Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Midland Regional Hospital Tullamore
Centre ID:	OSV-0001078
Address of healthcare service:	Arden Road Tullamore Co. Offaly R35 NY51
Type of Inspection:	Announced
Date of Inspection:	08/04/2026 and 09/04/2026
Inspection ID:	NS_0200

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). The hospital is in the HSE Dublin and Midlands Health Region†. Services provided by the hospital include:

- acute medical inpatient services
- elective surgery
- emergency care
- critical care
- diagnostics services
- outpatient care.

The hospital is a tertiary referral site for Orthopaedics, Ear Nose and Throat (ENT), Renal, Haematology/ Oncology and Rheumatology.

The following information outlines some additional data on the hospital.

Number of beds	233 inpatient beds 80 day case beds

How we inspect

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

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

* A Model 3 hospital typically admits undifferentiated acute medical patients, provides acute surgery, acute medicine, and critical care.
† The Regional Health Area HSE Dublin Midlands provides health and social care services to Dublin South City and West and Dublin South West, Kildare, West Wicklow, Laois, Offaly, Longford and Westmeath.
‡Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
08/04/2026	*08:45 – 16:50*	Sorcha Burns	Eileen O'Toole Laura Byrne Elaine Farrelly
09/04/2026	*08:30 – 15:40*	Sorcha Burns	Eileen O'Toole Laura Byrne Elaine Farrelly

Information about this inspection

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

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

The inspection team visited four clinical areas:

- Emergency Department and the Acute Medical Assessment Unit (AMAU)
- Clonmacnoise Ward (33-bedded medical ward)
- Shannon Ward (17-bedded paediatric surgical ward)
- Surge Ward (20-bedded ward for surge capacity within the day hospital).

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

Acknowledgements

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

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

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

During the inspection, staff were seen engaging with patients in a positive, caring and pleasant way. Inspectors observed open spaces in the hospital, with play areas for children and a sensory room furnished with supportive features such as specialised lighting, toys and ear protectors.

Inspectors spoke with a number of patients about their experience of the care received at Midland Regional Hospital Tullamore. Patients who spoke with inspectors praised staff and were complimentary of the service they received. Patients commented that staff were "exceptionally good", "very helpful" and "quick to come help when needed". They also reported that they were kept up to date and received efficient care.

While some patients knew how to make a complaint if needed, others were not aware about the process but said they would feel comfortable speaking with a staff member if they had any concerns.

Overall, patients who spoke with inspectors provided positive feedback regarding the care they received.

Capacity and Capability Dimension

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

The service was found to be compliant with national standard 5.5, substantially compliant with national standards 5.2 and 5.8 and partially compliant with national standard 6.1 assessed under this dimension. Key inspection findings informing judgments on compliance with these four national 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.

Midland Regional Hospital Tullamore had established corporate and clinical governance arrangements to support the delivery of safe, effective and quality healthcare services. The general manager was the accountable officer with overall responsibility for the governance of healthcare services in the hospital. This post had been filled on a permanent basis since the last inspection in 2024. Since the previous HIQA inspection, a number of changes had occurred at HSE level to align with the new HSE Health Regions configuration. The hospital's general manager reported to the regional executive officer (REO) via an integrated healthcare area (IHA) manager. Monthly reports were provided to the IHA manager outlining key performance metrics pertaining to finance, workforce, quality and safety risks, scheduled and unscheduled care access and hospital activity levels. Hospital management reported that regular engagement took place with regional representatives focused on human resources and finance.

The hospital had a clear organisational structure, with defined roles, responsibilities and reporting arrangements at local level that were understood by staff who spoke with inspectors and were consistent with the organisational charts provided. However, although reporting relationships at regional level were clear and well described to inspectors, organograms reviewed did not fully capture the new health regions configuration. In addition, the hospital's organogram pertaining to committee structure needed updating to accurately reflect all oversight committees within the hospital. This was rectified by senior management during the inspection.

The hospital had two clinical directors (CD) who provided clinical oversight and leadership, one for the medical directorate and one for the peri-operative directorate. At the time of the previous inspection, the peri-operative CD role was vacant and had since been filled. Both CDs reported operationally to the hospital's general manager and clinically to the regional clinical director. The permanent director of nursing (DON) post was filled on an interim basis at the time of the inspection. The interim DON was responsible for the organisation and management of nursing services at the hospital, reported to the general manager and had a professional link with the regional director of nursing and midwifery.

The general manager was supported by the senior management team (SMT) who oversaw the strategic and operational activities of the hospital, and membership was multidisciplinary. The SMT meetings were chaired by the general manager and met weekly, in line with its terms of reference. Meeting minutes submitted to HIQA indicated that a report was discussed from each area and key issues were addressed, though actions were not always clearly defined or time bound. In

addition, the general manager, director of nursing and head of operations did a one-in-three on call rota providing oversight of the hospital out-of-hours. The sustainability of this arrangement should be reviewed.

As per HIQA's previous inspection, the Clinical Governance Committee (CGC) had overall responsibility and accountability for the clinical governance and quality of healthcare services delivered at the hospital. The committee was chaired by the medical clinical director, included multidisciplinary representation and met monthly. While minutes demonstrated a structured agenda and were action-focused with responsibilities assigned, timelines were not consistently documented. To support integrated oversight, 12 sub-committees reported into, and provided an annual achievement report to the CGC. These sub-committees included the Drugs and Therapeutics, Infection Prevention and Control, Deteriorating Patient and Transitions of Care Committee.

The Infection Prevention and Control Committee (IPCC) was responsible for the development and oversight of the hospital's infection, prevention and control (IPC) program. The committee was chaired by the general manager, met quarterly in line with the terms of reference and membership was multidisciplinary and included a consultant microbiologist. Meetings were action orientated with actions assigned to individuals, however these actions were not always time bound. There were a number of sub-committees that reported into IPCC including the Decontamination Committee, Outbreak Control Team and the Hospital Hygiene Action Committee. From evidence provided during this inspection, the hospital had effective oversight and governance arrangements in place for the hospital's IPC programme.

The Drugs and Therapeutics Committee (DTC) oversaw the clinical governance of medication use and medicines management within the hospital. The committee met quarterly and was chaired by a consultant. The hospital had recently established an AMS Committee, which operated as a subcommittee of the DTC. Inspectors were informed that the Medication Safety Committee, referenced during the previous inspection, had since been subsumed into the DTC. The terms of reference provided were outdated and required revision to reflect this change. Inspectors also noted that not all actions in DTC minutes were time-bound or assigned to a named person.

A positive development since HIQA's 2024 inspection was the establishment of a Transitions of Care (TOC) Committee. The committee met quarterly, was chaired by the patient safety manager and had both clinical and non-clinical representation. Minutes received demonstrated a strong focus on quality, relating to aspects of transitions of care within the hospital including a review of relevant incidents, complaints and audits. The committee actions were tracked, but timelines for completion were not always clearly documented.

