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:	Regional Hospital Mullingar
Address of healthcare service:	Longford Road Robinstown Mullingar Co Westmeath N91 NA43
Type of inspection:	Unannounced
Date(s) of inspection:	9 and 10 October 2024
Healthcare Service ID:	OSV-0001072
Fieldwork ID:	NS_0097

About the healthcare service

The Regional Hospital Mullingar is a model 3* statutory, acute teaching hospital. In early 2024, with the planned reconfiguration of the health services, the hospital was realigned to Dublin Midlands Hospital Group (DMHG), having previously been a member of the Ireland East Hospital Group. At the time of this inspection, the Health Service Executive (HSE) was progressing with the establishment of six new regional health areas and as part of that process, the hospital will be integrated into the HSE Dublin and Midlands regional health area.†

The hospital provides a range of healthcare, maternity and specialised services to the population of Westmeath, Longford and the broader population in counties Laois, Offaly, north Meath, Kildare and Roscommon. The healthcare services provided at the hospital include:

- acute medical services
- elective surgery
- urgent and emergency care
- critical care
- obstetrics and gynaecology care
- paediatric care
- diagnostic services
- outpatient services.

1,804 births occurred in the hospital's co-located maternity unit in 2023.

The following information outlines some additional data on the hospital.

Number of beds	244 inpatient and day case beds

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

† The HSE Dublin and Midlands regional health area comprises ten hospitals - Children's Health Ireland at Crumlin, Children's Health Ireland at Tallaght, Children's Health Ireland at Temple Street, Midlands Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, Naas General Hospital, Regional Hospital Mullingar, St James' Hospital, Tallaght University Hospital and The Coombe Hospital.

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 unannounced inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* (version 1 2012) as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. This inspection follows on from HIQA's previous inspection of December 2022, where the hospital was judged to have significant levels of partial or non-compliance with the 11 national standards monitored. Subsequent to that inspection, hospital management submitted a compliance plan that detailed the actions taken or planned to bring the service into compliance with national standards. Progress in implementing the actions in that compliance plan was assessed as part of this inspection.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the hospital, unsolicited information and other publically available information since HIQA's last inspection in 2022.

During the inspection, the inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of the care and treatment received in the hospital
- 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 11 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 the inspector'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 the delivery of high-quality, safe 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
9 October 2024	09.00 –17.45hrs	Denise Lawler	Lead
		Geraldine Ryan	Support
10 October 2024	08.30 – 15.15hrs	Cathy Sexton	Support
		Mary Redmond	Observer

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm:

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

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

The inspection team visited the following four clinical areas:

- Emergency Department.
- Acute Medial Assessment Unit (AMAU).
- Surgical 1 (29-bedded surgical ward).
- Medical 2 (28-bedded general medical ward including a four bedded Stroke Unit).

During this inspection, the inspection team spoke with the following staff at the hospital:

- Representatives of the Hospital Executive Management Group (HEMG)
  - Hospital Manager
  - Director of Nursing (DON)
  - Assistant Director of Midwifery (ADOM)
  - Clinical Director
- Consumer and Legal Affairs Manager
- Assistant Director of Nursing (ADON) for Patient Flow
- Clinical Risk Manager
- Medical Manpower Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs).
- A representative from the:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Deteriorating Patient and Improvement Programme Committee
  - Urgent and Emergency Care Committee.

Acknowledgements

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

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

During the course of the inspection, the inspectors observed staff interacting and engaging with patients in a respectful, considered, empathetic and kind way. Staff supported and assisted patients with their individual needs and were observed to meaningfully promote and protect the patient's privacy and dignity when delivering care. Patients who spoke with the inspectors were complimentary about the care they received, about the staff and the hospital in general. Patients commented on how staff were "excellent", 'supportive", "kind" and "very good". Patients described how staff were "busy" and "doing their best "and that the number of patients attending the hospital, especially the emergency department was "greater than what the hospital could manage". Similar to previous inspection findings in 2022, patients said they had not received information about

the hospital's complaints process and or independent advocacy services. Patients said that if they wanted to make a compliant or had concerns about the care they received, they would speak with a *"nurse or the nurse manager"*. Information about the HSE's complaints process 'Your Service, Your Say'[‡‡] was displayed in the clinical areas visited. Information on independent advocacy services was displayed in one of the three clinical areas visited (Surgical 1), but not in the other two clinical areas – emergency department and Medical 2. This is discussed further in national standard 1.8.

Capacity and Capability Dimension

This section describes the themes and national standards relevant to the dimension of capacity and capability. It outlines the compliance with three national standards (5.2, 5.5 and 5.8) related to the leadership, governance and management of healthcare services and how effective they were in ensuring that a high-quality and safe service was provided. It also includes the compliance with one national standard (6.1) related to workforce.

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

Some integrated corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were in place at the hospital. These governance arrangements were defined and set out in a number of organisational charts that were revised and redrafted since HIQA's last inspection. Notably, at the time of inspection, four (44%) of the hospital's nine executive management positions — quality and patient safety manager, director of midwifery (DOM), operations and clinical services manager and human resources manager were unfilled. The four positions were important leadership positions with responsibilities and roles in ensuring the effective clinical governance and efficient delivery of healthcare services. The shortfall in the executive management team resulted in a void that had the potential to affect the effective governance and efficient delivery of healthcare services. Measures were in place to mitigate the actual and potential risks arising from the void, which included, the hospital manager and other members of the HEMG assuming the operational responsibilities of the unfilled positions. However, this arrangement, along with their own substantive roles and responsibilities was not sustainable in the medium and longer term.

The hospital's reporting relationships had changed in January 2024 as it moved from IEHG to DMHG. This arrangement was an interim one while the HSE reconfigured the

[‡‡] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

healthcare services into six regional health areas. When the six regional areas are fully established, the hospital will be aligned with the HSE Dublin and Midlands health region. The transition from IEHG to DMHG, followed closely by the ongoing transition to an evolving regional health configuration had resulted in a lot of restructuring and reorganisation in a short period of time. The inspectors were concerned about the impact the leadership void had on the day-to-day functioning of the hospital and especially on the senior executive management out-of-hours arrangements. These concerns were escalated to the HSE Dublin and Midlands health region's integrated healthcare area (IHA) manager. The IHA manager's response submitted to HIQA on 18 October 2024 provided details about the actions taken to ensure appropriate senior executive management out-of-hours cover. It also described how the IHA manager had commissioned a third-party review of the quality and patient safety governance and functions in the hospital. The review was due to commence the week of 16 October 2024 and the reviewer was due to be onsite in the hospital two days a week supporting and working with clinicians and managers to strengthen the quality and patient safety governance structures and develop a stronger culture of safety. Actions to address unfilled nursing and midwifery positions were also outlined, these are discussed in national standard 6.1.

As per previous inspection findings, the hospital manager was the accountable officer with overall responsibility for the quality and safety of the healthcare services delivered in the hospital. The hospital manager reported monthly to the interim chief executive officer (CEO) of DMHG. The hospital manager also reported to the HSE Dublin and Midlands health region's IHA manager, but the frequency of reporting was not formalised. The HEMG supported the hospital manager in ensuring that effective corporate and clinical governance arrangements were in place for monitoring the quality and continuous improvement of the healthcare services. Chaired by the hospital manager, the HEMG met monthly and functioned as per its terms of reference. Members of the HEMG also attended the monthly meetings between the hospital and DMHG, where items such as finance, workforce, quality and safety risks, scheduled and unscheduled care access and activity were reported on.

The HEMG were provided with assurances about the quality and safety of healthcare services by the multidisciplinary Hospital Clinical Governance of Risk, Quality and Safety Committee (HGovRQSC). Chaired by the clinical director, the HGovRQSC functioned as per its terms of reference. It monitored the quality of healthcare services and oversaw the management of clinical risks. There was no change since HIQA's previous inspection in the governance arrangements overseeing the hospital's performance in relation to the four areas of harm — Healthcare Associated Infections Committee (HCAIC), Drugs and Therapeutics Committee (DTC), Medication Safety Committee (MSC), Deteriorating Patient Improvement Programme Committee (DPIPC) and Urgent and Emergency Care Committee (UECC). The HCAIC, DTC, DPIPC and UEC updated and reported on the areas they had responsibility for at meetings of the HGovRQSC. The MSC updated and reported on medication safety to the DTC, who in turn reported to the HGovRQSC. This included reporting on the hospital's compliance with quality key performance indicators (KPIs), the

management of identified risks, findings and learnings from audit activity and the implementation of quality improvement initiatives. The governance committees are discussed further in national standard 5.5.

