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:	Tipperary University Hospital
Healthcare service/Organisation ID:	OSV-0001094
Address of healthcare service:	Western Road Clonmel, Co. Tipperary E91 VY40
Type of inspection:	Unannounced
Date(s) of inspection:	7 and 8 May 2025
Inspection ID:	NS_0147

About the healthcare service

Model of hospital and profile

Tipperary University Hospital is a model 3* public acute hospital. It is managed by the HSE Dublin and South-East† health region. Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- intensive and critical care
- paediatric care
- maternity, obstetrics and gynaecology care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	256 inpatient beds 14 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.

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

† HSE Dublin and South-East health region provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

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

During the inspection, inspectors:

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

About the inspection report

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

[‡]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.

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)
07/05/2025	08:40 – 17:30hrs	Danielle Bracken	Bairbre Moynihan Geraldine Ryan Laura Byrne Angela Moynihan
08/05/2025	08:45 – 14:50hrs	Danielle Bracken	Bairbre Moynihan Geraldine Ryan Laura Byrne

Information about this inspection

An unannounced two-day inspection of Tipperary University Hospital was conducted 7 and 8 May 2025.

This inspection focused on 11 national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. A description of the national standards assessed on this inspection can be found in Appendix 1.

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 six clinical areas:

- Emergency department (ED)
- Acute Medical Assessment Unit (AMAU)
- Gynaecology ward
- Medical 1 ward
- Slievenamon Unit East
- Paediatric ward.

The inspection team spoke with representatives of the hospital's executive management team (EMT), representatives from committees relating to the four key areas of focus, the quality manager, clinical and non-clinical staff, and patients using the services at the hospital.

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

Patients who spoke with inspectors in the emergency department and wards were positive about the care they received in the hospital describing it as "could not be better" and "everything is great". Patients were complimentary of staff, describing them as "really good", "nice", "helpful" and that "staff get to know you".

A number of patients who spoke with inspectors throughout the hospital were aware of their plan of care and were being kept up to date, with a patient telling inspectors that the "doctors explained everything".

One description of the emergency department was that it was "overcrowded". Staff were described as being "run off their feet" by one patient with another commenting that there was "always staff around" and they knew the nurse looking after them by name. Patients that had call bells, told inspectors that staff responded in a timely manner. Inspectors noted that patients on trolleys did not have call bells, although the general feedback from patients was that staff were "visible" and responded quickly. On the morning of the inspection there were eight patients on trolleys across corridors A and B in the emergency department. Inspectors observed that twelve patients were also placed on trolleys in ward areas to alleviate pressure on the emergency department.

Capacity and Capability Dimension

This section describes the themes and national 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.

Two national standards (5.8, 6.1) assessed on the inspection was found to be substantially compliant, with two national standards (5.2, 5.5) partially compliant. 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.

The governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, in relation to the four areas of focus and patient care were not providing the necessary oversight for hospital management to be assured about the quality and safety of care. Gaps in oversight in relation to the deteriorating patient and medication safety were identified in the emergency department, Slievenamon Unit East and Medical 1 ward. Gaps in oversight in relation to patient care were identified in Medical 1.

HIQA identified a number of concerns on inspection relating to the day-to-day governance and management. Immediately following this inspection, inspectors sent a high-risk letter to the interim hospital manager seeking assurance on the governance, management and oversight of:

- patient care in Medical 1 ward
- the deteriorating patient
- medication safety.

Hospital management submitted a response to HIQA, which detailed the governance, management and oversight arrangements, nursing assessments, metrics and audits completed, training, and staffing in relation to the three high risks detailed above. In addition, a time-bound quality improvement plan was included. Subsequently, HIQA sought additional information specifically in relation to:

- nutrition and hydration
- care plans
- patient toileting
- oral hygiene
- continence management.

Hospital management in their response to HIQA provided details of immediate actions taken in relation to the issues raised by HIQA.

The interim hospital manager was the accountable officer at the time of inspection with overall responsibility and accountability for the governance of the hospital, supported by the executive management team (EMT), and they were responsible for overseeing the quality and safety of the healthcare services provided. The interim hospital manager reported to the integrated healthcare area (IHA) manager for Carlow, Kilkenny and Tipperary South, and upwards to the regional executive officer

(REO) of HSE Dublin and South-East health region. These arrangements were outlined in the organisational chart reviewed by inspectors.

The clinical director and director of nursing (DON) were members of the EMT. The EMT and the quality risk patient safety governance group (QRPSGG), were assigned with the responsibility for ensuring the quality and safety of healthcare services at the hospital.

The EMT, chaired by the hospital manager, comprised of senior managers, had a standing agenda, and met every month in line with the terms of reference. Inspectors reviewed EMT minutes from January, February and March 2025. A number of departmental reports were given at each meeting. This included a clinical director report, a director of nursing report, and a quality and patient safety report. There was no evidence in the minutes reviewed of a surgical department report or radiology department report with representatives not present at these meetings. Although an action log was available for use at EMT meetings, there was one action in three months. Inspectors were told by the quality manager, that quality and patient safety walk arounds were completed in 2024 but had ceased in 2025 due to insufficient staffing levels to support this. This impacted on senior management's capacity to take a proactive approach to identifying risks and issues that inspectors identified on inspection.