The hospital had arrangements in place to support patient flow and discharge planning. Oversight of hospital activity was demonstrated through a monthly performance report on unscheduled and scheduled care, which was sent to the integrated health area manager. Inspectors observed a daily situation report, sent to the senior management team and to management within the emergency department which gave an oversight of daily admissions, discharges, delayed transfers of care (DTOC) and emergency department activity over the previous 24-hour period. Weekly length of stay meetings were held and the hospital's discharge coordinator held a telephone discussion twice per week with the region's community based general manager which provided an opportunity to escalate and discuss complex discharges.

The Deteriorating Patient Governance Group (DPGG) was responsible for developing, implementing and overseeing the hospital's deteriorating patient structures, processes and standards. The committee was co-chaired by the hospital's clinical lead for Irish National Early Warning System (INEWS)[§§] and sepsis. Minutes received indicated the DPGG met quarterly, in line with the terms of reference and that meetings were action orientated with actions assigned to individuals; however these actions were not always time-bound.

Similar to findings from the previous inspection, senior management reported that there was no formalised access to a paediatric consultant and no appointed clinical lead for paediatric surgery or paediatric anaesthesiology which had the potential to impact on the safety and quality of care provided to paediatric patients cared for at the hospital. This was identified by senior management as a risk, recorded on the corporate risk register and had been escalated to the integrated health manager. The absence of designated clinical leadership should be considered by the hospital in the context of the quality and safety of the paediatric service.

The hospital had defined lines of responsibility and accountability for medical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the on-call consultant in emergency medicine who was supported by non-consultant hospital doctors. A consultant in emergency medicine was the clinical lead for the emergency department. The clinical nurse manager, grade 3 (CNM3) reported to the acute-floor assistant director of nursing, who in turn reported to the director of nursing. The Emergency Department Governance Committee had responsibility for reviewing and improving the flow and experience of patients in the emergency department. The committee met quarterly, was chaired by the emergency

[§§] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

department clinical lead and had good multidisciplinary attendance.

Overall, inspectors found that services within the hospital had integrated corporate and clinical governance arrangements in place to support the quality and safety of healthcare services provided. It was noted that progress had been made since the last inspection, with the filling of senior management team vacancies and the development of a transitions of care committee. However, the formalisation of paediatric clinical leadership had not changed and should be considered in line with best practice. There was also some opportunity to strengthen assurance mechanisms including updating of certain organograms and terms of reference to accurately reflect regional reporting relationships.

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 hospital had effective management arrangements in place to support and promote the delivery of safe and reliable healthcare services.

An annual programme was developed by the infection prevention and control (IPC) team which set out the priorities and subsequent actions required. Inspectors reviewed the annual IPC report for 2025, which detailed the hospital's performance in relation to the monitoring of surveillance, compliance with IPC key performance indicators, achievements and quality improvement projects. This report was submitted to the IPC Committee. The hospital also had an antimicrobial stewardship (AMS) programme based on AMRIC*** AMS guidelines. The hospital had access to antimicrobial expertise through a 0.8 whole-time equivalent (WTE) AMS pharmacist and two consultant microbiologists available 24/7, one whom was on site during working hours and the second on call outside of working hours.

The hospital's pharmacy service was led by the pharmacy executive manager. Inspectors were informed that vacancies within the service had impacted the hospital's capacity to deliver a comprehensive clinical pharmacy service across all areas. Clinical pharmacy services were prioritised to larger wards. This is discussed further under national standard 6.1. A hospital Medication Safety Committee Strategy for 2023–2027 was in place and set out a five-year plan to improve

*** AMRIC stands for Antimicrobial Resistance and Infection Control Programme. It is a program run by the Health Service Executive (HSE), Health Protection Surveillance Centre (HPSC), and other Irish health organisations to combat antimicrobial resistance and promote effective infection prevention and control in healthcare settings.

medication safety. However, as the Medication Safety Committee was now part of the Drugs and Therapeutics Committee, inspectors were informed that the hospital was in the process of developing an updated medication safety strategy. Medication safety data was presented at the Drugs and Therapeutics Committee and an annual performance report was sent to the Clinical Governance Committee. The annual report reviewed by inspectors included analysis of medication incident data and trends.

Oversight of the recognition, escalation and management of the deteriorating patient was delivered through the Deteriorating Patient Governance Group (DPGG). Inspectors reviewed the 2025 annual report which gave a summary of the committee's activities and actions for the year. The National Early Warning System (INEWS), Emergency Early Warning System (EMEWS)[†††] and Paediatric Early Warning System (PEWS)[‡‡‡] were in place to support early identification and response to the deteriorating patient. At the time of HIQA's previous inspection EMEWS and PEWS were partially implemented. This has since progressed and both systems were fully established. However, while a designated clinical lead was in place for INEWS and EMEWS and a nurse lead for PEWS, there was no designated clinical lead for PEWS, which was not aligned with best practice.

The hospital provided services to both adult and paediatric patients. While children may present to and could be managed within the emergency department, an in-patient paediatric service was provided to a defined and limited cohort of surgical patients. The hospital had a dedicated paediatric surgical ward, where paediatrics were segregated from adult patients, and all patients on this ward were cared for by a designated paediatric nurse. A child safeguarding statement displayed on the wall within this area.

An existing paediatric surgical admission policy, which was out of date, referenced the American Society of Anaesthesiologists (ASA) Physical Status Classification System and stated that only ASA I (healthy patients) and ASA II (patients with mild systemic disease) were accepted. It also outlined minimum age thresholds for procedures: three years for orthopaedic and general surgery, and two years for ear nose and throat (ENT) procedures. Inspectors were informed that, in practice, additional factors such as patient weight and clinical complexity were also considered. Medical paediatric patients who presented to the emergency department and required admission were stabilised and transferred either to a hospital closer to their home with paediatric services or, if critically unwell to a children's hospital. This process was not clearly formalised leading to decision making on a case-by-case

[†††] Emergency Medicine Early Warning System (EMEWS) is recommended for adults patients (16 years and older) attending emergency departments to support the recognition of, and appropriate response to, the deteriorating patient.

[‡‡‡] PEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in children

basis in the emergency department. A working group had been established and a paediatric admission policy was in development, which was intended to standardise decision making in relation to both medical and surgical paediatric admissions.

There were established management arrangements in place to monitor hospital activity and address factors impacting healthcare service demand and the safe and effective transitions of care. These arrangements were working well on the day of inspection. A number of formalised daily and weekly meetings were in place including an operational meeting held three times per day to assess hospital capacity, scheduled and unscheduled care activity. Each ward also had a designated weekly time slot allocated for a discharge planning meeting, facilitated by the discharge coordinator. A structured review of all patients on the ward was undertaken to identify barriers to discharge and to determine actions required to facilitate a timely and appropriate discharge.

The hospital had established escalation plans in place for both the emergency department and wider hospital, which were reviewed by inspectors and had a series of clearly defined incremental steps, designed to support effective patient flow and capacity management. As part of the hospital's escalation plan, surge capacity could be utilised within the Acute Medical Assessment Unit (AMAU), paediatric ward and the day hospital. On the day of inspection, there were no admitted patients in the emergency department which was a positive finding. However, as the hospital was operating at level 2 escalation, 18 additional beds were in use on the surge ward within the day hospital. Inspectors observed that while overall oversight was provided by an assistant director of nursing and nursing administration, this area was otherwise staffed by agency and overtime, including an agency clinical nurse manager, which was identified as a risk on the corporate risk register. Senior management advised that this approach was a risk-based decision, balancing the risk against the alternative of admitted patients remaining in the emergency department.