The hospital's clinical director oversaw the quality of clinical services. The DON oversaw the organisation and management of nursing services. At the time of inspection, the DOM's position was unfilled so the ADOM oversaw the organisation and management of the midwifery services. There was evidence of devolved responsibility and accountability according to clinical specialty. Four clinical directorates — medicine and emergency department, peri-operative and radiology, women's health and paediatric clinical directorates governed, monitored and oversaw the quality of clinical services within their remit. Each clinical directorate had an assigned clinical lead. Clinical directorates' leadership team comprised a clinical lead, business manager, nurse manager at ADON grade. The clinical directorates provided an update and reported on the quality of services at each meeting of the HGovRQSC. Each directorate's clinical lead reported to the hospital's clinical director. The clinical director, clinical leads, DON and DOM were members of the HEMG. All provided an update on their respective areas of responsibilities at the monthly meetings of the HEMG. The reporting arrangements for most of the governance structures described to the inspectors were consistent with those outlined in the hospital's organisational charts. However, for two clinical directorates (peri-operative and radiology), the reporting arrangements differed from the terms of reference and or the reporting relationships described to the inspectors.

Overall, when compared to the previous inspection, there was no change in the judgment of compliance with this national standard. At the time of inspection, it was clear that there were integrated corporate and clinical governance arrangements at hospital level. Governance committees met and functioned in line with their agreed terms of reference. Committees had oversight of the hospital's performance and there was a formalised upward reporting structure to the HEMG and onwards to DMHG. However:

- there were gaps in executive leadership that had potential to impact on the effective and efficient clinical governance of healthcare services in the medium and long-term. At the time of inspection, other members of the HEMG had assumed additional responsibilities to ensure the hospital functioned efficiently, but this arrangement was not reliable or sustainable in the medium and long-term
- at the time of inspection, the structures and reporting arrangements to the HSE Dublin and Midlands health region's IHA manager were not defined and formalised
- reporting arrangements for the peri-operative and radiology directorates described to inspectors were different to those outlined in the hospital's organisational charts and each directorate's terms of reference.

Judgment: Partially compliant

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

The inspectors found there were management arrangements in place to support the delivery of safe, high-quality healthcare services. Several committees — HCAIC, DTC, MSC, DPIPC and UECC had devolved responsibility and accountability for the management of clinical services in their remit. The hospital did not have an overarching infection prevention and control strategy. However, the annual infection prevention and control plan set out the infection prevention and control priorities to focus on in 2024. The IPCT implemented the annual infection prevention and control plan and provided an update on its implementation at monthly meetings of the HCAIC and at each meeting of the HGovRQSC. The HCAIC's terms of reference did not detail the committee's reporting arrangements, but it was clear from minutes of the HGovRQSC meetings that the IPCT updated that committee about infection prevention and control practices and standards. The IPCT submitted an annual infection and prevention control report, which detailed the hospital's performance in relation to the monitoring of surveillance and compliance with infection prevention control practices and standards to the HCAIC and the HEMG. The antimicrobial pharmacist provided detailed updates on the implementation of the hospital's antimicrobial stewardship annual service plan and targets at each meeting of the HCAIC. This arrangement was an improvement on the previous inspection findings of 2022.

The chief pharmacist led the hospital's pharmacy service. Audit activity, quality improvement projects and staff training in relation to medication for 2024 was detailed in the medication safety annual operational plan, which was devised by the hospital's chief and senior pharmacists and approved by the multidisciplinary DTC and the MSC. The hospital's chief pharmacist and medication safety pharmacist implemented the plan and provided updates on its implementation at meetings of the DTC and MSC. The MSC was a subcommittee of the DTC and had a defined and formalised reporting arrangement to the DTC. The DTC had a defined and formalised reporting arrangement to the HGovRQSC and HEMG.

The hospital's deteriorating patient improvement programme was implemented under the clinical leadership of a medical consultant. The multidisciplinary DPIPC monitored the hospital's compliance with national guidelines on the early warning systems[§§] and sepsis management. The DPIPC reported on the hospital's compliance with national guidance to the HGovRQSC and upwards through individual reporting arrangements (clinical director, DON, DOM and hospital manager) to the HEMG.

There was no formalised multidisciplinary bed management or patient flow committee, but the UECC monitored the hospital's demand for urgent and emergency care, hospital

[§§] Early Warning Systems are used in acute hospitals settings to support the recognition and response to a deteriorating patient.

activity, surge capacity, compliance with national targets in relation to patient experience times (PETs), integrated care pathways, average length of stay (ALOS) and delayed transfers of care (DTOC). Chaired by the DON, the UECC met monthly and reported to the HEMG. Hospital activity and capacity, patient acuity and responsiveness to meet service demand was monitored and managed through a number of formalised daily and weekly meetings — handover meetings, senior nurse manager meetings and patient flow meetings. The hospital had an approved escalation plan to address demand for urgent and emergency care. Over the course of the inspection, the hospital was at level 1 escalation. Hospital management were implementing the actions set out in the hospital's escalation plan for that level of escalation. These actions included, the streaming of patients to the AMAU, prioritising diagnostics to facilitate patient discharge, using additional and available surge capacity in the hospital and externally in community services. Actions in the compliance plan, such as the appointment of an ADON for patient flow and the opening of a 10-bedded ward to facilitate patient transfer from the emergency department were also implemented. However, other actions such as the introduction of twilight shifts and the development of an acute floor model were not implemented at the time of this inspection.

Overall, there were responsive management arrangements in place to address the demand for healthcare services and support the delivery of high-quality, safe and reliable healthcare services. These arrangements supported the operational functioning of the hospital and ensured the quality of healthcare services in the four areas of harm. A judgment of substantially compliant represents an improvement in compliance with this national standard, but:

- some actions, like twilight shifts and an acute floor model had not been implemented since HIQA's previous inspection, so the planned efficiencies had not been fully achieved.

Judgment: Substantially compliant

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

Inspectors identified that the risk management structures and processes in place to identify and manage clinical risk in the hospital had improved since HIQA's previous inspection in 2022. Information obtained from a range of different clinical and quality data sources provided the HEMG, clinical directorates and DMHG with assurances about the quality and safety of healthcare services provided in the hospital. The hospital's risk management structures supported the efficient management of clinical and non-clinical risks. Hospital management had not implemented the most recent risk management

framework from the HSE. The management of reported risks related to the four areas of known harm is discussed further in national standard 3.1.

There was a coordinated approach to clinical audit activity at the hospital. Audit activity, audit findings and the progress of implementation of any related quality improvement plans was monitored by clinical directorates. As per previous inspection findings, there was a process in place to proactively identify and manage patient safety incidents. Patient safety incidents were entered on to the National Incident Management System (NIMS).*** The hospital's Serious Incident Management Team (SIMT) and clinical directorates were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Clinical directorates monitored the implementation of recommendations and quality improvement plans from the review of adverse events and patient safety incidents. However, hospital management told inspectors that staffing shortfalls in the quality and patient safety department had impacted on the timely implementation of those recommendations. Clinical directorates, the SIMT and HEMG monitored the implementation of actions developed to improve patient feedback from the National Inpatient Experience Surveys.

In summary, since HIQA's previous inspection, there was an improvement in compliance with this national standard. There were robust monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. However,

- the HSE's most recent risk management framework was not implemented
- the implementation of recommendations and the sharing of learning from reviews to support patient safety was not timely.

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.

There were several unfilled staff positions across the hospital, which had the potential to impact on the ability to fully support and promote the delivery of high-quality, safe and reliable healthcare services. There were a number of a high-rated risks related to staffing recorded on the corporate risk register. Actions were implemented to mitigate any actual and potential risks arising from staffing shortfalls, but hospital management described the management of these risks as challenging in the context of the HSE's and Department of Health's 2024 pay and numbers strategy.††† As discussed in national standard 5.2, four

*** The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
††† The pay and numbers strategy approval process is the funding information required for recruiting staff to the public healthcare services.

(44%) of the nine senior management positions in the hospital — quality and patient safety manager, DOM, operations and clinical services manager and human resources manager were unfilled, which resulted in a void in executive leadership.

Fourteen whole-time equivalent (WTE) ‡‡‡ (11%) of the 158.89 WTE funded medical and dental staff (medical consultants (7 WTE) and NCHDs (7 WTE)) positions across a range of specialties were unfilled on a permanent basis. Half (43%) of the 14 WTE unfilled medical positions were filled with agency staff. Hospital management confirmed that the majority of permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Consultants that were not registered on a specialist division of the register with the IMC were supported in accordance with the HSE's requirements. Medical staffing levels in the emergency department were maintained at levels to support the delivery of 24/7 emergency care. Similar to previous inspection findings, the emergency department had four WTE consultants in emergency medicine (three WTE consultants were appointed on a permanent basis and one WTE was appointed on a locum basis). A senior clinical decision-maker§§§ at consultant level was available 24/7 and was on-site in the emergency department during core working hours and off site outside core working hours. Seventeen NCHDs at registrar (nine WTE) and senior house officer (eight WTE) grades provided 24/7 medical cover in the emergency department.