The multidisciplinary QRPSGG, chaired by a consultant, met monthly in line with the terms of reference and reported to the EMT, providing a written report at each meeting. Inspectors reviewed meeting minutes from February, March and April 2025, and agenda items each month included risk, patient-safety incidents, patient experience and infection prevention and control. Audit findings were discussed at meetings. There was no evidence of oversight or discussion in QRPSGG minutes, or in QRPSGG reports submitted to EMT of performance in relation to nursing care metrics. The drugs and therapeutics committee and transitions of care and deteriorating patient group reported into the QRPSGG. Medication safety and the deteriorating patient were not standing agenda items at committee meetings, although there was some evidence of discussion in relation to these. For example, audits in relation to deteriorating patients such as sepsis audits were discussed. Discussion of medication safety related issues was noted in the 'any other business section' of meeting minutes. The QRPSGG was action-orientated, with a number of actions arising each month, although these were not always time-bound. This was a finding on a previous inspection of the service in August 2023.

The infection prevention and control committee was meeting quarterly in line with the terms of reference, chaired by the general manager, with a set agenda. The committee had oversight in relation to rates of infection acquired in the hospital, outbreaks of infection and antimicrobial stewardship. The separate hygiene

governance committee was scheduled to meet monthly according to the terms of reference. The committee had met in February, March and May of 2025, no meeting took place in April due to the quorum not being met. This committee had oversight in relation to support services staffing, issues with level of cleaning and environmental audit results. Both committees reported to the QRPSGG. Minutes of meetings of both committees reviewed by inspectors showed that they were action-orientated with assigned actions arising at each meeting, and followed up from meeting to meeting.

The drugs and therapeutics committee, which was co-chaired by two hospital consultants, was meeting four times a year in line with the terms of reference. The committee had oversight in relation to the medication safety programme which included reported patient-safety incidents, audit activity, pharmacy staffing, and staff education in relation to medication safety. In line with the terms of reference, the committee received antimicrobial stewardship updates twice a year, having last received an update in October 2024. The committee followed up on assigned actions from meeting to meeting.

The deteriorating patient and transition of care group, chaired by a consultant, aimed to meet quarterly as per the terms of reference. The committee had met in December 2024. One meeting, as scheduled, was held in 2025 which took place following the inspection on 15 May 2025. Meeting minutes were requested and provided to HIQA. Agenda items included quality improvements, audits and compliance rates for relevant training.

The unscheduled care group, which was a joint meeting between staff at the hospital and staff in the community, was co-chaired by the hospital manager and the general manager for older persons for Carlow, Kilkenny and Tipperary South. The group had oversight in relation to patient flow activity data, complex discharges and delayed transfers of care. An unscheduled care report was provided weekly at operational management team meetings. The committee had a set agenda, was meeting in line with the terms of reference, and followed up on actions from meeting to meeting.

In summary, while there were governance arrangements for assuring the delivery of high quality, safe and reliable healthcare in the hospital, issues relating to the following were identified:

- deficits in the governance management and oversight of patient care on Medical 1 Ward, the deteriorating patient and medication safety
- nursing care metrics, the deteriorating patient and medication safety were not discussed routinely or were standing agenda items at QRPSGG meetings

- quality and patient safety walk arounds which had previously been implemented were not taking place at the time of inspection.

Judgment: Partially Compliant

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

While management arrangements were in place in the hospital, these were not effectively supporting and promoting the delivery of high quality, safe and reliable healthcare services. Gaps were identified by inspectors in relation to the management of medication safety and or the deteriorating patient in the emergency department, Slievenamon Unit East, Medical 1 Ward, and the Gynaecology Ward, and in relation to patient care in Medical 1 Ward. The findings and hospital management's response have been discussed under national standard 5.2.

Nursing services in the hospital were managed and organised by the director of nursing who was supported in the role by assistant directors of nursing (ADONs). Gynaecology, Paediatric, Medical 1 Wards, and Slievenamon Unit East had clinical nurse managers (CNMs) of different grades who were responsible for the management and oversight of the clinical areas and operationally accountable to an ADON. However, while the nursing management structures were in place, the oversight and management arrangement were not effective, this was evidenced by:

- gaps in patient care in Medical 1 Ward including nutrition and hydration, care plans, patient toileting, oral hygiene, continence management
- lack of oversight of the deteriorating patient, for example, frequency of observations, escalation of care, and documentation that was not in line with national guidance
- lack of oversight of medication safety, specifically in relation to storage, custody and excessive stock levels of medicines in the emergency department, Slievenamon Unit East and Medical 1 Ward.

The hospital provided a clinical pharmacy service,[§§] which was led by the hospital's pharmacist executive manager. A clinical pharmacist-led medication reconciliation*** service was provided on a priority basis with patients on high risk medicines and

[§§] 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 is the process of comparing a patient's medication prescriptions to all of the medications that the patient has been taking. This process aims to avoid medication errors and can be carried out by pharmacists, doctors and nurses.

polypharmacy prioritised. A clinical pharmacist was recently appointed to the emergency department (ED). The provision of dedicated clinical pharmacy services elsewhere in the hospital was impacted by staffing deficits this is discussed further under national standard 6.1. In addition, inspectors identified a lack of oversight and management of medication safety, specifically in relation to storage, custody and excessive stock levels of medicines. A 2025 strategic and operational plan for medication safety which was provided to inspectors, outlined the approach to medication safety in the hospital.