Similar to findings of HIQA's previous inspection in 2024, the hospital was performing well in relation to unscheduled care key performance indicators. Emergency department attendances for April year-to-date were 12,020 and the hospital's admission conversion rate was 23.6%, which was below the national average of 25.3%. The overall average duration of time a non-admitted patient spent in the hospital's emergency department April year-to-date was 4.9 hours and 9.1 hours for admitted patients, both of which were again below the national average. In addition, there were no 24-hour Patient Experience Time (PET) breaches, which was another positive finding. Following the previous inspection, the compliance plan submitted by the hospital to HIQA included the development of an offsite minor injuries unit. Inspectors were informed this had not yet opened but was

progressing, with recruitment underway.

Hospital management monitored the average length of stay (LOS) and delayed transfers of care. On the day of inspection, the hospital's average LOS for inpatient discharges was 5.6 days. The LOS for surgical emergency patients was 6.33 days, and for surgical elective patients (excluding day cases) was 6.06 days, all of which were marginally above national targets. In contrast, the medical LOS was 6.65 days, which was below the national target of seven days. There were 11 patients experiencing a delayed transfer of care. The hospital had access to a range of convalescence, rehabilitation and residential beds in stepdown facilities and hospital management had contracted additional capacity in private facilities, to maximise flow of patients through the hospital. A 15 bed acute virtual ward had also recently been established to support early discharge, enabling patients to receive care, monitoring and treatment in their home rather than in hospital. 10 of 15 beds were operational on the day of inspection.

In summary, the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services. Efforts to standardise paediatric admission care pathways were underway and should be progressed. Inspectors found that sustained improvements had been made since the previous inspection, including the full implementation of PEWS and EMEWS and progression of initiatives aimed at improving emergency department patient experience times and hospital length of stay.

Judgment: Compliant

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

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Data was collected on a range of different clinical measurements related to the quality and safety of healthcare services. This information was reported nationally and provided the senior management team (SMT) with assurances regarding the quality and safety of the healthcare provided in the hospital.

Inspectors reviewed the hospital's Quality and Patient Safety strategy for 2026. The strategy set out key actions and associated metrics across risk management, incident management, clinical audit and patient advocacy. The hospital's had an annual Quality and Patient Safety report for 2025. This report detailed actions assigned to designated members of the quality team which were categorised by

priority and included status updates and details of any additional resources required to support completion.

Since the previous inspection in 2024, improvements were evident in the structures and processes in place for the management of risk, including the implementation of the *HSE's Enterprise Risk Management Policy*. Clinical nurse managers were responsible for the identification and management of risks within their respective clinical areas. This included implementing corrective actions and escalating high-rated risks through directorate structures, with further escalation to the SMT via the Quality and Patient Safety (QPS) team where required. Local risk registers were in place across the ward areas visited but not for the surge ward, despite the risks associated with the utilisation of surge capacity. The pharmacy, infection prevention and control and patient flow teams also maintained separate risk registers.

The general manager had oversight of the hospital's corporate risk register, which was reviewed on a quarterly basis by the SMT. While all risks on the register were up to date at the time of inspection, a number of associated control measures were overdue for review or completion. Additionally, inspectors found that the residual risk rating assigned to some risks required review. For example, a risk relating to a lack of pharmacy out-of-hours recorded on the corporate risk register had a residual risk rating recorded as red, but inspectors were informed that this was no longer considered a high rated risk.

Risks that could not be managed at corporate level were reviewed by the SMT and subsequently escalated by the general manager to the integrated health area manager. Inspectors were given examples of a number of risks that had been escalated in the reporting year.

Incident management processes were established and patient-safety incidents were reported and recorded using a paper-based system. Forms submitted from clinical areas were reviewed by the clinical risk manager with oversight from the QPS manager and entered electronically on to the National Incident Management System (NIMS).[§§§] The QPS department prepared and disseminated reports for clinical areas which included the analysis and trending of incidents. The hospital's Serious Incident Management Team (SIMT) were responsible for ensuring that all serious incidents were managed in line with the HSE's Incident Management Framework. In addition to scheduled monthly meetings, the SIMT was convened as required.

The hospital had an agreed audit plan, developed in January 2026, which was

[§§§] 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).

structured by the QPS department. The plan included nursing metrics and audit and monitoring activity across the four key areas of harm, including infection prevention and control, medication safety, the deteriorating patient and transitions of care. Inspectors were informed that local audit findings were reported through relevant committees and escalated to the Clinical Governance Committee as required. Inspectors reviewed examples where audit results had not met expected standards, and found that quality improvement plans had been developed and implemented in response to some but not all of the audits. In addition, similar to findings of the previous inspection, a limited number of medication audits were carried out aside from monthly nursing metrics which captured some aspects of medication safety. No Identify, Situation, Background, Assessment, Recommendation Read-Back Risk Tool (ISBAR3)**** audits were being conducted at the time of inspection.

Inspectors were provided with the hospital's Consumer Legal Affairs Department Strategy for 2026 which outlined oversight arrangements for complaints and compliments. Patient complaints and feedback were reported through the Clinical Governance Committee (CGC) with a quarterly consumer affairs report presented. Findings from national surveys were also reported through the CGC, including the HSE Staff Survey, published in July 2025, and the National Inpatient Experience Survey (NIES) published in December 2024, following the last inspection.

Overall, the hospital had systematic and functional monitoring arrangements in place to identify and act on opportunities to improve the quality, safety and reliability of healthcare services. Since the previous inspection, the hospital had implemented the *HSE Enterprise Risk Management Policy* and developed an annual audit plan, which supported a more structured approach to oversight and quality improvement. Notwithstanding these developments, there was some opportunity to improve the regular updating of the corporate risk register.

Judgment: Substantially Compliant

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

Hospital management had systems in place to plan, organise and manage the workforce to support the delivery of high quality, safe healthcare. Monthly human resources (HR) performance reports were submitted by HR to the hospital's general manager, the integrated health manager (IHA) manager and the regional director

**** A communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

for people. Workforce planning was also a standing agenda item at monthly HR and finance meetings with the IHA manager. The HR department at the hospital comprised of a HR manager and five administrative staff and at the time of inspection three of these posts were vacant.

In April 2026, the hospital's whole-time equivalent (WTE) staffing compliment was 1399.62, with 279.83 WTE vacancies across permanent and temporary posts. Senior management advised that the permanent vacancies included 38.6 WTE in nursing, 15.4 WTE healthcare assistants, 20.53 WTE health and social care professionals, 12 consultants, one WTE non-consultant hospital doctor and 17 WTE posts within management and administration. At the time of inspection, 217 of the 279.83 vacant posts were reported to be at various stages of the recruitment process. Despite this, the hospital's corporate risk register included a number of high-rated workforce-related risks arising from unfilled positions. Actions were implemented to mitigate potential risks arising from staffing shortfalls, but hospital management reported challenges in delays associated with the recruitment process and in the context of national workforce strategies.