Hospital management told inspectors that the hospital did not receive funding and approval to implement the Department of Health's nursing staff frameworks**** in 2024. The hospital was funded for 348.04 WTE nurses (inclusive of management and other grades) and at the time of inspection, 44.45 WTE (13%) of those positions were unfilled. While all the clinical areas visited during inspection had their rostered complement of nursing staff, shortfalls due to short-term absenteeism or statutory leave were reported. The hospital was funded for 80.82 WTE midwives (inclusive of management and other grades) and at the time of inspection, 16.44 WTE (20%) of those positions were unfilled. The hospital was funded for 68.56 WTE healthcare assistants and at the time of inspection, 9.13 WTE (13%) of those positions were unfilled. Shortfalls in nursing and midwifery staff were managed by redeploying staff from other clinical areas and or by using agency staff. A staff recruitment campaign was being progressed at the time of inspection. Hospital management were specifically concerned about the paediatric nursing staff numbers and had commissioned an independent review of the nursing staff requirements for the inpatient and emergency paediatric services. The review considered the skill mix required to deliver the paediatric services and governance of the paediatric

‡‡‡ Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.
§§§ Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.
**** Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

nursing services. Hospital management had received the final review report the day before HIQA's inspection and were considering its findings and recommendations. Hospital management were committed to implementing the recommendations and intended to develop a quality improvement plan to support that process.

All of the funded pharmacist (10.2 WTE) and pharmacy technician (8.6 WTE) positions were permanently filled at the time of inspection. However, 1 WTE senior pharmacist was on leave and this position was not backfilled. Notably, the hospital's pharmacy department provided pharmacy services to a number of community services, including St Loman's Hospital, St Joseph's Hospital, the National Ambulance Service and Public Health Nurses. A comprehensive clinical pharmacy service,[††††] was not provided to all clinical areas, but was provided to paediatrics, the Intensive Care Unit (ICU) and some adult in-patient wards.

The infection prevention and control team (IPCT) supported staff in implementing effective infection prevention and control practices across the hospital. All staff positions in the IPCT were filled at the time of inspection — 1 WTE infection prevention and control lead at ADON grade, 2.5 WTE clinical nurse managers grade 2 (CNM 2), 1.35 WTE surveillance scientist, 1 WTE antimicrobial pharmacist and 1 WTE consultant microbiologist. Since HIQA's previous inspection, the consultant microbiologist's position was regularised and was filled permanently. Staff confirmed they had access to microbiology support 24/7.

A centralised system to monitor the uptake of staff attendance at mandatory and essential training was not fully implemented since HIQA's previous inspection. However, the roll out of a system to enable staff to record their own training was started in June 2024. There was a process in place for CNMs, ADONs and DON to monitor and oversee nurses and healthcare assistants attendance at mandatory and essential training. NCHDs attendance at essential and mandatory training was recorded on the National Employment Record (NER) system and monitored by the medical manpower division in the human resource department. Staff who spoke with inspectors confirmed that they were expected to complete training in infection prevention and control practices, medication safety, the early warning systems and the use of Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool on the HSE's online learning and training portal (HSELanD). Staff also confirmed that they had received a formal induction on commencement of employment in the hospital. Training records reviewed by inspectors showed that the uptake of essential and mandatory training by nursing, medical, healthcare assistants and health and social care staff was very good, which was an improvement on previous inspection findings of 2022. Staff absenteeism rates were tracked by the human resource department and reported

[††††] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

monthly to the HEMG, DMHG and the HSE. Return to work interviews were completed with staff and occupational health supports were available to staff, when needed.

In summary, staff attendance and the monitoring of uptake of staff training had improved since HIQA's last inspection. However, at the time of this inspection:

- there was a significant difference in the funded and actual number of staff in managerial, nursing and midwifery positions
- the 13% shortfall in nursing staff, 20% shortfall in midwifery staff and 13% in healthcare assistant staff was managed in the short-term through staff redeployment and the use of agency staff, but this was not a reliable and sustainable way to manage the issue
- staff resourcing issues in the quality and safety department also impacted on the delivery of healthcare services.

Inspectors' concerns about the senior executive management out-of-hours cover arrangements and the reliance on agency staff to fill staffing shortfalls in the medium and longer term were escalated after the inspection to the HSE Dublin and Midlands health region's IHA manager. The IHA manager's response submitted to HIQA on 18 October 2024 provided details about the actions to be taken to address the inspector's concerns. These included:

- using agency staff to manage the clinical risk arising from the unfilled nursing and midwifery positions
- continuing to pursue the backfilling of unfilled staff positions pre and post-implementation of the HSE's and Department of Health's pay and numbers strategy
- escalating the requirement to ensure safe staffing levels and recruiting to permanent positions within the hospital's limit to the HSE for consideration and direction.

Collectively, the shortfall in staffing combined with deficits in the senior executive management out-of-hours cover arrangements represented a significant risk. Notwithstanding interim assurances received from the IHA manager to address the issue, adequate staffing, contingency and continuity arrangements need to be addressed in the medium to long-term to manage the staffing gaps on the days of inspection.

Judgment: Non-compliant

Quality and Safety Dimension

This section discusses the themes and national standards relevant to the dimension of quality and safety. It outlines the compliance with seven national standards related to the care and support provided to people receiving care in the service and if that care and support was safe, effective and person-centred.

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

Similar to previous inspection findings, staff were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be caring, kind and responsive to patient's individual needs. The inspectors heard staff explain to patients what they were doing when giving care. Generally, the physical environment in the inpatient wards supported the delivery of care that respected and promoted the patient's dignity and privacy. Privacy curtains were used when providing care in multi-occupancy rooms. Staff in the emergency department endeavoured to support and promote patient's privacy but it was challenging in a busy environment. Patient's privacy, dignity and confidentiality was compromised for those on trolleys and chairs in the emergency department's public corridors. A sensory room was located at the entrance to the emergency department, this room was not being used at the time of inspection. All the isolation rooms and multi-occupancy rooms in the clinical areas visited had en-suite bathroom facilities. Hospital management had implemented the 'hello my name is' initiative to help patients identify the different grades and professions of staff delivering care. Patients who spoke with inspectors felt they were involved in making decisions about their care. Patient's personal information and healthcare records were stored appropriately, in line with relevant legislation and standards. Overall, staff endeavoured to respect and promote patient's dignity, privacy and autonomy, but this was not always possible in all three clinical areas visited. Similar to previous inspection findings, the challenging environment in the emergency department did not support the promotion of dignity and privacy for all patients attending for urgent and emergency care.

Judgment: Partially compliant

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

The inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was confirmed by patients who spoke positively and were highly complimentary about their interactions with staff. Patients described staff as *"lovely,*

caring and kind". Staff were observed responding in a timely and calm way to a patient with complex needs and offered the patient reassurance and support. The hospice-friendly hospital programme ensured there was a concerted focus on the quality of end-of-life, palliative and bereavement care for patients who required that care. There were designated 'end-of-life' rooms available to relatives of patients receiving end of life care. Information leaflets on a range of health topics were readily available and accessible for patients. Overall, hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital and this was confirmed by the patients who spoke with the inspectors.

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.

There were effective processes in place at the hospital to respond to complaints and concerns received from patients and or their families. The hospital had a complaints management system and used the HSE's complaints management policy 'Your Service Your Say'. The consumer and legal affairs manager was the designated complaints officer assigned with the responsibility for managing complaints. The HEMG and clinical directorates did not monitor the effectiveness and timeliness of the hospital's complaints management processes.

Complaints were resolved at point of care where possible. The hospital was non-compliant with the HSE's target (75%) for complaints to be resolved within 30-days. Hospital management cited staff resourcing in the consumer and legal affairs department as a contributing factor to the non-compliance. The consumer and legal affairs manager tracked and trended the formal complaints received. Information about the number and type of complaints, emerging themes and categories was presented at meetings of the SIMT, nursing management meetings and hospital governance and operations meetings. There was a system in place to share the learning from the complaints resolution process. The consumer and legal affairs manager shared information about complaints with the CNMs, DON, DOM, clinical director, relevant heads of department and relevant consultants. The clinical director shared the information with the medical staff and the CNMs shared the information with staff in their clinical areas. 'Your Service Your Say' leaflets and information about independent advocacy services were displayed in Surgical 1, but were not clearly displayed in the Medical 1 or the emergency department. There was evidence that quality improvement plans were developed and actions were implemented to improve patient experiences and ensure recommendations from the complaints resolution process were implemented. For example, staff were required to

complete training on communication on HSELand. The HEMG, clinical director and DON monitored the implementation of the quality improvement plans.

Overall, there were effective processes in place to respond openly and effectively to complaints and concerns made by patients and or their families, but:

- the hospital was non-compliant with the HSE's target (75%) for complaints to be resolved within 30-days
- information on the hospital's complaints management process or independent advocacy services was not clearly displayed in Medical 1 or the emergency department.

