website. There was also information available on the feedback processes in the hospital and forms were available in one clinical area visited. One service user told inspectors they would speak to a nurse or a member of staff if they had a complaint; however, most patients who spoke with inspectors expressed their satisfaction with the care received. One service user told inspectors that they "wouldn't know how to give feedback" and another expressed a view that there would be "no point" making a complaint.

Inspectors were informed that local resolution to address stage-1 complaints (verbal complaints dealt with immediately or within 48 hours) was increasing within the hospital. In addition, they were told that there was a complaint log in each clinical area for verbal complaints, although some staff were unaware of this. Staff were aware that verbal complaints were resolved locally where possible in line with policy. Where resolution was not possible staff escalated the matter up through the line management structure or to the complaints coordinator.

Formal or written (stage-2) complaints received by the hospital were brought to the attention of the manager of an area, or to any staff member involved, and a response was formulated with the support of the complaints coordinator. In 2025, the hospital received a total of 150 stage-2 complaints, and this represented a reduction from 2023 and 2024. Inspectors were told that complaint resolution within 30 days of being acknowledged by a complaints officer ranged from 72% in early 2025 to 33% in late 2025. These figures were below the HSE National Service Plan target of 75% for 2025. Inspectors were informed of three stage-3 internal reviews and five Office of the Ombudsman reviews from complaints received by the hospital in 2025. Complaints were tracked and trended by department and by category.

Inspectors were told and saw documentation to show the emergency department received the most complaints and the top categories of complaints were access, communication and dignity and respect.

Staff informed inspectors of quality improvement plans that were in place following complaints. Patients in the waiting room in the emergency department were checked more frequently with a staff member designated to this role, while senior midwifery managers meet with women after the birth of their baby and prior to discharge home to discuss their care and their inpatient stay. A care bundle and staff training were in place in relation to skin care and pressure ulcers. A quality improvement plan was also in place within the quality risk and patient safety department to improve compliance with complaint metrics and point of contact resolution.

In summary, the hospital had systems and processes in place to respond to and manage complaints but these were not as effective as they could be. Hospital management should continue to implement measures to ensure national metric targets set by the HSE are met so as to improve the experience of people using the service and promote consistency in complaint resolution across all departments. Areas for focus include:

- continue efforts to encourage local resolution of stage-1 complaints
- sustain and measure the effectiveness of the quality improvement plan to improve compliance with HSE's 5- and 30-day KPI.

Judgment: Substantially 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.

During the inspection, inspectors observed the physical environment to be generally clean and well maintained in the clinical areas visited, with a few exceptions.

Nonetheless, a number of improvements were required to the storage of hazardous cleaning products, safe disposal of bodily fluid related items, management of sharps bins, management of a clinical emergency exit and the lack of storage space in the emergency department. Wear and tear to paint and woodwork and some floor surfaces were observed by inspectors in all areas inspected, which did not facilitate effective cleaning and posed an infection control risk. Each of the areas visited were observed to have adequate toilet and bathroom facilities for patient use. It was noted in the emergency department that a number of toilets did not have a call-bell mechanism to alert staff if a patient required assistance.

Wall-mounted alcohol-based hand-sanitiser dispensers were observed to be appropriately placed and readily available for clinical staff and those checked by inspectors were filled. Clinical hand-basins did not always conform to Health Building Note 00-10 (HBN 00-10) requirements and in two areas a blocked basin and a broken basin were brought to the attention of staff by inspectors. Infection control and prevention signage was in place where appropriate alerting staff to the precautions to be taken. Personal protective equipment (PPE) was available outside single-bed isolation rooms and along corridors and staff were observed using PPE correctly. Physical spacing of one metre around beds (as advised by the Health Protection Surveillance Centre) was maintained in multi-occupancy rooms in the inpatient areas visited. However, in the emergency department this distance was not maintained between trolleys in the overcrowding corridors (corridors adjacent to the department used in times of high activity).

Inspectors were told that the hospital had 32 single-bed isolation rooms. Seven more single-bed isolation rooms were due to be available by the end of June 2026 as work was progressing for the development of an additional 30 inpatient beds for the hospital. Risk assessments relevant to these building works and the risk of aspergillosis were provided to inspectors for review. The limited capacity for isolation at the time of inspection remained a significant challenge for the hospital.

Environmental cleaning was carried out by hospital staff and by contract cleaners employed by the hospital, with supervisors for both staff groups overseeing cleaning. A housekeeping quality coordinator was in post in the hospital, and their role was divided between managing hygiene and managing waste. Clinical nurse managers in each of the clinical areas visited also had oversight of cleaning and would liaise directly with cleaning staff if an area required immediate attention. In the emergency department, environmental cleaning schedules were not visible in the bathroom facilities inspected, and in one inpatient ward cleaning schedules were not always up to date. Inspectors also observed bodily fluid samples in a sluice room (a room used for the safe disposal of human waste and disinfection of associated equipment) which were yet to be discarded appropriately, and these were brought to the attention of the staff at the time.

Healthcare assistants carried out cleaning of hospital equipment in each of the clinical areas and inspectors observed cleaning schedules setting out the frequency of cleaning and green tags used to indicate that equipment was clean in the in-patient areas visited. Maintenance requests were made through an online request system and staff advised they could contact maintenance by phone if a request was more urgent. Inspectors were informed of maintenance work undertaken in Cashel ward in 2025. On equipment inspected, service history was noted to be in date.

