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:	Mayo University Hospital
Centre ID:	OSV-0001056
Address of healthcare service:	Westport Road Curragh Castlebar Co. Mayo
Type of Inspection:	Unannounced
Date of Inspection:	17 and 18 June 2025
Inspection ID:	NS_0143

About the healthcare service

Model of hospital and profile

Mayo University Hospital (MUH) is a model 3* HSE public acute hospital. It is one of six acute hospitals managed by the HSE West North West region†. The hospital provided 24/7/365 undifferentiated healthcare services to adults and children from County Mayo as well as those from the bordering counties, Galway, Roscommon and Sligo. The hospital was previously inspected by HIQA and assessed against the National Standards for Safer Better Healthcare in August 2022 and in June 2023.

Services provided by Mayo University Hospital include:

- accident and emergency care
- acute medical in-patient services
- emergency and elective surgery
- high-dependency and critical care
- maternity and neonatal care
- paediatric services
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Model of Hospital	Model 3
Number of beds	315 inpatient beds (including 34 off-site beds in St. John's ward at the Sacred Heart Home, Castlebar) plus 49 day case beds (including nine acute medical assessment unit (AMAU) beds)

* A Model 3 hospital typically admits undifferentiated acute medical patients, provides acute surgery, acute medicine, and critical care.

† The Regional Health Area HSE West and North West provides health and social care to people in Donegal, Leitrim, Sligo, West Cavan, Mayo, Galway and Roscommon.

How we inspect

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

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

During the inspection, inspectors:

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

About the inspection report

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

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

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
17/06/2025	9am – 6.15pm	Patricia Hughes	Robert McConkey Eilish Browne Eileen O'Toole
18/06/2025	9 am - 4 pm	Same as above	Same as above

Information about this inspection

This inspection was unannounced and focused on 11 of the 45 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 inspected four clinical areas:

- Emergency department (ED) which included the main ED and the ambulatory ED (which was located in the adjacent modular unit and was used to assess and treat ambulatory patients presenting to ED),
- B ward – medical ward
- G ward - gynaecology ward - also used for overflow from medical and general surgical wards
- St. John's ward – an off-site, low-acuity medical centre, located on the campus of the Sacred Heart Hospital, Castlebar, situated about two kilometres away from the main hospital.

The inspection team also visited the acute medical assessment unit (AMAU), day services unit (DSU), discharge lounge, C ward (medical) and the paediatric ward as described in this report.

During this inspection, the inspection team spoke with the following staff,

- members of the hospital management team
- representatives from the following:
  - infection prevention and control committee
  - drugs and therapeutics, and medication safety committee
  - deteriorating patient management committee
  - patient flow and bed management
- and a range of staff working in the clinical areas inspected or visited.

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

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

to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

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

People who attended the emergency department arrived through various pathways including, by ambulance, referral from their general practitioner (GP), or via self-referral. During the inspection, the emergency department was experiencing high levels of activity and in accordance with the hospital's escalation plan, was classified as being in red escalation.

Inspectors observed signage about hand hygiene, and access to hand rub gels on entering the emergency department. There was also signage requesting patients to alert reception staff immediately if presenting with signs and symptoms of infection. Hand hygiene posters and alcohol hand rub solutions were also strategically placed around the ward areas. Staff wore uniforms that complied with 'bare below the elbow'.

There was a water cooler and two vending machines in the department although one of these was noted to be out of order and this was brought to the attention of staff in the department.

Posters and patient information leaflets were on display in the main waiting areas, some of which were available in several languages and covered a range of subjects including emergency department information, Home First Team, falls prevention advice, 'Know my Medicines', delirium, bereavement, infection prevention and control, hospital statutory charges, protected mealtimes, explanation of the uniforms worn by various staff groups, and information on the project known as 'Hello, my name is..'.

A child safeguarding statement was clearly displayed as was a notice indicating zero tolerance to violence in the hospital.

Inspectors spoke with patients waiting in the emergency department and there were mixed views reported on their experience of the waiting times in the department, communication and responsiveness of staff. One patient reported that they had presented earlier that morning via ambulance and while they 'expected chaos', they were triaged promptly and they were very satisfied with the care they received, while also noting that the trolley was 'a bit uncomfortable'. Another patient had been in the emergency department for 24 hours when inspectors spoke with them. They were waiting on a diagnostic test and were hoping to get home after that. They said

that they found it hard to be there all night with 'full lights on'. They described the staff as being under 'severe pressure' and said that 'it was not their fault'. Another patient recounted how a pre-planned procedure was cancelled that day. Patients on the ward stated that the 'staff are beyond helpful and they go above and beyond for the patients' and 'I am extremely happy to be here' and the 'food is lovely and hot'. None of the patients spoken with while in the emergency department said they were aware of the HSE'S complaints system 'Your Service, Your Say' but said that they would speak with a staff member if needed.

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 standard related to workforce.

Inspectors found that the hospital was substantially compliant in National Standards 5.2 and 5.8, and partially compliant in National Standards 5.5 and 6.1. This reflected a downward change from 2023 findings (when the hospital was substantially compliant in National Standards 5.2, 5.8 and 6.1, and partially compliant in National Standards 5.5).

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

Inspectors found integrated corporate and clinical governance arrangements in place at the hospital, with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services.

With the introduction of the HSE regional health area structure, new reporting arrangements for the hospital general manager to the Integrated Healthcare Area (IHA) manager and upwards to the regional executive officer (REO) of HSE West Northwest (HSE WNW) region had been implemented since the last inspection in June 2023.

The hospital had a directorate structure in place, comprising four directorates (medical, perioperative, radiology, and laboratory) and participated in two managed clinical academic networks (MCANs) at regional level, the women and children's

MCAN and the cancer MCAN. Each of those were integrated within the hospital management team as outlined below.

The associate clinical directors in each of the four directorates and the two MCANs provided clinical oversight and leadership at Mayo University Hospital. They each reported to the hospital general manager and to their respective regional clinical director. The director of nursing reported to the hospital general manager and was responsible for the organisation and management of nursing services at the hospital. The director of midwifery reported to the hospital general manager and was responsible for the organisation and management of midwifery, and children's services at the hospital. The director of midwifery also had a reporting line to the group director of midwifery. Both the director of nursing and the director of midwifery had reporting lines to the chief director of nursing and midwifery at HSE WNW. Organisational charts submitted to HIQA reflected these reporting arrangements with the exception of the external professional reporting relationships of the director of nursing and the director of midwifery.

Hospital management explained that while meeting structures at IHA level were still in transition, the IHA manager was meeting with the general manager of the hospital once a month. There was no terms of reference or minutes of these meetings. Hospital management explained that discussion related to operational matters and performance measures which were provided by the hospital.

Organisational charts submitted to HIQA detailed the direct reporting arrangements of various internal governance and oversight committees at Mayo University Hospital. These arrangements aligned with inspectors' findings on inspection.

The committee governance structures in the hospital were unchanged since HIQA's previous inspection in 2023 in respect of:

- hospital management team meetings
- directorate and MCAN (managed clinical academic networks - in place for women and children's' services, and cancer services) meetings
- drugs and therapeutics committee
- infection prevention and control
- the deteriorating patient
- transitions of care
- quality and safety.

Terms of references for the committees were reviewed by inspectors and were noted to be up-to-date with some exceptions outlined as follows:

The Hospital Management Committee (HMT)

The HMT was the main governance structure at the hospital. Chaired by the hospital general manager, the HMT was a multidisciplinary team comprising the associate clinical directors, deputy hospital manager, director of nursing, director of midwifery, finance manager, medical manpower manager, human resource manager, academic officer, health and social care professional's representative and the quality and patient safety manager. The HMT met weekly with a different focus per week, for example, HMT 1 - Facilities focus, HMT 2 - Clinical focus, HMT 3 - Directorate focus, HMT 4 - Leadership and Workforce focus. Each area of focus therefore, was reviewed on a monthly basis. The membership of the HMT had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. Once a quarter, the hospital held a meeting on a fifth area of focus, HMT 5, which was concerned with strategic planning and risk management.

Minutes of HMT meetings, submitted to HIQA, showed that the meetings were well attended, followed a structured format, were action orientated and progress in implementing actions was being monitored from meeting to meeting. Risk and incident management was integrated as agenda items within both the HMT and the directorate and MCAN meetings, which were held monthly and chaired by their respective associate clinical directors. Each of those were attended by a quality and patient safety (QPS) staff member.

Infection Prevention and Control (IPC) Committee

The hospital's multidisciplinary infection prevention and control (IPC) committee was responsible for the governance and oversight of infection prevention and control at the hospital. It met monthly and was co-chaired by the hospital general manager and two consultant microbiologists. The committee comprised a number of sub-committees that reported into it, these included the hygiene services committee, antimicrobial stewardship committee, the decontamination committee, the environmental monitoring committee and the outbreak prevention committee. Minutes of meetings of the infection prevention and control committee held in April, May and June 2025 indicated that meetings were well attended and they showed progress on actions. The infection prevention and control committee was operationally accountable to the HMT and reported to it monthly. There had also been a regional forum for IPC and inspectors were informed that this forum had not met in the year to date due to restructuring at regional level.

Drugs and Therapeutics Committee (DTC)

The Drugs and Therapeutics Committee (DTC) had overall responsibility for the governance and oversight of medication safety practices at the hospital. The terms of reference had been due for review in February 2025. It was chaired by a consultant anaesthesiologist. The deputy chair was the chief pharmacist. The drugs and therapeutics committee comprised a number of sub-committees that reported into it, these included the medication safety committee, the antimicrobial stewardship committee, the venous thromboembolism (VTE) committee and the nurse prescriber medicines review team. Representatives from general practice and the medication safety and antimicrobial stewardship sub-committees were invited to attend the DTC as required. The DTC was operationally accountable to the hospital management team (HMT) and reported to it in writing every two months. Minutes of meetings of the drugs and therapeutics committee submitted to HIQA dated December 2024, January 2025 and February 2025, indicated that meetings were well attended and they showed progress on actions. Hospital management explained that the medication safety committee had merged with the DTC in October 2024, but had recently been separated out again due to the volume of work required to be worked upon by the medication safety committee.

The Deteriorating Patient Management Committee (DPMC)

This committee was responsible for the provision of a local governance structure to support the implementation and monitoring of compliance of the Irish National Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS) systems and the National Clinical Guideline No. 26 on Sepsis Management for Adults (including maternity) as set out in its terms of reference. The terms of reference had been due for review in November 2024. The committee was chaired by a consultant anaesthesiologist and the multidisciplinary membership comprised the hospital manager, director of nursing, director of midwifery, a range of consultant staff, consultant microbiologist, lead non-consultant hospital doctor (NCHD), a range of nursing and midwifery managers, the resuscitation training officer and the ADON sepsis lead for the HSE WNW region. The committee met every two months and reported to the HMT after each meeting in line with its terms of reference. The resuscitation committee was a subcommittee to the DPMC. Minutes of meetings of the DPMC submitted to HIQA, dated January, March and May 2025 indicated that meetings were well attended and they showed progress on actions.

Transitions of Care

Transitions of care includes internal transfers, external transfers, patient discharge, shift and interdepartmental handover. Mayo University Hospital had a number of structures and processes in place to help mitigate risk in the area of handover of care. A clinical handover quality improvement group committee had been established for the purpose of implementing clinical handover. It met fortnightly and was chaired by the quality and

patient safety manager. A medical consultant was the deputy chairperson. It comprised multidisciplinary membership and reported to the HMT 2 meetings. The stated purpose in its terms of reference was to implement clinical handover processes in all departments of the hospital. Minutes of meetings submitted to HIQA dated December 2024, February 2025 and June 2025, indicated that meetings were well attended and they showed some progress on actions although the meeting frequency did not align to the terms of reference. Inspectors were told that the hospital used the Identification, Situation, Background, Assessment and Recommendation (ISBAR)***** technique when transferring patients either internally or externally and were using the National Clinical Guideline no. 11 Communication (Clinical Handover) in Acute and Clinical Services. Inspectors found evidence of this being in place from meeting minutes, and audits of the handover process.