Judgment: Substantially compliant

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

During the inspection, the inspectors observed how the hospital's physical environment was secure and was generally well maintained with few exceptions. The CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place and the timeliness of response from the maintenance department 24/7. Discharge and terminal cleaning was carried out by the cleaning staff and multi-task attendants. Cleaning staff and multi-task attendants who spoke with the inspectors knew their roles and responsibilities, and could clearly describe the cleaning processes in place in the three clinical areas. CNMs and cleaning supervisors monitored the standard of cleaning. Patient equipment was observed to be generally clean in all three clinical areas visited. The cleaning of patient equipment was assigned to healthcare assistants and a system was used to identify cleaned equipment. Environmental and patient equipment audits were carried out monthly, these are discussed further in national standard 2.8.

Generally there was good storage space with supplies and equipment stored adequately and appropriately. Hazardous material and waste stored safely and securely. There was appropriate storage and segregation of clean and used linen. Sterile products were stored appropriately.

Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms in Surgical 1 and Medical 2, but this was not the case with some of the trolleys on the corridor in the emergency department.

Wall-mounted alcohol-based hand sanitiser was readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the hospital. Hand hygiene sinks in the three clinical areas conformed to required specifications.

During the 2022 inspection, patients described the cold and discomfort caused by the hospital's ageing windows. Works was underway at the time of this inspection to replace the windows throughout the hospital.

There was a formalised process in place to ensure appropriate placement of patients requiring transmission-based precautions. This process was overseen by the IPCT, but the number of isolation rooms were insufficient to meet the hospital's need. Personal protective equipment (PPE) was available outside single and multi-occupancy rooms with patients requiring transmission-based precautions. Appropriate signage was used to inform staff and visitors about the suitable transmission-based precautions to use. Patients on the corridor in the emergency department did not have a call bell to ring when they needed assistance, but the patients in those areas confirmed that nursing staff and healthcare assistants were available, visible and *"always around"*. Overall, the physical environment in Surgical 1 and Medical 2 supported the delivery of high-quality care, but the:

- spacing between trolleys and chairs located on the corridor in the emergency department was not always adequate
- number of isolation rooms were insufficient to meet the hospital's need and this presented a risk to limit the transmission of communicable disease.

Judgment: Substantially compliant

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

Compared to previous inspection findings, there was an improvement in compliance with this national standard. At the time of this inspection, there were assurance systems in place to adequately monitor, evaluate and continuously improve the healthcare services provided. Hospital management used information from a number of sources to compare and benchmark their healthcare services with other similar hospitals. Hospital management reported monthly on rates of Clostridioides difficile infection, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired Staphylococcus aureus blood stream infections, hospital-acquired COVID-19 and infection outbreaks. This information was also reported at meetings of the IPPC, HGovRQSC and with DMHG. Patients were screened for CPE in line with national guidance and compliance was audited, with a good level of compliance (ranging from 96% to 100%) reported in the months before this inspection.

The hygiene audit supervisor carried out environment and patient equipment hygiene audits monthly. Audit findings were reported at each meeting of the IPCC. A good rate of compliance with environmental and patient equipment hygiene standards was reported in the three clinical areas visited. Compliance rates ranged from 85% to 89% in the

emergency department, 91% to 92% in Surgical 1 and 91% to 92% in Medical 2. Time-bound quality improvement plans were devised when hygiene standards fell below the expected standards, with a named person assigned to ensure the implementation of the actions in the plan. The IPCT carried out monthly hand hygiene audits. In the months preceding this inspection, all three clinical areas visited were compliant with the HSE's hand hygiene standard of 90%. Additional hand hygiene education was provided by the IPCT when hand hygiene standards fell below expected standards. Compliance with peripheral venous catheter, urinary catheter and central venous catheter care bundles was also monitored, with good rates of compliance reported in Surgical 1 and Medical 2 in the months before this inspection.

Medication audits carried out in the months preceding this inspection included, audits on meropenem use, compliance with pre-mixed potassium bags, venous thromboembolism (VTE) prophylaxis use, vancomycin and gentamicin prescribing and usage. Medication use and practices were also monitored on a monthly basis as part of the nursing and midwifery quality care metrics, with good rates of compliance in Surgical 1 (range 93% to 97%) and Medical 2 (range 98% to 100%). Medication audit findings were reported to the MSC and DTC and there was evidence that quality improvement plans were developed to support and improve safe medication practices. In the sample of medication audits reviewed by the inspectors, a named person was not always assigned to oversee the implementation of the actions to improve safe medication use and practices.

The DPIPC monitored the rate of compliance with the early warning system's escalation and response protocol, the use of ISBAR$_3$, and the implementation of relevant quality improvement actions to improve clinical practice. The inspectors did not see any evidence of the auditing of compliance with national guidance on clinical handover, but an audit on safe surgical handover was carried out in quarter 1 of 2024. Time-bound actions to further improve surgical handover were identified and a named person was assigned to oversee the implementation of each action. Audit findings and actions to improve the escalation and response protocol for the early warning system were shared with CNMs for circulation to staff in their clinical areas. No audits were carried out in relation to the safe transitions of care, but data in relation to hospital activity and capacity, numbers of new attendances to the hospital's emergency department, PETs, ALOS and DTOC were reported and tracked in line with the HSE's reporting requirements. This data was discussed as part of the daily situational report and reviewed at meetings of the UECC. Collated data about unscheduled and scheduled care was also reported at meetings with DMHG. Audit findings and the implementation of quality improvement initiatives was tracked and monitored by the IPCC, MSC, DTC, and DPIPC, and at meetings of clinical directorates. Staff could provide examples of quality improvement initiatives implemented in response to findings from audit activity and the National Inpatient Experience Survey. Examples included, the introduction of the visual hospital platform to support and improve efficient patient flow, the 'Know, Check and Ask' campaign and the VTE Alert card used to help patients understand their

medications. Overall, compared to the previous inspection in 2002, there were some improvement in the compliance level for this national standard. Assurance systems were in place to monitor and support the continual improvement of healthcare services, but:

- no audits had taken place in relation to the safe transitions of care
- auditing of compliance with clinical handover use was not as per national guidance
- quality improvement plans to improve safe mediation practices did not always have a named person assigned.

Judgment: Substantially compliant

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

Arrangements were in place to ensure the proactive identification and management of significant risks. The CNMs and ADON, with support from the risk manager assessed, analysed and managed any actual and potential risks to patients in their clinical areas. Risks impacting on the effective functioning of the hospital were discussed at the daily operational huddle and safety huddles. Clinical directorates and the HGovRQSC monitored the effectiveness of any actions applied to mitigate any risks to patients. Each clinical directorate had their own risk register and risks not managed at directorate level were escalated to HEMG for review and possible recording on the hospital's corporate risk register. The HEMG reviewed the risks and the effectiveness of any mitigation actions on the corporate risk register regularly, which was an improvement on the previous inspection findings of 2022. The highest rated risks were presented and discussed at the meetings with DMHG. Staff were trained on risk management processes relevant to their roles and remit, but hospital management had no definitive plan to roll out staff training on the HSE's enterprise risk management policy and procedures.

Patients were screened for MDROs on admission to the hospital. The hospital's information patient management system (iPMS) alerted staff to patients who were previously in-patients with confirmed MDROs. Patients requiring transmission-based precautions were isolated. However, as per previous inspection findings, because of inadequate numbers of single isolation rooms, patients requiring transmission-based precautions were not always isolated in line with national guidance (within 24 hours of admission or diagnosis). When a single room was not available, suitable patients were cohorted in multi-occupancy rooms. At the time of this inspection, there were no infection outbreaks reported in the hospital. Two infection outbreaks (CPE and norovirus) were recorded in the months preceding the inspection. Hospital management had convened multidisciplinary outbreak teams to advise and ensure that the learnings and

recommendations from these infection outbreaks were shared with clinical staff, this was an improvement on the previous inspection of 2022.

A comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation was not undertaken for all patients. Medication reconciliation was carried out on prioritised patients, in accordance with a defined inclusion criteria. The hospital's list of high-risk medications aligned with the acronym 'A PINCHO.'[‡‡‡‡] Inspectors observed the use of risk reduction strategies to support the safe use of anticoagulants, insulin, opioids and potassium. There was a list of sound alike look alike drugs (SALADs). Up-to-date prescribing guidelines, including antimicrobial guidelines and other medication information, including alerts were available and accessible to staff at the point of care in hard copy format and through an application for smart mobile telephones.

The relevant version of the national early warning systems — the Irish national early warning system (INEWS) and Irish maternity early warning system (IMEWS) was used. 'Sepsis 6' care bundle and $ISBAR_3$ communication tool were used. Despite being an action in the compliance plan, the emergency medicine early warning system (EMEWS) was not implemented or used in the emergency department. Hospital management had a definitive date for commencing the implementation of EMEWS. Staff were knowledgeable about the INEWS escalation and response protocol, and there were efficient processes in place to ensure the timely management of patients with a triggering early warning system.

There were systems and processes in place to support the efficient flow of patients and transfer of patients within and from the hospital. These included:

- implementing the Virtual Hospital Programme
- using the SAFER bundle[§§§§] and the 'Red to Green' days approach[*****]
- holding daily, weekly and monthly bed management meetings to review and manage issues impacting on the efficient flow of patients within and from the hospital.