Corridors in the in-patient areas visited were generally clear of items, although one area had limited storage space and items were stored on the corridor. The lack of storage and space was also evident in the emergency department. A clinical emergency exit from one area out to a corridor in the emergency department was blocked by seating on the first morning of the inspection and was brought to the attention of staff. This exit was aimed at providing a quick exit from the paediatric bays to the resuscitation area in the event of an emergency. This sliding door was later observed to be still blocked in the afternoon and was brought to the attention of senior management by the inspectors as a risk. Inspectors were informed that the matter would be addressed. A storage room in the emergency department contained a mixture of ready to use clean items, such as PPE, and a rollable cage with discarded items, such as crutches. Numerous boxes of supplies were on the floor leaving very little circulation space for staff, posing an injuries risk that could impact on staff availability for patients attending the emergency department. The rollable cage had been noted by inspectors as an item for action for hospital management in the previous HIQA inspection in January 2025.

Hazardous chemicals used for cleaning were inappropriately stored on the floor in the emergency department sluice room, and sharps bins were found to be open or in a semi closed position in more than one area visited. Medicines were generally stored appropriately; however, inspectors noted insulin stored in the fridge in two areas visited where the patients had been discharged (best practice would be that such medicine be discarded once the patient is discharged).

The security office for the hospital was at the entrance of the emergency department, and inspectors were told that a security presence was stationed there throughout the day. Despite this, inspectors noted on more than one occasion during the first day of the inspection that a security presence was not available when inspectors called to the department. Inspectors noted during the inspection, that Closed-Circuit Television (CCTV) was in operation in the emergency department waiting room, and at the entrance to Cashel ward. It was brought to the hospital management's attention that the appropriate signage to inform service users of this was not in place.

In summary, the physical environment and patient equipment in the clinical areas inspected was observed to be generally clean. However, inspectors were not assured that the physical environment supported the delivery of high-quality, safe and reliable care, noting the insufficient number of single-bed isolation rooms, the lack of available storage in clinical areas, the inappropriate storage of hazardous materials and items left in a sluice room instead of being disposed of correctly.

Areas for focus include:

- items not discarded appropriately or immediately after use
- clinical emergency exit door blocked
- cleaning schedules not up to date
- inappropriate storage of hazardous materials
- no signage advising of CCTV is in place
- ensuring sufficient security presence in the emergency department, where gaps are identified.

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 in place to identify, evaluate and manage risks to service users in the four key areas of known harm; however, inspectors found that these could be improved upon. In the areas inspected, patients were not being adequately protected from the risk of healthcare-associated infections due to limitations arising from the hospital infrastructure. Inconsistencies in risk management processes in the hospital were identified by inspectors, which meant that patients were not always benefiting from measures aimed to reduce risks to them in the delivery of their care. At the time of inspection, six risks related to the four areas of known harm had been recorded on the corporate risk register for the hospital. The executive management team had oversight of the risks, controls and militating actions against the risks identified. These risks included:

- risk to patients developing a healthcare-associated infection
- transitions of care
- non-compliance with deteriorating patient improvement programme.

A number of these risks had remained on the corporate risk register for the hospital since 2023. The inspectors were not assured that all risks had been formally reviewed in line with the risk management processes for the hospital as outlined to inspectors. For example, inspectors were advised that the register had been validated in December 2025, while on review of the document by inspectors the last recorded action update was September 2025. Local risk registers were held in each clinical area visited by inspectors, and in some areas the clinical nurse manager 2 (CNM 2) had oversight of this and had responsibility for implementing actions to reduce the risk. In other areas, this was the responsibility of the CNM 3, clinical midwife manager 3 (CMM 3), the assistant director of nursing (ADON) or assistant director of midwifery (ADOM). While not mandatory in the hospital, not all staff who

spoke with inspectors, and who might benefit from such training, had received training in risk management.

Screening for multi-drug resistant organisms (MDROs) occurred in the hospital in a targeted manner. Each patient was risk assessed, and screening occurred based on this risk assessment. High-risk areas, including the intensive care unit, the dialysis unit and the special care baby unit, undertook screening on all patients on admission and weekly for the duration of the patients' stay. A sample of healthcare records reviewed by inspectors had this screening documented. The patient information management system for the hospital also identified patients who had previously had an MDRO. Inspectors spoke with infection prevention and control (IPC) representatives that informed them that an audit had been carried out in 2025 showing non-compliance with Carbapenemase-Producing Enterobacterales (CPE) screening, and feedback was given to individual ward managers in regard to this. In meeting minutes reviewed by inspectors the compliance rate reported ranges from 80-100%. To align with the HSE's National Clinical Guideline for CPE which had itself been updated in 2025, the draft CPE policy for the hospital had been written but was unavailable to staff at the time of inspection, until the approval process for policies within the hospital was complete. Staff in all clinical areas assured inspectors that they can contact IPC nursing staff during core working hours and contact a microbiologist 24/7. Staff also had access to an antimicrobial pharmacist.

At the time of the inspection, there were no active infection outbreaks in the hospital. The hospital provided inspectors with an overview of outbreaks in 2025 that came to a total of 33 for the year. Outbreak committee meetings were convened when required. An outbreak report provided to inspectors for review outlined control measures implemented to mitigate actual and potential risks to patient safety. It detailed contributing factors, lessons learned and recommendations to reduce the risk of reoccurrence. Inspectors also reviewed the policy for the management of outbreak of infection in University Hospital Kerry that was based on the National Clinical Guideline No.30. Due to the limited availability of single-bed isolation rooms in the hospital, patients with an infective status could not always be isolated within 24 hours of admission or diagnosis. This was contrary to national guidance. Nonetheless, in these instances, inspectors were informed that patients were accommodated together in a multi-occupancy room to mitigate against any potential risks of infection spreading further.