Operational management and oversight of the day-to-day workings of the emergency department was the responsibility of the onsite emergency medicine consultant, and the clinical nurse manager grade three (CNM3). A senior decision-maker was available 24/7. The emergency department catered for both adult and paediatric patients. Paediatric patients were triaged in the emergency department and then streamed to the appropriate pathway. An injury unit was located within the emergency department where patients triaged as suitable for the unit were reviewed. The injury unit was overseen by the emergency medicine consultant on call and had an allocation of one registrar, two senior house officers and two advanced nurse practitioners (ANPs), one of which was a candidate ANP.

The acute medical assessment unit (AMAU), which opened Monday to Friday from 8.30am to 7pm, had inclusion and exclusion criteria. The AMAU was overseen by the dedicated AMAU consultant and had an allocation of one registrar and two senior house officers. Nursing care was overseen by a CNM 2 who reported to the assistant director of nursing (ADON) for patient flow.

Since the previous inspection in August 2023, there had been an uplift in beds, with the opening of the 33-bedded Slievenamon Unit. Despite this uplift, the demand for inpatient beds remained a challenge. On the first day of inspection, the hospital was in 'red escalation' on the hospital's escalation plan due to the number of admitted patients on trolleys in the emergency department and the use of additional trolleys placed on wards to alleviate pressures on the department. A CNM 2 was assigned to oversee the care of patients admitted and awaiting a bed on trolleys in the department. Senior management spoke to inspectors about the challenges of balancing an effective response to overcrowding in the emergency department while maintaining continuity of other services such as the AMAU and theatre operating lists. To optimise this balance a 'surge capacity plan' had been introduced to be used in conjunction with the hospital escalation plan. The surge capacity plan detailed six separate colour-coded stages increasing in the escalation measures implemented to address capacity and demand. At the time of inspection the hospital was in 'amber surge 3' on this plan, and, as already outlined, in 'red escalation' on the hospital escalation plan.

Although both plans did not align in relation to the colour-coding system employed, there was alignment in relation to the measures taken to address overcrowding while maintaining other services in the hospital. On the first day of inspection, these measures included the use of three designated surge beds across two wards, and 12 surge trolleys across seven wards. The AMAU was unaffected and was functioning as normal. A focus on discharges resulted in 36 discharges the previous day with 30 discharges planned on day one of inspection. The discharge lounge was also in use to facilitate timely discharge, with three patients discharged from there on the first day of inspection. Notwithstanding these efforts, the arrangements for patient flow were not fully functioning in managing the mismatch between service demand and hospital capacity. As a result, twenty admitted patients were accommodated on trolleys in the emergency department and in patient ward areas while awaiting an inpatient bed. This is discussed further under national standard 3.1.

The infection prevention and control (IPC) team was led by one whole-time equivalent[†††] (WTE) onsite consultant microbiologist. This was a new post since the inspection on August 2023. Outside of normal working hours, microbiology consultant cover was available through University Hospital Waterford (UHW). Other members of the IPC team included an IPC assistant director of nursing (ADON), two WTE clinical nurse specialists, one WTE clinical nurse manager (CNM) grade 2, 0.8 WTE antimicrobial stewardship pharmacist, and a 0.5 WTE surveillance scientist based in the laboratory in University Hospital Waterford. Since January 2025 up until the week of inspection, the nursing complement on the team had been depleted by 50%. An IPC programme and an IPC work plan for 2025 were provided to inspectors. These outlined the governance, structures, systems, and processes to manage infection prevention and control and the associated work plan to carry out the requirements of the programme. Additionally, an antimicrobial stewardship (AMS) plan for 2025 was provided. IPC and AMS reporting is discussed further under national standard 5.8.

Inspectors identified a lack of oversight and management in the hospital in relation to the cleanliness of the physical environment. Findings included an unclean environment and or lack of documentary evidence that cleaning had been carried out with checklists not in place or not up to date. This will be further discussed under national standard 2.7.

The hospital had clinical leadership at consultant level for the implementation of the early warning systems (EWS) and sepsis guidelines (paediatric and adult) to facilitate the recognition and response to deteriorating patients at the hospital.

[†††] 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.

An assistant director of nursing (ADON) for patient flow in the hospital had oversight of unscheduled and scheduled care activity and led the patient flow team. The team included 2 WTE bed managers and 2 WTE discharge planners.

In summary, while management arrangements were in place for the four areas of focus of this inspection, not all were functioning effectively, with the following identified:

- gaps in relation to the management of medication safety and or the deteriorating patient in the emergency department, Slievenamon Unit East, Medical 1 Ward, and the Gynaecology Ward, in relation to patient care in Medical 1 Ward, and in relation to infection prevention and control and environmental cleanliness
- management arrangements were not successful in alleviating overcrowding in the emergency department at the time of this inspection. This was due to the mismatch between capacity and demand for inpatient beds at the hospital.

Judgment: Partially Compliant

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

Monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services in the hospital were not always identifying areas for improvement.

Information on a range of performance indicators and data related to the quality and safety of healthcare services was published, in line with the HSE's reporting requirements. Performance data was discussed at performance meetings between the hospital and IHA manager Carlow, Kilkenny, Tipperary South. Quality and patient safety was a standing agenda item at this meeting. A quality and patient safety performance report was submitted for review at each performance meeting. This included an overview of patient-safety incidents, complaints, and the top five risks on the hospital risk register. For example, the risk of overcrowding in the emergency department had been raised in April 2025. A separate quality report was submitted to the executive management team (EMT) meetings to ensure effective oversight of the content on a monthly basis. These reports included an overview of patient-safety incidents, audit findings, quality improvement initiatives, and patient experience.