Hospital management had access to 20 funded egress beds for patients requiring convalescence and or transitional care. Ten rehabilitation beds were available in the hospital's rehabilitation unit. Egress beds were also available in nine community hospitals and nursing homes in three other counties — Westmeath, Longford and Roscommon.

[‡‡‡‡] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants. The Regional Hospital Mullingar used 'A PINCHO' with O representing oxytocin.
[§§§§] The SAFER bundle comprises five elements of best practice – **S**enior review by a clinician, **A**ll patients have a predicated discharge date, **F**low of patients, **E**arly discharge of patients, **R**eview of patients with extended lengths of stay by multi-disciplinary team (MDT).
[*****] The 'Red to Green' approach aims to reduce a patient's length of stay and avoidable delays where a patient may be waiting for things, such as test, investigation and or referrals to happen to progress their care.

Hospital management had also contracted several inpatient beds within a defined criteria in a private hospital. Hospital admission avoidance initiatives were also used. These included:

- an offsite Minor Injury Unit provided by a private healthcare service provider
- the Community Intervention Team (CIT)
- the Mullingar Frailty Intervention Team (MFIT)[†††††]
- Integrated Care Programme for Older People (ICPOP) community specialist teams.

The hospital's four-bedded Acute Medical Assessment Unit (AMAU) was functioning well as an alternate pathway for patients who met the unit's inclusion criteria. Other actions set out in the compliance plan arising from the previous inspection, such as the establishment of the telemetry hub to monitor 10 patients, the introduction of a transit lounge and the reconfiguration of healthcare services into an acute floor model were not in place.

Over the course of the inspection, the demand for urgent and emergency care was similar to the previous inspection in 2022. On the first day of this inspection, at 11.00am, there was a total of 40 patients registered in the emergency department. Ten (25%) of these patients were admitted and lodging in the department while awaiting an in-patient bed in the main hospital. A Hospital Ambulance Liaison Person (HALP) was in place to support the timely handover process of patients who arrived to the emergency department via the national ambulance service. The average waiting time from:

- registration to triage was 8 minutes (range 1 minute to 61 minutes), which was a significant improvement on the average of 35 minutes in 2022
- triage to medical assessment was 3 minutes for non-urgent patients, which was a significant improvement on the average of 2 hours 11 minutes in 2022
- decision to admit to actual admission in an inpatient bed was 2 hours 14 minutes (range from 35 minutes to 3 hours 55 minutes), which was a significant improvement on the average of 6 hours 6 minutes in 2022.

The hospital was non-compliant with the majority of the HSE's PETs. Of the 40 patients registered in the emergency department:

- 50% were there for more than six hours (national target 70%), an increase on the 35% found in 2022
- 40% were there for more than nine hours (national target 85%), similar to the findings (39%) of 2022

[†††††] The Mullingar Frailty Intervention Team (MFIT) was based in the emergency department and provided a geriatric assessment for older persons attending for care. The assessment informed clinical teams about the care needs required to support admission avoidance and to reduce the length of stay for these patients when admitted to an inpatient bed.

- 5% were there for more than 24 hours (national target 97%), a slight improvement on findings (9%) of 2022.

Twelve (30%) patients in the emergency department were aged over 75 years. Of these:

- 50% were there for more nine hours (national target 99%), an increase on the 13% found in 2022
- all were discharged or admitted to an inpatient bed within 24 hours (national target 99%), an improvement on 2022 findings.

Over the course of the inspection, the hospital's ALOS for medical patients (4.6 days), was less than the HSE's target (≤7.0 days), an improvement of nine days on previous inspection findings. The ALOS for elective (5.5 days) and emergency (3.9 days) surgical patients was lower than the HSE's targets (≤5.0 days and ≤6.0 days respectively), a significant improvement (13 days) on previous inspection findings. The number of DTOC was small at two. The ALOS and the DTOC did not impact on flow of patients.

Staff had access to a range of up-to-date infection prevention and control and medication policies, procedures, protocols and guidelines through the hospital's intranet. Some locally developed policies, procedures, protocols and guidelines were overdue for review and needed updating. All policies, procedures, protocols and guidelines were being moved to a new document management system. In the interim, using two different systems to store and retrieve policies, procedures, protocols and guidelines was a risk because different versions of the documents were available to staff.

In summary, while there were arrangements in place to protect patients from the risk of harm, some inspection findings had the potential to affect patient safety. Specifically:

- a number of locally developed policies, procedures, protocols and guidelines were not updated within the prescribed three year time frame
- there was two systems in place to make policies, procedures, protocols and guidelines available to staff
- a comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation was not provided for all patients
- the hospital was non-compliant with the majority of PETs
- the EMEWS was not used in the emergency department
- some actions to improve efficient patient flow, set out in the compliance plan were not implemented
- clinical staff had not received training on the HSE's enterprise risk management policy and procedures.

Judgment: Partially compliant

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

The hospital had systems to ensure patient safety incidents were identified, reported and managed but the implementation of recommendations from patient safety incident reviews was not always timely. Hospital management reported the number of clinical incidents per 1,000 bed days used (BDU) to NIMS monthly. The number of clinical incidents reported and reviews in progress and or completed were also reported at meetings with DMHG. Information on the number and types of reported patient safety incidents, serious incidents and serious reportable events were tracked and trended at the hospital and information from this process was presented at the meetings of clinical directorates, HGovRQSC, HEMG and SIMT. Staff were able to describe to inspectors how a patient safety incident was reported and how the learning from patient safety incidents was shared. Incidents in relation to infection prevention and control were monitored by the IPCT and reported at meetings of the IPCC. Medication safety incidents were categorised using the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) and were monitored by the MSC and DTC. The hospital was compliant with the national targets for the reporting of patient safety incidents to NIMS and the completion of concise and comprehensive reviews of patient safety incidents within 125 days of notification. Clinical directorates monitored the implementation of recommendations and quality improvement plans from patient safety incident reviews, but the timely implementation of the recommendations and the sharing of learning was impacted by the shortfalls in staffing in the quality and safety department.

Overall, there were systems in place to effectively identify, manage and report patient safety incidents and while there was some improvement in compliance with this national standard, the:

- electronic point of entry to NIMS was not implemented as per the compliance plan
- implementation of recommendations and the sharing of learning from reviews of patient safety incidents was not always timely.

Judgment: Substantially compliant

Conclusion

Capacity and Capability

Compared to previous inspections in 2022, there was some improvement in the compliance level with two (5.5 and 5.8) of the four national standards assessed under the capacity and capability dimension. The remaining two national standards were judged to be partially complaint (5.2) and non-complaint (6.1). The non-compliance in national standard 6.1 was a decline in compliance, while the partial compliant in national standard 5.2 was the same as previous inspection findings. There was evidence that some of the actions in the compliance plan had and or were in the process of being implemented, while others were not implemented.

The hospital's governance and management arrangements were in a state of transition. The hospital had moved from IEHG to DMHG and was in the process of transitioning to the HSE Dublin and Midlands health region, this was a lot of change and restructuring in a short period of time. Structures and arrangements to report on the hospital's performance to the IHA manager was not defined and formalised. In addition, at the time of this inspection, four (44%) of the hospital's nine executive management positions were unfilled. This shortfall resulted in a leadership and management void that had the potential to affect the effective governance and efficient delivery of healthcare services. Additionally, there was a significant difference in the funded and actual number of nursing, midwifery and healthcare assistant staff — 13% shortfall in nursing staff, 20% shortfall in midwifery staff and 13% shortfall in healthcare assistant staff. Risks arising from staffing shortfalls were managed in the short-term through the redeployment of appropriate staff and the use of agency staff, but these arrangements were unreliable and unsustainable in the medium and longer term. The staffing shortfalls represented a significant risk to patients and was the subject of a high-risk letter issued to the HSE Dublin and Midlands health region's IHA manager after the inspection. While the IHA manager's response to HIQA outlined the measures taken to mitigate the risk, the inspectors remained concerned about the prevailing risk to patient safety arising from the shortfalls in staffing. Monitoring arrangements to identify opportunities to improve the quality, safety and reliability of the healthcare services were efficient and effective. Nevertheless, the most recent HSE risk management framework was not implemented and the timely implementation of recommendations from patient safety reviews was impacted by staffing shortfalls in the quality and patient safety department.

Quality and Safety

Since HIQA's previous inspection in 2022, there was some improvement in the compliance level with four national standards (1.7, 2.7, 2.8 and 3.3) in the quality and safety dimension. Compliance remained the same for two national standards (1.8 and 3.1) and there was a decline in compliance for one national standard (1.6).

