Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of healthcare service provider: | Midland Regional Hospital Tullamore |
| Address of healthcare service: | Arden Rd<br>Puttaghan<br>Tullamore<br>Co Offaly<br>R35 NY 51 |
| Type of inspection: | Unannounced |
| Date(s) of inspection: | 5 and 6 November 2024 |
| Healthcare Service ID: | OSV-0001078 |
| Fieldwork ID: | NS_0103 |

## About the healthcare service

### Model of hospital and profile

The Midland Regional Hospital Tullamore is a model 3* statutory hospital owned and managed by the Health Service Executive (HSE). 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 and will be a member of the HSE Dublin and Midlands Health Region. The hospital is the largest hospital in the midlands of Ireland and serves a population within Laois, Offaly, Longford and Westmeath Kildare, West Wicklow and parts of South Dublin. Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- critical care
- diagnostics services
- outpatient care

The hospital is a tertiary referral site for Orthopaedics, ENT, Renal, Haematology/ Oncology and Rheumatology.

**The following information outlines some additional data on the hospital.**

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|---|---|
| **Number of beds** | 232 inpatient beds<br>26 day beds |

## How we inspect

Among other functions, the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out an unannounced inspection of Midland Regional Hospital Tullamore to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, healthcare inspectors* reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and unsolicited information† and other publicly available information.

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

† Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

During the inspection, inspectors:

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

## About the inspection report

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

### 1. Capacity and capability of the service

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

### 2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centered 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 |
|---|---|---|---|
| 5 November 2024 | 08:45hrs – 17:15hrs | Cathy Sexton | Lead |
| | | Eileen O'Toole | Support |
| 6 November 2024 | 08.45hrs – 15.50hrs | Elaine Egan | Support |
| | | Robert McConkey | Support |

## 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* - version 2 2024. The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited four clinical areas:

- The emergency department
- Pallas ward (22-bedded fully occupied medical ward)
- Brosna ward (31 bedded fully occupied medical ward specialties: renal, geriatric, cardiac and palliative care)
- Allan ward (31-bedded fully occupied surgical orthopaedic ward)

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

- Representatives of the hospital's Senior Management Team (SMT):
- Interim General Manager (GM)
- Quality and Patient Safety Manager
- Clinical Lead emergency department
- Clinical Director medical directorate
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- A representative from the:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Deteriorating Patient Governance Group

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

- Patient flow team.

**Acknowledgements**

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

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

Inspectors spoke with patients on both days of inspection. Feedback from patients was positive and people stated they were happy with the care they received and were very complementary of staff. Some of the comments included "*staff are great, could not praise them enough". "I was seen straight away and then seen by medical staff who were all brilliant". This is an "excellent hospital and I have used many hospitals"*. Patients stated that the staff in the emergency department were "*highly efficient" and I have experience how they fast track the elderly".* I had "*great follow up"* from this hospital.

Inspectors observed effective communication approaches used by staff to support patients who required reassurance and support. Staff were also observed engaging in a positive manner with patients' relatives. An information screen was placed in the waiting room to advise patients on how the emergency department works and what to expect when you attend, with examples of the questions you may be asked. Patients advised inspectors that they would speak with a nurse manager if they had a concern or complaint about their care. A new patient information booklet was developed in the hospital and was available by QR code and in hard copy at the main entrance to the hospital. Inspectors saw the QR code at bed spaces in the clinical areas visited during the inspection. This booklet provided very useful information for patients and relatives, for example there was information on Patient Advocacy Services, how to make a complaint, and links to the HSE "*Your Service Your Say*" (YSYS) complaints policy. A feedback box was available near the registration desk in the emergency department. Inspectors were advised that a coffee dock was installed outside the waiting area in emergency department and this was part of a quality improvement plan as a result of service users' feedback in 2021.

## Capacity and Capability Dimension

Inspectors' findings related to the capacity and capability dimension are presented under four standards from the themes of leadership, governance, management and workforce. Midland Regional Hospital Tullamore was found to be compliant with one (5.8) national standard, substantially compliant with two national standards (5.2 and 5.5) and partially compliant with one national standards (6.1). Key inspection findings informing judgments on compliance with these four standards are described in the following sections.

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

Inspectors found there was evidence of integrated corporate and clinical governance arrangements in place at the hospital. An interim general manager (GM) was the accountable officer with overall responsibility and accountability for the quality and safety of the healthcare services delivered in Midland Regional Hospital Tullamore. At the time of inspection, a formalised process was not in place between the Senior Management Team (SMT) and to the Integrated Healthcare Area (IHA) Manager. While awaiting these structures, an informal reporting relationship was in place.

Inspectors were advised that the permanent GM position was vacant and that the Director of Nursing (DON) was covering that position as the Interim General Manager. In addition, the interview process for an interim DON position was scheduled for the week following the inspection.

The interim general manager was supported by the SMT and the members of the SMT reported to the interim general manager. The SMT had weekly meetings in line with its terms of reference. The SMT provided strategic management and monitored hospital activity to ensure quality services were delivered to patients in a timely manner within a safe environment. The clinical director for the medical directorate was a member of the SMT and oversaw the quality of clinical services. Inspectors were advised that at the time of inspection the position of clinical director in the peri-operative directorate was vacant and an expression of interest for this position had been circulated. Inspectors reviewed three sets of minutes from the SMT meetings submitted to HIQA following the inspection. The clinical directors provided updates at SMT meetings. On the last inspection in 2022, the clinical director in the medical directorate position was vacant and this role had since been filled. The quality and patient safety manager (QPSM) reported to the interim general manager and was a member of the SMT. All members provided an update on their respective areas of responsibility at weekly meetings of the SMT. Training was recorded monthly in KPI's and discussed bi-monthly at QPS team meetings.

Decision-making, responsibility and accountability for delivery of clinical and non-clinical care was devolved to senior managers with clearly defined reporting arrangements, which were understood by staff who spoke to the inspectors. Organisational charts seen by inspectors detailed the direct reporting arrangements for hospital management and the various governance and oversight committees within the hospital. These were consistent with what inspectors were told on the day. The update of these charts was an improvement on the findings from the previous HIQA inspection in 2022.

The Clinical Governance Committee (CGC) had overall responsibility and accountability for the clinical governance and quality of the healthcare services delivered in the hospital. The chairperson of the committee was the peri-operative clinical director with multidisciplinary representation, and according to the terms of reference meetings were held monthly. Inspectors found that the meetings submitted to HIQA as part of the post inspection documentation indicated that the frequency of meetings did not take place in line with the terms of reference. However, the General Manager indicated that nine meetings had taken place in 2024. Inspectors found on this inspection that the hospital had governance and management arrangements in place, supported by a comprehensive committee structure. A quarterly report was prepared by the QPS team and this report provided an update on Hospital Patient Safety Indicator Reports (HPSIR) data, risks, incidents, service users' feedback, legal cases, and training delivered by the QPS team. This information was shared at the CGC. Each department also received a report on incidents reported in their area from the QPS department. The CGC had oversight of research and audit, health and safety and healthcare records. The hospital risk register updates were provided quarterly. The findings from monitoring and evaluation of the service were analysed, tracked and trended with quality improvement plans put in place. This information was shared at CGC and directorate meetings.

The medical and emergency department were part of one directorate but had separate department meetings. The peri-operative and radiology departments had joint directorate meetings and oversaw the quality of clinical services within their remit. Each clinical directorate had a leadership team that included a clinical director, assistant director of nursing (ADON) and a health and social care professional (HSCP) lead.

Several hospital committees were established by hospital management since the last inspection to achieve the planned objectives and to ensure the effective management of the four areas of known harm. These committees were accountable to the CGC and included the Drugs and Therapeutics Committee (DTC), Infection Prevention and Control Committee (IPCC) and the Deteriorating Patient Governance Group (DPGG). Each committee functioned as per the terms of reference. Each committee had an agenda with relevant MDT membership, where regular updates given and timebound actions were monitored meeting to meeting.

The IPCC was a multidisciplinary committee responsible for the governance and oversight of infection prevention and control at the hospital. The interim GM was the

chairperson of the IPCC. The infection prevention and control ADON reported to the DON. The minutes of meetings of the IPCC submitted to HIQA, were comprehensive with identified actions, responsible person appointed and an action due date assigned. Meetings were well attended.