Patient experience was discussed as a standing item at QRPSGG meetings and was presented at each EMT meeting as part of the quality report. This included an

update on national patient experience survey findings and quality improvement plans, and updates on patient service users' group and inclusion group meetings. Complaints data, including the number and type of complaints was included in quality reports for EMT and discussed at each performance meeting with the IHA. The HSE's complaints response timelines of responding to 75% of complaints within 30 working days were not being met. Performance in achieving the target for complaints response timelines was not discussed at EMT or QRPSGG meetings in the sample of minutes of these meetings reviewed by inspectors. Complaints management is discussed further under national standard 1.8.

The hospital risk register was reviewed every two months at meetings of the risk register management group, which was a subgroup of and reported to the QRPSGG, where risk was discussed as a standing agenda item each month. Inspectors reviewed the hospital risk register which had last been updated in April 2025. High-rated risks relating to the four areas of focus of this inspection included the risks associated with infrastructural deficits, hospital-acquired infection, emergency department overcrowding, and deteriorating patients requiring external transfer. Risks had an assigned risk owner, and control measures to reduce the risks were documented.

Patient-safety incidents were discussed at EMT, QRPSGG and performance meetings with the IHA. Evidence was provided that the serious incident management team (SIMT), met when a serious incident occurred. The SIMT last met in March 2025 and prior to that in January 2025, where they had discussed preliminary assessments relating to patient-safety incident reviews. Of note, the terms of reference for SIMT had not yet been updated to reflect new reporting arrangements to the HSE Dublin and South-East health region.

Quarterly IPC progress reports and an annual IPC report were submitted to the infection prevention and control committee. There was a delay in IPC reporting. The most recent quarterly report discussed at the committee was the quarter three 2024 report and this had been discussed in February 2025. The quarterly report provided an overview of hospital-acquired infection rates, outbreaks of infection, IPC audit and education activity. The annual report provided an overview of performance in the aforementioned topics for all of 2024. Quarterly antimicrobial stewardship (AMS) reports, submitted to both the infection prevention and control committee, and the drugs and therapeutics committee outlined information on antimicrobial consumption levels, AMS audit findings, and education on AMS provided to staff.

The drugs and therapeutics committee had an annual audit plan tracker, this was reviewed by inspectors who noted that five planned audits were complete or in progress, with three out of fourteen planned audits overdue, and this was attributed to staffing issues in the documentation provided following inspection. The committee

submitted an annual report to the QRPSGG and this outlined audit activity completed throughout 2024, including medication management audits.

At the time of inspection there were no audits or metrics being carried out in the hospital in relation to care plan development and evaluation, and continence assessment and management. As a result, deficits in relation to these areas were not being actively identified. Audits and metrics are discussed further under national standard 2.8.

Monitoring arrangements did not always identify opportunities to continually improve the quality, safety and reliability of healthcare services, with the following identified:

- evidence of oversight in relation to the achievement of complaints response timelines was not found in minutes of senior governance meetings reviewed, despite HSE targets not being met
- there were no audits or metrics being carried out in the hospital in relation to care plan development and evaluation, and continence assessment and management.

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.

Gaps were identified in the workforce arrangements at the hospital to support and promote the delivery of high-quality, safe and reliable healthcare. Vacancies in the hospital at the time of inspection included an emergency medicine consultant position, pharmacist positions, and deficits in the infection prevention and control team (IPC). Workforce was a standing agenda item for hospital performance meetings with HSE Dublin and South-East.

Vacant pharmacy posts at the time of inspection included, 3 WTE pharmacist posts, and 2.5 WTE pharmacy technician. Vacant posts were compounded by non-replacement of staff on statutory leave. Vacant pharmacist posts were due to recent promotions within the pharmacy department. Assurances were provided by the interim general manager that backfill for these posts had been approved. The impact of vacant pharmacist posts was that a full clinical pharmacy service was not provided, with services such as pharmacist-led medication reconciliation provided on a prioritised basis. Additionally, inspectors identified issues relating to oversight of

medication safety including storage and excessive stock of medicines as discussed under national standard 5.2.

Inspectors were told by the ADON for IPC that up until the week of inspection, the team had been depleted by 50% since January 2025 due to statutory leave. This impacted on the team's ability to provide IPC training, discussed below, and to carry out IPC audits, which is discussed further under national standard 2.8. Additionally, inspectors were told by the interim general manager that there were a number of vacant support staff positions, including cleaner posts and a cleaning supervisor post. Assurances were provided by the interim general manager that interviews to fill these posts had been arranged. The impact of these vacancies included inadequate standards of cleaning and is discussed further under national standard 2.7.

On a previous inspection of the emergency department in August 2023, the hospital had approval for five WTE consultants in emergency medicine, with three positions filled. At the time of this inspection there were 3.6 WTE out of 4.0 WTE emergency medicine consultants with approval for a fifth consultant awaited. The emergency medicine consultants were supported by 19 NCHDs and all of these positions were filled. A senior-decision maker for the emergency department was available either onsite or on call 24/7.