Staff promoted a culture of kindness, consideration and respect for patients. Staff also respected and promoted patient's dignity, privacy, confidentiality and autonomy. The physical environment in the inpatient clinical areas generally supported the delivery of high-quality care, but the demand for urgent and emergency care created a challenging environment in the emergency department. Patients' privacy and dignity was compromised in the emergency department. There was a process in place to respond openly and effectively to complaints and concerns made by patients and or their families, but the hospital was non-compliant with the HSE's target that 75% of complaints be resolved in 30 days. There were assurance systems in place that supported the monitoring, evaluation and continual improvement of healthcare services, but some quality improvement plans reviewed by inspectors had no named person assigned to implement the agreed actions. Structures and processes were in place to protect patients from the risk of harm, but as per national standard 6.1 findings in relation to shortfalls in staffing posed a risk to patient safety. A comprehensive clinical pharmacy service was not provided to all clinical areas. The EMEWS was not used in the emergency department and the hospital was non-compliant with the majority of PETs. There was a system in place to effectively identify, manage and report patient safety incidents, but the implementation of recommendations and sharing of learning from patient safety incident reviews was not always timely.

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

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

Compliance classifications

An assessment of compliance with 11 national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection in the Regional Hospital Mullingar. 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.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Non-compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially 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	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2 Compliance Plan: Service Provider's Response

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

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

Directorate/Department/Speciality	Oversight of the quality and safety of healthcare
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	At the time of inspection, four (44%) of the hospital's nine executive management positions — quality and patient safety manager, director of midwifery (DOM), operations and clinical services manager and human resources manager were unfilled.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	Person (s) Responsible	Timeframe (delete as appropriate)
Appointment of an Interim DOM	IHA Manager	– **Immediate (0-1month)**
Permanent post for DOM to be advertised and interviewed Q2 2025	Hospital Manager	– **Medium term (3-6 months)**
Permanent post for Operations Manager at General Manager Grade to be advertised, interviewed and appointed in Q2 2025	Hospital Manager	– **Medium term (3-6 months)**
Permanent post for QPS post at Grade VIII to be advertised, interviewed and appointed in Q1 2025	Hospital Manager	**Short term (0-3 months)**

Permanent post for HR Manager at Grade VIII to be advertised and interviewed Q1 2025	Hospital Manager	**Short term (0-3 months)**

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

Directorate/Department/Speciality	Oversight of the quality and safety of healthcare
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	The inspectors were concerned about the impact the leadership void had on the day-to-day functioning of the hospital and especially on the senior executive management out-of-hours arrangements.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Senior executive management out of hours arrangement move to one in three with appointment of I/DOM	IHA Manager	– **Immediate (0-1month)**
Senior executive management out of hours arrangement move to one in five with appointment of remaining Senior management team members	Hospital Manager	**Short term (0-3 months)**

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

Directorate/Department/Speciality	Oversight of the quality and safety of healthcare
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	The hospital manager reported monthly to the Interim chief executive officer (CEO) of DMHG and the HSE Dublin and Midlands health region's REO, but the frequency of reporting to the REO was not formalised.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**

Monthly performance meetings to be established with the IHA manager.	IHA Manager	– **Immediate (0-1month)**

Standard Number and Name	Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Appendix Number: 1 RHM Governance for Quality Reporting Structure

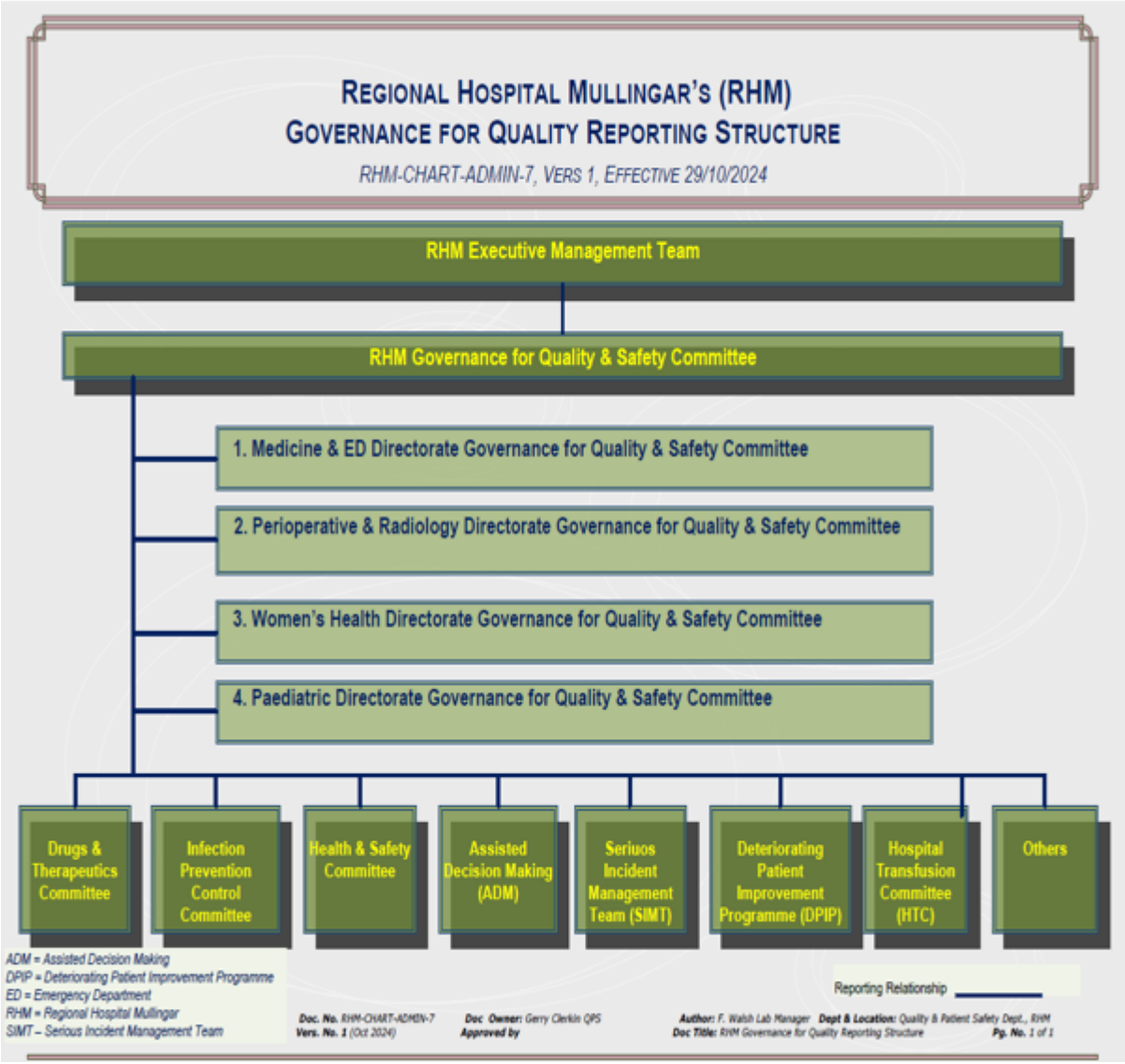
Directorate/Department/Speciality	Perioperative and Radiology Directorate
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	For two clinical directorates (peri-operative and radiology), the reporting arrangements differed from the terms of reference and or the reporting relationships described to the inspectors during inspection.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
The Perioperative and Radiology Directorate is to review its Terms of Reference and align with the Governance for Quality Reporting Structure as detailed in Appendix 1. The Terms of Reference will clearly outline its operational function and reporting relationship.	Business Manager Divisional Nurse Manager Clinical Director	– **Immediate (0-1month)**
Each sub-committee of the Perioperative and Radiology Directorate will have their Terms of Reference updated to align with the Governance for Quality Reporting structure. Each sub-committee will have direct reporting to the Perioperative Governance Committee.	Business Manager Divisional Nurse Manager Clinical Director	– **Immediate (0-1month)**
The updated Terms of Reference will be agreed and circulated to all members of Perioperative Directorate and its sub committees.	Business Manager	– **Short term (0-3 months)**
A repository of Terms of Reference for the various committee structures has commenced and this will determine those committees that are active with a clear purpose and reporting line and awareness of responsibilities and accountabilities.	Quality, Risk and Patient safety manager	– **Short term (0-3 months)**

Appendix Number: 1 RHM Governance for Quality Reporting Structure



Timescale:

Medium term (3-6 months)

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

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

Directorate/Department/Speciality	Workforce
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	There were several unfilled staff positions across the hospital, which had the potential to impact on the ability to fully support and promote the delivery of high-quality, safe and reliable healthcare services.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
Appointment of an Interim DOM	IHA Manager	– **Immediate (0-1month)**
Permanent post for DOM to be advertised, interviewed and appointed in Q2 2025	Regional HR recruitment	– **Medium term (3-6 months)**
Permanent post for Operations Manager at General Manager Grade to be advertised, interviewed and appointed in Q2 2025	Regional HR recruitment	– **Medium term (3-6 months)**
Permanent post for QPS post at Grade VIII to be advertised, interviewed and appointed in Q1 2025	Regional HR recruitment	**Short term (0-3 months)**
Permanent post for HR Manager at Grade VIII to be advertised and interviewed Q1 2025	Regional HR recruitment	**Short term (0-3 months)**
Rolling Midwife campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**