Inspectors were told that the clinical pharmacy service provision was not comprehensive across all clinical areas in the hospital, with some clinical departments having no dedicated pharmacist. Inspectors were advised that a pharmacist was present in the emergency department for three to four days per

week focusing on patients for admission and carrying out medicine reconciliation in order to detect potential prescribing errors. Inspectors were advised that the absence of a dedicated pharmacist for the intensive care unit was on the risk register. Staff who spoke with inspectors were aware of risk reduction strategies implemented in the hospital to support the safe use of high-risk medicines. Posters detailing these strategies were observed in some of the clinical areas visited, and inspectors reviewed a draft quality improvement plan for managing patients on time-critical drugs in the emergency department. Audit activity and the development of policies, procedures and guidelines for medicines had been negatively impacted by vacancies within the pharmacy department.

Measures to promote and support good prescribing were described to inspectors, such as the use of prescribing reference apps on computer desktops throughout the hospital. However, staff that spoke with inspectors in the emergency department were not aware of these and were unable to locate them on computer desktops in the resuscitation area when asked by inspectors. Designated areas for the preparation of medicines were available, and refrigerators for medicine storage were appropriately locked, but monitoring of the refrigerator temperature was not recorded consistently in each of the clinical areas visited. Inspectors observed good storage and custody of medicines in three clinical areas. An issue with the storage of controlled medicines in one clinical area was brought to management's attention while on inspection, and inspectors were also made aware of an incident that occurred in another clinical area in relation to the custody and storage of controlled medicines. In correspondence with hospital management following the inspection, HIQA highlighted its concerns in relation to these occurrences and received assurances from management at the hospital of additional measures being implemented to mitigate against associated risks.

There were structures and processes in place in the hospital to recognise the deteriorating patient. In clinical areas visited the national early warning systems for the deteriorating patient were being used, including the Irish National Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Emergency Medicine Early Warning System (EMEWS) and Paediatric Early Warning System (PEWS). These early warning systems are based on recorded clinical observations by nursing staff throughout the patient's journey. The use of ISBAR$_3$ (a structured communication framework to improve patient safety) was also encouraged for clinical handover. As mentioned in national standard 6.1, compliance with mandatory training for the early warning systems ranged from: INEWS 26–56%, IMEWS 48–100%, EMEWS 29–77% and IPEWS 6–48% across specialities. Mandatory training for sepsis ranged from 42%–100%. In 2025, a practice called 'intentional rounding' had been introduced. This involved senior nursing staff checking the status of

patients who had been flagged through the various early warning systems as being at risk of their condition deteriorating. In this way staff were seen to be supported in the management of this risk. A morning and afternoon safety huddle had also been rolled out on a phased basis for the medical wards and compliance with attendance was monitored. Inspectors reviewed quality improvement plans that had been developed to improved attendance.

One audit undertaken for the last three months of 2025 reviewed by inspectors showed that clinical documentation relating to deteriorating patients required significant improvement. Despite this, no quality improvement plan associated with this audit finding was included in documentation provided to inspectors following the inspection. Audit results, provided to inspectors, relating to the completion of venous thromboembolism assessment on admission to the maternity services showed that this assessment was undertaken on all charts audited. Nonetheless, meeting minutes reviewed by inspectors detailed that University Hospital Kerry was trending higher than other hospitals for the occurrence of venous thromboembolism. In a number of clinical areas inspectors observed that the resuscitation trolleys had not been checked in line with the process in place in the hospital. Staff who spoke with inspectors were aware that this was an issue following a recent audit of resuscitation trolleys. Policies for managing the deteriorating patient (adult and obstetric), including sepsis, within the hospital were reviewed by inspectors and it was noted that for a number the date for review had passed. Inspectors were also made aware of a number of incidents being managed under the HSE's incident management framework relating to deteriorating patients.

The oversight for transitions of care within the hospital lies with the executive clinical director through the executive quality, risk and patient safety committee. Inspectors were informed that the list of priorities relating to transitions of care were being reviewed at the time of the inspection with the quality risk and patient safety department. Regional and community links were in place to optimise discharge from the hospital with members of community clinical teams attending the hospital for ward rounds and case conferences. Delayed transfer of care (DTOC) numbers in relation to patients ready to be discharged from the acute setting were high at the time of inspection and in the preceding months prior to the inspection. This was because discharge of patients from the hospital was difficult for complex cases despite daily meetings with the community intervention team (CIT) and staff from the integrated care programme for older persons (ICPOP). Delayed transitions of care were also discussed at a weekly hospital DTOC meeting and weekly at HSE regional level. They were also highlighted and discussed at the monthly Integrated Healthcare Area Kerry-UHK performance meeting.

Inspectors reviewed a small number of policies related to transitions of care within and from the hospital. Inspectors discussed risks associated with comprehensive

patient transfer processed and concerns that such transfers required enhanced policies and procedures. Following HIQA's previous inspection in 2025 a policy relating to the transfer of patients to a private provider was to be developed. This policy was noted by inspectors on this inspection to be in draft format only and did not cover aspects such as escort of patients or mode of transport for patients being transferred. Following the inspection, HIQA wrote to hospital management seeking assurances in relation to this aspect of care. One item had been escalated to the corporate risk register and remained there since 2024 relating to other aspects of transitions of care. While existing controls had been documented as being in place, inspectors found that some of these controls were not active at the time of inspection, such as the presence of a transitions of care committee.

Concerns in relation to the effectiveness of clinical handover processes within the hospital was in the hospital's corporate risk register. Senior staff in the emergency department highlighted clinical handover as a risk in the absence of a real-time electronic whiteboard, compared to the need to manually update the existing whiteboard and marker system in use in the department. An audit of documentation of clinical handover undertaken on maternity patient charts showed only 24 of 99 charts reviewed had documented the clinical handover in full, and inspectors were provided with the quality improvement plan that had been developed to target this low result.

The following data was made available for inspectors to review in the HSE's Urgent and Emergency Care Performance Report. This recorded that there had been 48,531 attendances at the emergency department during 2025. Of these, 8,289 were aged 75 years and over, and 3,012 left the department without being seen or having their treatment completed. The department had processes in place to follow up these patients.