At the time of the previous inspection in 2024 there were nine vacant permanent consultant posts across the hospital. At the time of this inspection, while there were 12 WTE permanent consultant vacancies, all posts had approval for permanent recruitment and 10 of these posts were being covered on a locum or temporary basis. In addition, two consultant radiology posts had been filled since the previous inspection. Hospital management outlined that while all permanent consultants were registered on the relevant specialist division of the Irish Medical Council (IMC) register, some of the temporary and locum consultants were not, but a structured process was in place to ensure oversight and compliance with HSE requirements.

At the time of inspection, there was one senior house officer (SHO) rostered overnight to cover three surgical specialties: ear, nose and throat (ENT), general surgery and orthopaedics. This was a high-rated workforce-related risk on the corporate risk register with a risk of delays in reviewing patients and in admitting surgical, orthopaedic and ear, nose and throat (ENT) patients through the emergency department. A business case had been submitted to the IHA manager seeking approval for additional SHO posts to enable two SHOs to be rostered at night.

The hospital's absenteeism rate remained high and had not improved since the previous inspection. At the time of this inspection, absenteeism across all staff grades was 8.71%, which was over twice the HSE's target absenteeism rate of ≤4%. Inspectors were informed that return-to-work interviews were undertaken by clinical nurse managers at ward level and exit interviews were completed when staff resigned. Senior management highlighted challenges with access to occupational

health services, which were managed regionally. HR had introduced a number of initiatives to improve attendance management, including attendance management training for managers and staff. Additional staff engagement initiatives included a monthly staff coffee morning and participation in the Nursing Nightingale Award Programme to recognise outstanding contributions to patient care.

Similar to the findings of the previous inspection, the hospital remained reliant on agency staff. At the time of this inspection, senior management reported that agency usage exceeded 200 WTE across all staff grades. To reduce this reliance the agency conversion initiative was underway to recruit regular agency staff into permanent or fixed-term contracts. At the time of inspection, 94 WTE posts were identified as eligible under this initiative with 37 WTE posts approved in principle and recruitment processes underway.

Medical staffing levels in the emergency department supported the delivery of 24/7 emergency care. The department had eight WTE emergency medicine consultants, including a clinical lead, all of whom participated in the on-call rota. The on-call consultant was on site Monday to Friday from 11am to 9pm and on Saturdays from 10am to 5pm. Outside of these hours a consultant was on call from home. A minimum of eight non-consultant hospital doctors were rostered over each 24-hour period and started at staggered times to support medical cover within the emergency department.

Hospital management identified temporary nursing vacancies in the emergency department as an area of concern. At the time of inspection, the department had a 22% nursing vacancy rate, with many of the vacancies in temporary posts, which management reported were difficult to fill. Staff informed inspectors that shortfalls were managed through redeployment from other clinical areas, overtime and agency staffing. While rosters reviewed showed minimal deficits against planned staffing levels, inspectors noted that three to four shifts per day were routinely filled by agency staff. Staff reported that this could negatively affect skill mix, particularly where agency staff had limited or no emergency department experience. On the day of inspection, one nursing shift was unfilled, resulting in no nurse being assigned to undertake post-triage EMEWS assessments for patients in the waiting room. At the time of the previous inspection, there had been shortfalls in healthcare assistants in post in the emergency department, which affected the department's ability to roster a HCA on night duty. At the time of this inspection, this issue had been addressed, with all HCA posts filled and HCAs were rostered on both day and night duty.

Safer nursing staffing levels in line with the *Framework for Safe Nurse Staffing and Skill Mix* were in place across the hospital. Staffing levels were generally maintained across ward areas visited with minimal deficits identified on rosters reviewed. However, on the surge ward it was noted that all staff including the clinical nurse

manager (CNM) were agency staff with no regular staff rostered on the day of inspection. Management reported that efforts were made to assign regular agency staff to provide continuity and that there were plans to recruit permanent nurse management for the ward. While inspectors were informed that agency staff were required to present their "passport" confirming mandatory training compliance there was no formal ward-specific orientation or induction for staff unfamiliar with the area. CNM cover for this clinical area was Monday to Friday only, with no weekend cover.

The infection prevention and control (IPC) team comprised one WTE assistant director of nursing, one full-time and one part-time CNM2 and one newly appointed WTE staff nurse, providing approximately two WTE staff Monday to Friday. The team was supported by two surveillance scientists and two consultant microbiologists.

Hospital management reported that pharmacy staffing had improved since the previous inspection and posts included a pharmacy executive manager, a chief II pharmacist for aseptics and an advanced specialist medication safety pharmacist. However, key vacancies remained including two chief pharmacist posts. Due to these deficits, a dedicated clinical pharmacy service was provided to the larger 30-bed wards but not smaller wards. At the time of inspection, a comprehensive clinical pharmacy service was available on Clonmacnoise Ward but not in the emergency department, Shannon Ward or the Surge Ward.

Inspectors found that improvements had been made since the previous inspection with the introduction of a shared hospital-wide database for maintaining mandatory training records. This was updated by managers and overseen by the quality and patient safety department. Monthly reports were generated and presented to the Clinical Governance Committee. While this had improved oversight, training records reviewed by inspectors demonstrated poor uptake of mandatory and essential training across disciplines. For example:

- hand hygiene compliance was 72% for nurses and HCAs, 55% for non-consultant hospital doctors (NCHDs) and 20% for support staff which included housekeeping
- infection prevention and control training compliance among nurses ranged from 30% (standard based precautions) to 60% (transmission based precautions), among HCAs ranged from 15% (standard based precautions and donning and doffing) to 27% (outbreak management), while no compliance was recorded for NCHDs
- medication safety training compliance among nurses was 43%

- Basic Life Support (BLS) compliance was 56% for nurses and 64% for NCHDs
- INEWS training compliance was 78% for nurses and 81% for NCHDs.

PEWS training was monitored in areas caring for paediatric patients including the emergency department, theatre and Shannon Ward. While compliance was commendable on Shannon Ward with 94% of nurses trained, the compliance in the emergency department was only 58% and in theatre was 59%. EMEWS training compliance was 79% for emergency department nurses. NCHD compliance was not monitored for PEWS or EMEWS training which represented a gap in oversight. Senior management also reported challenges in delivering PEWS training due to the absence of online training and a lack of dedicated resources to facilitate the in-house programme for both NCHDs and nursing staff. Compliance with sepsis training was notably better, with 80% of nurses and 86% of doctors trained.

Overall, there were some positive developments since the previous HIQA inspection, with progress in filling consultant and some pharmacy posts, and the agency conversion initiative for nursing and health care assistant staff had commenced. However, considerable staffing level deficits remained when comparing approved levels to actual staff employed across key healthcare professions. While significant staffing level deficits were not observed in the clinical areas inspected, there were high absenteeism rates and high reliance on agency staff. There was now a system in place for maintaining mandatory and essential training records but overall there was poor uptake of mandatory and essential training across disciplines and this should be addressed.