The approved complement of nursing staff including management grades in the emergency department was 69.53 WTEs with 68.62 WTEs posts filled, which represented a deficit of 0.91 WTEs (1%). On the day of inspection, the emergency department had its full complement of nursing staff on duty. The nursing staff complement included two WTE clinical skills facilitators, with both posts filled, advanced nurse practitioners for the injury unit was 3 WTEs with 2 WTEs in post. At the time of inspection, senior management told inspectors that plans were underway to recruit additional ANPs for the emergency department and AMAU.

Ward areas visited were fully staffed on the days of inspection, vacant posts in these areas were minimal, ranging from 0.54 WTE staff nurse on Medical 1 Ward to 1.06 WTE staff nurse in AMAU.

A number of staff induction programmes were available at the hospital and this included induction for nursing staff and NCHDs. The induction timetable for nursing staff was provided to inspectors. A regular medicine education programme for NCHDs was implemented in the hospital, with education timetables provided to inspectors. An inspector observed a simulation suite, located beside the emergency department, contained equipment to provide scenario-based training.

Oversight of mandatory training was the responsibility of local managers. A list of mandatory training was available for nursing staff and NCHDs and this was provided

to inspectors. High training compliance levels were noted for nursing staff in relation to medication safety, basic lifesaving support and Irish National Early Warning System (INEWS) with the exception of INEWS training in the emergency department for nursing which was 77%. Standard and transmission-based precautions and hand hygiene training was provided by face to face training, which had not been provided to the date of inspection in 2025, due to staffing constraints within the IPC team as described earlier in this standard. Compliance training rates with this training for nursing staff in the Gynaecology Ward was 77% and for healthcare assistants in Slievenamon Unit East 57.1%, Medical 1 Ward 71.4%, Gynaecology Ward 55.5%, and AMAU 50%.

In summary, there were gaps in the workforce arrangements in place at the hospital to support and promote the delivery of high-quality, safe and reliable healthcare, with the following identified:

- the IPC team complement had been depleted by 50% since January 2025 up until the week of inspection which impacted on the ability to provide IPC training, and carry out IPC audits
- INEWs training in the emergency department was 77%.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and national 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.

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

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

Inspectors observed that staff respected and promoted the dignity, privacy and autonomy of patients. However, privacy in particular was a challenge to maintain for patients on trolleys in the emergency department and in ward areas. Additionally, confidentiality of patient information was not always maintained.

At 9.30am on the first day of inspection inspectors observed eight patients on corridors in the emergency department, three in corridor A, five on corridor B. Privacy screens were available and inspectors noted these in use. A number of cubicles and rooms were observed to be empty at this time. Inspectors were informed that cubicles were kept free in order to respond to those most in need as the department became busier throughout the day and as a result, patients were placed on trolleys due to limited space in the department, with one adult and one paediatric resuscitation room available. Conversations between patients on trolleys in corridors and staff could potentially be overheard. Management stated, and inspectors observed, that patients undergoing active treatment were reviewed in cubicles and bays which afforded more privacy. However, one instance of a doctor having a conversation with a patient on a trolley was observed. Patients on trolleys in the emergency department who spoke with inspectors did not report a lack of privacy as an issue.

Privacy curtains were used in designated bed spaces throughout the wards visited. Inspectors also observed that there were patients on trolleys in Surgical B Ward, Slievenamon Unit East, and the Gynaecology Ward. Privacy screens were observed in Surgical B Ward and the Gynaecology Ward but not in Slievenamon Unit East. The trolley placement in Surgical B Ward was not ideal as the trolley was in the middle of a six-bedded room, which compromised patient privacy. Although there were privacy screens in place on both sides of the trolley, it was challenging to fully screen the trolley. Additionally, the inspector noted the trolley was underneath a television which was loud, and there was nowhere to store patient belongings.

Privacy and dignity at end of life was promoted in the hospital. Discreet signage was observed on doors (end-of-life symbol). The use of the symbol was explained in the patient and visitor information booklet, encouraging staff, patients and visitors to create an atmosphere of quiet and respect.

Instances of confidentiality of patient information not being maintained were observed by inspectors in a number of clinical areas. Whiteboards were displayed in areas where the public could view information, including patient names and details about their care. Information included details of tests and investigations in the AMAU, and dietary information in Medical 1 and Gynaecology Wards. Patient names

were displayed beside the bedside in Medical 1 Ward and Slievenamon Unit East, with the inclusion of other information such as assistance required with mobility.

Patient information such as nursing notes and assessments were stored in public areas in the corridor in the emergency room, Medical 1 Ward, Paediatric Ward and Slievenamon Unit East. The information was accessible to the other patients and the general public. In other areas such as the Gynaecology and Paediatric Wards, patient healthcare records were stored in unlocked trolleys. These findings were brought to CNMs attention in the relevant clinical areas.

In summary, staff respected and promoted the dignity, privacy and autonomy of patients. Notwithstanding this:

- trolleys in corridors in the emergency department and in ward areas compromised dignity and privacy
- privacy screens for patients accommodated on trolleys in wards were not available or fully effective in all wards
- confidentiality of patient information was not always protected in the clinical areas inspected.

Judgment: Substantially Compliant

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

Staff working in the hospital were committed to promoting a person-centred approach to care. Patients who spoke with inspectors were complimentary of the care provided. Staff were observed by inspectors to be kind and caring towards patients. In Slievenamon Unit East, a healthcare assistant was observed to respond immediately to a call bell. An inspector noted the use of a communication aid to help a patient, the interaction was kind and helpful. Information to aid communication with patients in different languages was available in the Gynaecology Ward.