Inspectors were told and provided with documentation stating that unscheduled care was integrated into the HMT meetings. A multidisciplinary meeting, of the 'patient flow action group', chaired by the general manager was held monthly. There was no terms of reference available for this group. Minutes were provided for the two most recent meetings held in May and June 2025. They demonstrated that meetings were well attended and were action-oriented. There was special emphasis placed on provision of 'predicted date of discharge (PDD)' and a standard operating procedure was drafted to support same. Implementation of the PDD was rolled out on the week of inspection.

Quality and Patient Safety (QPS)

The hospital did not have a separate QPS committee. Instead, quality and patient safety was integrated within both the monthly directorate and MCAN meetings, and the HMT meetings, each of which were attended by the QPS manager who provided updates on the hospital's risk register, patient-safety incidents, complaints management, feedback on patient experiences, and progress on implementation of patient safety quality improvements.

Serious Incident Management Team (SIMT)

Inspectors were told on inspection that regional structures were in transition and inspectors viewed a copy of a presentation from a workshop held prior to inspection outlining the proposed changes. The serious incident management team operated at regional level. It met monthly and was chaired by the group clinical director for QPS. This is discussed further under NS 3.3.

In summary, HIQA inspectors found that Mayo University Hospital had formalised and functioning governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. The meeting structures however, between the hospital and the integrated healthcare area (IHA) were yet to be formalised (including the provision of

terms of reference and meeting minutes). Some committees had yet to update their terms of reference and one was not meeting in line with its terms of reference.

Judgment: Substantially Compliant

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

On the first day of the unannounced inspection, hospital management explained that the hospital was in 'red escalation' and that there had been an increase in attendances at the emergency department (ED). Red escalation referred to the status of the hospital as set out by the HSE's 'System-Wide Escalation Framework and Procedures'. Inspectors heard that the number of presentations was rising over time and the age profile of the patients presenting was rising. Inspectors viewed documentation showing that children accounted for over 20% of new emergency department presentations.

The hospital had access to a senior decision maker 24/7. Consultants were on-duty on-site in the emergency department from 9 am to 9 pm each Monday and Tuesday and from 9 am to 8 pm on Wednesday, Thursday and Friday each week. Consultants employed on a different contract also worked on-site on a Saturday for six to seven hours. Additional staffing of the inspected clinical areas is discussed under National Standard 6.1.

The HSE patient safety indicator reports (HPSIR) for the hospital were reviewed for the first six months of 2023, 2024 and 2025. These demonstrated a 15% increase in new emergency presentations over the previous two years. The reports indicated that the hospital was seeing over 41,000 new emergency presentations per year in an ED that staff reported was built for 25,000 attendances per year. The target for admitted patients being cared for on trolleys at 08.00 hours was set at 320 or less per month. For the first five months of 2025, prior to inspection, this figure averaged at 370 per month (range 439 – 668). Staff explained that they could safely maintain up to five patients on trolleys at a time on the corridor however, this number was regularly exceeded and averaged between 14–16 trolleys per day at the time of inspection. This trend aligned with the HSE TrolleyGAR for Mayo University Hospital, published daily.

On the first day of the inspection, at about 09.30 am there was 27 patients registered in the emergency department who were either waiting to be triaged or awaiting a medical review. In addition to those, there were eight admitted patients waiting on trolleys in the emergency department for an inpatient bed and a further

ten admitted patients were on trolleys located on wards, also awaiting beds. By 11 am that morning, there were 30 patients registered, 17 had self-referred, 10 came in via ambulance and three had been referred by their GP. Five patients were over the age of 75 years. There were eight admitted patients on trolleys in the ED awaiting a bed. There were 11 patients in hospital that day whose discharges were delayed, due either to lack of beds in residential care, or delays in obtaining care packages. The hospital provided data demonstrating a reduction of 50% on the number of admitted patients on trolleys in the ED at 8 am in 2024 compared to the same period in 2023 and a 32.1% reduction in total trolleys (across the ED and wards) for the same period. Both of these had risen substantially, for the first four months of 2025.

The range of time from registration to triage for the 30 registered patients at 11am was 1-130 minutes (HSE target 15 minutes). The outlier of 130 minutes related to a patient who was brought in via ambulance, was accompanied by ambulance personnel and was reported to be stable throughout. The mean time was 25 minutes. The time interval experienced by patients from triage to medical assessment ranged from 17 - 279 minutes, the mean was 89 minutes. The time interval from medical assessment to decision to admit, ranged from 73-699 minutes with the mean being 233 minutes.

Also at 11am that day, the hospital was compliant with the six-hour, nine-hour and 24-hour HSE targets for patient experience times relating to all patients, and for 99% of patients aged 75 years or more being admitted or discharged within 24 hours of registration. It was non-compliant however, with the following: only 60% of patients aged 75 years or more were admitted or discharged within six hours of registration (HSE target: 95%) and only 40% of patients aged 75 years or more were admitted or discharged within nine hours of registration (HSE target: 99%).

The clinical operations team led three on-line hospital-wide safety huddles each day, Monday to Friday, at 9 am, 12.30 pm and at 2.30 pm. Inspectors noted recent records where staff attendance at these huddles was very good. In addition to those, the emergency department held its own safety huddles four times per day at 7.30 am, 11 am, 2 pm and at 4 pm using the ISBAR (identify, situation, background, assessment, review) communication tool.

On average, 10 patients attended the AMAU daily and seven were discharged home on the same day. Over 80% of them were admitted or discharged home within six hours of registration. The average length of stay for medical patients was 9.3 days (5.9 days when the '30 days +' stays were excluded). It was 4.7 days for surgical patients. The average number of patients with delayed transfers of care (DTOC) per

month for the first six months of the year was 10 in 2023, 9-10 in 2024 and 11 in 2025. The target for the hospital was seven or less.

The conversion rate for the hospital in 2024 (the number of patients who are admitted to the hospital as a proportion of the total number of people who presented to the emergency department) was high at 32.3%. The hospital had a 'Home First team' in place to support early and comprehensive assessment and either discharge home or timely admission of patients aged 75 or more. It was reported to be making an impact on conversion rates, and for the first five months of 2025, the conversion rate was averaging 31.8%. This team comprised a physiotherapist, an occupational therapist, a medical social worker, a clinical pharmacist and a clinical nurse manager. They met and assessed patients to help identify any needs that would delay them from leaving hospital after treatment, in order to minimise any delays. Hospital management suggested that the higher conversion rates were associated with an ageing population and wider social issues where older people lived remotely and had increased need for occupational therapy and other support services, which were not easily available in the community.

The nearest local injury unit was located in Roscommon, approximately 85 km from Castlebar. A further local injury unit was being planned to open in Ballina later in the year (38 km away). Hospital management explained that plans were underway to commence a capital development project in 2027 to expand the existing emergency department at Mayo University Hospital. This would help address deficits in existing space and environmental issues but would not necessarily increase bed capacity. Hospital management also reported that funding had been approved to commence the design of a new 90-bed block.

The emergency department comprised the main emergency area and the ambulatory ED which was located within a modular unit adjacent to the main department. The ambulatory ED was open and staffed daily from 7.20 am to 11pm. It had specific inclusion criteria which included triaged patients categorised as three or four using the Manchester Triage System. It also accepted category two patients if stable and as required. All patients aged 65 years or more were screened on presentation to the emergency department, using a rapid clinical test for signs of delirium and cognitive impairment.

Children were triaged in the main ED following registration using the Irish Children's' Triage System (ICTS). Those triaged as category one were cared for in the resuscitation room in the emergency department. Children triaged as category two were cared for in the main emergency department while children triaged as categories three, four and five were directed to the paediatric decision unit (PDU) located in the centre part of the paediatric ward for medical review and ongoing care. This service was available 24 hours a day. The PDU had five spaces for

patients. The PDU was also used to facilitate six scheduled reviews (blood tests, weight checks and or medical reviews) per day. Inspectors spoke with staff there and noted the policy and the standard operating procedure (SOP) which was in place to support decision making. Of the total number of between 9-10,000 paediatric admissions to Mayo University Hospital per year, over 4,000 children were reviewed in the PDU. Staff explained that in the context of a frequently overcrowded ED, this was a workaround where every effort was made to mitigate risk.

The nine bedded acute medical assessment unit (AMAU), located on the ground floor of the main building, was used to accept transfers from GPs and or the emergency department. At the time of inspection, four of the beds were occupied by admitted patients. Inspectors heard how admitted patients may be cared for in this unit for several days.

The hospital had access to the HSE health performance visual platform (HPVP) which was used to help improve efficiency and productivity by providing an online and up-to-date operational view of the patient journey through the emergency department. A screen was located at the nurses' and doctors' work station in the main ED. It provided information on the number of patients registered in the department and the status of their episode of care, for example, 'awaiting triage'. It also collated the patient experience time for each registered patient.

The hospital had established a discharge lounge since the previous HIQA inspection. It was located in a screened-off area adjacent to the emergency department, the café and toilet facilities. It was open three days a week from 8 am to 5 pm on Monday, Tuesday and Thursday. It was used to accommodate patients who had been medically discharged and who were required to vacate their beds by 11 am but were awaiting transport home. Inclusion criteria required patients to be mobile or need no more than 'the assistance of one person' to mobilise. The discharge lounge was also being used to conduct simple reviews of patients required to return for blood tests, scans or blood pressure checks.

The emergency department was part of the medical directorate. Access to care in hospital was via the emergency department or the AMAU. Inspectors heard and viewed minutes of monthly medical directorate meetings where it was evident that there was good two-way communication between the directorate and the HMT. Issues of concern were discussed and action-oriented decisions were recorded.

Infection prevention and control

The IPC team met weekly while the IPC committee met monthly. Inspectors viewed the hospital's annual IPC plan which set out the aims and objectives of the committee and scheduled the goals relating to education, audits and compliance

with targets (hand hygiene, IPC general audit, care bundles and carbapenemase-producing *enterobacterales* (CPE) screening). It was also responsible for the development and or review of policies, procedures and guidelines as indicated, active surveillance of hospital acquired infections, quality improvement plans, ward rounds and support of staff and antimicrobial surveillance. The IPC team oversaw the declaration, management and closure of outbreaks at the hospital and inspectors viewed reports of outbreaks with documented shared learning.

Staff on the inspected wards reported good access to the IPC team and they outlined how outbreaks were identified and managed. Inspectors viewed close-out reports on the most recent three outbreaks and found that these followed standard requirements. Inspectors observed that infection status was recorded in the standard discharge letter. Carbapenemase-producing *Enterobacterales* (CPE) screening was being conducted based on target age, and multidrug-resistant organism (MDRO) screenings were being carried out in high-risk patients in accordance with the hospital's MDRO screening guide. The IPC team demonstrated good practice regarding equipment maintenance and outlined how water pooling had been noted to occur in some HBN[§§] compliant sinks. This was escalated to the manufacturer resulting in replacement of all such sinks.

Medication safety

At the time of inspection, the hospital had a list of medication safety priorities set out for the year, which included the responsible person and the timeline for each. Of the 14 short-term objectives, five were complete, there were five medium-term objectives (all in progress) and four long-term objectives (one of which was in progress, two of which were not being progressed, and one was deferred until quarter one of 2026). There was a strong emphasis on medication safety, audit, risk and incident management in the records of the drugs and therapeutics committee (DTC) minutes. A first 'medication safety champions' meeting had been held in January 2025 and audits on storage of 'sound alike and look alike drugs' (SALADS) had indicated areas for attention and plans were being reviewed to address these.