Judgment: Partially Compliant

Quality and Safety Dimension

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

Midland Regional Hospital Tullamore was found to be compliant with national standard 1.8 and substantially compliant with national standards 1.6, 2.7, 3.1 and 3.3. Key inspection findings informing judgments on compliance with the five national standards are described in the following sections.

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

Inspectors found that staff adopted a person-centred approach to care, treating patients with respect while upholding their dignity, privacy and autonomy. Similar to findings of the previous inspection, staff interactions with patients were observed to be kind and respectful. Patients who spoke to inspectors described staff as "fantastic", "compassionate", and "can't fault them".

Patients' privacy and dignity were generally well supported across clinical areas visited. In the emergency department, there were no patients were accommodated on trolleys in corridors on day one of the inspection. In the cubicles where patients were being treated, inspectors noted that curtains were drawn when providing care. Dedicated waiting areas for adult and paediatric patients were in place with patient information screens to provide general advice and patient information available. Dementia-friendly bays with orientation clocks and supportive signage were also observed.

The layout of inpatient areas comprised a mix of single and multi-occupancy rooms. Patients on both Clonmacnoise and the surge ward were observed to be accommodated in mixed-gender bays. This practice was supported by individual risk assessments and patient consent was obtained prior to transfer. On Shannon Ward, gender allocated rooms for paediatric patients were in place and prioritisation of single rooms for older adolescents supported privacy needs. Facilities were also available to enable parents to stay with their children.

The surge ward was accessed via the endoscopy unit. This created a thoroughfare for staff, patients and visitors, which could compromise the privacy and dignity of patients attending the unit. Similarly, patients in the endoscopy unit requiring bowel preparation had to use a toilet on the surge ward, with no dedicated space available within the endoscopy unit itself.

Patients' autonomy and independence were supported, with patients reporting that they were kept informed about their plan of care and were involved in decision-making. Call bells were observed to be accessible at bedsides, and patient information leaflets were readily available.

Inspectors observed designated spaces that enhanced person centred care throughout the hospital. The hospital had three special care suites prioristised for patients requiring end-of-life care. One such suite on Clonmacnoise Ward was observed to be spacious and well-equipped, including a designated kitchenette, sitting area, and ensuite facilities. On Shannon Ward, two play areas were available

for children, comprising both an indoor and an outdoor playroom, each stocked with toys. Within the emergency department, a dedicated sensory room was provided. This space was bright, spacious and equipped with sensory supports such as lighting features, toys and ear protectors.

In 2025, the Healthcare Assistant for Activities role was introduced as a quality improvement initiative to enhance person-centred care and promote engagement among patients with a prolonged hospital stay. An audit of patients who participated demonstrated positive feedback from patients.

For the most part, patient confidentiality was maintained during the inspection. Healthcare records were appropriately stored in locked trolleys, and personal information was handled securely in the clinical areas visited. In two clinical areas visited, the privacy covers on patient whiteboards were open with patient information visible from public corridors. This was brought to the attention of staff and was rectified immediately.

Overall, staff promoted a person-centred approach to care, however, the layout and co-location of the surge ward and endoscopy unit did not always support patient's dignity and privacy.

Judgment: Substantially Compliant

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

The hospital had effective processes in place to respond to feedback and complaints received from patients and or their families. Since the previous inspection, the hospital had strengthened its complaints management structures. Key posts were now filled including the consumer and legal affairs manager post and the patient advisory liaison service (PALS) officer. The consumer and legal affairs manager, who reported to the quality and patient safety manager was the hospital's designated complaints officer. Oversight of complaints management, including monitoring of response times, was provided through the hospital's Clinical Governance Committee (CGC).

Complaints were managed in line with the *HSE's Your Service Your Say Policy*. Information on how to make a complaint was displayed in the clinical areas visited by inspectors. Feedback boxes were also observed in these areas. Information on accessing independent advocacy services was displayed throughout the hospital. The majority of patients who spoke with inspectors were not aware of the

complaints procedure but stated they would speak with a nurse if they had a complaint to make. Staff aimed to resolve complaints at the point-of-care. Inspectors were informed that verbal complaints were documented in patients' healthcare records. Verbal complaints received through the complaints department were also recorded on a complaints log. Complaints that could not be resolved locally were escalated to the consumer and legal affairs manager.

As part of the compliance plan submitted following the last inspection, the hospital had committed to implementing a documented process for managing complaints. Inspectors found that this process was in place at the time of this inspection. Each department received a complaints and compliments report quarterly, which included the status of complaints and any associated recommendations. Inspectors were also informed that learning from complaints was disseminated through directorate structures to staff in clinical areas. There was evidence of quality improvement initiatives implemented as a result of complaints and feedback received. For example, a photography and videography policy was introduced along with posters which were on display in clinical areas visited.

The hospital demonstrated good compliance with national key performance indicators for complaints management which represented an improvement since the previous inspection. In 2025, the hospital received 241 complaints, of which 96% were acknowledged within the required five working days, exceeding the national target of 90%. At the time of inspection in April 2026, the hospital had received 61 complaints year to date, of which 93% were acknowledged within five working days. Similarly, significant improvement had been made in the timely closure of complaints. At the time of inspection in April 2026, 91% of complaints were resolved within the national target of 75%.

Senior management informed inspectors that all non-consultant hospital doctors received complaints management training as part of corporate induction. Complaints management training had also been provided to clerical staff working on wards across the hospital. While no formal complaints management training was in place for nursing staff, inspectors were informed that nurses were encouraged to complete relevant online training.

Overall, the hospital had effective processes in place to respond promptly, openly and effectively to complaints and concerns. Inspectors found that improvements had been made since the previous inspection, including improved performance against national targets, the stabilisation of staffing within the complaints department and the implementation of a more structured process to action learning and recommendations arising from complaints.

Judgment: 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 visited four clinical areas: the emergency department, Clonmacnoise Ward, Shannon Ward and the surge ward. Overall, inspectors found that the physical environment was generally clean, well maintained, secure and supported the delivery of safe care.

Adequate physical spacing was observed between beds in multi-occupancy rooms on Clonmacnoise and Shannon wards. However, on the surge ward, two beds were observed to be non-compliant with national guidance, with less than one metre of space between beds. Adequate toilet and shower facilities were available for patients on Clonmacnoise and Shannon wards, with all bays and rooms having ensuite facilities. In contrast, within the emergency department, while there were three shower facilities, two were located in ensuite rooms, leaving only one shower in the main department for patient use. Similarly, on the surge ward, none of the three eight-bedded bays had ensuite facilities and patients had access to only one bathroom located on the main corridor which was inadequate for the number of patients on the ward at that time.

Inspectors were informed that the Infection Prevention and Control (IPC) team conducted daily rounds and supported the prioritisation of patients requiring isolation. Where no single rooms were available, the hospital had implemented a formalised process using the HSE prioritisation matrix to support the appropriate placement of patients requiring transmission-based precautions.