A library was available for children in the Paediatric Ward. The ward ethos was clearly displayed. Inspectors observed staff speaking kindly to patients and assisting them in the emergency department. A 'keep in touch' poster on how to get in contact with patients while in hospital was displayed in Medical 1 Ward.

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.

Overall, while-systems and processes within the hospital to respond effectively to complaints were in place, complaints response timelines were not being met in line with the national target.

The HSE's complaints process 'Your Service Your Say' was implemented in the hospital. The hospital manager was the designated complaints officer for the hospital. Formal stage 2 complaints were responded to through the office of the operations manager and entered in to the HSE's complaints management system (CMS). The quality manager had oversight in relation to complaints. A complaints recommendations database was used in the hospital. Information from the database reviewed by inspectors showed that actions were assigned but not time bound. Ten out of twelve recommendations were complete with two in progress. Where a review of a complaint was required (stage 3), inspectors were informed that this was carried out by the quality manager. A review of meeting minutes showed that complaints were discussed at executive management team meetings, and at performance meetings with the Dublin South-East health region.

The HSE target for the response to complaints within 30 days is 75%. Documentation received following the inspection indicated that (43%) of complaints in 2025 up until the date of inspection were outside response timeframes and 23% of complaints from 2024 were still open and outside of response timeframes.

Staff in the wards inspected focused on resolving complaints locally, although capture of local complaints was not formalised or consistent between areas. Common complaints themes included waiting times in the emergency department and communication in ward areas. Inspectors were informed by staff in some clinical areas inspected that complaints were communicated at ward meetings.

Patients who spoke with inspectors did not voice complaints. When asked if they knew how to make a complaint the majority said they would talk to staff. A mixture of information on how to make a complaint, patient advocacy information, and information on the patient advocate liaison service (PALS) was noted by inspectors in the areas visited. All of this information was not available consistently across wards, for example, inspectors did not find information on how to make a complaint in Medical 1 Ward or the Gynaecology Ward, although advocacy information was available in the Gynaecology Ward.

In summary, while there were systems in place at the hospital to respond effectively to complaints, the following were identified:

- complaints response timelines in the hospital were not being met in line with the national target
- information on how to make a complaint was not available in all clinical areas inspected.

Judgment: Substantially Compliant

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

The physical environment did not fully support the delivery of high quality, safe, reliable care. All areas visited as part of this inspection had issues with one or more of the following: storage, environmental cleanliness, and infrastructure.

Inspectors observed multiple instances of unclean environments in a number of clinical areas. For example, unclean floors were noted in the emergency department and Paediatric Ward corridors, the injury unit, and toilet floors in the emergency department, the Paediatric Ward, and AMAU. A foul smell was in the toilet in AMAU, inspectors were uncertain when the toilet had last been cleaned as there was no cleaning checklist in place. Inspectors noted black residue at the base of a shower tray in Medical 1 Ward, and stains on the base of a bath in the Paediatric Ward were also found. Inspectors noted dusty equipment stored on the corridor in Medical 1 Ward. Cleaning checklist records were either not in place or were not completed to provide evidence that areas were cleaned. For example, the cleaning records for the injury unit in the emergency department had not been completed since 13 April, the Paediatric Ward had records completed for 5 and 6 May but prior to this the last record was 20 April. These issues were brought to the attention of managers in the relevant areas. In AMAU, dust was found on top of bins and ledges and a sink in the clean utility room. These issues were brought to the attention of the CNM, who told inspectors that there was no assigned cleaner for the unit and that limited cleaning hours were provided in the morning and afternoon. Inspectors were told by the CNM in the injury unit that routine cleaning did not take place in this area, that cleaning had to be requested, and that this had been escalated to hospital management.

Notwithstanding this, a cleaner who spoke with inspectors on Medical 1 Ward was knowledgeable in relation to cleaning processes. In addition to routine cleaning, household staff carried out a deep clean (terminal cleaning) when patients were discharged. The chemical press in the cleaners' store in Medical 1 Ward was unlocked. Similarly, the cleaners' room in Slievenamon Unit East was unlocked with keys in the door of the chemical press, this was rechecked later and the room had been locked.

Clinical staff in a number of areas were uncertain about how often curtains were changed. Cleaning staff in Medical 1 Ward and Slievenamon Unit East informed

inspectors that routine curtain changes took place every three months. This was confirmed in records reviewed.

A tagging system was implemented in the hospital to identify equipment that had been cleaned. Inspectors observed these in use on equipment such as commodes and weighing scales. Inspectors observed some equipment that was not clean or had visible rust. For example, commodes in Slievenamon Unit East and commodes and a shower chair in Medical 1. Inspectors observed a medicines trolley in the emergency department was unclean. In the Gynaecology Ward a glucometer (medical equipment) docking station was noted to be dusty, however, the glucometers were clean.

Hazardous waste and linen were stored appropriately with some exceptions identified. In Slievenamon Unit East, clean linen bags were observed on the floor. Inspectors noted several instances of inappropriate storage of items. This included storage of staff personal belongings, for example, handbags, in the emergency department injury unit and store rooms located on Medical 1 and Gynaecology Wards. The stock presses in AMAU used to store clean linen and non-sterile items was not ideal. The presses were located on the corridor into the dirty utility, staff carrying used commodes and soiled linen had to pass by the presses in order to reach the dirty utility. Medical 1 Ward, chairs were inappropriately stored in a bathroom, IV cannulas and syringes were stored in a store room that was not secure. Additionally, blood vials were overstocked. The storage room in Slievenamon Unit East had cardboard boxes with extra stock stored on the floor. In the Gynaecology Ward non-medicinal items were found in the medicines fridge.