The hospital pharmacy service was led by the pharmacy executive manager. The hospital Drugs & Therapeutics Committee (DTC) provided overall governance of all aspects of medicines management associated with the day to day delivery of services across the hospital. Inspectors reviewed minutes and attendance at the DTC meeting submitted to HIQA as part of the post onsite documentation. Two out of the three meetings were well attended, but one of the three minutes submitted did not have an attendance record attached. The committee was chaired by a clinical director and meetings were held quarterly. The Medication Safety Committee (MSC) was a subcommittee of the DTC and a medication safety pharmacist was in post.

The DPGG was chaired by the lead consultant in emergency medicine. Meetings were held quarterly. Membership included clinical skills facilitators, resuscitation officer, divisional nurse managers, CNMs from all clinical areas, lead NCHDs, QPS department representative, IPC team member, antimicrobial pharmacist (as required) and an infectious diseases consultant (as required). The DPPG reported to the CGC annually. The clinical leads advised inspectors that feedback was provided to the clinical directorates. Each member attending provided feedback to their respective teams. There were consultant leads for INEWS and sepsis.

The hospital had arrangements in place to support patient flow and discharge planning. Inspectors were informed that all requirements for beds in the hospital was coordinated by the bed flow team. There arrangements were working well on the day of inspection. The bed flow team comprised of a patient flow ADON, a discharge coordinator, a bed manager clinical nurse manager (CNM) 3, Community Intervention Team (CIT) and an Outpatient Parenteral Antimicrobial Therapy (OPAT) coordinator. A Transition of Care committee (ToC) had been set up in 2024 and was awaiting on clinical membership nominations and sign off on their terms of reference. These four committees are discussed further in national standard 5.5.

The hospital had an Urgent and Emergency Care Governance Group (UEC). The Integrated Urgent Emergency Care Governance Group (IUEC) functioned as per the terms of reference. This was an integrated cross-care group its purpose was to optimise patient flow into and out of the hospital and to provide assurance on the management of urgent and emergency care. The function of this group was to ensure appropriate governance was exercised in the delivery of sustainable Integrated Urgent and Emergency Care, by measurable improvements in Patient Experience Time (PET) and

TrolleyGar[‡‡] numbers achieved through a collaborative hospital wide approach in line with the HSE National Service Plan metrics. The group had meetings every two weeks. The ADON for patient flow provided an update at each IUEC meeting outlining if the HSE National key performance indicators (KPI) targets.

Inspectors found that at the time of inspection there was evidence of integrated corporate governance and clinical governance arrangements in Midland Regional Hospital Tullamore for assuring the delivery of safe, high-quality healthcare services. Inspectors met with some members of the SMT members and all were clear on their role, area of responsibility and accountability. There was evidence that meetings were action focused, responsible person assigned and timelines were set to follow up on any actions required. The CGC meeting records submitted to HIQA indicated meetings were not monthly as indicated in the terms of reference. While some positions were in the process of recruitment, this had little effect on governance arrangements at the time of inspection.

**Judgment:** Substantially compliant

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

The inspectors found there were defined management arrangements in place to support and promote the delivery of safe, high-quality healthcare services in Midland Regional Hospital Tullamore.

The IPC team was led by a consultant microbiologist and reported on the monitoring of surveillance and infection prevention control practices to the IPCC. The hospital's infection prevention and control team (IPCT), together with the hospital's multidisciplinary IPCC had devised an infection prevention and control work plan for 2024, which set out the priorities for the year. Inspectors reviewed the end of year report which outlined the work undertaken by the IPCC in 2023 in relation to IPC practices, surveillance, monitoring compliance with national standards and key performance indicators (KPIs). The hospital's performance in these areas is discussed further in national standards 2.8 and 3.1. The committee comprised of a number of sub-committees that reported into it, these included the decontamination committee, outbreak committee, and the Hospital Hygiene Action Team (HHAT). The Antimicrobial Stewardship committee (AMSC) had access to a dedicated consultant microbiologist and implemented the hospital's antimicrobial

[‡‡] TrolleyGar numbers refer to the daily report on hospital trolley numbers, which show how many people are on hospital trolleys or waiting or waiting for discharge

stewardship programme, and reported to the DTC and had a dual reporting structure to IPCC and DTC.

The hospital pharmacy service was led by the pharmacy executive manager. The overarching committee was the DTC, who had oversight of the medication safety in Midland Regional Hospital Tullamore. The DTC had quarterly meetings, had a set agenda, a consultant chaired the meetings. Attended by the AMST, consultant microbiologist, QPSM, risk manager, pharmacy executive manager and nurse practice development. The DTC reported to the CGC. Subcommittees that reported into the DTC included medication safety committee and the VTE committee.

Measures to support medication safety practices in the hospital were set out in a five year medication safety strategy approved in 2023 and due to run until 2027. This strategy was devised by the medication safety committee and overseen by the DTC. However, this subcommittee was not meeting at the time of inspection and inspectors were informed one of the reasons for this was pharmacy staffing levels.

Implementation of the priorities in the medication safety strategy was monitored by the pharmacy executive manager and progress on the implementation of the strategy was reported to the DTC. There was evidence that updates on progress with the work streams from the medication safety pharmacist was presented at DTC meeting minutes reviewed by inspectors. At the time of inspection the medication safety pharmacist was providing medication training at grand rounds and induction. There was a dispensing robot in pharmacy. There was a commitment in the 2023-2027 medication safety strategy to adopt a 'digital first' solution if available, depending on HSE nationally. Medication reconciliation was not in place for all patients. A limited service was provided with a focus on high risk medications and education of patients on these medications. There was a minimum of two sources of information used to validate patient medication history. Clinical pharmacists determined who required medication reconciliation from reviewing ward census data and dispensary interventions. The CNMs advised that the pharmacy team could be contacted for advice or if reconciliation was required for a patient. Overall the DTC was functioning as per their terms of reference. However, additional measures need to be put in place to advance a comprehensive medication reconciliation service for patients.

The antimicrobial stewardship team (AMST) was led by a consultant microbiologist and included an antimicrobial pharmacist and a microbiologist surveillance scientist. The team reported to the DTC on antibiotic usage and AMS pharmacist work streams. The AMST had developed an action plan for 2024 to support antimicrobial stewardship in the hospital. Inspectors were informed by the AMST that an action plan for 2025 was progressing which included monitoring KPIs, education of clinical staff, reporting findings to governance committees on audit data, updates on policies and antimicrobial prescribing. Members of the AMST visited in clinical areas and provided advice and education to clinical staff. The DTC were also updated on antimicrobial stewardship

guidelines and prescribing practices, audit findings, compliance with antimicrobial KPIs, staff training and education.

To support effective management arrangements in relation to the care of the deteriorating patient, a deteriorating patient improvement programme[§§] under the clinical leadership of two clinical leads who had managed the sepsis and INEWS committees. At the time of this inspection the two committees has amalgamated into one governance group called the Deteriorating Patient Governance Group (DPGG). This was reflected in the terms of reference. The consultant lead for INEWS and sepsis provided the updates to their teams. There was no consultant paediatrician on the DPGG. Children were admitted under the care of surgical, orthopaedic and ENT services in the hospital with online training available on PEWS and paediatric sepsis for NCHDs in those specialties.

The bed flow team were members of the transition of care (ToC) committee and advised inspectors that this committee had completed and implemented a number of work streams. These included the development of policies on admission, transfer and discharge policy, clinical handover policy with overarching procedures for best practice for nursing handover in the hospital. Also they had introduced an intra-hospital transitions of care handover sheet for clinical teams and inspectors saw these documents used by clinical staff in practice in the clinical areas. On the day of inspection there were no extra trolleys on the wards, however, the hospital was in red escalation with 18 surge beds open in the day ward. It was evident to inspectors that actions aligned with the escalation plan for the hospital. Inspectors saw evidence of monitoring of patient experience times (PETs) at SMT meetings. The bed flow team and patient flow manager facilitated meetings three times daily. The bed flow team, senior managers and multidisciplinary teams attended the patient flow meetings and huddles in the clinical areas. Communication between the bed flow team and community managers to identify availability of beds or services for the community intervention team. The bed flow team reviewed the key performance indicators weekly in the hospital and these arrangements functioned well.