Data reviewed for 2025 showed that the hospital did not align with the HSE's targets for patient experience times in the emergency department, and each measure had declined since HIQA's previous inspection in January 2025, including as follows:

- 54.9% of patients were admitted to a hospital bed or discharged within six hours after registration (HSE 2025 target 70%)
- 72.6% of patients were admitted to a hospital bed or discharged within nine hours after registration (HSE 2025 target 85%)
- 95.1% of patients were admitted to a hospital bed or discharged within 24 hours after registration (HSE 2025 target 97%).

Representatives of the executive management team told inspectors that the emergency department had seen an increase in attendances and attributed this to

an ageing population, global migration-related increase in the population within the hospital catchment area and reduced access to general practitioners (GPs). An increase in the number of non-consultant hospital doctors rostered by night to assist patient flow and mitigate inherent risks was noted by inspectors. Admission avoidance pathways such as the redirection to the Acute Medical Assessment Unit (AMAU) had also been implemented and was overseen at consultant level. The Paediatric Assessment Unit (PAU) was also operating out of Cashel ward and following triage in the emergency department, children who meet a specified criteria were redirected to the PAU for further assessment. This was in an effort to create more space for adult patients within the emergency department; however, on the first morning of inspection inspectors observed an adult awaiting clinical assessment in one of the dedicated paediatric bays while a child was also awaiting assessment in an adjacent bay. This was brought to the attention of management on the day as it conflicts with the HSE's National Healthcare Charter for Children 2018, which outlines that there should be audio-visual separation of children from adults within an emergency department. In addition, the paediatric bays in the emergency department were left without nurse cover whenever the nurses covering the paediatric bays had to perform other essential duties elsewhere, this was a similar finding during HIQA's inspection in 2025. In correspondence following the inspection, HIQA reiterated its concern regarding the separation of adult and children in the emergency department to hospital management, along with its concern regarding nurse cover for the paediatric bays in the department. Hospital management had responded to HIQA with proposed measures to address these issues at the time of preparing this inspection report.

In summary, HIQA was not satisfied that the hospital had adequate systems in place to identify and manage the potential risk of harm to patients at the hospital. The corporate risk register for the hospital should be formally and regularly reviewed and updated, and continued education provided for relevant staff in relation to risk assessment and risk management. Not all patients were being adequately protected from the risk of healthcare-associated infections in the areas inspected. A greater focus and structure on transitions of care within and from the hospital is required to ensure compliance with best practice and national policies and guidelines. Compliance with mandatory and essential training in relation to early warning systems along with staffing deficits in the pharmacy department need to be addressed as a priority.
Areas for particular focus include:

- associated controls and actions recorded on the corporate risk register not in place are reviewed and updated regularly
- insufficient number of single-bed isolation rooms available
- clinical pharmacy service provision not available in all clinical areas

- staff training for early warning systems sub-optimal
- clinical handover not supported with live data in the emergency department
- policy relating to the transfer of patients to a private provider not in place
- transitions of care committee not in place.

Judgment: Non Compliant

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

Patient-safety incidents were directly reported to the National Incident Management System (NIMS), in keeping with the HSE's Incident Management Framework. On the HSE South West Region Quality and Safety Dashboard reviewed by inspectors there were a total of 1,495 clinical incidents reported in 2025. The number of serious incidents and serious reportable events on the quality and safety dashboard for 2025 was fifteen and two respectively.

Incidents were being notified through an electronic point of entry (ePOE) and the icon for this system was seen by inspectors on computer desktops in the clinical areas visited. Training on incident reporting had been provided to the staff who spoke with inspectors; however, members of the executive management team told inspectors more training and education was required to improve incident reporting.

Once reported on NIMS, incidents must then be approved for them to be visible to senior hospital management teams. In data provided by the hospital to HIQA after the inspection, inspectors noted that 234 electronic point of entry notifications were awaiting approval in the hospital, as of the 22 January 2026. Inspectors reviewed meeting minutes from the executive quality risk and patient safety committee that considered increasing the number of approvers within the hospital and to further develop the local incident management teams associated with each directorate to improve oversight.

As previously mentioned in national standard 5.8, Category 2 incidents were reviewed by local incident management teams (LIMTs) where directorates were established and by the Serious Incident Management Team (SIMT) where the directorate was still progressing. More serious Category 1 incidents were reviewed by SIMT. Incidents were tracked and trended by the quality and patient safety department and discussed at the executive quality risk and patient safety committee and at the executive management team meeting. In 2025, a review of all recommendations from patient safety events (category 1 and 2) was undertaken,

cross referencing data held by the hospital with details held on the National Incident Management System. In a status report of this review, submitted by the hospital to the integrated healthcare area manager and reviewed by inspectors, recommendations from patient safety events were shown to now be organised by directorate allowing for directorate-led oversight of all recommendations, with SMART (Specific, Measurable, Achievable, Relevant and Time-bound) methodology applied.

Evidence of directorate-led oversight was seen by inspectors in minutes from the Women and Infants Directorate Management Team meetings, one of the established directorates in the hospital. It was confirmed when inspectors met with members of this directorate that they held a local incident management team meeting called the Maternity Incident Management Team (MIMT) meeting every two weeks for the review of all category 2 and 3 incidents. The women and infants directorate also had regional links with the Ireland South Women and Infants Network in relation to incident management.

Medication incidents had previously been reviewed by the Medication Incident Review Team (MIRT), but inspectors were told that this would be the responsibility of the Medication Safety Committee in the future. Inspectors also reviewed meeting minutes that suggested medication incidents would be reviewed at local directorates. Members of the drugs and therapeutics committee informed inspectors that incidents are classified in line with the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) categorisation. One hundred and forty one incidents involving medicines were recorded for 2025, one hundred and twenty two of these were categorised as 'no harm' incidents. Medication incident reporting was noted to be very low in meeting minutes reviewed by inspectors.