Rolling Staff Nurse campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**
Remaining funded vacant 2024 promotional nursing and midwifery posts to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**
HSCP funded vacant 2024 posts to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**
MTA, HCA and support roles from 2024 funded vacancies to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**

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

Directorate/Department/Speciality	Workforce
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	A centralised system to monitor the uptake of staff attendance at mandatory and essential training was not implemented since HIQA's previous inspection.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Roll-out Training on the HCI portal and Q-Pulse	Lab Manager	- **Short term (0-3 months)**
Process to be agreed on set up of new staff and leavers to ensure percentage compliance remains accurate	PPPG Committee	– **Short term (0-3 months)**
Complete roll-out of bar-codes to all staff for scanning into training events.	Dept Line Managers Lab Quality Manager Security	– **Short term (0-3 months)**

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

Directorate/Department/Speciality	Workforce
Date of Action Plan	14/02/2025
Document Owner	[name provided to HIQA]

HIQA Finding/Summary	there was a significant difference in the funded and actual number of staff in managerial, nursing and midwifery positions

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Appointment of an Interim DOM	IHA Manager	– **Immediate (0-1month)**
Permanent post for DOM to be advertised, interviewed and appointed in Q2 2025	Regional HR recruitment	– **Medium term (3-6 months)**
Permanent post for Operations Manager at General Manager Grade to be advertised, interviewed and appointed in Q2 2025	Regional HR recruitment	– **Medium term (3-6 months)**
Permanent post for QPS post at Grade VIII to be advertised, interviewed and appointed in Q1 2025	Regional HR recruitment	**Short term (0-3 months)**
Permanent post for HR Manager at Grade VIII to be advertised and interviewed Q1 2025	Regional HR recruitment	**Short term (0-3 months)**
Rolling Midwife campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**
Rolling Staff Nurse campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**
Remaining funded vacant 2024 promotional nursing and midwifery posts to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**

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

Directorate/Department/Speciality	Workforce
Date of Action Plan	14/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	the 17% shortfall in nursing staff, 46% shortfall in midwifery staff and 13% in healthcare assistant staff was managed in the short-term through staff redeployment and the use of agency staff, but this was not a reliable and sustainable way to manage the issue

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Appointment of an Interim DOM	IHA Manager	– **Immediate (0-1month)**

Permanent post for DOM to be advertised, interviewed and appointed in Q2 2025	Regional HR recruitment	– **Medium term (3-6 months)**
Rolling Midwife campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**
Rolling Staff Nurse campaign to be advertised Q1 to fill funded vacancies	Regional HR recruitment	**Short term (0-3 months)**
Remaining funded vacant 2024 promotional nursing and midwifery posts to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**
MTA, HCA and support roles from 2024 funded vacancies to be advertised through Q2 and Q3	Regional HR recruitment	**Longterm (6 months+)**

Standard Number and Name	Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Appendix Number: 2 Proposed Quality and Patient Safety Department Structure in RHM

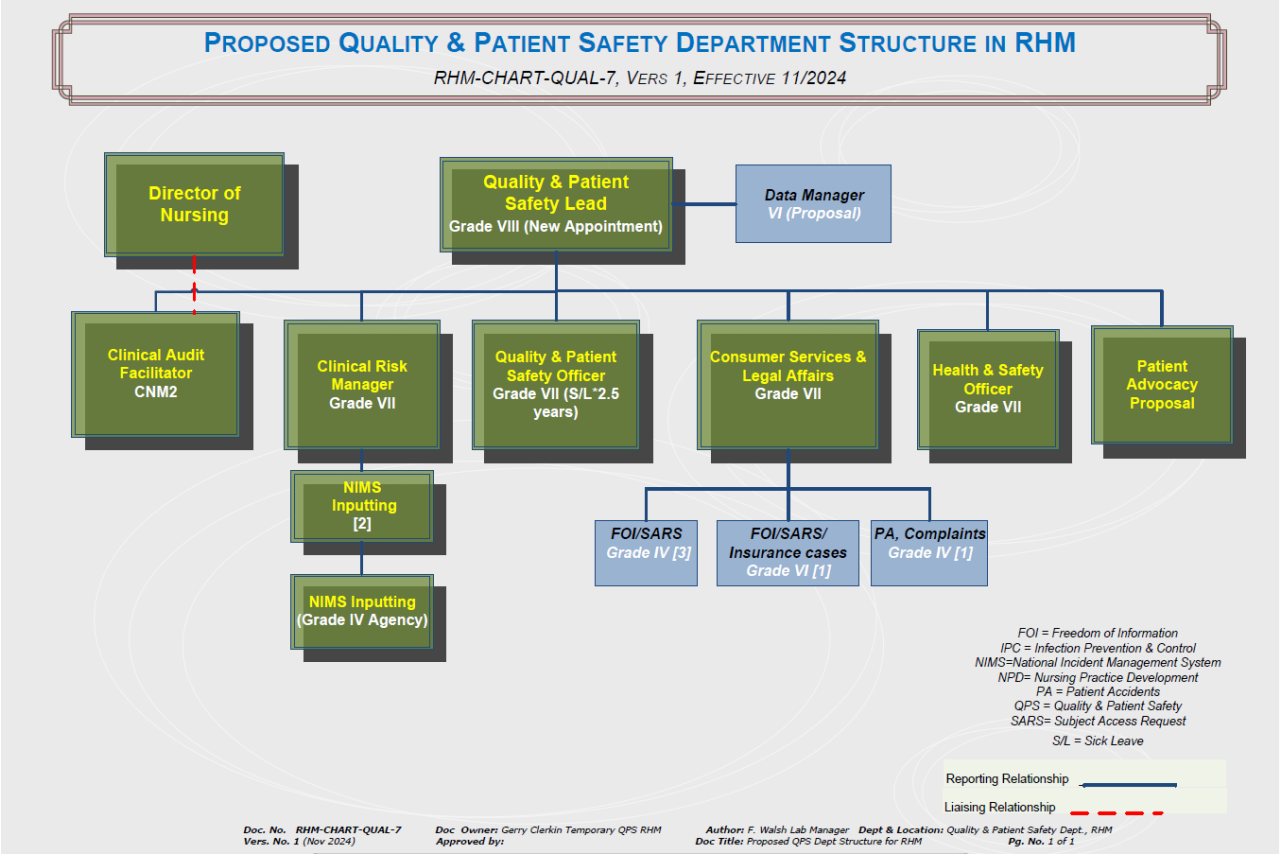
Directorate/Department/Speciality	Quality, Risk and Patient Safety
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	Staff resourcing issues in the quality and safety department also impacted on the delivery of healthcare services.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Permanent post for QPS post to be advertised and interviewed Q1 2025	Hospital Manager	**Short term (0-3 months)**
Business Case for temporary backfill of Grade 7 QPS to be submitted.	QPS Manager	**Short term (0-3 months)**
Business Case for Patient Advocacy Liaison Service (PALS) post to be submitted to IHA Manager.	Hospital Manager	**Short term (0-3 months)**
Proposal to restructure existing staffing into a department as per QPS Consultancy Support Review to be considered by IHA Manager.	IHA Manager	**Short term (0-3 months)**
Business Case for additional resource as per QPS Consultancy Support Review of posts to be submitted.	QPS Manager	**Short term (0-3 months)**

Appendix Number: 2 Proposed Quality and Patient Safety Department Structure in RHM



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

Directorate/Department/Speciality	Workforce
Date of Action Plan	14/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	Twenty-three whole-time equivalent (WTE) ‡‡‡ (28%) of the 82.32 WTE funded medical staff (medical consultants (11 WTE) and NCHDs (12 WTE)) positions across a range of specialties were unfilled.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** **(delete as appropriate)**
- Interviews planned to ensure all January 2025 NCHD posts are filled.	Medical Manpower Manager	– **Immediate (0-1month)** –

- Agency cover for vacant NCHD and Consultant posts to be requested.	Medical Manpower Manager	– **Immediate (0-1month)**
Advertise non training NCHD positions due to fall vacant in July 2025.	Medical Manpower Manager	– **Short term (0-3 months)**
- Seek approval from HSE Dublin and Midlands to conduct campaigns for temporary filling of vacant Consultant posts pending their advertisement and filling in a permanent capacity by Public Appointment Service	Medical Manpower Manager	– **Short term (0-3 months)**
- Submit application to CAAC for approval of permanent filling of vacant Consultant posts.	Medical Manpower Manager	– **Short term (0-3 months)**

Timescale:

Longterm (6 months+)