Hospital management explained that two of the pharmacy technicians had been trained locally on 'protocol-guided medication reconciliation' to support medicine reconciliation for patients in the emergency department and on the medical wards.

[§§] HBN refers to standards of sanitary facilities in healthcare environments. 20250828_DoH_InfectionPrev_Main_No30_2023_PRINT_v2_Vol_1_Rev_wth_Linked.pdf

The training and practice of the pharmacy technicians in this role was supervised and overseen by the pharmacy executive manager.

While there was no clinical pharmacist assigned to St John's ward (the off-site ward), there was a pharmacy technician assigned to the ward who was responsible for top-up of the supply, on a twice weekly basis. In the event that medication was required out-of-hours, supply was provided from the main campus using the hospital's approved transport arrangements. At the time of inspection, the hospital did not have a documented procedure in place to support this practice.

The deteriorating patient

Inspectors heard, and viewed minutes of the meetings held by the deteriorating patient management committee (DPMC) in January, March and May 2025. These demonstrated good oversight of issues associated with recognition, treatment and oversight of the deteriorating patient including associated audit activity and mandatory training. Inspectors noted that since introduction of a specific audit tool in October 2024, there was an 85% - 90% compliance with the escalation and response protocol however deficiencies were being found in respect of completion of the modified Irish National Early Warning System (INEWS) escalation response protocol. This was being addressed with medical staff via the directorate structure and at induction. Staff on the wards described the process used for escalation of early warning scores or other patient concerns. The emergency early warning system (EMEWS) was not in use in the emergency department and this was reported to be due to a shortfall in staffing. The INEWS was used instead unless the Irish Maternity Early Warning System (IMEWS) or the Paediatric Early Warning System (PEWS) where indicated.

The DPMC reviewed uptake of mandatory training related to the deteriorating patient on a quarterly basis. They had reviewed and updated the hospital INEWS policy and were currently working on a draft patient-centred policy in line with the national policy for responding to escalation and treatment of patients who were at end-of-life stage.

Transitions of care

Inspectors were told of, and viewed records of two safety huddles held in the emergency department during the inspection. The documentation included details on the numbers of patients present, their current status, triage category, specific information, staffing levels on duty, team and location assignment and names of consultant and managers on duty. Safety huddles in wards took place at the whiteboard two to three times per day and a handover sheet was used which incorporated the ISBAR communication tool. A formal 'Friday handover' between medical teams had been established using ISBAR, since the last inspection. It was

used to highlight patients of concern, deteriorating patients and patients that may be ready for discharge over the weekend. It was consultant-led and attended by the consultants and their teams and by nursing staff from the clinical operations team (COT).

The patient flow team attended the morning site safety meeting, the weekly integrated discharge rounds and the weekly 14-day length of stay meetings. The team liaised with the community intervention team and the three district hospitals (Ballina, Belmullet and Swinford) who accepted transfers from Mayo University Hospital. The team continuously monitored length of stay for the 'greater than 8-day stay' and 'the greater than 14-day stay'. The team liaised with the radiology manager where examinations were the limiting factor in a discharge home or transfer to residential care. The team were actively involved in the planning and launch of the predicated date of discharge (PDD). There was an admission avoidance pathway in place which was said to function very well but only when the hospital was not in surge.

Discharge letters were issued on the day of discharge. Any cases of outstanding discharge letters were escalated to the general manager on a weekly basis.

Quality and patient safety

Staff from this department reported into the HMT three times a month and also had representation at the directorate and MCAN meetings for feedback on complaints and incidents. The department provided support to staff on audit activity and on quality improvement plans. The local QPS team had met the regional manager for QPS in January 2025 but there had been no further meetings while transitioning to the new RHA structures.

In conclusion, inspectors found that Mayo University Hospital had some effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. The hospital collated and closely monitored their data at the HMT and at various associated hospital committees. The hospital was not yet meeting all of the HSE key performance indicators for patient experience times as outlined above. The overcrowded emergency department and inadequate space for children in the main emergency department was the reason for redirection of children categorised at levels three, four and five to a paediatric decision unit in the paediatric ward, located on the hospital's first floor.

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.

The hospital participated in the submission of data for the HSE key performance indicators and the hospital patient safety indicator reports (HPSIR). The quality and patient safety (QPS) department maintained a tracker for oversight of HSE key performance indicators which inspectors viewed. The hospital had a Clinical Audit Committee chaired by a medical consultant. It was supported by the quality and patient safety (QPS) department. Inspectors viewed the hospital's 2025 clinical audit plan and schedule and noted that the four areas of key harm were covered by the plan. Inspectors viewed documentation providing evidence of preparation for the national sepsis compliance audit at the hospital.

Inspectors viewed the hospitals quality improvement plan (QIP) for 2025 based on feedback through the complaints system and or learning from reports of near misses and incidents. This was discussed at the relevant directorate and MCAN meetings and at HMT. The plan provided details of the recommendation, the specific improvement, the required actions, responsible person, timeline, quarterly status update, outcome and current status. QIPs included rollout of the national healthcare communication programme, medication safety, provision of a breastfeeding space for visitors to the hospital, AMAU clinical governance, and provision of an access intercom for St. John's ward. At the time of inspection, these were in progress or yet to be commenced.

Mayo University Hospital participated in the National Inpatient Experience Survey 2024 where they scored 85% (good to very good experience) which equated to the national average score. Highest scoring questions related to 'care on the ward' and lowest scoring questions related to 'discharge or transfer'. In response, quality improvement plans related to increased patient engagement, improved utilisation of the patient information booklet, effective communication, and better discharge planning including use of a predicted date of discharge. Inspectors found that not all staff spoken with were aware of the results of the survey or how the findings were being addressed.

The hospital participated in the National Office of Clinical Audit (NOCA) activity since 2022. Staff outlined to inspectors how the hospital was noted to be an outlier for the rate of sepsis in 2023 and to a lesser extent again in 2024. The national sepsis group had contacted the hospital following the 2023 findings and a detailed look-back study was undertaken on a sample of cases. It was noted that there was an initial high assumption for sepsis however, when screening showed that sepsis was not confirmed, this had not always been de-escalated in documentation. This was brought to the attention of clinical staff via quality and safety input at the

directorate, MCAN and hospital management meetings, via the deteriorating patient management committee (DPMC) and highlighted at induction.

In summary, inspectors found that Mayo University Hospital broadly had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. These included findings from the National Patient Experience Programme, internal audits, complaints, risk management and review of incidents. However, there was a low level of awareness of some of these findings and associated quality improvement plans among staff in the inspected areas.

Judgment: Substantially Compliant

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

Inspectors were informed and viewed documentation which showed that the approved staff complement at the time of inspection was 1535 WTE. However, there were 1501.32 whole-time equivalent (WTE) staff in post at the hospital including those on paid leave at that time.

The hospital employed 73 WTE consultants. All but seven consultants were on the specialist register of the Irish Medical Council, and the hospital outlined that applications for registration to the specialist register were underway. The hospital manager confirmed that support arrangements were in place and in line with HSE guidance for those not yet on the specialist register. There were 12 registrars and 13 senior house officers employed by the hospital.

In relation to the anaesthesiologist staffing situation as outlined in the 2022 and 2023 HIQA reports, hospital management confirmed that the situation had now been resolved in that the model of care involving two consultant anaesthesiologists being on-duty 24/7, as set out by the College of Anaesthesiologists of Ireland was now in place. There were 12 consultant anaesthesiologists employed by the hospital and there were two consultants plus a registrar and an SHO on duty 24/7. The senior house officer also covered maternity services along with a registrar and consultant anaesthesiologist.

The hospital employed seven WTE consultant radiologists. An eighth permanent post had recently been approved and hospital management explained that approval for a ninth post for a period of 12 months had also been granted.

At the time of inspection, there had been two vacancies among the complement of five cardiac technicians which had not been filled despite recruitment efforts. Hospital management explained that this was having an impact on access to diagnostics and in turn, impacting the length of stay and delayed transfers of care.

The hospital employed five emergency medicine consultants equating to 4.75 WTE. A further two consultants were employed on a locum basis for the emergency department. Consultants were scheduled to provide on-site cover over six days per week as follows: cover from 9 am to 8 pm Monday to Friday extending to 9 pm on two days per week plus for six to seven hours on a Saturday. Two emergency medicine consultants were on duty during the day of inspection. Staff explained that access to on-call consultant cover was available outside of those hours and on Sundays as required. There was 24/7 on-site cover by a medical registrar with responsibility for the emergency department and AMAU. There was also a medical registrar on-duty 24/7 for the inpatient wards and an onsite gynaecology registrar on-duty 24/7 at the hospital. Inspectors heard how the hospital had been approved for basic speciality training (BST) by the relevant postgraduate body since the previous HIQA inspection in 2023 and that the hospital were now working towards approval for higher specialist training (HST).

There were 645 WTE nurses and midwives employed at the hospital. That figure excluded the intern nurses who were employed for 36 weeks of the year as part of their training programmes. Hospital management explained that extra funding had been made available for an assistant director of nursing, three advanced nurse practitioners and one clinical nurse midwife specialist. Recruitment was in progress for these posts. Fifteen WTE posts for nurses and 14 WTE healthcare assistant (HCA) posts had also been approved since the last inspection and these had previously been filled. Phase 1 of the HSE's Safe Staffing Framework had identified the need for a further 30 WTE nurses and 5.5 WTE healthcare assistants for the hospital. Phase 2 of the HSE's Safe Staffing Framework (for the emergency department) was not yet complete at a national level. Inspectors were told by hospital management that this had been escalated by the Mayo University Hospital to regional and national levels in view of the current staff to patient ratio in the ED, and a response was awaited. Inspectors viewed documentation showing that there had been 41 leavers and 49 new starters in nursing since the beginning of the year to date of the inspection, showing a net increase of eight nurses.

Total sickness absence was averaging over 7% for each of the first four months of 2025 which is above the HSE's target absenteeism rate of 4% or less. Most of this related to short-term illness and inspectors heard that 'managers were booked in' to attend a managing attendance webinar. Engagement with occupational health, and

return to work meetings were in place. Performance measurement in relation to absence was discussed with the IHA manager.

The post of human resource manager had been vacant for nine months and a new post holder was due to take up post later that month. A patients advice and liaison services (PALS) coordinator was also being recruited where the post had been vacant for four months. The director of midwifery post had been filled to align with the retirement of the pre-existing director of midwifery.

The emergency department including the ambulatory ED was staffed from the current complement of 49 WTE staff (excluding the ADON and Advanced Nurse Practitioner (ANP) posts). The 49 WTE comprised one CNM3, one WTE clinical skills facilitator, seven WTE CNM2s, 8 WTE CNM1s and 32 WTE nurses. This allocation included a deficit of 5.32 WTE nurses - due to long term leave, vacancies and maternity leave. Risk assessments relating to vacancies and leave had been undertaken and escalated to the IHA. In addition, there were two registered ANPs and one candidate ANP employed for minor injuries, one candidate ANP for rapid access treatment and one candidate ANP for paediatric emergencies employed in the emergency department.