Inspectors were told at the time of inspection that ten incident reviews were ongoing for the hospital. These were divided between comprehensive or concise reviews in line with the HSE's Incident Management Framework. A radiology review conducted in 2025 had been completed and submitted to the Commissioner of the review. Inspectors were also informed that a review of the National Inpatient, Daycase and Planed Procedure and Gastrointestinal Waiting List Management Protocol had been undertaken when the hospital discovered it had not adhered to the HSE National Waiting List Protocols resulting in a breach of key performance indicators in 2025.

In summary, it was evident from discussions with hospital staff and review of documentation provided to HIQA that considerable efforts regarding patient safety incidents and overview of recommendations arising from incidents had been made.

Further delivery of training would support a stronger culture of reporting. In addition to this, progression of the clinical directorate structure would facilitate a more structured oversight of incidents and of the implementation of recommendations coming from incident reviews. Areas for focus include:

- incident reports awaiting approval
- local incident management teams not in place for all directorates
- implementation of incident review recommendations not time-bound
- under-reporting of medicine related incidents.

Judgment: Partially Compliant

Conclusion

HIQA conducted an unannounced inspection of University Hospital Kerry to monitor compliance with nine of the national standards from the National Standards for Safer Better Healthcare. The inspection focus was on the four key areas of known harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, inspectors found the hospital to be substantially compliant with two national standards (1.6 and 1.8), partially compliant with six standards (5.2, 5.5, 5.8, 6.1, 2.7 and 3.3) and non-compliant with one standard (3.1). Inspectors found many examples of committed staff giving good care and routinely checking on the quality of care provided to patients in the clinical areas visited. Opportunities for improvement were identified in the areas of formalised governance arrangements and their effectiveness, monitoring of the quality of service, workforce planning, the management of complaints, physical hospital environment and responding to patient safety incidents. In addition, significant action is required to improve compliance with the standard on protecting service users from the inherent risk of harm associated with the delivery of healthcare services.

Capacity and Capability

HIQA inspectors found that University Hospital Kerry had defined corporate and clinical governance arrangements in place; however, these were in a state of transition as the hospital moved towards a clinical directorate structure. Challenges in service demand regularly diverted the focus of the executive management team. Hospital committees, in particular those relating to the four areas of known harm, need to ensure they are operating in line with their terms of reference to assure the executive management team that healthcare services in the hospital are of a high-

quality, and are safe and reliable. This is required to be fully compliant with the national standards.

Operational measures to assist with patient flow had been implemented in the time period before the inspection but on review of data and through observation while on inspection these measures did not address the difference that existed between service demand and in-patient capacity. Pharmacy arrangements for the hospital were inconsistent and clinical handover required a continued focus. There was systematic monitoring at department level to improve the quality, reliability and safety of care, and improvements in centralised oversight and governance would further improve this.

Despite efforts by the hospital to recruit key clinical personnel, notable deficits remained in the number of medical consultants, senior pharmacists, physiotherapists, dieticians and healthcare assistants in post. Participation in mandatory and essential training was lower than expected. It is essential that the executive management team ensure that staff compliance with mandatory and essential training is in line with the objectives of the national standards.

Quality and Safety

Staff that spoke with inspectors were aware of the need to respect and promote the dignity, privacy and autonomy of patients receiving care in the hospital. Despite this, the physical infrastructure in the emergency department and the lack of inpatient capacity negatively impacted the patient experience in the department. Furthermore, the physical environment while generally clean was not supportive of high-quality, reliable and safe care due to the insufficient number of single-bed isolation rooms and storage available in clinical areas.

Systems to identify and manage the inherent risk of harm to patients receiving healthcare services were found to be inadequate. Risk assessment, management and oversight required strengthening and the executive management team need to ensure that enhanced controls are in place to mitigate identified risks. A greater focus on the four areas of known harm is essential to protect service users from the risks associated with healthcare services.

HIQA was aware of the efforts made to ensure patient safety incidents were appropriately identified, reported, managed and responded to in line with the national incident management framework. Further progression of the clinical directorate structure would provide greater governance and oversight to this process. Quality improvement measures to ensure compliance with complaint management timelines in place in the hospital need to be sustained.

Inspectors saw limited evidence of progression in relation the compliance plan submitted by hospital management to HIQA following the previous inspection in 2025. Immediately after this inspection in February 2026, HIQA correspondence was issued to hospital management highlighting concerns that inspectors had in relation to four potential risks. These potential risks related to placement of patients in surge areas, separation of children and adults in the emergency department, management of controlled medicines and patient transfer policy. In response to this correspondence, hospital management assured HIQA that immediate measures were being put in place to reduce any actual or potential risk to patient safety.

Following the inspection, HIQA will, through the compliance plan submitted by the hospital's executive management team as part of the monitoring activity (appendix 2), continue to monitor the progress of the hospital in implementing the required actions. HIQA will continue to monitor these short-, medium- and long-term actions being employed by the hospital's management team to improve compliance with the national standards assessed during the inspection.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially 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.	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.	Non Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance Plan for University Hospital Kerry

Inspection ID: NS_0189

Date of inspection: 24 and 25 February 2026

Compliance plan provider's response:

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

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

5.2.1 Undertake a focused review of Clinical Governance following the establishment of clinical directorates to include;

- Each directorate will undertake a review of clinical governance arrangements to ensure effective reporting arrangements are maintained and clearly identifiable.
- Submission of a Clinical Governance Organogram for each Directorate to Executive Quality Risk and Patient Safety Committee.
- Clearly defined reporting relationship / report schedule for each directorate within this agreed clinical governance structure.
- QIP to address gaps identified as a result of this review.