Infrastructural improvements included in the hospital's compliance plan in response to the inspection findings of August 2023 included expansion of the emergency department, refurbishment of the AMAU and opening of Slievenamon Unit. At the time of inspection the expansion of the emergency department was at design stage with an anticipated completion date of early 2027. Refurbishment of the AMAU was complete, and the 33-bedded Slievenamon unit, based in a newly refurbished building had been opened. The main entrance to this unit, opened out to the carpark and was locked, accessible by swipe access with a buzzer system to request entry.

Infrastructural issues in the emergency department included limited space in the department compared to demand, limited availability of toilet and shower facilities, and a lack of audio-visual separation between adult and paediatric patients in the waiting room, main department and injury unit. These were findings on a previous inspection of the service in August 2023. The injury unit within the department was

congested with two bays and two chairs in a tight space. Walls and doors in this area were scuffed.

Doors, walls and skirting boards were scuffed and in need of repair in Medical 1 Ward. At the time of inspection, painting was in progress on the ward. The infrastructure here presented some challenges. Twelve patients in one area were sharing one shower and toilet. In addition, a second toilet on the ward was blocked. Inspectors were told that this had been reported to maintenance, who would attend that day to fix the issue.

The corridor in the Paediatric Ward was a busy thoroughfare, patients and families were observed walking through the ward corridor to access the Paediatric Assessment Unit and the Paediatric Day Ward. This had the potential to present an infection prevention and control risk. Damage to the floor covering, wall paintwork, doorframes and shelving was observed by inspectors in this ward. Two toilets were located off the corridor with one of these out of order. An overgrown and unmaintained enclosed garden space was accessible from the Paediatric Ward through a door that was not securely locked. This was escalated to the CNM.

A number of clinical hand wash sinks within the hospital did not conform to the required standard.[‡‡‡] This included the sink in the side room of an isolation room and in other multi-occupancy rooms in the Gynaecology Ward, the Paediatric Ward, and the clean utility in AMAU. Posters on handwashing technique were clearly displayed at clinical hand wash sinks and alcohol-based hand rub was available. The sink flushing records for Slievenamon Unit East were shown to an inspector who noted gaps. The records, which should have been completed on a daily basis, had been completed 18 times since 24 March 2025 to 7 May 2025.

Facilities to isolate patients with a multidrug-resistant organism (MDRO) varied between inspected areas. Hospital management had access to two negative pressure rooms,[§§§] in the hospital. Medical 1 Ward had four single rooms, one of which did not have an en-suite toilet or shower. The Paediatric Ward had seven single rooms one of which had en-suite facilities, there were an additional five single rooms available in the paediatric assessment unit should these be required for isolation. Slievenamon Unit East had three single rooms all with en-suite facilities. Similarly, the Gynaecology Ward had three single rooms, one of these had an anteroom for donning and doffing of personal protective equipment (PPE).

[‡‡‡] Clinical hand wash basins should conform to Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

[§§§] Negative pressure rooms, also called isolation rooms, are a type of hospital room that keeps patients with infectious illnesses, or patients who are susceptible to infections from others, away from other patients, visitors, and healthcare staff.

Inspectors noted that PPE was readily available and accessible to ward staff in all areas inspected.

There was a total of 11 designated treatment spaces in the emergency department. This consisted of six glass-fronted cubicles, two isolation rooms and three curtained bays. A number of patients were observed on trolleys in the department's corridors that were spaced less than one metre apart, which is not in line with national guidance.[****]

Inspectors visited wards in which additional patients were placed on trolleys to alleviate overcrowding in the emergency department. This included Slievenamon Unit East and the Gynaecology Ward where a fourth patient was placed in a three-bedded room on both wards, and Surgical B Ward where a seventh patient was placed in a six-bedded room. One trolley on Surgical B was placed in the middle of the room as discussed under national standard 1.6. There was emergency equipment available in the ward although no oxygen point or suction was available for additional trolleys. Staff told inspectors and documentation confirmed that there were documented criteria for those suitable for a trolley. Patients had to be mobile and independent patients with non-complex medical issues. Those requiring high flow oxygen were not suitable for placement on a trolley.

In summary, the physical environment did not fully support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care, with the following identified:

- multiples instances of an unclean environment were identified
- a lack of oversight of cleaning checklists which were either not in place or not being kept up-to-date in a number of clinical areas to evidence that cleaning had been carried out
- inappropriate storage of staff personal items in a number of clinical areas
- some equipment was observed as being unclean and or rusty
- not all hand wash sinks were compliant with the required specification in the Gynaecology Ward, the Paediatric Ward, and AMAU
- issues with general wear and tear were found in a Medical 1 Ward and the Paediatric Ward.

Judgment: Partially Compliant

**** Infection Control Guiding Principles for Buildings Acute Hospitals and Community Health and Social Care Settings. Health Service Executive. RESIST. Version 8.2, April 2025.

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

While the hospital had systems and processes to monitor, analyse, evaluate and improve the effectiveness of healthcare, in some instances these were either not in place or were ineffective in identifying issues. For example, medication management audits did not identify gaps that were found by inspectors and re-audit of hand hygiene practice by the infection prevention and control team was not always carried out in a timely manner when targets were not reached.