Inspectors were told by management that separate to the Safer Staffing Framework proposed for EDs, an additional one WTE clinical nurse manager and 21 WTE staff nurse posts were funded to provide 24/7 care for admitted patients being boarded in the ED. At the time of inspection, four of these 21 posts were vacant. In addition to the nursing team in ED, a multi-task attendant (MTA), a HCA and two porters were allocated to the department per shift. Inspectors viewed rosters for the four weeks prior to the inspection and noted that there were no gaps in the levels for which the hospital was funded. Sick leave had been covered by redeployment primarily within the directorate and no agency staffing had been used during that period. There was an overall clinical nurse manager (either a CNM1 or a CNM2) on-duty at all times in the emergency department to provide senior nursing leadership and co-ordination of activity. There was a MTA on duty each day in the ED.

There were two nurses and a healthcare assistant on-duty in the ambulatory ED at the time of inspection. The clinical nurse manager ordinarily worked Monday to Friday 8 am - 4 pm. Medical cover commenced at 9 am and included a registrar and two senior house officers plus cover from one of the two consultants on-duty. Inspectors spoke with non-consultant hospital doctors (NCHD) who spoke positively about the quality of induction, and their rosters.

The acute medicine assessment unit (AMAU) was staffed for AMAU activity over a five-day week using eight WTE nursing staff. On a daily basis, Monday to Friday,

there was a clinical nurse manager on-duty from 8 am - 4pm and there were 3-4 nurses on-duty for 12-hour shifts for the 5 day week.

Where inpatients were cared for within the AMAU, staffing was augmented by the clinical operations team to cover the gap during the out-of-hours period and in line with the acuity and dependency of the admitted inpatients there. Inspectors noted that there was a minimum of two nurses and one healthcare assistant on-duty 24/7 when inpatients were accommodated in the AMAU. The AMAU was also staffed using two registrars and one senior house officer (SHO), whose shifts overlapped each other between 9 am and 8 pm. Medical cover for inpatients out-of-hours, was via the registrar on-duty for the AMAU or the registrar on-duty for inpatients.

The discharge lounge was staffed by a clinical nurse manager and a staff nurse. On the day of inspection, there was one nurse on-duty in the lounge. If assistance was required, they would contact the ADON on-duty from patient flow or the clinical operations team.

The paediatric decision unit (PDU) was staffed by the paediatric ward staff which had received an uplift of 3 WTE nurses to support the running of this service.

Inspectors noted that approved staffing on B-ward comprised six nurses, two healthcare assistants (HCA) and one multitask attendant (MTA) on day duty, seven days a week and four nurses and one HCA on night duty. Rosters for the previous month were reviewed by inspectors who noted 12 shifts across the month where staffing was short by one staff nurse. Nine shifts were covered from existing resources and three remained vacant.

Seventeen WTE nursing personnel were allocated to G ward. Staffing of G ward on a daily basis comprised either a clinical nurse manager 1 or 2, plus three staff nurses and one healthcare assistant. At night, the ward was staffed with two staff nurses and a healthcare assistant. There were no vacancies on this ward but maternity leave was not backfilled. There were no gaps in the roster for the week prior to this inspection.

The consultant with responsibility for all patients on St. John's ward visited daily Monday to Friday. There was also two senior house officers (SHO) on-duty in the ward from 9am to 5pm (one SHO on-duty from 9pm to 9am and one SHO on-duty from 1pm to 5pm). There was a registrar on-duty on the ward from 9am to 5pm. The funded nursing complement for the ward was 24 WTE nurses however, 2.2 WTE of these posts were vacant at the time of inspection. The healthcare assistants on this ward were all regular staff employed through an agency. St John's ward was staffed with either a clinical nurse manager 1 or 2, on day shift, plus four nurses and two health care assistants or five nurses when all beds were open. At night, the ward was staffed with three staff nurses and one healthcare assistant. Inspectors

viewed the rosters for up to four weeks prior to the inspection and confirmed that there was no gaps in the prescribed staffing levels during that time period. All patients having to return to the main hospital campus were escorted by a healthcare assistant from the ward.

Infection prevention and control

The infection prevention and control team comprised two WTE microbiologists, one WTE assistant director of nursing, three WTE clinical nurse specialists and one WTE clerical person. A staff nurse had recently been allocated to the team to assist with audit activity. The team was also supported by an assistant director of nursing (ADON) who was the region's lead for sepsis. At the time of inspection, the surveillance scientist post had been vacant for three years. Hospital management advised that recruitment was now underway.

Medication safety

At the time of inspection, inspectors heard and viewed documentation showing an approved complement of 18 WTE pharmacists and 16 WTE pharmacy technicians including vacancies and longterm leave. This included one WTE pharmacy executive manager, one WTE deputy executive pharmacy manager, one WTE antimicrobial pharmacist, one WTE Home First pharmacist and three WTE aseptic oncology pharmacists. Two of the 18 posts were vacant at the time of inspection including the medication safety pharmacist post. Hospital management explained that recruitment was underway. The impact of the vacancies and a further 1.5 WTE long-term leave within the overall complement resulted in no dedicated pharmacy cover being available for each ward. This is discussed further under National Standard 3.1. Staff however, told inspectors that pharmacy support was available via telephone or on request as needed. Staff spoke to inspectors about the 'noticeable' shortage of pharmacy staff at the hospital. Inspectors heard from hospital management that Mayo University Hospital was also providing a dispensary service to a total of 190 beds across an outlying community hospital and Mental Health Commission approved centres.

Inspectors heard and viewed documentation which showed that there were 30 registered nurse or midwife prescribers in the hospital at the time of inspection. Hospital management later revised this downward to 23 for the month of June 2025.

Deteriorating patient

Membership of the deteriorating patient management committee included one WTE resuscitation officer and multidisciplinary staff drawn from specialty areas. A clerical

officer in the hospital provided clerical support to the committee as required. The regional ADON for sepsis also provided support to the hospital.

Transitions of care

The patient flow team comprised of 1 WTE assistant director of nursing, 2 WTE patient flow coordinators and 2 WTE discharge coordinators. The ADON reported to the director of nursing. The one WTE bed manager reported to the general manager.

Quality and patient safety (QPS)

The department had seven WTE staff including one WTE QPS manager. Staffing included the post of patient advice and liaison services (PALS) officer which had been vacant for four months at the time of inspection although inspectors were told by hospital management that recruitment for this post was underway.

Inspectors observed notices displayed in some inspected ward areas, advertising access to the employee assistance programme. Staff also had access to an occupational health department.

Training records

Ward managers explained that they had oversight of compliance with mandatory training by staff in their areas of responsibility. The managers issued reminders to staff as renew dates were approaching.

Compliance with mandatory training (among the nursing staff) ranged from 67-85% on B ward. This related to antimicrobial resistance and infection control (AMRIC) based hand hygiene, basics of infection prevention and control, personal protective equipment, standard and transmission-based precautions, medication safety, early warning systems, and basic life support. There was no available data in relation to training in clinical handover. Compliance with mandatory training (among the nursing staff) ranged from 92-100% in the emergency department across the same training domains. There was no available data for training on clinical handover in ED while 83% of staff in the emergency department who were eligible to undertake triage had received training on its use.

Inspectors observed a refresher session in progress for a multidisciplinary audience on advanced cardiac life support (ACLS), being held in the ED. Staff spoken with in various clinical areas showed good knowledge of the escalation process used in respect of abnormal early warning scores and or, any other concerns and they were complimentary of the responsiveness of medical staff. They also reported use of the sepsis six form in the event of a case of suspected sepsis.

In summary and notwithstanding ongoing recruitment, the hospital was short of key members of staff as outlined and some, for long periods. In particular, the hospital was short of pharmacists, cardiac technicians, surveillance scientist, PALS officer and nursing staff particularly in the emergency department. Some of the staffing needs in nursing as identified in phase 1 of the HSE Safer Staffing Framework were yet to be funded for the hospital. Phase 2 of the Safer Staffing Framework was incomplete at a national level and inspectors heard how the hospital had escalated this in view of the staff to patient ratio in the ED. Sickness absence levels at 7%, breached the HSE target of 4% or less.

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.

Inspectors found that the hospital was compliant in National Standard 1.7, substantially compliant in National Standards 1.6 and 1.8, and partially compliant in National Standards 2.7, 2.8, 3.1 and 3.3. This reflected a downward change from 2023 findings (when the hospital was compliant in National Standards 1.7, 1.8 and 3.3, substantially compliant in National Standards 1.6 and 2.8 and partially compliant in National Standards 2.7 and 3.1).

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

Inspectors heard how staff at the hospital were seeking to build a strong partnership with patients using the services. The hospital had a patient and family engagement officer and a patient council in place. The patient information booklet had been distributed to GPs in the area to promote engagement with patients. The patient advice and liaison service (PALS) officer post had been vacant for four months but recruitment was underway.

When patients were asked if they had received information about the hospital either before, or on admission, the responses were positive. Catering staff met with patients daily to offer menu choices. A mobile hospital shop visited the ward areas.

Inspectors noted the availability of a room on C ward that patients could use to watch television or spend time with their visitors. There was access there to tea and coffee-making facilities. There was also a range of patient information leaflets on display. Inspectors noted the designation of a 'wellness walkway' which patients could use to mobilise. Staff were observed to respond promptly to call bells on the ward areas. Notice boards explaining the various staff uniforms worn by the various staff disciplines were observed in the emergency department and in G ward. The patient information board on G ward also provided information on the 'Hello, my name is…' initiative.

Inspectors noted the presence of privacy screens in use around patients on trolleys, who were located on the ward corridor. While it was far from ideal to be located there, it was clear that attempts were being made to enhance privacy where possible. Inspectors spoke with patients in each clinical area inspected. Most patients, with some exceptions, expressed general satisfaction with the care and the service received. One patient said how they would value more involvement in the medical decision making of their care. This was also a finding from the National Inpatient Experience Survey at Mayo University Hospital. Another expressed disappointment regarding a breakdown in communication that they had experienced while in the emergency department and one patient complained about the '*indignity of being on a trolley, that was head to toe with the next patient*'.

Inspectors noted occasions in clinical areas where the trolley of patient healthcare records was open and temporarily unattended on corridors. This was brought to the attention of staff who placed the trolley in the office area, supervised by staff.

Staff spoke about the paediatric audit conducted in February and March 2025 which had been undertaken with the consent of parents. One of the outputs of this, was the plan to trial the practice whereby a young child could be held and comforted by a parent rather than by a staff member and encouraged by their parent while undergoing some tests including blood tests. Inspectors noted that preparation for this was underway at the time of inspection.

Inspectors heard from staff how there was online access to an advocacy service for older people and that the medical social worker provided input and support to patients requiring this service. Inspectors did not see information on advocacy services on display for patients in the inspected areas.

In summary, inspectors found evidence of the service provider's efforts to promote the dignity, privacy and autonomy for patients, and conversations with patients validated those although there is an opportunity for improvement in the reduction of numbers of admitted patients being accommodated on trolleys in the emergency department and in the ward areas, the provision of a patient advice and liaison

service officer, increased promotion and protection of health care records at ward level and provision of information to patients about advocacy services.

Judgment: Substantially Compliant

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

Inspectors observed interactions by staff with patients throughout the inspection and noted that these were responsive, kind and respectful. Patients spoke positively about the staff caring for them. Staff explained to inspectors that no intimate procedures were conducted on admitted patients while they were located on corridors in the emergency department or on the wards. Instead the patient was moved to a side room. Staff were observed assisting patients at mealtimes, with mobilisation, explaining medication, and drawing screens around beds when indicated. They were also heard to address patients by their first names, and kind and encouraging language was used. Staff were heard ensuring the patients' comfort and they were observed assisting patients preparing for discharge home and or transfer to a nursing home.

Whiteboards detailing the name of the assigned nurse per room was on display outside of the nurses' station on B ward. Inspectors heard that, where possible, patient preferences for accommodation in gender specific multi-occupancy rooms was sought although it was not always possible to provide this. Inspectors noted that there was one bay on an inspected ward, occupied by both men and women.