Short Term - Q2 2026

5.2.2 Ensure governance and oversight committees identified are meeting in line with their terms of reference and have yearly schedule to update ToR.

EMT to oversee the request of a due diligence report from the following committees;

- Drugs & Therapeutics Committee (inclusive of Medication Safety Committee and VTE Committee),
- Infection Prevention Control Committee (inclusive of Antimicrobial Stewardship Committee),
- Deteriorating Patient Committee (inclusive of Early Warning Score / Sepsis / Resuscitation Committees),
- Executive Quality Risk and Patient Safety Committee

<u>This report will include :</u>

a) Annual Meeting schedule.
b) yearly review and updating of ToR.
c) reporting and escalation responsibilities are outlined in ToR.
d) Contingencies are outlined during periods of high acuity / activity to ensure strategies are in place to ensure cancelled meetings are rescheduled timely.

5.2.3 Oversee the establishment of a Transitions of Care (TOC) Committee with scheduled reporting arrangements during implementation phase to EMT to include:

a) Inter Hospital transfer (including routine & critical transfers)
b) Processes for Discharge against medical advice / leaving before completion of treatment in the Emergency Department
c) effectiveness of measures in place to ensure improved performance with >75yrs KPI PETs.
d) Evaluation the patient placement used for surge.

TOC Committee to be established with clear time bound objectives and R&R outlined as per recommendation 5.2.1.
Short term – Q2 2026

TOC Committee to ensure all relevant risk assessments relating to Transitions of Care are undertaken and ongoing monitoring of controls are in place.
Short term – Q2 2026

TOC Committee to work closely with the Deteriorating Patient Committee as relevant to support effective communication and documentation of care at transitions of care of critically unwell patients.
Long-term – Q4 2026

5.2.4 Executive Management Team will undertake a review of administrative support available across all Committees to ensure effective support is in place to deliver the strategic objectives of these Committees.

This review will examine administrative resources available to Patient Safety Committee's in UHK, with particular focus on the 4 priority pan hospital committees:

1) Infection Prevention Control - inclusive of Antimicrobial Stewardship (AMS) Committee
2) Drugs & Therapeutics – inclusive of Medication Safety Committee & Venous Thromboembolism (VTE) Committee
3) Transitions of Care Committee
4) Deteriorating Patient Committee – inclusive of Early Warning Scores / Sepsis / Resuscitation Committees.

The Executive Management Team will then examine risks of shortfalls informed by this review, and escalate as appropriate.

Short term Q2 2026

5.2.5 Oversee immediate communication to ensure all new committees/working groups/steering groups established in UHK seek Clinical Governance approval through the established Clinical Governance Structure to ensure all standards relating to Clinical Governance are maintained to include details on:

a) Rationale for development – aligned with Standards/legislation/patients safety priority.
b) Terms of Reference

Short term – Immediate

5.2.6 Finalise the Quality and Patient Safety Accountability Framework undertaken Q4 2025/Q1 2026.
Short term – Immediate

5.2.7 Implementation of the Quality and Patient Safety Accountability Framework
Medium - Long term : Commenced Q2 2026

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

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

5.5.1 Immediate review of existing Clinical Pharmacy resources and ensure prioritisation of high-risk areas for clinical pharmacy service.

a) Formalise delivery of a 5/7 pharmacy reconciliation service in the Emergency Department (ED) with immediate effect to:
   - Focus on admitted patient medicines reconciliation in ED
   - Staff education to include clinical prescribing resources
   - Raise awareness, identification & management of patients on high medications.
   - Support recognition and increase of medication incident reporting

Short term – Immediate

b) Medication Safety Pharmacist- post filled.
c) Medication Safety Committee established.
d) Recruitment to fill deficits in approved pharmacy staffing posts progressing to interview, with dates set for interview May 2026.
e) Undertake a review based on incoming staffing uplift to support a service delivery plan for the Pharmacy department to include:
   - Business cases to support clinical pharmacy reconciliation service and escalation of unapproved posts to IHA.
   - Risk register review, and escalation as identified.
   - Monitor and examine effectiveness on service delivery through the appointment of an ED & Medication safety Pharmacist.
   - -Oversee implementation of the audit schedule developed and outputs from same.

Medium term - Q3 2026

5.5.2 Continued support from local and regional management to reduce DTOC and continued focus on capital projects to maximise delivery of extra beds to support demand.

a) Continued oversight arrangements through daily integrated calls with DON & GM in community and weekly integrated meetings. Re-establishment of a regional steering group - in place.
b) A nine-bed unit is in construction phase (seven of the nine beds are single rooms) - Delivered.

c) Guideline developed for review of patients with an admission of greater than 14 days, overseen by EMT.
d) 30 beds (20 single rooms, five twin rooms), seven are due for completion - Q3 2026
e) Remainder 23 beds due for completion - Q2 2027
f) Progress recruitment of OPAT CNM II, establish OPAT service Q3 2026
g) Development of a Transitions of Care Committee overseen by the Operations Directors & Executive Clinical Director to oversee Quality Improvement to address gaps identified in Standard 5.2 - Q3 2026.

5.5.3 Ensure continued effectiveness of Acute Floor and Emergency Department processes to ensure improved PETs, inclusive of >75 kpi's;

a) Through expansion of the Acute Medical Assessment unit (AMAU) with 8am to 10 pm opening with senior cover - Immediate / in place.
b) The Acute Floor has had increased NCHD presence and extended Acute medical consultant presence focused on ensuring that conversion to admission rates remain low - Immediate / in place.
c) The expansion of Rapid Assessment Medical Clinic functionality has provided alternative to GP attendance once more offering a viable alternative to admission through the ED processes - Immediate / in place.
d) The combined increase in medical senior presence will oversee improved conversion to admission and reduced LOS within the acute floor when admission has been selected. This is reflected and monitored in the national acute care audit statistics represented on HIPE - Immediate / in place.