In summary, while improvements should be progressed to support a comprehensive medication safety programme in Midland Regional Hospital Tullamore, inspectors found that the hospital generally had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

**Judgment:** Substantially compliant

[§§] Deteriorating Patient Improvement Programme is a standardised, high quality systematic approach to the recognition, response and management of the deteriorating patient through the implementation of National Early Warning Systems (EWS). Access online from: https://www2.healthservice.hse.ie/organisation/qps-improvement/deteriorating-patient-improvement-programme/

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

The hospital had implemented improvements from the last inspection in 2022 to support monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Information on a range of different clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with the HSE's reporting requirements. This information provided the SMT with assurances regarding the quality and safety of the healthcare provided in the hospital. From the previous inspection in 2022 there were improvements in the structures and processes in place for the management of risk. The hospital had employed a risk manager who had put in place the structures and processes which aligned with the HSE's risk management framework. This supported the proactive identification, analysis, management, monitoring and escalation of reported clinical and non-clinical risks. The clinical risk manager was responsible for oversight of risk and reported to the QPS manager who reported to the SMT on the effectiveness of the risk management structures. There was evidence of local risk registers and local risk assessment completed in the clinical areas.

The hospital's corporate risk register was reviewed four times a year at a risk register meeting which included all members of SMT. The CGC had oversight of risks related to the governance committees (DTC, IPCC, DPGG and TOC) and there was evidence of monitoring of the risk register. Any risks that could not be managed at directorate or committee level were escalated to the hospital's corporate risk register.

Inspectors reviewed the corporate risk register which had 29 inherent risk ratings in the red of which 18 were in red under residual risk status, which was the risk rating after consideration of existing controls was in place. Six risks were related to the DTC and all risks had mitigating measures in place to manage the risks identified. An example of such risk was patients not receiving prescribed medications due to lack of pharmacy out-of-hours and medication not ordered within pharmacy hours. The controls put in place included communication from senior pharmacists to all clinical areas to ensure timely ordering within pharmacy hours, an automatic cabinet was to be commissioned, additional orders were made for bank holidays and weekends, and nursing administration provided out-of-hours service.

Clinical staff in directorates informed inspectors that risks were escalated that could not be managed locally in their department. An example of a risk identified in the emergency department directorate that was escalated, related to a delay in turnaround time (TAT)*** for X-ray reporting and this risk was placed on the directorate risk register in

*** Turnaround time (TAT) in imaging is the interval between an imaging examination and a verified report being made available to the referring clinician. Keeping TATs as short as possible is essential for the timely diagnosis and treatment of patients.

the emergency department. This risk was escalated to the SMT and at that time to DMHG. This is further discussed in national standard 3.1.

The Serious Incident Management Team (SIMT) was responsible for ensuring that all serious reportable events and serious incidents were reported to the National Incident Management System (NIMS)[†††] in line with the HSE's Incident Management Framework. Attendance at SIMT included members of the SMT. Meetings took place monthly. The SIMT had oversight of the timeliness and effectiveness of the management of adverse events and patient-safety incidents reported in the hospital. The clinical leads in the clinical directorates had oversight of the timely and effective management of adverse events and patient-safety incidents reported in their area of responsibility. Clinical directorates, clinical leads, the QPSM and SMT oversaw the implementation of recommendations to emerge from the review of adverse events and patient safety incidents, and the sharing of learning from reviews. There were effective internal and external communication processes to learn from patient safety incidents to improve the quality, safety and reliability of the healthcare service. A quarterly report on incidents reported on NIMS was prepared by the QPS team for each ward /department and a number of the reports were reviewed by inspectors.

Hospital management collated performance data, which included quality and performance metrics from the hospital. This information was reviewed at quarterly CGC meetings, IPCC meetings, and monthly SMT meetings. Patients were screened for *Carbapenemase-Producing Enterobacterales* (CPE) in line with national guidance and no outbreaks were recorded. The support service manager and team carried out the environmental audits and the IPCC reviewed the results and reported the findings at the IPCC meetings. Quality and safety walk rounds were taking place at Midland Regional Hospital Tullamore.

In summary, the QPS manager notified SMT of any new risks and standing item at weekly SMT. The corporate risk registers were reviewed quarterly. There was evidence of quarterly QPS reports with tracking and trending of quality data shared with the SMT, CGC and clinical directorates. A separate quarterly NIMS data report was prepared by the QPS department and sent to each department. Overall, the hospital had made significant improvements from the last inspection in 2022 by implementing effective systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

**Judgment:** Compliant

[†††] 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).

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

Inspectors found that the hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare, and workforce management, but there were a number of vacancies in key positions leading to gaps in service provision. The total headcount of staff was 1,389 Whole Time Equivalents[‡‡‡] (WTEs) in September 2024, the HR department provided evidence that indicated the number of agency staff across all staff grades was 152 WTE. The absenteeism rate was (8.7%) in September 2024 which was double the national target (4%). Staff absenteeism rates in the hospital were monitored and reported monthly as per the HSE's requirements. There was action plans in place in relation to absenteeism, these included attendance management training, provided at the hospital induction programme. The human resources department had facilitated attendance management training sessions for managers and staff. The human resources department had ongoing control measures in place such as back to work meetings with managers and referrals to occupational health services.

The workforce arrangements in a number of areas in Midland Regional Hospital Tullamore was recorded on the corporate risk register. At the time of inspection there was four WTE consultants' posts, progressing through the recruitment stages (two WTE haematology, one WTE general surgeon, and one WTE palliative medicine). There were a number of vacant consultant posts included (three WTE consultant radiologists, two WTE consultants microbiologist, consultant otolaryngologist and one WTE anaesthesiologist). One WTE endocrinologist and one WTE rheumatologist posts were filled in a temporary capacity. Overall vacant posts were having an impact on the service and the SMT had recorded this deficit on the corporate hospital risk register. The risks identified included risk of harm to patients from delayed diagnosis/delayed treatment and unsatisfactory service for patients.

The vacancies in the consultant radiologist posts were discussed with the SMT and examples of controls in place included outsourcing of reporting and two of the posts were due to be filled in December 2024. The peri-operative directorate had oversight of radiology services. A business manager in radiology monitored the TAT compliance (discussed further in standard 3.1). The peri-operative directorate had no clinical director and the SMT advised an expression of interest was progressing. A clinical director for the medical directorate was in place and this was an improvement from the HIQA inspection in 2024 when this position was not filled.

Patients who attended the emergency department were assigned to an emergency department consultant on-call. When a patient was admitted they were assigned a primary consultant. There are eight consultants in emergency medicine employed comprising of seven permanent and one temporary post. One consultant has a service commitment to another hospital and the total number of WTEs was 7.65. The emergency department had

[‡‡‡] 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.

a lead consultant and seven consultants in emergency medicine provided the on-call service. The consultant on-call was on-site Monday to Friday 11am to 9pm. At the weekend, the consultant on-call was on site from 10am to 5pm on Saturday. Outside those times the consultant was on-call from home. A minimum of two other consultants in emergency medicine are rostered to work the day shift Monday to Friday.

There were 21 WTE NCHDs supporting consultants in the emergency department and were onsite 24/7. There were three specialist registrars, ten registrars and eight senior house officers. The hospital was an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. The SMT advised that there was two SHO vacancies in general medicine.

The hospital had funding under the nursing safe staffing framework. All the posts allocated were filled in the emergency department. The interim general manager advised that there were challenges with 25% of the nursing staff on maternity leave. The management team had to put contingency plans to backfill posts with staff overtime and agency staff. This had created challenges due to financial constraints and agency reduction strategies in place. During the last emergency department inspection in February 2024 the total approved and funded staff complement of healthcare assistants (HCAs) were 7.5 WTE. However, only four of these positions could be filled at the time of this inspection, resulting in a shortfall of 47%. Inspectors found this shortfall continued. This was reported as challenging for the department due to redeployment of HCAs to the wards to provide one-to-one care. The number of HCAs in the department did not allow for the allocation on night duty, which was reported as impacting on patient care, restocking and cleaning audits. This risk was escalated to the directorate risk register and discussed with the Director of Nursing (DON). One of the controls put in place was rostering one HCA on each shift and recruitment of additional HCAs for the twilight shift.