Patients complemented the quality and range of food provided at mealtimes and spoke positively of the communal television room on ward B, saying 'it is great to have a space to chat with other patients'. Patients in St John's ward were very complementary of the care received, 'call bells are answered quickly', 'everyone very friendly', 'care is very good', 'curtains are pulled around and privacy maintained', 'transition from the main hospital was very good', 'doctors kept me up to-date on my plan of care'. Most patients however, said they were not aware of the HSE 'Your Service, Your Say' on how to make a complaint, should they have a reason to but said that they would speak with a staff member of needed. Feedback from patients on G ward was mostly positive, 'staff couldn't be nicer', 'privacy is good- draw the curtains anytime you want', 'I'd make a complaint to my nurse if I needed to', while a patient also stated dissatisfaction related to a two-day stay before being assigned a bed, a further patient described how they felt after a staff member 'made me feel I did not need to be here' and 'I considered leaving as a result of this'. One patient reported feeling 'vulnerable while nursed on the corridor' and said 'I know how to go about making a complaint but I did not

receive the information since I came to the hospital', and another said, 'I can see how hard the nurses are working'.

Some staff outlined quality improvements that were developed in response to reports from the HSE's, 'Your Service Your Say'. They included the establishment of the discharge lounge, the re-zoning of the minor's area of the emergency department and the purchase of specific toys for neuro-divergent children including use of a virtual reality (VR) headset to show children what happens next, for example, during the x-ray pathway.

The hospital engaged and coordinated the services of a group of volunteers. Inspectors spoke with staff who explained that volunteers offered cover for three-hour shifts between the hours of 9 am and 3 pm, Monday to Friday to the hospital. They were engaged in activities such as 'meet and greet' for visitors and patients to the hospital and in giving directions or assisting patients to their destination, where required. Their input and service was reported to inspectors as 'very valuable' and 'much appreciated'.

In summary, inspectors found that the hospital was promoting a culture of kindness, consideration and respect as described above.

Judgment: Compliant

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

Inspectors observed posters advertising the HSE 'Your Service, Your Say' in the inspected areas in the hospital. Inspectors heard how 90% of complaints received by the hospital were received via the HSE 'Your Service, Your Say' portal. The Quality and Patient Safety (QPS) Department managed the complaints process for the hospital. Four of the six staff in the quality and patient safety department had completed formal complaints management training and two further staff were scheduled to be trained. Outside of this, hospital staff were encouraged to undertake the complaints management training available on HSELand, while the QPS department provided a talk to non-consultant hospital doctors (NCHDs) at the two NCHD inductions per annum, on dealing with, and managing complaints.

The hospital had been using the HSE complaints management system (CMS) since February 2025 and inspectors viewed the first quarterly report for 2025. Formal complaints were tracked and trended and informal complaints and compliments were also logged by QPS staff although they could not verify that all informal feedback was

logged. Feedback was provided to staff verbally and in writing by a report to the directorates, MCANs and to the HMT. Almost a third of complaints in the year to date were associated with the emergency department. The QPS team worked on developing quality improvement plans arising from complaints in conjunction with relevant directorates.

The hospital had received 188 formal complaints in 2023 and 208 in 2024, all of which were resolved and closed. At the time of inspection, the hospital had received 69 complaints in 2025, 46 of which were closed. Of the remaining 23 open complaints, five of those were open for more than 30 days. The hospital was also monitoring its compliance with the HSE targets of 75% of complaints being resolved and closed within 30 days of receipt. It was at 56% in March, 83% in April and 55% in May 2025. Staff told inspectors that compliance with the target was affected by staff leave.

At the time of inspection, the patient advice and liaison service post was vacant but recruitment was underway to fill it. Staff on St. John's ward explained that they would seek to deal with verbal complaints from patients and or their families at the point of contact where possible. However, they did not log the informal complaints. Inspectors noted the presence of posters explaining how complaints could be made.

In summary, inspectors found that service users' complaints and concerns were being responded to promptly, openly and effectively with clear communication and support provided throughout this process. There was a tracking and trending system in place, there was evidence of feedback to the directorate and the HMT, quality improvement plans were seen to be devised in respect of same and the hospital was monitoring its compliance against the HSE target - 75% resolution of complaints within 30 days. There is still room for improvement in meeting this target.

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.

Apart from the emergency department, the inspected areas of the hospital appeared generally clean and tidy with some exceptions as described per area below. These were brought to the attention of relevant staff in the areas. There was however, notable chipped woodwork and scuffed paintwork in most of the inspected areas.

Hand hygiene posters and hand hygiene alcohol stations were strategically placed in all of the inspected areas and at each bedside. The clinical hand wash sinks viewed by

inspectors were all HBN*** compliant. Hospital management explained that there were still some non-HBN compliant sinks in the hospital and that there was a replacement programme underway.

The hospital used contract cleaners for maintenance of hygiene in the physical environment. This was supervised by the supervisor from the contact company.

Equipment was cleaned by health care assistants and multi-task attendants (MTA) and clean equipment was denoted in some but not in all of the inspected clinical areas by use of a tagging system. Hospital management later informed HIQA that it was not hospital policy to use the tagging system. Equipment cleaning schedules were viewed and were found to be signed off twice a day by the person assigned to do the cleaning. There was no formalised verification of this process in place. The temperatures of the drug fridges in the inspected areas were controlled and monitored by pharmacy. Any deviation from the norm resulted in an audible alert conveyed to staff in the clinical area for review and action. Staff reported good responsiveness from maintenance department to requests however they also reported some long-standing issues that have had to be resubmitted.

On the first morning of inspection, the emergency department (ED) was observed to be very overcrowded with trolleys placed 'head to foot'. As described in previous HIQA reports and as reflected in the HSE TrolleyGAR, the ED has been consistently overcrowded for a number of years. The infrastructure in the ED was old and worn with floor staining, lack of storage and a very small space for the sluice room. There were no call bells available for patients on trolleys on the corridors. Office spaces were very small and congested. There was chipped woodwork, sticky tape used to hold unlaminated and shabby paper signs on doors. Old COVID-19 stickers remained on display in the emergency department and in other inspected areas throughout the hospital.

The emergency department comprised the main emergency area, and the ambulatory ED which was located within a modular unit adjacent to the main department. It had a waiting area with capacity for 46 seated patients. Inspectors observed 10 people seated in this area. Ambulance access for patients on trolleys was via an entrance at the back of the current main ED. There were 10 patients waiting and a further three patients were being reviewed in individual rooms in the ambulatory ED at the time of inspection. Inspectors noted that the hospital was not compliant in ensuring at least one metre distance between trolleys located on the corridors. This arose from the overcrowding in

*** HBN refers to standards of sanitary facilities in healthcare environments. 20250828_DoH_InfectionPrev_Main_No30_2023_PRINT_v2_Vol_1_Rev_wth_Linked.pdf

the department after a certain number of trolleys were exceeded and in use on the corridors.

The combined planned capacity of treatment areas in the accident and emergency department and the ambulatory ED included space for 24 patients undergoing triage, assessment and or treatment. The layout comprised:

- a primary triage room
- a secondary triage room
- one resuscitation room with capacity for two patients on trolleys. It also accommodated a resuscitator for a baby requiring resuscitation
- four major treatment cubicle areas
- two minor resuscitation cubicles
- two isolation spaces in the main ED (en-suite except for shower facilities)
- a gynaecology room
- an eye room
- a mental health room
- two treatment and plaster rooms
- a paediatric assessment bay with capacity for one child. This was not audio-visually separate. The National Model of Care for Paediatric Healthcare in Ireland[†††] recommends audio-visual separation of children and adults in emergency departments.
- seven single rooms in the external but adjacent ambulatory ED, two of which were used as waiting rooms
- There was access to a disabled access toilet as well as other toilet facilities within the main emergency department and in the ambulatory ED.
- Toilet facilities in both the main emergency department and in the ambulatory ED

A paediatric decision unit was located on the paediatric ward. There was no designated 'end-of-life care' room in the emergency department. Instead staff contacted the bed manager and the palliative care team to assist in the identification of the most suitable alternative area available to which a patient at this stage of life, could be transferred to for more dignity.

Staff spoke with inspectors about how space was so limited in the department and how challenging it was to try to isolate patients there as well as meet the general requirement for trolleys to be placed at least a metre away from each other. All patients requiring isolation in the department at the time of inspection were being isolated. One of the rooms used to accommodate an isolated patient was not marked with the appropriate infection prevention and control signage. There was storage of items on the floor in the store room. There was no APINCH (high risk

[†††] A National Model of Care for Paediatric Healthcare Services in Ireland – Paediatric Emergency Medicine (HSE and RCPI) https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/paediatric-emergency-medicine.pdf

drugs) drug alert on display in the medical treatment room in the ED. These matters were brought to the attention of the nurse manager on-duty.

The acute medical assessment unit (AMAU) was a nine-bedded unit which included an isolation room, reception area, work station, and toilet and shower facilities. The day services unit (DSU) comprised a reception area and work station, two six-bedded and one three-bedded bays, and an endoscopy suite. Three of the 15 DSU beds were identified as surge beds and on the day of inspection, five of the beds were being used for admitted patients. The hospital was participating in the national bowel screening service and the endoscopy unit was operational seven days a week to meet demand from this service. The discharge lounge had a work station area plus capacity for eight patients using electronically operated recliner chairs. It was equipped to enable staff carry out vital signs and weight checks, and take bloods. Patients using this service could easily access the café and toilet facilities.

B-ward was a 38-bedded medical ward which was fully occupied on inspection. Entrance to this ward was via swipe access and the doors were closed on inspection. The back door was unlocked. It had five single rooms each with en-suite facilities, and six multi-occupancy rooms each with en-suite facilities (four six-bedded rooms, one five-bedded room and one four-bedded room). The single rooms did not have anterooms and there was no negative or positive air pressure facility on the ward. Five patients were being isolated in the single rooms. Doors were closed and appropriate signage was placed on each in line with standards. Inspectors noted an air mattress left on the ground in a store room. Staff reported that maintenance staff were due to put in shelving in this room. Stocks of toilet roll were observed on the floor in the cleaners' room. Curtain changes were dated on the curtains and these were changed in line with hospital policy. Whiteboards detailing the name of the assigned nurse per room was on display outside of the nurses' station. The emergency telephone number was displayed on the phones observed. A patient dashboard was available in the nurse's station and was protected from public view. It included the predicted date of discharge and other relevant information for each patient. Cleaning checklists viewed by inspectors were complete with no gaps. Staff explained that whoever used the equipment was required to clean it after use. Some sharps boxes were not closed as required between uses. Medicines were safely stored. Infusions containing potassium were stored separately. High risk medicines were identified with a red sticker. There were APINCH (high risk medicines) and 'sound alike look alike drugs' (SALADs) lists on display on this ward. There was three gaps in the daily check list for the oxygen checks within the previous month. These issues were brought to the attention of the nurse in-charge.

G ward was a 16-bedded ward which provided accommodation for a mix of patients with gynaecology and early pregnancy issues (up to 16 weeks gestation), medical patients, and surgical patients. It comprised two six-bedded wards and four single

en-suite rooms. Each six-bedded bay also had en-suite facilities. The single rooms did not have variable air pressure units. One of the single rooms had an ante-room. Six of the 16 beds were ring-fenced for gynaecology and early pregnancy patients. At the time of inspection, there were 16 patients on the ward. There were also two unoccupied trolleys, used for surge activity, on the corridor. There was no swipe access to the ward. Egress via the back stairs was not restricted. The ward had a small room which was used for holding sensitive conversations. Patient charts were stored in locked trolleys. The storage areas were neat and tidy however, excess storage was placed on the corridors, and although it was not impeding access, it made the area look congested. The floor in the main ward areas were stained and did not look clean. There was debris and pieces of paper noted in several areas. Inspectors brought this to the attention of the staff who explained that the cleaners were yet to attend the ward to clean the floors. Inspectors spoke with the cleaning supervisor about the requirement for floor cleaning. A locked cleaners' room was located outside the ward. Inspectors spoke with staff who were knowledgeable about the names and strengths of the solutions and agents used for cleaning. The ward whiteboard which was used to list the patients and their status was protected from public view. A noticeboard for hand hygiene updates displayed the results of audits. This is discussed under National Standard 2.8.