Challenges relating to storage capacity, identified during the previous inspection, remained evident. Inspectors observed a large number of trolleys and beds stored in an open area in the ground floor entrance which had not been identified as a health and safety risk. In the emergency department, it was noted that corridors were untidy with storage of unused equipment and empty trolleys. In addition, storage arrangements were poorly organised in places, with unclaimed patient property stored in the linen press and boxes observed on the floor of a store room despite adequate shelving space being available. These issues were brought to the attention of staff on the first day of inspection and were addressed. Similarly, on Clonmacnoise Ward, boxes were stored on the floor of an otherwise tidy store room which did not support effective cleaning.

On the day of inspection, for the most part, inspectors observed appropriate implementation of isolation precautions, including clear signage and closed doors. In all clinical areas visited, wall-mounted alcohol-based hand sanitiser dispensers were

strategically located and readily accessible to staff and visitors. Hand-hygiene signage was clearly displayed. While hand-hygiene sinks on Shannon Ward met the required specifications[††††], not all sinks observed in the other clinical areas visited met the necessary requirements. Inspectors were informed that there was a plan to upgrade sinks across the hospital, with 12 sinks already upgraded. However, the hospital's immediate infrastructural priority was the implementation of a structured flooring replacement programme due to damaged flooring being identified as a high-rated risk on the corporate risk register. Some high-priority areas, including theatre, had already been completed, with further upgrades planned in line with available funding.

The clinical nurse managers (CNMs) who spoke with inspectors reported that maintenance requests were responded to promptly by the facilities department. They were also satisfied with the level of cleaning resources in place. Cleaning staff were directly employed by the hospital, with dedicated cleaners assigned to each clinical area. Cleaning schedules were maintained and monitored by the cleaning supervisor. Inspectors reviewed a cleaner's store, which contained appropriate cleaning equipment and securely stored chemicals. All clinical areas were cleaned daily and patient rooms were terminal cleaned following discharge. On the wards visited, cleaning services were provided from 7.15am to 6pm, with an on-call service available overnight. In the emergency department, cleaning staff were available on site 24/7. In some clinical areas, cleaning staff were employed as multi-task attendants (MTAs) and undertook cleaning, catering and portering duties. Inspectors were assured that that there was a clear process in place to minimise cross-contamination risks.

Patient equipment was cleaned by nursing staff or healthcare assistants. For the most part, equipment inspected was visibly clean and was labelled with green "I am clean" tags following decontamination. However, on Clonmacnoise Ward, two of the three commodes inspected were visibly soiled. In addition, on Shannon Ward, one playroom was cluttered with a large number of toys. Both of these issues were brought to the attention of staff and rectified during the inspection. Curtains were clean and within the hospital's three-month replacement timeframe, in line with policy. Appropriate segregation and storage of linen, waste and hazardous materials were observed in all areas visited. Environmental hygiene audits were completed monthly by MTAs and reviewed by the CNM.

In summary, inspectors found that the physical environment supported the delivery

[††††] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

of high-quality, safe and reliable care. However, there was insufficient bed spacing and bathroom facilities on the surge ward, some storage issues were identified and not all hand hygiene sinks conformed to the required standards.

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

Overall, inspectors found that the hospital had established arrangements to identify, evaluate and manage immediate and potential risks to patients.

Risks relating to infection prevention and control (IPC) were managed through a local IPC risk register with oversight from an assistant director of nursing. Risks were discussed at weekly IPC team meetings and escalated to the hospital risk register, in consultation with the hospital's risk manager, where required. A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks. A sample of outbreaks reports were viewed by inspectors which indicated that the management of infection outbreaks was in line with national guidance.

In line with national guidance and based on a risk assessment, patients were screened for multidrug resistant organisms (MDROs) on admission to the hospital. In addition, there was an appropriate process in place for the re-screening of high-risk patients. The hospital's information patient management system alerted staff to patients who had previously been admitted and had a confirmed MDRO. Inspectors were informed of an increase in hospital-acquired *Clostridioides difficile* (C.difficile) infection rates since 2024. At the time of inspection, the year-to-date rate was 2.3 cases, which remained marginally above the national target of 2.0 cases. As part of a quality improvement initiative to improve compliance, the IPC team had recently introduced monthly commode cleanliness audits across all inpatient wards. Audit results demonstrated sustained improvement over time. Inspectors were also shown a standard operating procedure (SOP) for the use of ultraviolet (UV) technology, which had recently been introduced to evaluate the effectiveness of environmental cleaning.

Pharmacy maintained their own risk register, overseen by the pharmacy executive manager which was reviewed quarterly. High-rated risks were escalated to the general manager as required. Inspectors identified a risk in relation to the monitoring of fridges in clinical areas. Senior management informed inspectors that a tendering process was underway to procure a new provider for remote monitoring and that there was currently no remote monitoring or oversight in place. The new system was expected to be in place by quarter three of 2026. A risk assessment

completed in March 2026 was reviewed by inspectors. As part of the interim control measures, staff in clinical areas were required to report any fridge temperature deviations to clinical engineering. However, inspectors found that manual fridge temperature checks were only being completed in some of the clinical areas inspected.

Risk-reduction strategies were observed for high-risk medicines, including posters for and segregation of Sound-Alike-Look-Alike Drugs and use of red "high alert" stickers. Up-to-date medicines information was available in clinical areas through a hospital-specific mobile application accessible to staff. Medicines in all clinical areas inspected were generally stored securely in designated medication rooms. However, in the emergency department, one storeroom containing additional stock of high-risk intravenous fluids was found with the door held open. In addition, the treatment room on the surge ward was also noted to be unlocked. Both issues were brought to the immediate attention of staff and were rectified during the inspection.

As part of the hospital's compliance plan developed following the previous inspection, medication reconciliation[‡‡‡‡] was to be standardised by 2025. At the time of inspection, a proforma document was being developed to support a standardised approach, however, this had not yet been implemented. Similar to previous inspection findings, pharmacy-led medication reconciliation was not undertaken for all patients. Instead, reconciliation was prioritised for specific patient groups, including all intensive care unit and coronary care unit patients, newly admitted patients and patients awaiting discharge. Inspectors noted that paediatric patients were not routinely included in this risk-based approach.

The hospital had systems in place to recognise, respond to and manage the deteriorating patient. The Irish National Early Warning System (INEWS), Emergency Medicine Early Warning System (EMEWS) and Paediatric Early Warning System (PEWS) were implemented. A digital early warning system was in place in one of the clinical areas visited. On review of healthcare records, inspectors also noted the completion of the new national sepsis forms, where appropriate.

The hospital operated an emergency response team comprising the medical registrar and senior house officer on call, an anaesthesiologist and the resuscitation officer during working hours or a representative from nursing administration outside of working hours. The team responded to internal rapid response calls using a tiered response system, with different bleeps for a deteriorating patient which was defined as an INEWS score greater than seven, and for cardiac arrest calls. Senior management confirmed that all team members were trained in advanced cardiac life

[‡‡‡‡] Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

support (ACLS).