The clinical nurse manager three (CNM3), had overall responsibility for the nursing service within the emergency department. The CNM3 reported to the Assistant Director of Nursing for the emergency department (ADON-ED). The emergency department had 13 WTEs staff nurses on days and ten WTEs on night-duty rostered Monday to Friday. There was a CNM rostered on duty every shift. Inspectors reviewed the nursing rosters in the emergency department. The vacant shifts was managed by using regular agency staff and according to the CNMs this was working well for the department as they had regular agency staff with clinical experience in emergency medicine. Clinical skills facilitators supported the nursing teams in practice. The clinical staff spoken to by inspectors was familiar with the escalation framework plan in place to address overcrowding. The frailty at the front door team had two WTE physiotherapists and two WTE occupational therapists positions and was functioning well.

Allen and Brosna ward had approval for two CNM1 posts and the posts were unfilled in both wards. Pallas ward had a vacant CNM2 post which was covered by the CNM1. Pallas ward received an increase in staffing levels from the safer staffing framework. This resulted in an increased in staff nurse positions from 19 to 23.5 WTE. Brosna ward had a shortfall of

one WTE in nursing and one WTE, HCA. This shortfall was managed by agency staff and the CNM advised this was working well.

The total number of HCAs approved across the wards visited by inspectors with 31.5 WTE with only 21 WTE post at the time of inspection. The SMT informed inspectors that additional recruitment will be required to fill HCA vacant positions and the deficit in HCAs across the hospital was on their risk register and seen by inspectors. Overall there was a good skill mix of staff in the clinical areas visited and patients were responded to in a timely manner.

The pharmacy executive manager informed inspectors that pharmacy staffing was challenged due to seven WTE vacant positions. This risk was added to the corporate risk register. The SMT had put in place contingency plan to mitigate the risk. The hospital had approved four WTE agency staff but at the time of inspection there was 2.2 WTE in position.

Across the hospital there were four physiotherapy positions and three occupational therapy positions vacant.

When HIQA inspectors carried out the previous inspection in 2022, the QPS team were new and were developing the service. The QPS team consisted of a QPS manager, consumer and legal affairs manager, patient advocacy manager, patient safety officer, clinical risk manager, health and safety manager, clinical audit facilitator and two grade four clerical officers. The QPS Manager informed inspectors that some roles were vacant due to prolonged periods of leave and that the patient advocacy manager or the consumer and legal affairs manager's roles were not replaced. This had resulted in delays releasing files for legal cases, freedom of information requests and the management of complaints. This was escalated to the corporate risk register.

The HIQA inspection in 2022 found that there no central mechanism in the hospital to record and monitor staff attendance at mandatory and essential training. A compliance plan was put in place this included a shared drive with an excel sheet to record training and the CNMs were responsible for updating the training records. A hospital induction programme was introduced in 2023 and the hospital developed an information booklet for new clinical and non-clinical staff. This booklet contained information on mandatory training programmes and how to access this training.

The antimicrobial stewardship team and the IPC team, provided training to staff at induction, at ward level and at grand rounds. A formal induction programme for international nurses was in place. The nursing teams had clinical facilitators available in the clinical areas to address training needs. The QPS team provided short training sessions on incidents, risk, complaints and open disclosure. An update on this training was provided in the quarterly report prepared by the QPS Manager and Team and shared at the CGC and SMT meetings.

Inspectors reviewed the data base excel sheets on mandatory training provided by the SMT during the inspection.

- Medication safety training was completed by 98% of nurses and 100% of doctors across the hospital and antimicrobial stewardship completed by 100% NCHDs
- INEWS training was completed by 89% of nurses, 72% NCHDs, EMEWS training was completed by 81% of nurses.
- Basic life support (BLS) training was completed by 37% nurses and 64% of doctors
- Sepsis training was completed by 79% of NCHDs, standard based precautions, transmission based precautions, donning and doffing were ranging from 35-97% across clinical and non-clinical staff
- Hand hygiene training averaged between 66-97% across the hospital.

The hospital medical manpower had oversight of consultants and NCHD training which was recorded on a different database. The mandatory training included sepsis eLearning, hand hygiene and INEWS. The SMT advised inspectors there was a plan to move to an electronic system. This was recorded as a risk on the corporate risk register.

Inspectors found that the current system for maintaining training records did not provide sufficient oversight for senior hospital management in relation to the uptake of mandatory training at the hospital. It was evident that staff education was discussed at some meetings but inspectors did not see evidence of actions arising to improve compliance with mandatory training.

Overall, inspectors found that the hospital were planning, organising and managing their nursing, medical support staff to support the provision of high-quality, safe healthcare however improvements were required. There were a number clinical posts vacant at the time of this inspection. The peri-operative directorate had no clinical director. Across the hospital there was nine vacant consultant posts recognised as a risk on the hospital's risk register. The pharmacy department had a number of vacant post covered by agency staff and this risk was on the hospital's risk register. Staff training is an essential element in planning, organising and managing a workforce. There was room for improvement with regards to records on mandatory training and uptake of mandatory and essential training for staff.

**Judgment:** Partially Compliant

## Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. Midland Regional Hospital Tullamore

was found to be compliant with two national standards (1.6 and 1.7) and substantially compliant with two national standards (2.7 and 2.8) and partially compliant with three national standards (1.8, 3.1 and 3.3) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

Inspectors observed how staff in the emergency department and wards visited were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients and responded to their individual needs. There was a notable improvement from the 2022 inspection. Patients in the emergency department and the wards visited during the inspection were communicated within a manner that respected their dignity, privacy and autonomy. There was a calm atmosphere in the department.

This was in contrast to previous inspection by HIQA in 2022 when inspectors found that due to overcrowding in the emergency department privacy, dignity and confidentiality was impacted due to patients accommodated on trolleys on corridors and patients accommodated on trolleys had no means of alerting staff when they required assistance.

Following the inspection in 2022 the emergency department governance group developed a QIP to improve service user's dignity, privacy and autonomy. A risk assessment was completed on alert systems for non-ambulatory patients on trolleys. The waiting area in the emergency department had a patient information screen provides general advice and patient information. Patients were assigned a cubicle and when a patient was on a trolley or chair they were moved to a room for an examination. The cubicles had adequate space for personal belongings. Patients were made familiar with their immediate surroundings and advised about how to use their call bell to request assistance. There was good signage and an orientation clock visible on the wall. Patients were supported with their specific individual needs to ensure their dignity and privacy was respected, curtains were available to screen patients. End-of-life care coordinated and managed by the shift lead in the emergency department was designed and delivered in a manner that promoted the dignity, privacy and autonomy of patients and their families. The shift lead would communicate if necessary with the end-of-life coordinator, relevant clinical teams including bed flow team and palliative care services. There was access to a sensory room that also served as a relative's room and could be used for private or sensitive conversations.

When a decision was made to admit a patient and if the bed allocated was in a mixed-gender ward, a risk assessment was carried out. Consent from the patient or family member was required. If consent was refused the patient remained in the emergency

department until a same sex ward placement was available. This process was confirmed by clinical staff in the areas visited during the inspection.

Inspectors spoke with patients in the emergency department and on the wards visited and they were complementary about the staff and advised that they communicated and provided clinical care in a manner that respected their privacy and dignity.

Patients' personal information were protected in the hospital, as their names were covered and not displayed on notice boards, beds or doors. Inspectors noted that no personal information was provided over the phone and healthcare records in the main were stored securely. On one ward, healthcare records were observed in a public area, once this was brought to the CNM's attention and was addressed. Overall, the hospital had systems in place to ensure that the personal information of patients was protected. Patient were communicated in a manner that respected their dignity, privacy and autonomy.

**Judgment:** Compliant

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

Inspectors observed staff attending to patients and being kind and caring. Inspectors observed numerous thank you cards on display in the clinical areas. There was evidence of clinical staff actively promoting a culture of kindness, consideration and respect though their communication, interactions and recognising the individuality of the patients. Staff were observed communicating openly and in a sensitive manner actively listened to and enable patients to express their preferences and needs. Patients described their experience as *'excellent care and 'very happy with the care'.* Others commented that *'I am newly admitted and the staff keep me up-to-date',* and *'came in to hospital through ED and experienced a very good journey 2-3 hours only to get to the ward'.* Patients informed inspectors that they were offered opportunities to raise any issues relevant to their care and were supported to explore and discuss issues with the nursing team. In doing so their views, values and preferences were actively sought and taken into account when supporting them with their care needs. Patients had their meals times protected from unnecessary interruptions from clinical staff. Support staff were observed encouraging and assisting patients at mealtime and while mobilising. Inspectors were informed that the hospital proactively identifies and recognises stages of care (for example, approaching end of life). One of the initiatives inspectors were told about was the purple heart project. When a patient passed away each family was given two crochet hearts, one heart remained with the deceased patient and one heart could be taken home. This represented the symbol of the continued bond between families.