St. John's ward was located on the campus of the Sacred Heart Hospital, Castlebar. It was a 34-bedded low acuity medical centre, under the governance of Mayo University Hospital. It provided medical care for patients who required continuing treatment including intravenous antibiotics or who were medically discharged and who were awaiting transfer of care either to home or to residential care. Access to the ward was restricted via a locked door. It comprised four single en-suite rooms and six bays containing six beds each. Each bay included an en-suite toilet and shower facility. One of the six-bedded bays was 'closed' and was not included in the bed census. It was used only for escalation purposes to provide three beds for surge during 'black escalation'. Staff told inspectors that the bay was opened for the first time in April 2025 and remained open for three weeks.

St. John's ward was noted to be bright and airy and apart from a small amount of scuffing of paint, the ward was noted to be clean and tidy. There was adequate spacing between beds of at least one metre. Curtains were clean and were dated when last changed. The hospital policy was to change curtains as part of a terminal clean at the time of discharge, on a three monthly basis or immediately on any occasion if soiled or contaminated. Items were appropriately stored on this ward. There was a daily and a weekly cleaning schedule in place for the equipment. There was no tagging system in use in this ward and staff reported that the practice in place was that the user cleaned the equipment after each use. Inspectors noted that cleaning chemicals were in an

unlocked cupboard in the cleaners' room and this was brought to the attention of the nurse in-charge at the time.

At the time of inspection, there was a total of 21 inpatients on St. John's ward. All patients who required isolation at the time of inspection were provided with a single room. Inspectors noted that one of these room doors was open and there was no signage on it. This was brought to the attention of ward staff who immediately applied signage and closed the door.

Hospital management explained that an intercom system was due to be installed at the door to more closely monitor activity at the entrance and egress however, there was no agreed date for this at the time of inspection. Family members had to telephone the ward to gain access. This is discussed further under National Standard 3.1. Ample supplies of gloves, masks, aprons, and alcohol gel stations, were strategically located throughout the ward. There was a resuscitation trolley, defibrillator, oxygen and suction available on the ward. Inspectors checked this and found it to be in order. Inspectors noted that the staff canteen was accessible from St. John's ward. This was brought to the attention of the nurse in-charge.

C Ward was visited to follow up on reports about the physical infrastructure. There were three admitted patients on trolleys located in this ward. Screens were used around the trolleys for privacy and dignity. Fire exits were clear. Chipped paintwork and chipped woodwork was noted. Staining was noted on the floor covering in the corridor and in room 60. Staff explained that despite extensive cleaning, it had not been possible to remove the staining. A hole was noted on the floor under the sink in the clinical room which had been referred to maintenance.

The paediatric ward was visited to ascertain arrangements for the entry and egress of children. It was a 22-bedded ward where both scheduled and unscheduled care was provided. The paediatric decision unit (PDU) was based in the centre part of the ward and had five spaces for patients. Children (inpatients) were primarily allocated accommodation on the ward based on their age groupings, for example, younger children were accommodated further from the entrance. While entry was via controlled access, egress from the ward was via activation of a button placed at height to minimise accidental egress by small children. This is discussed further under national standard 3.1.

Inspectors were informed by the IPC team that some funding had been received by the hospital for repairs to walls which were affecting compliance with environmental hygiene standards in the main hospital. The IPC team were involved in the oversight of monitoring the environment for Aspergillus and in the sign-off of method statements prior to commencement of any building and repair works in the hospital. The hospital had a flushing policy in place to help prevent the incidence of *Legionella*. The flushing

was undertaken and signed off by the cleaner on-duty and compliance was monitored by the environmental health committee who reported into the infection prevention and control committee.

In summary, while the off-site ward, St John's ward had been recently renovated, many of the clinical areas inspected appeared in need of refurbishment due to scuffed paintwork, chipped woodwork and heavy floor staining. There was a lack of capacity in the emergency department and in some of the ward areas. The DSU and AMAU were being used to accommodate inpatients. The floor on G ward was dusty and unclean. Although the equipment cleaning list was signed by the person who undertook the cleaning, there was no system in place to verify same. Inspectors observed two breaches in the standards relating to IPC signage and closure of a doors in the case of isolated patients. Cleaning chemicals were in an unlocked cupboard in the cleaners' room of this ward. These issues were brought to the attention of the nurse in-charge during the inspection. St John's ward was awaiting installation of an intercom system but there was no planned date for this. Access and egress from wards was inconsistent, some had swipe access but access was also possible via back stairs.

Judgment: Partially Compliant

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

Inspectors noted reference to audit activity in each of the inspected areas. The audit schedule on wards included the following: controlled drug stock check - fortnightly, INEWS audit – twice weekly, INEWS escalation - weekly, hygiene audits - monthly, nursing care metrics - twice weekly, carbapenemase-producing *Enterobacterales* (CPE) audit – weekly, and patient experience survey (eight patients) bi-monthly. Audit activity in some areas was undertaken less frequently. Audit results and quality improvement plans in progress were listed on the quality boards however, overall scores of audit activity displayed on one ward were brief, for example, 'patient experience - 93.18%'. The details such as, date of audit or what was measured was absent.

Infection prevention and control

At the time of inspection, the latest published results for hand hygiene compliance was 84.8% in October to November 2024. This was the lowest in the three latest sets of results and below the HSE target of 90%. It was 89.5% in October – December 2023 and that was down from 93.8% in May - June 2023. Inspectors spoke with the staff who explained that internal audits of compliance with the 'WHO Five Moments of Hand Hygiene' on the general wards were meeting the HSE target

however they had identified three areas which were not meeting this standard. These areas were re-audited and two of them were still not meeting the target for compliance so a quality improvement plan was devised. It included daily rounds by the IPC team and additional hand hygiene education sessions provided for staff. They were to be re-audited frequently until the standard was met. The IPC team facilitated weekly education sessions based on the national AMRIC (antimicrobial resistance and infection control) guidelines. There was evidence of monthly IPC audits carried out on the wards including compliance with the WHO's 'Five Moments of Hand Hygiene' and 'bare below the elbow' practice. The results for compliance with these in ED in March 2025, were 63.3% overall.

Inspectors noted that results from monthly environmental hygiene audits from January to May in 2025 averaged at 97.4% for the emergency department and 99.8% for the AMAU. St. John's ward provided details of quarterly infection prevention and control audits, of the environment and equipment, with compliance ranging from 75-85%. The cleaning supervisor from the contract cleaning company also undertook monthly audits of hygiene levels. General infection control was audited in May 2025 on elderly medicine ward (85% on re-audit), paediatric ward (84%), D ward (81%) and C ward (79%). Areas for attention were noted on each result sheet but there was no update or sign-off available at the clinical area as to when or if the actions had been undertaken. Hospital management later informed HIQA that all IPC general audits are reviewed by the IPC committee, and actions and updates are discussed within the committee. Inspectors viewed the minutes of the IPC committee meetings held in April, May and June and found that these referred to general commentary rather than specific action plans. There was a hand hygiene notice board on G ward displaying compliance results of 93.3% for hand hygiene and 100% for 'bare below the elbow' practice in May 2025. Audit records from the IPC team dated May 2025 showed 100% compliance with the care bundles for peripheral vascular catheter care, central venous catheter or PICC line, and urinary catheter care in D ward, and ICU. ICU also scored 100% for compliance with the care bundle for arterial line care. The maternity ward scored 67% for compliance with the care bundle for peripheral vascular catheter care. Although the number of cases in maternity was small (three) there was no action plan documented for such results.

Compliance with carbapenemase-producing *Enterobacterales* (CPE) screening was audited in May 2025. 'A' ward and ICU scored 100% while B ward scored 73.5%. The hospital also monitored monthly use of antimicrobials.

At the time of inspection, there was no published or internal data available on infection rates year to date including *Staphylococcus aureus* blood stream infection (SABSI), carbapenemase-producing *Enterobacterales* (CPE) or *Clostridium difficile*. Published data for 2024 for eleven months only (Jan – Nov 2024, no data available for December 2024) included a SABSI rate of 0.38 per 10,000 bed days used, (up

from 0.33 in 2023) against a HSE key performance indicator (KPI) of less than 0.8 cases per 10,000. The rate of *C. difficile* was 0.55/10,000 down from 1.24 in 2023 and against a HSE KPI of less than 2 cases per 10,000, 39 new cases of CPE were identified on universal screening on admission. This was up from 20 cases in 2023. There is no HSE target for new CPE cases. Inspectors spoke with staff about possible reasons for the increase in the number of new CPE cases and were informed that it was not possible yet to explain and that the cases were of various strains.

Medication safety

At the time of inspection and in line with the medication safety priorities listed for 2025, inspectors were told that auditing was now due to commence on a monthly basis and would be conducted by pharmacy and nursing staff. Monthly medication safety audits viewed by inspectors on St. John's ward resulted in scores of 80-85% but no details of these audits were available although corrective actions were recorded where the standard was not met. One medication management ward audit was provided for B ward dated May 2025. Seven areas were audited as follows, medication storage (58%), MDA storage (90%), sources of information (100%), potassium (60%), insulin (100%), SALADS (0%) and high alert (50%). The items were listed but no overall result was provided. The audit was signed by the auditor but it did not state if the ward manager had been informed. There was one comment relating to the placement of 'sound alike, look alike drugs' (SALAD) but no other instruction for correction or associated quality improvement plan. The audit on the controlled drug stock checks in ED was noted to be 90.91% in June 2025.

Inspectors audited a sample of patient healthcare records where 83% of the charts did not have a documented clinical pharmacist review and did not have a record of medicine reconciliation as required by the local policy.

Deteriorating patient

Findings of monthly audits of compliance with use of early warning systems, conducted by clinical nurse and midwife managers, were reviewed by the DPMC at their bi-monthly meetings. Compliance with early warning systems (EWS) were audited on two charts per week in St John's ward, one on compliance with the early warning systems in general and one on a case where the EWS had resulted in escalation. B ward produced five sets of audit results related to compliance with INEWS documentation, carried out monthly from February to June 2025 inclusive. Results ranged between 80.5% and 99.4%. The ward also produced five sets of audit results carried out monthly for the same time period relating to compliance with INEWS escalation and response. Results ranged between 100% on the first

audit to 80% on the most recent one. There was no associated quality improvement plan provided when results below 90% were recorded.

Transitions of care

Inspectors found that there were no audits available on clinical handover in the inspected areas**.** While the predicted date of discharge (PDD) was being piloted that week in the hospital, and each patient on St John's ward had a PDD listed on the whiteboard, it was not recorded on all of the patient healthcare records on the first day of inspection.

Overall, while there was some evidence of audit activity in the inspected areas, and the IPC team had a selection of audits available centrally as above, inspectors found there was a lack of available audits within the inspected clinical area for inspectors to view, with the exception of infection prevention and control. Audits were not always accompanied by a quality improvement plan.