5.5.4 Continued Directorate lead focus on AvLoS to align with HSE KPIs - as per 5.5.3.d Immediate & ongoing

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

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

5.8.1 Executive Management Team to oversee a review of Corporate and Local Risk Registers for all surge and overflow areas identified for patient placement to ensure effective implementation of control measure to prevent harm.

a) EMT, supported by the Transitions of Care Committee, to review corporate risk register to examine effectiveness of control measures taken to reduce harm where risk assessments have been escalated.
b) Clinical directorates, through the Transitions of Care Committee, review local risk registers to examine effectiveness of control measures taken to reduce harm where risk assessments have not been escalated.

c) TOC Committee to oversee immediate action taken to reduce harm where control measure are deemed to be ineffective – including re-evaluation of risk rating & escalation as appropriate.
d) Formalise escalation from CRR to IHA of Risks as appropriate at monthly performance meetings.

Short term - Q2 2026

5.8.2 Develop a schedule for local Risk register review.
Clinical Directorates to oversee a stock take of risk assessments across all services / departments under their remit.

a) Develop a schedule to ensure routine review of all risks held on local risk registers.
b) Ensure clear pathways for escalation of risks in line with policy developed (see 3.1).
c) Outline local strategy to support, where risks are across multiple hospital directorates / pan hospitals services, with clearly identified escalation and detail in hospital's Risk Management Policy (see 3.1)

Medium term - Q3 2026

5.8.3 Establish centralized coordination for clinical audit.

a) Through the Clinical Directorate structure promote clinical audit prioritisation & registration process to enhance capture of clinical audits underway in UHK - in place.
b) Formalisation of Clinical Audit findings tracked at directorate level - Q2 2026.
c) Escalate recruitment of Clinical Audit facilitator to support development and oversight of hospital wide clinical audit function in UHK - Q2 2026.
d) Escalate resourcing of document management system to include audit and QI modules for ease of oversight to Regional ICT lead through Operations Manager - Q2 2026.

5.8.4 Develop a schedule for clinical audit, identifying the criteria for prioritising audit activity and outlining the process for development of Quality Improvement and implementation of recommendations and re-audit is dependent on 5.8.3.(b)
Long term- Q4 2026.

5.8.5 Continued delivery of electronic Point of Care (ePOE) incident reporting training for all staff.

a) 2026 QRPS department prospectus and walk about sessions for training of all staff on incident reporting.

Bi annual newslwtter for staff to support induction and contact details for all staff on ePOE training oppurtunities.

In place

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.

Continue to address vacancies of medical consultants , health and social care professionals and healthcare assistants through:

Medical -

a) Fortnightly meeting in place which reviews medical staffing between all directorates, Head of Service and Medical Manpower. All vacancies, contingency plans, including CACC applications, upcoming leaves, new service development and working time directives, dynamic risk assessment performed with regards vacancies discussed. SECC forms completed and escalated as required - in Place.
b) Risk Management of vacancies is a standing item agenda - in place.

Health Social Care Professionals (HSCP) -

a) Line management structure in place for the routine review and management of workforce and mandatory training performance for each HSCP group through the Operations Manager- in place.
b) Suboptimal training is managed and escalated through this structure.
c) Operations manager is a member of EMT where workforce is a standing item agenda to allow for escalation of risks identified from HSCP groups.

Health Care Assistants
A panel in place for nursing and midwifery and discussed at workforce scheduled updates at COG / EMT.

Workforce management

a) Workforce is a standing agenda item on monthly EMT to allow for identification and escalation of risk - Closed.
b) Delays in recruitment process which directly impact on service delivery are escalated through EMT to IHA and regional HR - Closed.

6.1.2 Focus on improving current absenteeism rate through;

a) QIP plan on absenteeism completed, to include audit compliance with back to work interviews, QIP to be rolled out across UHK - Q3 2026.
b) Short- and long-term sick leave currently under review - in progress.
c) Training for Line Managers on the management of absenteeism is currently been undertaken with a large volume of training completed since January 2026.
d) Human Resource department to have monthly meetings with ADONs to review long term sick leave.
e) Request update from the IHA manager on the unapproved Health & wellbeing officer post - Q3 2026.
f) Regional Steering Committee which includes UHK representation to support staff enhancing mechanisms for the management of absenteeism - in place.

6.1.3 Improve compliance with mandatory and essential training with specific focus in medicine / midwifery/ nursing workforce, supported by a mandatory training strategy to be put in place by each directorate and be reported as a performance metric at monthly COG. Short term - Q2 2026

6.1.4 HSCP mandatory training is managed as per 6.1.1 - in place.

6.1.5 In order to provide assurance and oversight of compliance of mandatory training across all disciplines, progress resource deficits to support this function;

a) Request update from the IHA manager on approval of unapproved training and development officer post - Q2 2026.
b) Seek update on escalated absence of centralized system for the monitoring and oversight of mandatory training & quality management system from the regional ICT lead (linked with 5.8.3).

Medium term - Q3 2026

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

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

2.7.1 Medicine & Integrated care Directorate to provide assurance to EMT of immediate actions taken in the Emergency department to address areas of non-compliance identified.

a) Emergency Department Management team will engage with support services & relevant patient safety committees to immediately undertake a review of quality assurance mechanisms in place to ensure effective monitoring and oversight of performance with standards relating to ;

- Waste segregation & disposal
- Fire safety
- Department safety statements
- Storage/access of hazardous chemicals
- Environmental cleaning schedules
- Environmental audit schedules & associated open actions
- Closed circuit Television signage & monitoring
- Security presence

and develop a QIP with time bound SMART Recommendations to address any gaps identified - Q2 2026

Ensure sharing of learning with gaps identified at Directorate meetings, EQRPSC & EMT/COG as relevant - Q3 2026.