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| Overall, there was evidence of the hospital management and staff actively promoted a culture of kindness, consideration and respect for patients and their families. |
| **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.** |
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| Since the last inspection in 2022, a Patient Advocate Liaison Officer (PALs) had been employed. Information leaflets on how to make a complaint and how to access independent advocacy services was distributed to the clinical areas. The hospital promoted and facilitated, independent advocacy services. Staff recorded patients' complaints and tried to resolve them informally where possible. The complaints policy aligned with the HSE's *'Your Service Your Say'* policy. As previously stated in Standard 6.1, at the time of inspection the PALs position was vacant and the QPS manager was covering the role.<br><br>As the consumers and legal affairs officer role was vacant, the Quality and Patient Safety Officer reviewed all formal complaints and linked with the clinical teams to address the issues raised in the correspondence. A recently retired Assistant Director of Nursing (ADON) supported the QPS team two days a week and supported managers with nursing complaints management.<br><br>Each patient received a feedback form on discharge from the hospital. Midland Regional Hospital Tullamore had a patient information leaflet which was available in the clinical areas visited by inspectors and was available on the hospital website. A feedback box was seen by inspectors in the emergency department next to the registration desk and was also available in the main entrance to the hospital. Inspectors were informed that complaints training was available to all staff and delivered at the nursing induction programme. The training was also delivered by the QPS manager when requested by clinical areas. Clinical staff informed inspectors that complaints training was not mandatory and it was not listed in the staff induction book with the list of mandatory training. The QPS team delivered complaints training to staff in the emergency department. Posters and leaflets on `*Your Service Your Say'* were observed in some areas of the hospital, but not on all the wards visited.<br><br>There was oversight and monitoring of the timeliness for responding to and management of complaints. This involved taking into account the requirement to fully address the issues raised by the complainant. The QPSM informed inspectors that all complaints were acknowledged within five days of receipt of the complaint. However, timelines for responding to complaints within 30 days (Target 75%) was achieved by the hospital from January to June 2024 with a slight drop in quarter three 2024 when the consumer and |

legal affairs post became vacant. The SMT, CGC, clinical directorates provided oversight and monitoring of the timeliness of responses to the management of complaints.

The quality and patient safety team prepared a quarterly report on complaints and this had been previously tracked and trended but this was not happening at the time of inspection. Point of contact (POC) resolution was used to resolve complaints and the POC form was completed by CNMs on the wards visited by inspectors. Verbal complaints were managed informally in the emergency department and the majority of feedback from complaints was related to communication and waiting times in the emergency department. Inspectors were informed that feedback from complaints was shared verbally with staff at one to one meetings and at huddles.

The QPSM informed inspectors that 33% of issues raised in complaints were upheld with recommendations. The QPSM informally communicated with the clinical teams on the learning from complaints. The recommendations from complaints were managed by the clinical directorates. If there was a concern regarding a clinical complaint, a pathway was in place to enable the QPS Manager to discuss concerns at Senior Incident Management Team (SIMT) for clinical oversight. The QPS manager was working on the learning from complaints with clinical teams.

Overall, there was evidence the hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. There was evidence of oversight and monitoring of timelines for responding and managing complaints. Midland Regional Hospital Tullamore achieved good compliance in responding to complaints within 30 days in the first half of 2024 with a slight decrease in quarter three 2024 when the consumer and legal affairs post became vacant. Recommendations from complaints were not coordinated with a documented process, for example a QIP with an action plan, timelines and a named person assigned to take responsibility for implementation the learning from issues raised by patients and people using the service.

**Judgment:** Partially compliant

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

During the inspection, inspectors observed that the environment was clean and generally well maintained.

The emergency department had the following facilities:

- a waiting area had 30 seats and the paediatric waiting areas were separate.

- four isolations rooms, two of which had en-suite facilities and one was a negative pressure room[§§§]
- access to a vending machine and a coffee dock were in close proximity to the emergency department
- a triage room
- a resuscitation room with two bays
- a separate negative pressure resuscitation room for patients requiring isolation
- an ANP room
- an assessment room with two bays, one used for rapid assessment and treatment and one for frailty assessment
- an assessment room with two door access which could be used for mental health assessment
- a third assessment room
- six cubicle spaces in the majors area for more acute patients with shared access to a toilet and shower
- eight cubicle spaces in the minors area for less seriously ill/injured patients, two cubicles were dementia friendly, there were no toilets in this area of the ED
- ENT treatment room

Cleaning schedules were updated and monitored by the clinical supervisor, who had oversight of them daily. Cleaning supervisors and CNMs had oversight of the standard of cleaning in their areas of responsibility. Hazardous waste was observed to be safely and securely stored. Patient equipment was cleaned by HCAs and there was a system to indicate the equipment was cleaned. Inspectors were informed by the HCA that when a patient was discharged a deep clean was completed by the HCAs. Environmental audits were completed and this will be discussed further in national standard 2.8. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited and CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place and the timely response of the maintenance service.

Inspectors noted beds and other equipment stored in open area on the ground floor to the right of the main foyer. Allan ward (orthopaedic ward) had large pieces of equipment stored on the corridors as it was needed for patient care. The CNM advised that a risk assessment had been completed and mitigation actions applied. The SMT informed inspectors that an equipment library was available in the hospital. Inspectors observed some storage of patient equipment in the linen room and housekeeping room in Pallas ward and the CNM was informed and this was addressed.

[§§§] Negative pressure rooms refer to isolation rooms where the air pressure inside the room is lower than the air pressure outside the room. Therefore, when the room door is opened, potentially contaminated air or dangerous and infective particles from inside the room will not flow outside to non-contaminated areas.

Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms visited by inspectors. Patients requiring transmission-based precautions were isolated where possible and there was evidence of appropriate placement of patients requiring transmission-based precautions. The number of isolation rooms was a challenge when HIQA inspected in 2022 and the situation had not changed. The SMT advised inspectors that they have plans to increase the number of isolation rooms. Signage in relation to the correct and appropriate use of transmission-based precautions was displayed, clear to read and in place.

A lock had been removed by maintenance from a clean utility room which stored medication. The issue was highlighted during the inspection and the lock was replaced before the inspection was completed.

In summary, at the time of inspection, the physical environment supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care in the hospital. The number of isolation rooms remained an issue and plans were in place to address the need for additional isolation rooms. Patient equipment was observed to be generally clean and well maintained. Storage of large pieces of equipment was a challenge despite the availability of an equipment library in the hospital.

**Judgment:** Substantially Compliant

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

The hospital was found to be partially compliant with this standard when HIQA carried out an inspection in 2022. Inspectors were informed that since the 2022 inspection, a clinical audit facilitator was now in post. Hospital management used information from a variety of sources (including KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, complaints and patient experience surveys) to compare and benchmark the quality of their healthcare services with other similar hospitals. This was an improvement from the inspection in 2022.

Inspectors found on this inspection, that hospital management monitored and publically reported monthly on rates of hospital acquired *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE) and hospital-acquired *Staphylococcus aureus* blood stream infections. A gap analysis with the national policy for CPE screening had been conducted and action plan was implemented. Close monitoring of hospital acquired *Clostridioides difficile* infection cases by the IPC team was evident in the hospital. Inspectors were informed by the consultant microbiologist that a review was completed on all hospital acquired *Clostridioides difficile infections.* Evidence of learning from an outbreak was demonstrated where two outbreak meetings took place and reviews were completed. Recommendations were made, which included monthly hand

hygiene audits completed at ward level, incident form to be completed for all hospital acquired infection and monthly IPC education sessions for clinical staff was implemented.

Patients were screened for CPE in line with national guidance. Compliance with this guidance was audited in October 2024 the hospital was over 95% compliant. The hospital had nine CPE cases identified in quarter three 2024 and on review of the IPCC meeting in October 2024. Inspectors were told that ongoing control measures to prevent CPE transmission had been implemented and monitored through the relevant hospital committees. Healthcare associated surveillance was a key focus of the IPCT since the inspection in April 2022. The KPIs and trends in particular around CPE, *clostridium difficile* and bacteraemia blood stream infections were closely monitored at the CGC (monthly) and IPC meetings. This has led to a reduction in healthcare associated infections for 2023 in particular for bacteraemia blood stream infections.

Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (HAT/VTE) committee was established in June 2023. An audit was undertaken and the finding reviewed by inspectors. The audit identified that 60% of patients had the appropriate pharmacological prophylaxis prescribed. The HAT/VTE committee had developed a number of QIPs with assigned responsible person and the QIPs were time bound. HSE patient blood clot alert card was introduced, a hospital VTE policy was being developed along with an updated VTE risk assessment form.

The IPCC had oversight of a number of audits such as environmental, patient equipment, hand hygiene audits and monitored the hospital compliance with IPC policies, procedures, guidelines and protocols. The hand hygiene compliance was over 90% in the majority of areas of the hospital. However, in four clinical areas this level of compliance could be improved based on audit findings, ranging from 84.5%-88.9%. There was evidence of good compliance with equipment and environmental hygiene standards in most areas visited in the months before the inspection (>90%).

When the level of compliance had fallen there was sufficient evidence observed that quality enhancement plans were developed and implemented when environmental, patient equipment and hand hygiene standards fell below the expected standards. Inspectors noted examples of actions taken, these included repairing fixtures, fittings, cleaning patient equipment and maintenance requests completed. Monthly hand hygiene audits, environment and patient equipment audits were undertaken by the IPCT using a standardised approach and audit findings were reported to the IPCC. Action plans were put in place with time bound actions and a responsible person identified to implement the action plan.

The pharmacy executive manager informed inspectors that only a limited number of medication audits were carried out in 2024. An audit on antibiotic prescribing practices was completed by the AMS team and reviewed by pharmacist and learning from the audit was shared with clinical teams. A "medication not in stock audit" was completed and

compared to previous audit in 2021 there was some improvement noted and some room for improvement. The DTC had oversight of medication audits. Medication practices (storage and custody) were also monitored monthly as part of the nursing and midwifery quality care metrics with good levels of compliance noted by the inspectors in the clinical areas visited.

The emergency department had INEWS in place for admitted patients. Clinical staff in the areas visited by inspectors had a clear understanding of INEWS, escalation and management of the deteriorating patient and how to escalate care in a timely manner. Inspectors reviewed the patients' healthcare records and noted that the INEWS was completed correctly. The Identify, Situation, Background, Assessment, and Recommendation ($ISBAR_{3)}$) communication tool was used for the escalation of the care of the deteriorating patient. There was also a focus on urinary output recording on the fluid balance chart, with a prompt card to remind staff to complete the documentation. The INEWS escalation and response was audited a total of three times in 2024 until time of inspection. The overall compliance in January 2024 was 61.6%. The audit was repeated in June 2024 with overall compliance 96.8% and 77.3% in October 2024.

The bed flow team had a QIP in place to implement clinical handover and $ISBAR_3$ tool. The QIP had actions, timelines and a responsible person assigned. A pilot of the $ISBAR_3$ tool in Q2 on Pallas ward had very positive feedback. Policies and procedures were developed and were awaiting stakeholder approval. Training had taken place and inspectors observed the use of the tools in the clinical areas. Full implementation of the $ISBAR_3$ process was evident in the clinical areas. A clinical handover policy and handover sheets have been developed and the roll out was in progress when HIQA inspected the hospital. Auditing of compliance with clinical handover and $ISBAR_3$ use was scheduled for Q1 2025.

The predicted date of discharge audit was completed by the bed flow team in quarter Q1 and Q3 2023 over a 17 day period. Results indicated that in Q1 61% (of patients predicted to be discharged at 12:30 were discharged at that time, 140% predicted patients for discharge at 12:30 were discharged at 16:00. In Q3 76% (of patients predicted patients for discharge by 12:30) were discharged by that time, 150% predicted patents were discharged by 16:00. All patient were given a predicted date of discharge and the bed flow team monitored this at huddles and at multidisciplinary meetings.

Allan ward participated in the Irish hip fracture data (IHFD) from the National Office for Clinical Audit (NOCA), achieving 75% of medically fit patients received surgery within 48 hours this was an increase from 40-50% from previous years. A QIP had been in place and extra theatre slots were put in place to meet the KPI with the support of the trauma coordinator driving the compliance.

Data in relation to the hospital activity and capacity, numbers of new attendances to the hospital's emergency department, patient experience times (PETs), medical and surgical patients' average length of stay (ALOS) and (DTOC) were tracked in line with the HSE's

reporting requirements. Collated data was submitted as part of the daily situational report and reviewed by the SMT. Data on quality metrics relating to scheduled care was also reported on and reviewed by the SMT.

Overall, there were assurance systems in place in Midland Regional Hospital Tullamore to monitor, evaluate and continuously improve the healthcare services and care provided in the hospital. There were arrangements in place to ensure there was a proactive approach to the identification, evaluation and the management of actual and potential risks to patients receiving care in Midland Regional Hospital Tullamore. Performance was monitored and evaluated using clinical and non-clinical audits with quality improvements plans implemented based on the findings. There were plans to audit compliance with clinical handover and ISBAR$_3$ in early 2025.

**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**

Since the last inspection carried out by HIQA in 2022, inspectors found there were some improvements in place to ensure the proactive identification, evaluation, analysis and management of significant information and risks to the delivery of safe healthcare services. Hospital management informed inspectors that training on the HSE Enterprise Risk Management Policy was not yet implemented and this was to be addressed by advancing training.

In the emergency department clinical staff proactively identified, assessed and managed immediate and potential risks to patients. Risk assessments were completed and added to the hospital risk register in relation to overcrowding in ED and control measures were put in place to prevent this from happening. The CNMs and ADONs in the emergency department had oversight of the implementation the hospital escalation plan in relation to the emergency department. Any risks identified that were impacting on the effective functioning of the emergency department were discussed at emergency department clinical governance meetings. The CNM3 and ADON managed the emergency department risk register. The clinical directorates and the EMT monitored the effectiveness of any actions applied to mitigate any risks to patients.

In the other wards visited by inspectors, examples of formal risk assessment completed by clinical and non-clinical staff were seen by inspectors. This included patients who required isolation, patients at risk of falls and required direct patient observation (DPO). An exit door to the ward not working correctly and waiting on replacement. Control measures were put in place to mitigate the risks identified.

Clinical staff in the emergency department informed inspectors that there was delay in the reporting of X-rays in radiology and this risk was added to the risk register in the emergency department. Inspectors were provided with assurance that this issue was

being addressed. A risk assessment had been completed by the Hospital which included long and short term plans to address the back log. Actions taken by the hospital to improve TATs included the outsourcing of the reporting of CT and MRIs. Senior hospital management should maintain close oversight of compliance with TAT standards and ensuring that, there are clear escalation routes in place for any reports due to fall outside the TATs.

Patients were screened for MDROs on admission. The hospital's information patient management system (iPMS) alerted staff to patients who were previously inpatients with confirmed MDROs. Once the decision was made to admit a patient, there was a clear process for managing isolation rooms with input of the IPCT and as per hospital and national policy. There was no infection outbreaks at the time of the inspection. Patients requiring transmission based precautions were isolated in a single room and if none were available, suitable patients were allocated to a multi-occupancy rooms. Two infection outbreaks of clostridium difficile infection were recorded in 2024. Hospital management had convened multidisciplinary outbreak teams to complete a review to identify what happened, why it happened and ensure that the learnings and recommendations from these infection outbreaks were shared with clinical staff. Consultant microbiology cover was available 24/7 to support clinical teams.

A comprehensive clinical pharmacy service[****] was not provided for all patients as pharmacy-led medication reconciliation[††††] was not undertaken for all patients. Reconciliation of medication was provided for all ICU/CCU patients. Otherwise, the aim of the service was to undertake reconciliation of medication for all newly admitted patients – but given resource constraints, clinical pharmacists prioritised workloads to provide this service to the most high-risk patients within this cohort. The CNMs informed inspectors that the pharmacy team could be contacted for advice or if reconciliation was required for a patient. There were a number of medication policies, procedures and guidelines due for revision. The medication policy was under review and will include the process for accessing medication out-of-hours. The deficit in pharmacy was reported as impacting by the following:

- No antimicrobial stewardship pharmacist cover when on leave.
- The reconciliation of medication was carried out on all ICU/CCU patients but for other admitted patients was based on prioritisation of the most high risk patients.
- The medication safety committee was not meeting as a committee due to work demand and incorporated the committees function to the DTC.
- The pharmacy technicians approved WTE was 19.5 and there was 15.5 WTE in post at the time of inspection.