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

Corporate Risk Register

Inspectors viewed the redacted risk register dated June 2025. Risks were classified and risk rated. Each item had existing control measures described and some had additional control measures added. Inspectors viewed the red rated risks associated with the four key areas of known harm which included pharmacy staffing for medication safety (medication safety pharmacist position was being recruited), lack of cardiac technicians (posts remained unfilled despite recruitment efforts), no cancer care co-ordinator, no home parenteral nutrition service, staff shortages in clerical administration, no podiatry service, no diabetic dietetic support in paediatrics, lack of capacity within the emergency department, lack of in-patient bed capacity, hospital operating at 110% occupancy (capital development plans at design stage), suboptimal communication and clinical handover (being audited). Existing and additional control measures and dates of most recent review were recorded. The action owner was identified for some but not all risks. There was no record of risk associated with patient absconsion. At local level, QPS staff assisted ward managers to carry out risk assessments in their areas of responsibility. Inspectors noted however, that while the hospital was tracking and trending events relating to absconsion, this was not on the risk register and there were no risk assessments on the inspected wards who had reported such events. Inspectors also

viewed out of date risk assessments in some wards.

Infection Prevention and Control

The hospital carried out targeted screening for carbapenemase-producing *Enterobacterales* (CPE) and they screened patients for MRSA in line with national guidelines. Patients who were deemed positive for either infection were escalated to the clinical operations and bed management team for isolation in line with HSE guidance.
According to the HSE published hospital patient safety indictor reports (HPSIR), there were 12 new cases of CPE identified in the first six months of 2023 (there is no HSE target for this) and the rate of new cases of *Clostridium difficile* was 4.1 per 10,000 bed days (above the HSE target of less than 2 per 10,000 bed days). There was a further 12 new cases of CPE identified in the first six months of 2024 and the rate of new cases of *C. difficile* was 3.2 per 10,000 bed days. The rate of new cases of hospital acquired *Staphylococcus aureus* bloodstream infection was 2.1 per 10,000 bed days (above the HSE target of less than 0.8 per 10,000 bed days). At the time of inspection, there was no publically available data for 2025 in respect of these measurements although hospital management reported that it was submitted to the HSE on a monthly basis. Inspectors heard and viewed evidence of minutes where it was confirmed that each ward had a nominated sepsis champion in place and that training was ongoing. While the IPC team visited the clinical areas daily, the consultant microbiologist also visited clinical areas where there were persistent issues with compliance with standards on screening and or audit activity. Access to a consultant microbiologist was available 24/7 and the consultant microbiologist confirmed that they had online access to the relevant laboratory test results if required.

Medication safety

Inspectors viewed the medication management policy which was dated June 2023 but remained in draft format. Following discussion with staff, it remained unclear why this had not yet been approved for use, especially, as prescribing practices were noted to be the most commonly associated cause of near misses and incidents in each of the previous two years of analyses as well as in 2025, year to date of inspection. Inspectors heard and viewed documentation that was shared with the HMT outlining the concerns relating to compliance with best practice. Following this, inspectors noted that hospital management wrote to the consultant body and explained that medicine reconciliation was not solely a role for pharmacists and that while others were also undertaking this role, they were not all recording it in the standard location of the chart. This then could be missed and so the hospital was working to reach consensus on location of the medicine reconciliation record. It was

also noted in conversation with staff and in minutes of the drugs and therapeutics committee (DTC) that local district hospitals accepting transfers from Mayo University Hospital were noting and reporting medication incidents associated with transfers from Mayo University Hospital.

While there were computers available in the inspected areas, demonstration of access to up-to-date medicines information by staff to inspectors was effective in only one of the inspected areas. While there was hard copies of the British National Formularies (BNF) present, these were found to be out-of-date (more than 6 months old) in all inspected areas with the exception of one. All hard copies of the GUH intravenous guidelines were dated 2019. Some staff reported use of a HSE WNW University Hospital Galway app on their personal phones to access up-to-date medicine information as opposed to the hard copies of same on the wards. Inspectors observed a breach of standard relating to pre-preparation of medications. These matters were brought to the immediate attention of the staff in-charge of the respective areas and to the hospital management team on the day. Hospital management assured inspectors that it was not hospital policy to pre-prepare any medication and were following up on this with DSU staff.

A good reporting culture is noted when all incidents and near misses are routinely reported using the hospital's reporting system. Inspectors noted however, that no medication safety incidents or near misses had been reported in the year to date on St John's ward. Inspectors further noted that with the exception of one of the inspected clinical areas, there was a very low level of reporting of medication incidents or near misses. The ward that did report, did so about twice a month, which was also lower than expected. The reported incidents related mostly to prescribing errors. This was discussed at the drugs and therapeutics meetings, directorate and MCAN meetings and at HMT. Medication safety was discussed at induction.

The pharmacy issued safety alerts to staff and monthly safety bulletins via email. Controlled drugs were checked twice a day at report time in the inspected areas by two registered nurses at morning and evening handover and the checks were recorded in the drug registers.

The deteriorating patient

The hospital was using national early warning systems (INEWS, IMEWS and PEWS) on the relevant cohorts of patients. Inspectors were told and viewed documentation where it was stated that the hospital was unable to implement the national emergency early warning system (EMEWS) in the emergency department due to staff shortages although staff training had already taken place. The issue had been escalated to the HSE and was for further discussion at the June 2025 Phase 2 Safer

Staffing meeting. The communication tool, Identify, Situation, Background, Assessment, Recommendation (ISBAR), was used to escalate concerns re elevated early warning scores or any other concerns about a patient. The DPMC were actively following up on audit activity to assess compliance with the systems in place to anticipate, recognise and manage the deteriorating patient.

Inspectors noted documentation whereby the deteriorating patient management committee (DPMC) were working on a draft pathway for patients in the approved mental health unit who were attending the acute hospital for specific procedures.

There was no access to a cardiac arrest team on the off-site ward, however there was 24/7 access to the on-site doctor on-duty. In the case of a cardiac arrest, help was requested via alerting the doctor on duty, a 999 telephone call for an ambulance and basic life support was initiated by the staff attending the patient.

It was noted that the hospital were an outlier in the National Office of Clinical Audit (NOCA) for sepsis although when investigated, the anomaly related to the over assumption of sepsis which had not been de-escalated before discharge.

Transitions of care

Launch of a 'predicted date of discharge' was planned and supported by a standard operating procedure dated May 2025. Multidisciplinary meetings had taken place to plan and update all staff on the initiative which was rolled out on the week of inspection. Safety huddles were taking place on inpatient wards three times a day at 8 am, 12 midday and at 4 pm. They were generally led by the nurse manager or nurse in-charge. The GP liaison nurse monitored the number and rate of patients who registered to attend the emergency department and who subsequently left the ED before being assessed or before completion of the episode of care. The GP liaison nurse followed up on such patients by the following working day to provide information and advice relating to a return to hospital and how to make contact with alternative sources of support. If deemed necessary, contact with their GP, next of kin, or other emergency contact could also be established.

Other risks

In the months prior to the inspection, the hospital had experienced a number of 'near miss' incidents relating to absconsion of in-patients, where a patient had left the ward and was subsequently safely recovered. The hospital was tracking and trending such incidents and had an absconsion policy in place - covering adults and children, which was viewed by inspectors. This included assessment on risk of patients on admission, identification and provision of an increased level of monitoring including appropriate location placement and review of entry and egress points on the ward. It also outlined the steps to be taken in the event of a patient

deemed 'missing'.

Absconsion occurred from the main hospital and from the off–site ward despite patients being assessed for suitability for transfer out to the off-site ward. Hospital management explained that the hospital had a high percentage of older patients where changes may manifest in short-term confusion for some, following a transfer. Staff outlined the assessment of patients on admission to St. John's ward following transfer. This included height and weight checks, mental capacity assessment, and an alert, confusion or cognition score. The hospital had a wandering alarm system in place which was used on selected patients with their consent (or their family's consent if indicated). Hospital management explained that the patients who had absconded had not met the criteria for application of the wandering alarm. Hospital management explained that an intercom system was due to be installed at the door of the off-site ward to more closely monitor activity at the exit and entrance doors. Security staff assisted in search for persons who left the ward and An Garda Síochána was routinely informed once a patient was deemed to be 'missing'. Inspectors found however, that there was no risk assessment performed at ward level in the inspected ward areas where absconsion had been reported.

An inspector visited the paediatric ward which had CCTV in place and controlled access. The inspector was admitted to the ward without enquiry as to who they were, or the purpose of their visit. This breach was brought to the attention of the person in charge and hospital management. The inspector had visited the ward to follow up on security of patients and risk of absconsion. Notices were placed on the wall close to the entrance doors alerting parents that children wishing to leave the ward for any reason were required to be accompanied by a parent. This was highlighted among staff at the handover and children at risk of leaving (for example, those who had difficulty sleeping) were also highlighted to staff at handover. It was noted to be an ongoing risk especially as there was increased patient traffic on the ward relative to the number of beds, due to the nature of the service provided by the paediatric decision unit (PDU). However, it was not listed on the corporate risk register.

Inspectors followed up with hospital staff from the Women and Children's' managed clinical academic network (MCAN), to seek an update on implementation of quality improvement plans arising from reports of maternity related incidents and clarification on collation of data submitted to the HSE for the monthly Maternity Safety Statements (MSS). Hospital management confirmed that the new HSE guidelines on a) induction of labour and b) reduced fetal movements were being implemented at the hospital.

Inspectors heard and viewed documentation stating that basic life support (BLS)

training had recommenced in September 2024 but capacity of the venue was for a maximum of six people and this had impacted on the ability of staff to keep up-to-date. This had been escalated to the HMT as an issue. At the time of inspection, hospital management confirmed that this was now resolved and a more suitable location had been found which could accommodate 12 learners at a time. Inspectors viewed documentation confirming same.

The hospital was using CCTV in the hospital. Its use and scope were set out in the CCTV hospital policy, which was viewed by inspectors. Inspectors heard and viewed documentation relating to a major emergency simulation exercise held in December 2024. The major emergency plan and action cards were being updated following the exercise.

Policies procedures and guidelines (PPGs)

Inspectors requested access to specific PPGs on inspection and found that with the exception of two local PPGs ('sound alike, look alike drugs' (SALADS). - due for review in 2022, list of high risk medicines and policy - due for review in 2023) and one national policy on complaints management, due for review in 2020, all others relating to IPC, medication safety, the deteriorating patient and transitions of care were formally approved and up-to-date. There was a policy and a standard operating procedure (SOP) in place to support decision making in the paediatric decision unit although these documents were undated.

Access to policies was via the hospitals electronic document management system available on the ward desktop computers. Staff were asked to demonstrate access to those policies at ward level and most but not all, were able to do so when asked.

In-service training

Inspectors heard that the HR department were overall responsible for collating up-to-date information on compliance with attendance at mandatory training however due to staffing deficits in recent months within the HR department, departments were required to send their information to the general manager for oversight.

In summary, hospital management were risk assessing and managing risks in most areas of focus of this inspection however there were deficits noted in risk management of medication safety and risk of absconsion. The risk of absconsion was an ongoing issue which was being tracked and trended by the hospital but was not listed on the risk register and inspectors noted that there was no risk assessments available on the inspected inpatient wards where this had previously occurred.Standard practice was not followed in respect of enquiry when the HIQA inspector sought entry to the paediatric ward. The hospital had yet to implement the emergency early warning system (EMEWS) in the emergency department. This was

reported to be impacted by current staffing levels as discussed under national standard 6.1. The installation of an intercom system at St. John's ward was awaited at the time of inspection. Inspectors also viewed out-of-date risk assessments in some wards. All of these matters were brought to the attention of staff in the relevant areas and to hospital management.

Judgment: Partially Compliant

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

The hospital was using the direct national incident management reporting system (NIMS) since February 2025. Each incident report was reviewed online by quality and patient safety staff to ensure completion and then it was forwarded on to the state claims agency.