2.7.2 Conduct a local needs assessment – utilising local measures put in place to support off site storage as appropriate to each department's needs to address the risk posed by the lack of appropriate storage facilities.

Medium term - Q3 2026.

Oversee coordination of effective storage solutions across each directorate to include environmental solutions, for all future Capital projects outlined in 5.5 for storage of equipment and supplies relating to:

- Patient Care
- Support Services
- Health & safety
- Biomedicine
- Logistics

Long term - Q4 2026.

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

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

3.1.1 To ensure the arrangements and oversight of Risks are in place and effective;

a) Develop and implement a Policy for the management of the Corporate Risk Register. This will include a process for the notification, communication and escalation of Risks through the established governance system - Short term - Q2 2026.
b) Formalise mechanisms in place to support escalation of the CRR to the IHA Manager - Short term - Q2 2026.

3.1.2 Capital projects are ongoing as detailed in standard 5.5 to ensure sufficient number of single-bed isolation rooms to meet increasing demands for isolation rooms.

3.1.3

a) Oversee the establishment of a Transitions of Care(TOC) Committee with scheduled reporting arrangements during implementation phase to EMT to include timelines for the following actions;
    a) Inter Hospital transfer (including routine & critical transfers).
    b) Processes for Discharge against medical advice / leaving before completion of treatment in the Emergency Department.
    c) effectiveness of measures in place to ensure improved performance with >75yrs KPI PETs.
    d) Evaluation of the patient placement used for surge.

b) TOC Committee to prioritise the finalisation of a UHK Transfer policy and Policy for the transfer of patients to a private provider - expanded to include escort and governance agreements during this transition of care.
Short term – Q2 2026

c) Operations Directors to review the appropriateness of the continued use of the Post-natal beds allocated for surge.
Short term – Q2 2026

TOC Committee to ensure all relevant risk assessments relating to Transitions of Care are undertaken and ongoing monitoring of controls are in place.

Medium term - Q3 2026

TOC Committee to work closely with the Deteriorating Patient Committee as relevant to support effective communication and documentation of care at transitions of care of critically unwell patients.

Long-term – Q4 2026

3.1.4 Address shortfalls in early warning systems training for relevant staff

a) Immediate measures to address sub-optimal staff training for early warning systems to improve compliance with mandatory and essential training with specific focus in medicine / midwifery/ nursing workforce, supported by a mandatory training strategy to be put in place by each directorate and be reported as a performance metric at monthly COG.

Short term - Q2 2026

b) Line management structure in place for the routine review and management of workforce and mandatory training performance for each HSCP with particular focus on physiotherapy staff compliant with early warning systems training will be immediately reviewed by the Operations Manager-(Line Management Structure in place). Strategies to ensure training compliance will be actioned immediately, managed and escalated through this structure. As mentioned in 6.1.1 The Operations manager is a member of EMT where workforce is a standing item agenda to allow for escalation of risks identified from HSCP groups.

Short term - Q2 2026

3.1.5

a) Deteriorating Patient Clinical Lead and CNM2 Deteriorating Patient to oversee an immediate comprehensive Quality Improvement Plan to address shortfalls in the compliance with documentation of escalation.

Short term - Q2 2026

b) Deteriorating Patient Clinical Lead and CNM2 Deteriorating patient to engage with Directorate Clinical Directors/Leads and ADONs/DOM to ensure the effective communication , oversight and management of EWS/Sepsis/Resuscitation audits at

Directorate level, to enhance oversight of performance and allow for risk prioritisation strategies to address suboptimal performance.

Medium term - Q3 2026

3.1.6 Clinical Pharmacy – in addition to actions being taken as highlighted in standard 5.5 & 3.3, immediate action has been undertaken by the Interim Director of Nursing to oversee immediate action to ensure effective monitoring of the following:

a) Daily schedules for temperature checking of fridges to be overseen by CNM2 across all areas and audit by SNM to ensure compliance
b) Daily schedules for checking of Resuscitation Trolley, inclusive of Medication trays, to be overseen by CNM2 across all areas and audit schedule frequency increased to include SNM led audit.
c) Nursing & Pharmacy led review of the Control drug policy for UHK to identify areas for improved compliance, and review of existing education and audit schedules.
3.1.7 Escalate request for resource requirements to support the implementation of Live data in the Emergency Department, to the Regional ICT Lead & IHA Manager, to support the implementation of Live data in UHK - immediate.

3.1.7 Escalate request for resource requirements to support the implementation of Live data in the Emergency Department, to the Regional ICY Lead and IHA Manager, to support the implementation of Live data in UHK – immediate.

3.1.8 Immediate communication has been issued and signage put in place regarding the "protection of access" to ensure audio-visual separation of children from adults in ED, regarding the use of the assigned Paediatric area within ED. This is now subject to random inspection by the CNM3 for ED and overseen by the ADON. Immediate – close

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

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

3.3.1 Executive management team to review current process for incident approval and put immediate actions in place to address gaps identified - immediate.

3.3.2 Schedule in place to ensure local incident management teams are meeting frequently and this includes a schedule for the time bound management of recommendations per directorate - immediate / Closed.

3.3.3 Establish a Quality Improvement Project aimed at delivering medication incident reporting in line with National KPI.

a) Medication Safety Committee to design and deliver a quality improvement project to improve medication incident reporting to meet the national KPI for reported medication incidents.

Short term – Q3 2026

Update and oversight of this project to be provided in Quarterly updates to the D&T Committee.

Medium term -Q3 2026

Delivery of this project to be evaluated after 6 months.

Medium term -Q4 2026