[****] A 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.
[††††] Medication reconciliation: involves using a systematic process to obtain an accurate and complete list of all medications taken prior to admission.

- The hospital had approved four WTE agency staff and at the time of inspection there was 2.2 WTE in position.

The red apron initiative for the administration of medication on medication rounds was in place in the hospital. The hospital's high alert medication list was provided to inspectors. All applications for addition to the formulary was through the DTC. 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. This information was available in hard copy format (BNF) and through an application for smart mobile phones.

The hospital used the most recent version of the national early warning system (INEWS), the emergency medicine early warning system (EMEWS) and the paediatric early warning system (PEWS) to support the recognition, response and management of a deteriorating patient. The use of ENEWS was not fully implemented in the emergency department at the time of the inspection, as EMEWS was not used for admitted patients and the INEWS and PEWS was partially implemented.

In the clinical areas visited during the inspection the INEWS was available in hard copy and some wards had an electronic version. Inspectors were informed by staff that there was no delay in contacting clinical teams. The 'Sepsis 6' care bundle was also implemented and being used in the hospital. The $ISBAR_3$ communication tool was also in use and seen by inspectors in the clinical areas visited. Clinical staff were familiar with the process for escalation when a patient deteriorated. There was a deteriorating patient recognition and response improvement programme committee in place. There was policies, procedures, protocols and guidelines guiding the early detection and emergency response for patients whose condition was deteriorating.

There were systems and processes in place to support the efficient flow of patients and transfer of patients within and from the hospital. Inspectors were informed that all patients had a predicted date of discharge. The bed flow team coordinated and managed daily huddles and meetings were held with representation from the hospital MDTs and community services. Concerns or challenges that impacted on the discharge process, such as complex discharge cases were discussed at daily huddles and MDT meetings. Any action required by the MDTs to enable the safe discharge of patients were discussed and agreed at these meetings. The number of new attendances to the hospital emergency department, PETs, ALOS of medical and surgical patients and DTOC were tracked in line with the HSE's requirements. Daily situation report reviewed and updated daily at 08:00hrs/11:00hrs.

These included:

- Huddles several times daily.

- COPD virtual care at home.
- Using the SAFER bundle[‡‡‡‡] and the 'Red and Green' days approach[§§§§].

There were a range of community based hospital admission avoidance measures such as community day services, home supports and an outpatient parenteral antibiotic therapy service (OPAT).[*****] The hospital had access to 12 beds in a nursing home with 6 in a private facility for November 2024 (intermediatory care).

The 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)
- chest pain pathway
- Integrated Care Programme for Older People (ICPOP) community specialist teams.

On this inspection, inspectors found a number of services and pathways were available for patients such as an acute medical assessment unit (AMAU), a rapid access treatment team pathway, a rapid access frailty team and an advanced nurse practitioner (ANP) pathway. In the event that a patient required specialist services or treatment there was a process in place for transfer to specialist hospitals via protocol 37[†††††] as required.

A Hospital Ambulance Liaison Person (HALP) was in place and supported the timely handover process of patients who arrived to the emergency department via the national ambulance service. The average waiting time on the day of inspection from:

- The mean waiting time in the department from registration to triage was five minutes. The mean waiting time from triage to medical assessment was 47 minutes for non-urgent patients. The decision to admit to actual admission in an inpatient bed was 121 minutes.
- 11.6% had been waiting over six hours to be seen, which was in line with KPI target of number of attendees at emergency department are discharged or admitted to a ward within six hours of registration.
- 11.6% were in the emergency department greater than nine hours this was in line with national key performance indicators
- 25% (3 patients) of all attendees aged 75 years or over who are in the emergency department are discharged or admitted to a ward within 6 hours. This was not in

[‡‡‡‡] The SAFER bundle comprises five elements of best practice – Senior review by a clinician, All patients have a predicated discharge date, Flow of patients, Early discharge of patients, Review 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.
[*****] Outpatient parenteral antibiotic therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.
[†††††] Protocol 37 is the name used to describe the HSE's emergency inter-hospital transfer policy.

line with national key performance indicators (KPI) where 99% of all attendees aged 75 years and over in the emergency department should be discharged or admitted within 6 hours of registration.

- There were 2 patient who were over 75 years who were in the emergency department greater than nine hours. This was not in line with national key performance indicators (KPI) where 99% of all attendees aged 75 years and over in the emergency department should be discharged or admitted within 9 hours of registration.
- There were no patients over the age of 75 years in the department greater than 24 hours of registration.

The hospital's Average Length of Stay (ALOS) for medical patients in 2024 was 6.34%, this was a slight increase from 2023 at 6.25% and less than the HSE's target (≤7.0).The ALOS for surgical patients in 2024 was 4.97% and there was an increase from 4.75% in 2023. The percentage of emergency department patients who left before completion of treatment in 2023 was 4.27% and the number dropped to 2.58% in 2024.

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 due for updating in 2018. The QPS manager informed inspectors that all policies, procedures, protocols and guidelines were in the process of been updated and were being moved to a new electronic document management system.

In summary, the majority of the HSE KPIs relating to PET times were in place at Midland Regional Hospital Tullamore but on the day of inspection more work was required to manage KPIs relating to patients over 75. It was noted that there were no patients over the age of 75 years in the department greater than 24 hours since registration at the ED. More generally, management should progress full implementation of the HSE Enterprise Risk Management Policy 2023. In addition, further work is required to ensure that improvements relating to turn around times on reporting in radiology are followed up and closely monitored. Finally, improvements should be progressed to support a comprehensive medication safety programme in Midland Regional Hospital Tullamore.

**Judgment:** Partially Compliant

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

There was a system in place to identify, manage, respond to and report patient-safety incidents, in line with national legislation, standards, policy and guidelines.

Hospital management reported on the number of clinical incidents reported to NIMS in the monthly hospital patient safety indicator report. Staff who spoke with the inspectors knew how to report patient safety incidents. The HSE Enterprise Risk Management Policy and Procedure was not implemented in the hospital and the QPS manager informed inspectors that education on the policy had commenced. An update on this training was provided in the quarterly report prepared by the QPS Manager and Team and shared at the CGC and SMT meetings.

The QPS Manager prepared a report which included tracking and trending of incidents reported each quarter. Patient safety incidents were classified using an agreed taxonomy. The QPS Manager quarterly report was reported at the IPCC, CGC and SMT meetings. The QPSM had oversight of the management of serious incidents in line with national policy. A quarterly report was sent to each department with a summary report of all incidents reported. Each department received a separate report on incident reported in their area and inspectors were provided with examples of the reports. The CNMs informed inspectors that paper based incidents forms are used in the clinical areas and forwarded to the QPS team. The CNMs in the clinical areas informed inspectors that learning from incidents were shared at safety pauses and ward meetings and this was confirmed by staff nurses. The majority of incidents reported were from the nursing and pharmacy teams and this was reflected in previous inspections. A proactive approach was taken to incident management and investigations where incidents are reviewed. Inspectors were told of a plan to have anonymised learning notices shared with all staff where learning can be shared outside the area where the incident occurred.

Medication safety incidents were reported by clinical staff and are uploaded to NIMS and reviewed by the medication safety pharmacist and clinical risk manager. Learning notices and alerts from incidents were shared and this was communicated to inspectors by clinical staff on inspection.

The bed flow team reviewed incidents in relation to transitions of care. There was evidence of implementation of recommendations to improve transition of care from other hospitals. The DPGG monitored any incidents associated with the deteriorating patient. In February 2024, the deteriorating patient committee ran a media campaign to educate the public about sepsis. The hospital's serious incident management team (SIMT) provided a governance structure to the hospital management of category one and other serious reportable events (SREs) which occurred in the hospital.

Inspectors were informed that an external look-back review had been undertaken to in relation to radiology. This report was completed and a number of recommendations were made by the review team. The recommendations included; participation in the National Radiology Improvement Programme, improvement in consultant radiologist staffing levels and improvements to the culture of safety. Hospital management need to follow-up and continue to progress the implementation and oversight of the recommendations.