The average rate of reported clinical incidents per month for the first six months of the year was 18-19 per 1000 bed days in 2023 and 17-18 in 2024. At the time of inspection, data was available for the first four months of the year for 2025 and the average monthly rate of reported clinical incidents was 24 per 1000 bed days. This was within the overall expected range of reporting (5.8 to 48.0 per 100 bed days) and can be indicative of a good reporting culture. Inspectors viewed the quality and patient safety (QPS) report on incidents that had occurred between January and May 2025 inclusive. These were being tracked and trended and the three most commonly occurring incidents were highlighted.

The hospital had reported a total of 20 serious reportable events in 2024. At the time of inspection, the hospital had reported a total of seven serious reportable events in 2025.

QPS staff led out on the completion of preliminary assessment reports (PAR) of incidents which were then circulated to the staff members caring for the patient involved, for their input. The finalised PARs were discussed by QPS staff at the relevant directorate or MCAN meetings. The directorate or MCAN made the decision as to whether to close or to submit to pre - serious incident management team (pre-SIMT). Pre-SIMT was a subset of the broader SIMT and comprised the senior management team at regional level. The pre-SIMT decided what incidents were to proceed to SIMT. The full SIMT included QPS staff. QPS staff presented a summary report of incidents to the HMT meetings.

The SIMT met monthly. Staff outlined the process used in the management of a serious incident. Inspectors viewed data in relation to the numbers and types of

serious reportable events and serious incidents currently open at the time of inspection. Staff at ward level explained that learning was shared at staff huddles, the 12-midday safety pause and at clinical handover of patients.

The launch of the open disclosure policy occurred on the first day of the inspection and QPS staff were assisting in the training of staff.

Infection Prevention and Control (IPC)

Inspectors spoke with the IPC team on a range of past IPC incidents and outbreaks and noted that these were managed in line with hospital and national guidance.

Medication safety

Inspectors viewed the analysis of reported medication safety incidents as provided for each of the years 2023, 2024 and 2025. There was 158 medication incidents reported in the full year of 2023, 242 in the full year 2024 and 114 for the first six months of 2025. Prescribing errors was the most commonly reported incident followed by administration errors and then medicine reconciliation. Some of those reports were being submitted by the three district hospitals who were identifying anomalies on transfer from Mayo University Hospital. Smaller numbers of incidents related to preparation and dispensing, supply, ordering and transport, storage, and monitoring. Tracking and trending of reported incidents was shared at the drugs and therapeutics committee as well as at directorate and MCAN and HMT meetings via a written report. Overall this level of reporting medication safety incidents and near misses was lower than that expected. Inspectors viewed documentation and staff confirmed that efforts were being undertaken to seek to improve medication safety overall. These included monthly release of 'learners bulletins' and workshops held in December 2024 and May 2025 where training was provided to 49 staff.

In summary, while the hospital now had direct online access to report to NIMS, and there was a culture of reporting incidents, there was still a low level of reporting of medication safety incidents and or near misses across most of the inspected clinical areas.

Judgment: Partially Compliant

Conclusion

HIQA conducted an unannounced inspection of Mayo University Hospital on 17 and 18 June 2025 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm, infection prevention and control, medication safety, the deteriorating patient, and transitions of care. The inspection also included reference to the hospital's compliance plan issued by the hospital following the previous inspection in 2023.

Capacity and Capability

Inspectors found that the hospital was substantially compliant in National Standards 5.2 and 5.8, and partially compliant in National Standards 5.5 and 6.1. This reflected a downward change from 2023 findings (when the hospital was substantially compliant in National Standards 5.2, 5.8 and 6.1, and partially compliant in National Standards 5.5).

HIQA inspectors found that Mayo University Hospital had formalised and functioning governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. The meeting structures at IHA level were yet to be formalised and some committees had yet to update their terms of reference.

Mayo University Hospital had some effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. The hospital collated and closely monitored their data at the HMT and at various associated hospital committees. The hospital was not yet meeting all of the HSE key performance indicators for patient experience times as outlined above. The overcrowded emergency department and inadequate space for children in the main emergency department was the reason for redirection of children categorised at levels three, four and five to a paediatric decision unit in the paediatric ward, located on the hospital's first floor.

Mayo University Hospital broadly had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. These included findings from the National Patient Experience Programme, internal audits, complaints, risk management and review of incidents. However, there was low levels of awareness of some of these findings and associated quality improvement plans among staff in the inspected areas.

Notwithstanding ongoing recruitment, the hospital was short of key members of staff as outlined and some for long periods. Some of the staffing needs in nursing as identified in phase 1 of the HSE Safer Staffing Framework (ward areas) were yet to

be funded for the hospital, phase 2 of the Safer Staffing Framework- affecting ED staffing was incomplete at national level and so the hospital had escalated the risk of the patient to staff ratio in ED while they awaited approval and funding for additional staffing. Sickness absence levels at 7% breached the HSE target of 4% or less.

Quality and safety

Inspectors found that the hospital was compliant in National Standard 1.7, substantially compliant in National Standards 1.6 and 1.8, and partially compliant in National Standards 2.7, 2.8, 3.1 and 3.3. This reflected a downward change from 2023 findings (when the hospital was compliant in National Standards 1.7, 1.8 and 3.3, substantially compliant in National Standards 1.6 and 2.8 and partially compliant in National Standards 2.7 and 3.1).

Inspectors found evidence of the service provider's efforts to promote the dignity, privacy and autonomy for patients and conversations with patients supported that. Inspectors observed interactions by staff with patients throughout the inspection and noted that these were responsive, kind and respectful. There is an opportunity for improvement in the reduction of numbers of admitted patients being accommodated on trolleys in the emergency department and in the ward areas, in the provision of a patient advice and liaison service officer, increased promotion and protection of health care records at ward level, and provision of information to patients about advocacy services.

Inspectors found that service users' complaints and concerns were being responded to promptly, openly and effectively with clear communication and support provided throughout this process. There was a tracking and trending system in place, there was evidence of feedback to the directorate and the HMT, quality improvement plans were seen to be devised in respect of same and the hospital was monitoring its compliance against the HSE target of resolution of 75% complaints within 30 days. There is still room for improvement in meeting this target.

On examination of National Standard 2.7, many of the clinical areas inspected appeared in need of refurbishment due to scuffed paintwork, chipped woodwork and heavy floor staining. There was a lack of capacity in the emergency department and in some of the ward areas. As a result, the day services unit (DSU) and the acute medical assessment (AMAU) were being used to accommodate inpatients. The floor in G ward was dusty and unclean. Although the cleaning staff signed for cleaning equipment, there was no evidence of oversight at ward level of this. These issues as well as storage of cleaning chemicals and signage for isolation rooms were brought to the attention of the nurse in-charge during the inspection. St John's ward was awaiting installation of an intercom system but there was no planned date for this. Access and egress from wards was inconsistent, some had swipe access but access was also possible via back stairs.

While there was evidence of audit activity in the inspected areas, and the IPC team had a selection of audits available centrally as above, there was a lack of available audits in the inspected clinical areas for the current year, for inspectors to view, relating to the four areas of known key harm, with the exception of infection prevention and control. Audits were not always accompanied by a quality improvement plan.

The hospital were risk assessing and managing risks in most areas of focus of this inspection however there were deficits noted in risk management of medication safety and risk of absconsion. The risk of absconsion was an ongoing issue which was being tracked and trended by the hospital but was not listed on the risk register and inspectors noted that there was no risk assessments available on the inspected inpatient wards where this had previously occurred. The hospital had yet to implement the emergency early warning system (EMEWS) in the emergency department. This was reported to be impacted by current staffing levels. The installation of an intercom system at St. John's ward was awaited at the time of inspection. Inspectors also viewed out-of-date risk assessments in some wards. All of these matters were brought to the attention of staff in the relevant areas and to hospital management.

While the hospital now had direct online access to report to NIMS, and there was a culture of reporting incidents, there was a low level of reporting of medication safety incidents and or near misses across most of the inspected clinical areas.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the six national standards identified above as partially or non-compliant with national standards.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially Compliant

quality, safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance Plan from Mayo University Hospital

Inspection ID: NS_0143

Date of inspection: 17 and 18 June 2025

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

- ED extension enabling works complete.
- Contractor selected for ED build, aim to start at the end of Q2 2026.
- A designated paeds area has been designed in the new build.

A steering group has been established to oversee this process. Aim for completion at the end of 2027.

Funding approved for Ballina Minor Injuries Unit. Recruitment in progress. Plan to be fully functioning by the end of 2026

Health Planning clinical scoping and demand and capacity modelling near finalised, business case and SHIF submitted for 96 Bed ward block in line with National Acute Bed Expansion allocation and MUH DCP. Ward block at stage 1 design stage. This is a priority for site to progress.

Awaiting approval for enhanced diagnostics and extension of the AMAU

Emergency medicine early warning score (EWS) has been fully implemented in Jan 26

Timescale: Expectation that early Q3 will start to see significant improvements in the overcrowding and PET times in ED extension build completion expected in 2027

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

- Pharmacists:
  - Med Safety Pharmacist started Sep 25
  - Oncology Pharmacist Chief II in post
  - Other roles returned from planned leave
- Cardiac Technicians:
  - Recruited to 2 x staff grades, further interviews scheduled
  - Chief II Cardiac Physiologist role for interview
  - 2nd Senior Cardiac Technician has been recruited
- Surveillance Scientist in post
- PALS started Sep 25
- Nursing- ED:
  - Safer staffing stage 1 & 2 fully implemented in the ED and also the ED EWS.
  - 16.5 WTE nursing funded – significant numbers already in place with a further 2 to start in April, 1 in May and 2 remain outstanding due to OH/Stamp clearances.
  - MUH WTE is currently 1593. At the time of the HIQA inspection this was 1501.
- Absenteeism: Full action plan in place in all departments. This continues to be a work in progress with monthly updates and clear accountability at management level.

Timescale: Complete

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.

- Full system in place for auditing cleaning and monitoring this with results being positive.
- Swipe access consistent on wards now
- St Johns intercom in place

Timescale: Complete

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

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

- Full hospital audit plan in place for 25 & 26. Local audits will be shared and available on wards in line with all required HIQA standards and other legislative requirements.
- Full policy in place re Planned Date of Discharge (PDD). Regular auditing for the documentation of PDD in medical notes and on IPMS is in place.
- Clinical audit assurance committee will work towards enhanced local awareness re audits carried out in areas of responsibility, ensuring linked quality improvement plans are implemented and monitored in 2026

Timescale: Part of business as usual

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

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

- Clear absconsion policy in place. With ~45,000 attendances to the ED annually and inpatient capacity of close to 30,000. The probability v the impact is locally managed on a case by case basis, rather than as an overall hospital risk.
- Emergency medicine early warning score EWS has been fully implemented in Jan 26
- Health & Safety Level 1 audits carried out regularly with appropriate action plans in place
- Health & Safety officer in post facilitating improved risk management in departments
- St Johns intercom in place

Timescale: Complete

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.

- Med Safety pharmacist started Sep 25

- Hospital wide targeted programme in place for ensuring that medical staff are fully involved in medication reconciliation.
- It is recognised that the introduction of the ePOE NIMS system impacted medication incident reporting initially but this is improving. 2025 full year medication incidents were 236. With the first Quarter of 2026 reporting 85 Medication incident reports. Previous incident numbers were provided from the NIMS system. Previous QPulse system figures give a true picture of 2023 (248) and 2024 (385) data up to go live on ePOE NIMS on the 28th January 2025
- Incident Management training is continuing on an ongoing basis including 1-1 NIMS training for ward managers.

Timescale: Complete