Inspectors found that adult emergency trolleys were appropriately stocked and checked in all clinical areas inspected. However, on the surge ward, which was located within the day hospital and staffed by agency staff, oversight was provided by staff from the adjacent endoscopy unit. As the endoscopy unit was closed at weekends, daily emergency trolley checks were not completed. This represented a gap in monitoring arrangements and was not in line with hospital policy. In addition, while the paediatric emergency trolley on Shannon Ward was appropriately stocked and checked, inspectors noted that within the emergency department, a number of items in the paediatric emergency trolley had been identified as out-of-date but had not been removed for use or replaced. This was rectified on the day of inspection.

Inspectors were informed that the Identify, Situation, Background, Assessment, Recommendation Read-Back Risk Tool (ISBAR3) communication tool was used for escalation of care, however, there was no documented evidence of its use for escalation of care from the sample of patient records reviewed. There was evidence of the use of ISBAR3 stickers for transitions of care and handover between departments.

In the emergency department, the local risk register was overseen by the emergency department clinical nurse manager 3, the acute-floor assistant director of nursing and the clinical director, and was reviewed quarterly. At the previous inspection, delays in radiology reporting for emergency department patients had been identified as a risk. At the time of this inspection, no issues were identified in relation to radiology access for the patients cared for in the emergency department. Inspectors were informed that radiology turnaround times and issues with access were subject to ongoing monitoring, and a plan was in place to address delays where required.

Patients presenting to the emergency department were triaged and prioritised in line with the Manchester Triage System. On the day of inspection, there were 31 patients registered at 11.00am. The average waiting times were as follows:

- Registration to triage ranged from 0 to 18 minutes, with only one patient not meeting the national 'time to triage' key performance indicator (KPI).
- Triage to medical assessment ranged from 12 to 35 minutes, with an average of 19.5 minutes.
- Medical assessment to decision to admit ranged from 15 minutes to 1 hour and 15 minutes, with an average of 43.3 minutes.

Inspectors reviewed triage audits conducted quarterly. Where periods of reduced compliance with national targets were identified, improvement actions were

implemented. For example, from January to March 2026, audits found that triage times increased to between 20 and 24 minutes between 12.00pm and 3.00pm, with KPI compliance reducing to 40%–48%. In response, a quality improvement initiative was introduced, including a midday surge triage model operating between 10.00am and 4.00pm which included the allocation of a dedicated flow nurse to prevent delays caused by lack of trolley space, the establishment of a rapid assessment bay when all triage rooms were occupied, and cover arrangements for triage nurses' lunch breaks to maintain staffing levels of two nurses.

The hospital demonstrated good compliance with the HSE's key performance indicators for patient experience times. On the day of inspection, only one patient had been in the emergency department for more than six hours from registration and one patient had been in the department for more than nine hours. There were no patients aged over 75 years waiting more than six or nine hours, representing an improvement since the previous inspection. Similarly, there were no patients in the department for more than 24 hours and no admitted patients awaiting an inpatient bed.

The emergency department had a number of patient pathways in place to streamline patients' journeys through the department and improve patient flow. These pathways included; acute stroke, cardiac chest pain, new-onset atrial fibrillation, deep vein thrombosis and pulmonary embolism, non-invasive ventilation and severe shoulder pain. In addition, a number of initiatives were in place and were operational at the time of inspection to provide alternatives to the main emergency department, facilitate early discharge and avoid unnecessary admissions. These included:

- The acute medical assessment unit (AMAU), which operated from 8am-6pm Monday-Friday and had a clear referral criteria. The unit had a planned capacity of 12 patients and accepted patients directly after triage.
- The virtual hospital ward, established in October 2025, with capacity for 15 patients and operating 24/7 to facilitate early discharge or avoid admission to an inpatient bed for medical patients.
- The rapid access frailty team (RAFT), which included a consultant geriatrician review of all frail patients aged over 75 years presenting to the emergency department with the aim of facilitating early discharge or providing an alternative to admission.

Staff had access to a range of policies, procedures, protocols and guidelines (PPPGs) which were available on an electronic system. However, inspectors observed that some policies were in draft form or required updating. Since the previous inspection, a PPPG committee had been established to review all hospital policies to ensure they

were in the correct format, had a clearly defined scope and had appropriate multidisciplinary review prior to approval by the senior management team or the appropriate committee. Quarterly reports were issued to departments as a reminder of PPPGs requiring review.

Overall, the hospital had arrangements in place to protect patients from the risk of harm. There were some issues identified; there was no system in place at the time of inspection to monitor medication fridge temperatures, ISBAR3 tool was not consistently applied for escalation of care and not all emergency trolleys were checked as per hospital policy. Nonetheless, inspectors noted that senior management had taken actions to address findings identified on the previous inspection. The hospital was performing well in relation to HSE patient experience times and had a number of effective emergency department and hospital wide pathways in place to improve patient flow and patient experience times.

Judgment: Substantially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. The hospital used the *HSE Incident Management Framework* to guide and support the management of patient-safety incidents and serious reportable events (SREs). Patient-safety incidents were reported on the national incident management system (NIMS). At the time of inspection, there was a dual reporting system within the hospital, manual on paper and through the electronic point of entry. Staff who spoke with inspectors demonstrated awareness of how to report incidents.

A total of 4,570 incidents were reported in 2025, including medication-related incidents. Systems were in place for the tracking and trending of patient-safety incidents. Analysis of incidents were provided in quarterly reports sent by the quality and patient safety (QPS) department to all clinical areas. Learning from incidents were shared at ward meetings and huddles, and staff described learning from incidents shared with them.

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious patient-safety incidents and SREs. The hospital was compliant with national targets for reporting incidents to NIMS. Of the reviews carried out during 2025, 67% were completed within the national 125-day timeframe. SIMT maintained oversight of recommendations arising from reviews.

Senior management informed inspectors that all incidents presented at SIMT were reviewed to determine whether they met the criteria for notifiable incidents under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. This was supported by hospital policy which outlined statutory notification requirements to HIQA. However, discussion with staff and documentation reviewed indicated that there was scope to strengthen the oversight arrangements in relation to the identification and reporting of notifiable incidents.

Infection prevention and control (IPC) related incidents were monitored by the IPC team, with themes discussed at IPC committee meetings. IPC related incidents included suspected healthcare-associated infections, non-adherence to IPC processes and environmental risks. For example, issues relating to unclean commodes had been identified and resulted in the introduction of targeted audits (as discussed in national standard 3.1. In addition, a HSE review tool was used for severe healthcare-associated infections, including *Clostridioides difficile* (CDIFF) infection requiring intensive care or colectomy, hospital-acquired *Staphylococcus aureus bloodstream infection* (SABSI), and other healthcare associated infections as appropriate.

Medication incidents were categorised in line with the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) framework. The number of medication incidents was tracked year on year. Incidents were reviewed by the medication safety pharmacist, with trends discussed at the Drugs and Therapeutics Committee. In addition, a monthly QPS report, reviewed by inspectors, was submitted to the integrated health area manager and included medication safety data.

The Transitions of Care (TOC) Committee had oversight of incidents relating to clinical handover, hospital transfers and communication failures. Inspectors were informed that relevant incident trend and data reports were reviewed at committee meetings. A sample of minutes reviewed demonstrated discussion of audits undertaken and quality improve initiatives implemented in response to identified findings.