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

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

Directorate/Department/Speciality	Emergency Department
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	The challenging environment in the emergency department did not support the promotion of dignity and privacy for all patients attending for urgent and emergency care.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	Person (s) Responsible	Timeframe (delete as appropriate)
Relocate Acute Medical Assessment unit (AMAU) adjacent to the Emergency department to reduce numbers seen in ED, reduce overcrowding, reduce numbers of patients on corridors and improve patient experience.	Divisional Nurse Manager CNMII AMAU ADON Patient Flow HEMG	– **Immediate (0-1month)**
Open newly designated 2 bedded area for the Mullingar Frailty Intervention Team (MFIT) adjacent to the AMAU.	ECC Consultant Geriatrician CNMII AMAU HEMG	– **Immediate (0-1month)**
Allocation/equipping of a phlebotomy room near Triage /Waiting rooms to reduce the numbers entering /leaving the ED department for phlebotomy.	Divisional Nurse Manager	– **Immediate (0-1month)**
Dedicated space for patients to wait for phlebotomy adjacent to this area freeing up space in the waiting rooms for a period of time.	Divisional Nurse Manager	– **Immediate (0-1month)**

Opening of hub for telemetry with a capacity of four patients which can facilitate the timely transfer of patients out of ED to the wards thus reducing trolley numbers.	Hospital Manager Divisional Nurse Manager	– **Immediate (0-1month)**
Allocated nurse named on a white board on the corridor. Patients can refer to their Nurse by name when requiring information and assistance.	Divisional Nurse Manager CNMIII ED	– **Immediate (0-1month)**
Submit plan for new five story RHM development plan which includes a new ED onto National Capital Funding Plan.	HEMG Regional Estates	– **Longterm (6 months+)**

Timescale:

Longterm (6 months+)

National Standard	Judgment
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. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

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

Directorate/Department/Speciality	Clinical risk
Date of Action Plan	13/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	hospital management had no definitive plan to roll out staff training on the HSE's enterprise risk management policy and procedures.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
A memo to go to all heads of department and clinical staff containing a link to the HSELand module Fundamentals of Enterprise Risk Management and staff have been asked to submit their certificates of completion to monitor uptake.	Clinical Risk Manager	– **Immediate (0-1month)**
Make policy available to all staff on the HCI knowledge portal	Clinical Risk Manager	– **Immediate (0-1month)**
Circulate explanatory information document including FAQs on the HSE Enterprise Risk Management policy.	Clinical Risk Manager	– **Immediate (0-1month)**
New QPS lead to roll out further targeted training	Hospital Manager	– **Short term (0-3 months)**

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

Directorate/Department/Speciality	Pharmacy
Date of Action Plan	11/02/2025
Document Owner	
HIQA Finding/Summary	A comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation was not provided for all patients.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe**
Pharmacy department to continue to provide medication reconciliation on request to areas without a designated clinical pharmacist.	Pharmacist Executive Manager	– **Immediate (0-1month)**
A senior clinical pharmacist is due to return from Maternity Leave in November 2025. On return, she will be designated a ward and will provide additional pharmacy support to clinical areas without a designated pharmacy service.	Pharmacist Executive Manager	**Longterm (6 months+)**
The Pharmacist Executive Manager will work with Hospital Management and HR to submit a business case for further pharmacist posts to meet the needs of all clinical areas.	Pharmacist Executive Manager	**Longterm (6 months+)**

Standard Number and Name	3.1 : Service providers protect service users from the risk of harm associated with the design and delivery of health care services	Appendix Number: For completion by Hospital Management

Directorate/Department/Speciality	Emergency Department
Date of Action Plan	13/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	EMEWS was not implemented or used in the emergency department

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**

Education of all relevant ED clinical staff on the National Clinical Guideline No.18: Emergency Medicine Early Warning Score System (EMEWS)	ADON Nurse & Midwifery Practice Development Co-ordinator DNM, ED CNM 111, ED CSF, ED Clinical Lead , ED	– **Immediate (0-1month)**
Implementation of the EMEWS under the descriptor- option 3 in NCG No.18 in section 2.3 Human Resources & Staffing.	DNM , ED CNM 111, ED CSF, ED	– **Short term (0-3 months)**
Audit the impact of the introduction of EMEWS in RHM's ED	DNM, ED CNM 111, ED CSF, ED	– **Long-term (6 months+)**
Develop and submit business case to IHA manager around the additional staffing resources needed to fully implement EMEWS.	DNM, ED CNM 111, ED CSF, ED	**Long-term (6 months+)**

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

Directorate/Department/Speciality	Patient Flow
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	The establishment of the telemetry hub to monitor 10 patients, the introduction of a transit lounge and the reconfiguration of healthcare services into an acute floor model were not in place

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
Opening of hub for telemetry with a capacity of four patients which can facilitate the timely transfer of patients out of ED to the wards thus reducing trolley numbers.	Hospital Manager Divisional Nurse Manager	– **Immediate (0-1month)**
Submit a business case through the regional structures for the additional permanent staffing required to open a transit lounge	Bed management / Patient flow team	– **Short term (0-3 months)**
Reconfigure space within the acute floor for the transit lounge	Hospital Manager Business Manager Divisional Nurse Manager	– **Long-term (6 months+)**

Application for UEC funding for staffing to temporarily open a transit lounge as part of winter plan 2025/2026 to be submitted.	Business Manager Divisional Nurse Manager	**Long-term (6 months+)**
Relocate Acute Medical Assessment unit (AMAU) adjacent to the Emergency department to reduce numbers seen in ED, reduce overcrowding, reduce numbers of patients on corridors and improve patient experience.	Divisional Nurse Manager CNMII AMAU ADON Patient Flow HEMG	– **Immediate (0-1month)**
Open newly designated 2 bedded area for the Mullingar Frailty Intervention Team (MFIT) adjacent to the AMAU.	ECC Consultant Geriatrician CNMII AMAU HEMG	– **Immediate (0-1month)**

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

Directorate/Department/Speciality	Emergency Department
Date of Action Plan	12/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	The hospital was non-compliant with the majority of the HSE's PETs

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe (delete as appropriate)**
Relocate Acute Medical Assessment unit (AMAU) adjacent to the Emergency department to reduce numbers seen in ED, reduce overcrowding, reduce numbers of patients on corridors and improve patient experience.	Divisional Nurse Manager CNMII AMAU ADON Patient Flow HEMG	– **Immediate (0-1month)**
Open newly designated 2 bedded area for the Mullingar Frailty Intervention Team (MFIT) adjacent to the AMAU.	ECC Consultant Geriatrician CNMII AMAU HEMG	– **Immediate (0-1month)**
Dedicated phlebotomy service 7 days a week in ED.	Divisional Nurse Manager	– **Immediate (0-1month)**

Opening of hub for telemetry with a capacity of four which can facilitate more timely transfer of patients out of ED to the wards thus reducing trolley numbers.	Hospital Manager Divisional Nurse Manager	– **Immediate (0-1month)**
Appointment of a patient Flow manager for the Emergency Department.	DON	– **Immediate (0-1month)**
Ongoing monitoring of ED PETs at ED Workflow Meeting and UEC Committee meeting on a monthly basis.	Clinical Lead for ED DNM ED UEC Committee	– **Immediate (0-1month)**
Submit plan for new five story RHM development plan which includes a new ED onto National Capital Funding Plan.	HEMG Regional Estates	– **Long-term (6 months+)**

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

Directorate/Department/Speciality	Wider Hospital
Date of Action Plan	14/02/2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	Some locally developed policies, procedures, protocols and guidelines were overdue for review and updating.

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
Upload QPulse icon to all PCs in Hospital (HCI Knowledge portal already on all PCS)	Hospital ICT Lead	– **Immediate (0-1month)**
Primary licences for QPulse to be issued to department leads to allow draft review and approval of PPPGs	Laboratory Manager	– **Short term (0-3 months)**
Training to be rolled out on the Document Module of QPulse to include how QPulse functions to prompt revision and review of documentation	Laboratory Manager Laboratory Quality Manager	– **Short term (0-3 months)**
Review all PPPGs on QPulse to identify and update review dates and inform document owners	QPS admin support	– **Short term (0-3 months)**

Audit PPPG review dates to ensure decrease in number of documents overdue for review and updating.	PPPG Steering Committee	– **Long-term (6 months+)**

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

Directorate/Department/Speciality	Wider Hospital
Date of Action Plan	14.02.2025
Document Owner	[name provided to HIQA]
HIQA Finding/Summary	Two different systems to retrieve policies, procedures, protocols and guidelines was a risk because different versions of the documents were available to staff

ACTION PLAN

To be submitted along with your Compliance and Feedback Report to [name provided to HIQA]

Action Required	**Person (s) Responsible**	**Timeframe** (delete as appropriate)
PPPG committee to decide a date when to deactivate the Hospital Wide PPPG shared folder so there is no duplication in process.	PPPG Committee	– **Immediate (0-1month)**
PPPG committee to revise the below documents to ensure document flow process is clear: • RHM-PPPG-QUAL-2 Document Control policy for Regional Hospital Mullingar • Process-M/HOSPQ/1 Document Process flow map to be revised • RHM-FORM-QUAL-1 approval checklist to be revised • TOR-HOSPQ4 Terms of reference for the PPPG Steering committee	PPPG Committee	– **Short term (0-3 months)**

Timescale:

Long-term (6 months+)