Overall,

- HSE Enterprise Risk Management Policy and Procedure was not fully implemented.
- Midland Regional Hospital Tullamore should ensure that the recommendations of the look-back review are progressed and fully implemented.

**Judgment:** Partially Compliant

## Conclusion

HIQA carried out an unannounced inspection of Midland Regional Hospital Tullamore on the 05 and 06 November 2024 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four key areas of harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care.

**Capacity and Capability**

Midland Regional Hospital Tullamore had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. On the day of inspection there was organisational charts which were seen by inspectors and were available and in place in the hospital, these were previously not in place when HIQA inspectors completed an inspection in 2022. An Integrated Urgent Emergency Care Governance Group (IUEC) had been put in place since the last inspection in 2022. Its purpose was to optimise patient flow into and out of the hospital and to provide assurance on the management of urgent and emergency care.

On the day of inspection, the hospital's emergency department was relatively quiet and was functioning well. Attendees to the department were not waiting for long periods to be triaged and or medically reviewed. On the day of inspection, the emergency department achieved most of the HSE targets. With two targets not achieved related to patients aged 75 years and over been discharged or admitted within 6 and 9 hours of registration. As three patients (25% of patients over 75 years or over) who were in the emergency department and not discharged or admitted to a ward (within 6 hours and two of these patients were greater than nine hours in the department. There were no patient over the age of 75 years in the department greater than 24 hours of registration. A surge escalation plan and safety huddles was in place in the hospital. The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. The hospital committees overall were functioning as per their terms of reference. The TOC committee were still awaiting sign off on their terms of reference from the CGC.

The risk register was a standing item at weekly SMT meetings for the QPS manager to notify SMT of new risks this was an improvement from the last inspection. The corporate

risk registers were reviewed quarterly. The hospital had occupational health and other support systems in place to support staff in the delivery of high-quality, safe healthcare. Despite this, there was a number of posts vacant at the time of this inspection. The peri-operative clinical director's position was vacant. Across the hospital there was nine vacant consultant posts recognised as a risk on the corporate risk register. The pharmacy department had a number of vacant post covered by agency staff and this risk was on the hospital's risk register.

The oversight and uptake of essential and mandatory training required attention. Significant work was required to meet national targets for mandatory and essential training, especially in the area of infection prevention and control, across all professions and staff grades. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with local or national policy.

**Quality and Safety**

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital. People who spoke with inspectors were positive about their experience of receiving care in the emergency department and in the wards visited by inspectors and were very complimentary of staff.

The hospital's physical environment adequately supported the delivery of high-quality, safe, reliable care to protect patients receiving care. Inspectors observed adequate spacing between patients in the emergency department and in the wards visited which decreased the risk of cross infection and enabled patients to store their personal belongings. Signage in relation to the correct and appropriate use of transmission-based precautions was displayed, clear to read and in place.

The hospital was not consistently compliant with the HSEs timelines for responding to complaints within the 30 days' timeline. Recommendations from complaints was not formally documented to provide assurance that the learning was shared and implemented.

HIQA was satisfied that the hospital had systems in place to monitor and improve services. There was evidence that hospital management acted on opportunities to continually improve the quality and safety of services. The hospital was monitoring compliance with the national guidance on clinical handover and had implemented quality improvement initiatives in relation to multidisciplinary team clinical handover. There was evidence of risk assessments completed when a risk was identified in the clinical areas, directorates, committee level and added to the risk register locally or at hospital level. The QPS Manager compiled and distributed quarterly incident trends to all departments, directorates, CGC and EMT.

In relation to the four areas of known harm, the hospital had systems in place to identify, prevent or minimise unnecessary or potential risk and harm associated with the provision of care and support to people receiving care at the hospital.

A look-back review relating to radiology had taken place, resulting in a range of recommendations which Midland Regional Hospital Tullamore should prioritise for implementation.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with mandatory training and implementation of the recommendations from the look-back review.

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

### Compliance classifications

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

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

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

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| quality, safe, reliable care and protects the health and welfare of service users. | |
| Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved. | **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. | **Partially Compliant** |

**Compliance plan provider's response:**

| **Standard** | **Judgment** |
|---|---|
| Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare. | Partially compliant |
| Outline how you are going to improve compliance with this national standard.<br><br>The endocrinologist and one rheumatologist post are filled in a temporary capacity.<br><br>The scale of MRHT vacant positions has been caused by:<br><br>1) the HSE recruitment pause and subsequently the implementation of the HSE pay and numbers strategy in 2024<br><br>2) the development of the new HR and Finance structure and processes with respect to the HSE pay and numbers strategy and recruitment in the Dublin Midlands Region HSE Region caused significant delays in advancing recruitment for the service.<br><br>A new recruitment process has been approved at HSE Dublin and Midlands mid-April 2025. The senior management team in MRHT team are now actively engaging with this new process to progress the approval and recruitment into posts for replacement.<br><br>The peri-operative directorate clinical director role has been filled and the postholder has been in post since December 2024.<br><br>The hospital is exploring alternative methods to record and manage mandatory training records including a module to be added to the current Qpulse system that another similar | |

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| size hospital is now using. The aim is that the senior management team will have full oversight of all staffs mandatory training by December 2025. |
| **Timescale:** December 2025 |

| Standard | Judgment |
|---|---|
| Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. | Partially compliant |
| Outline how you are going to improve compliance with this national standard.<br><br>The consumer and legal affairs manager was on Maternity leave at the time of inspection On her return we aim to develop a documented process for managing complaints that will include QIPs for all upheld complaints. These QIPS will outline the specific actions required to address the complaint raised. For complaints, action plans will include clear steps to address the concerns, with realistic timelines for competition of each action, with the progress tracked regularly. A member of the team will be responsible for overseeing the implementation of the action plan and will be responsible for communicating progress of same. The QIP will be reviewed regularly to ensure that it remains effective and aligned with best practice. We will also ensure that the outcomes from complaints are communicated to relevant staff and integrated into training, policies and procedures where necessary. When the consumer and legal affairs manager returns from her maternity leave in August this will be put into action. | |
| **Timescale:** Q4 2024. | |

| 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.<br><br>The hospital is now using the HSE Enterprise Risk Management Policy. The local policy to reflect the national document is in development and will be completed by June 2025. Education on the new national policy is ongoing and the new risk assessment forms are used for all new risk assessments. The policy will be fully implemented by June 2025.<br><br>The pharmacy department has a Medication Safety Strategy in place for MRHT which currently runs until 2027. A plan is now in place to standardise medication reconciliation across the hospital in 2025. | |

MRHT are committed to manage PETs in the ED and there is a daily focus on compliance with all PETs with a specific focus on the over 75 age group. This is through three times daily huddles, unscheduled care group meetings, ED governance and by the IHA manager at monthly performance meetings. Ongoing initiatives to improve ED PETs include a newly developed diabetic foot pathway, a review of ambulance presentations by geographical area and the development of a minor injuries unit in Athlone.

Turnaround times and reporting backlogs in radiology are being closely monitored by the peri-operative directorate. A specific focus for radiology ED TATs over the past few months have led to significant improvements. A risk assessment has been completed by the directorate and actions agreed for the management of backlogs. In addition, in 2025 the National Radiology Diagnostic Waiting List Management Protocol will assist MRHT in keeping within KPIs.

**Timescale:** September 2025

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

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

The hospital is now using the HSE Enterprise Risk Management Policy. The local policy to reflect the national document in development and will be completed by June 2025. Education on the new policy is ongoing and the new risk assessment forms are used for all new risk assessments. The policy will be fully implemented by June 2025

Turnaround times and reporting backlogs in radiology are being closely monitored by the peri-operative directorate. A specific focus for radiology ED TATs over the past few months have led to significant improvements. A risk assessment has been completed by the directorate and actions agreed for the management of backlogs. In addition, in 2025 the National Radiology Diagnostic Waiting List Management Protocol will assist MRHT in keeping within KPIs.

The Radiology Look-back Review made 6 recommendations. MRHT are committed to implementing these recommendations. Recommendations no's 1, 3, 4 and 6 are completed. Recommendations 2 and 5 are in progress and have timelines attached to them. Recommendations are being monitored by the QPS dept. in MRHT and by the IHA. The last update was given to the IHA on 23/04/2025.

**Timescale:** September 2025