Incidents relating to the deteriorating patient were reviewed by the QPS team and escalated to the Deteriorating Patient Governance Committee. Inspectors were provided with an example of a quality improvement initiative arising from incident trending. An audit conducted in 2025 found that escalation parameters were not consistently applied and that the nurse deferral option was underutilised. In response, targeted education initiatives were implemented.

An external radiology look-back review had been undertaken by the hospital prior to HIQA's previous inspection in 2024. Of six recommendations arising from the review,

five had been implemented and closed, with one remaining in progress. Hospital management should continue to progress the outstanding recommendation to completion, in line with the agreed compliance plan.

Overall, there were systems in place to effectively identify, manage, respond to and report on patient-safety incidents. However, the hospital should strengthen oversight arrangements to support the timely identification and reporting of notifiable incidents, in line with legislative requirements. In addition, outstanding actions from the radiology look-back review should be fully implemented within agreed timeframes.

Judgment: Substantially Compliant

Conclusion

The two day announced inspection of Midland Regional Hospital Tullamore was carried out to assess compliance with the *National Standards for Better Safer Healthcare.* The inspection focused on four key areas of harm – infection, prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital was judged to be compliant with two national standards (5.5 and 1.8), substantially compliant with six national standards (5.2, 5.8, 1.6, 2.7, 3.1 and 3.3) and partially complaint with one national standard (6.1) assessed.

Capacity and Capability

Overall, the hospital demonstrated established governance, management and workforce arrangements to support the delivery of safe and effective healthcare services. Inspectors found a clear organisational structure with defined roles, responsibilities and reporting arrangements. Management arrangements were in place to oversee care across the four key areas of harm: infection prevention and control, medication safety, the deteriorating patient, and transitions of care.

Progress has been made since the previous inspection, including the filling of senior management team vacancies and the establishment of a transitions of care committee. Improvements were also noted in clinical areas, including the full implementation of PEWS and EMEWS. The hospital was performing well in relation to unscheduled care key performance indicators and inspectors noted that the emergency department had systems in place to support effective patient flow and timely access to care.

Monitoring systems, including risk registers and performance oversight processes, were in place and the hospital had implemented the *HSE Enterprise Risk*

Management Policy. However, a review of risk controls and ratings on the corporate risk register should be undertaken. From a paediatric perspective, formalisation of clinical leadership arrangements should also be progressed in line with best practice.

While improvements in workforce stability were evident, including progress in recruitment and agency conversion initiatives, challenges remained with high levels of vacancies, absenteeism and reliance on agency staff. Compliance with mandatory and essential training across all staff groups required focus.

Quality and Safety

The physical environment was clean, secure and generally well maintained, and infrastructural and environmental risks relating to hand hygiene sinks and damaged flooring were recorded with plans in place to address them. However, bed spacing and the availability of bathroom facilities on the surge ward should be reviewed to ensure alignment with national guidance.

Inspectors found that the hospital had established arrangements to identify, evaluate and manage immediate and potential risks to patients. A number of effective emergency department and hospital-wide pathways were in place to improve patient flow and patient experience including the development of a new virtual ward. Notwithstanding these strengths, some opportunities for improvement were identified in relation to the deteriorating patient including ensuring that emergency trolleys in all areas are checked as per hospital policy. Similarly, while staff were familiar with Identify, Situation, Background, Assessment, Recommendation Read-Back Risk Tool (ISBAR3), its use in the escalation of the deteriorating patient was not consistently applied across all clinical areas. Hospital management should also ensure that a system is in place to monitor all fridges in clinical areas.

There was evidence of learning from patient-safety incidents shared. However, actions are required to strengthen established processes to identify statutory notifications.

Inspectors found areas of good practice in relation to person-centred care and complaints management. Staff were observed to treat patients with dignity, respect and compassion and patient feedback was positive. Effective systems were in place to manage complaints and gather patient feedback with sustained improvements made since the previous inspection.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for Midland Regional Hospital Tullamore

Inspection ID: NS_0200

Date of inspection: 8 and 9 April 2026

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

The Hospital is committed to strengthening workforce planning and management to achieve the service objectives for high quality, safe and reliable healthcare.

1. Recruitment:
Strategic monitoring of workforce across the organisation by the General Manager, Senior Management Team and through Heads of Service.
Daily and weekly focus on recruitment by HR dept. and ADON workforce planner.
MRHT HR and SMT to prioritise hospital recruitment in line with clinical risk (weekly)
MRHT HR and SMT to review the requirement for and request bespoke campaigns for specialist areas where deemed clinically relevant (ongoing as specific risks arise).
MRHT HR manager will ensure all relevant documentation submitted through the local, IHA and RMCG pay bill process in a timely manner/ in line with deadlines and all submissions tracked on HR tracker and a HR Platform.
MRHT HR has requested weekly updates from Regional Recruitment to ensure recruitment is progressing through the relevant stages.

2. Reducing absenteeism:
(A) Assign responsibility for absence management to Directorate Leads, Heads of Service and Line Managers, as appropriately identified. Continue to promote and encourage engagement with virtual HSeLanD training webinars and managing attendance programmes for managers and staff. Identify Managers who have not attended previously facilitated on-site refresher training workshops and ensure attendance at the next available onsite workshop. Assign responsibility for maintaining records of attendance and completion of all training to strengthen awareness of respective responsibilities under the HSE's Managing Attendance Policy
Persons responsible: General Manager /HR Manager/Directorate Leads/Heads of Service
By Sept 30th 2026

(B)Through communication and support, reinforce management responsibility for attendance at local level. Ensure return to work interviews are completed for all absences, monitor certification compliance, review long term absences (greater than four weeks), initiate follow up actions as required, promote available staff wellbeing supports (Employee Assistance Programme, Occupational Health etc.).
Persons responsible: Directorate Leads/Heads of Service/Line Managers, Ongoing
(C) Implement and ensure that managing attendance compliance and level of absenteeism rates, compared with National Target of 4%, is a standing agenda item at all Heads of Service and Departmental meetings. This will provide ongoing oversight and reinforce expectations regarding workforce management practices.
Persons responsible: Heads of Service / Departmental Managers, Immediate and ongoing
(D) Spot-check audits (6 monthly) to be completed by senior management in areas of high absenteeism to ensure compliance with the managing attendance policy. Escalate high absence areas for targeted review by the Senior Hospital Management Team. HR Manager, to commence July 2026.

3. Monitoring compliance with training
Action 1: The senior management team will agree an action plan to address compliance with mandatory training to be completed by 14/07/2026. This plan will include a review of mandatory training by each head of service to ensure that mandatory training will be based on National and International Guidelines including HSE, AMRIC, American Heart Association/ Irish Heart Foundation, Health and Safety Authority. This will be completed by 30th Sept 2026.
Action 2: The head of each service will then need to provide a list of compliance with the agreed training to the Quality and Patient Safety Dept. every quarter. This list will be shared with the Directorate or relevant senior manager/ line manager for action.
Action 3: Areas of poor compliance will be examined by a relevant member of the senior management team and an action plan for that area will be put in place. E.g., for nursing, the Director of Nursing.

Timescale: Timescales for each action included above