Nursing and Midwifery Quality Care Metrics were measured on a monthly basis. Inspectors reviewed a sample of metrics and noted that in all cases where the metrics fell below the expected target (90%), a quality improvement plan was developed. However:

- gaps in assessment of and attendance to patient care needs were found by inspectors on Medical 1 Ward. Metrics for Medical 1 Ward from March 2025 identified similar findings to those on inspection. For example, a small number of patients did not have their oral health assessment completed
- as discussed under national standard 5.8, there were no audits or metrics being carried out in the hospital in relation to care plan development and evaluation, and continence assessment and management.

Hand hygiene audits carried out by the infection prevention and control (IPC) team were reviewed by inspectors, with long gaps between audits noted by inspectors when the target of 90% had not been achieved. For example, the Gynaecology Ward had scored 80% in February 2025, a re-audit had not taken place at the time of inspection. No audit results for 2025 were provided for the emergency department or Slievenamon Unit East, as requested on the day of inspection. For clinical areas that had not achieved the target of 90% recommendations were made and these included compliance with the '5 moments' for hand hygiene and for staff to attend mandatory hand hygiene training and individual action plans for each area were developed. As discussed under national standard 6.1, staff deficits in the IPC team from January 2025 were impacting on the ability to carry out audits. Additionally, inspectors were told by the ADON for IPC that audits of hand hygiene facilities and the clean and dirty utility were on hold.

Environmental and equipment hygiene audits were reviewed by inspectors. The physical environment had scored highly in Medical 1 Ward, Paediatric Ward, Slievenamon Unit East and Gynaecology Ward, with 100% achieved in these areas in January 2025. The AMAU (98%, February to May 2025) and emergency department

(96%, March 2025) also scored highly. These audit results did not align with inspectors' findings of the physical environment as outlined in national standard 2.7.

Measurement of medication management, carried out as part of ward assessment process audits was reviewed by inspectors. Issues identified that aligned with inspectors' findings included storage and custody of medicines, stock control, and documentation of patient weights and allergy status. These will be discussed under national standard 3.1. Issues with safe custody of medicines, found in both the adult and paediatric resuscitation rooms in the emergency department had not been identified through audit. Inspectors noted that questions in relation to stock control processes and overstock were not included as part of the audit.

Audits related to recognising and responding to deteriorating patients carried out in the hospital included audits of adherence to the Irish National Early Warning System (INEWS) for adults, Paediatric Early Warning System (PEWS) for children, and sepsis guidelines. Hospital audit findings in relation to INEWS included vital signs not recorded every time, time of escalation not recorded and time for medical review not documented. PEWS audits reviewed showed high levels of compliance, with 100% achieved in March 2025 and 97.8% achieved in April 2025, an area for improvement identified related to correct calculations of early warning score. This is in line with the findings on the days of inspection.

Metric findings from the Gynaecology Ward (scored 83% in February 2025) and Medical 1 Ward (scored 81% in February 2025) identified gaps that aligned with inspectors' findings, and these included:

- the ISBAR communication tool was not being used to escalate care
- no documented evidence of increased monitoring of vital signs in response to deterioration, and
- observations not being carried out at the correct frequency.

Recommendations for improvement included to remind all staff to assess, review, escalate and reassess INEWS observation as per policy.

Audits of practices in relation to adult and paediatric sepsis had been carried out in February 2025 on data from 2024. These audits found that performance in some indicators had improved or had been sustained, such as the taking of blood cultures, antimicrobials given with the correct timeframe, and increased urine and lactate measurements. Sepsis form completion for paediatric patients had improved 60% (up from 33% in 2023). However, sepsis form completion for adults had fallen from 12% completion in 2023, to 0% completion in 2024. Recommendations included promoting the use of the sepsis form, however these were not assigned or time-bound. Inspectors reviewed minutes of the deteriorating patient and transition of care group which took place on 15 May 2025 following the inspection. Findings in

relation to adult and paediatric sepsis audits were discussed at the meeting. Feedback on a quality improvement plan to address the adult sepsis audit findings was sought by the deteriorating patient and transition of care group. It was documented that the paediatric sepsis audit had been signed off by the paediatric governance committee on 12 May 2025.

Quality boards were observed in ward areas and these included information on performance in relation to pressure ulcers and patient falls.

Some systems and processes to monitor, analyse, evaluate and improve the effectiveness of healthcare were in place in the hospital, however, a number of gaps were identified:

- quality improvement plans were developed where metric targets were not achieved, however, some issues persisted, such as compliance with the early warning systems in use to recognise clinical deterioration. This included findings such as frequency of observations, timely escalation of care, and documentation of modified parameters not completed in line with national guidance, which aligned with inspectors' findings
- sepsis form completion was not meeting the target for adult patients, this was identified in 2023 and remained an issue
- findings on medication management audits, which aligned with inspectors' findings, had not been sufficiently addressed as they were reoccurring, and some inspector findings relating to storage and custody of medicines had not been identified through these audits
- findings from environmental audits where clinical areas had achieved high scores did not align with inspectors' findings of levels of cleanliness in those areas
- hand hygiene audits by the infection prevention and control team when the target of 90% had not been achieved were not re-audited in a timely manner to facilitate improvement
- audits did not always have an associated quality improvement plan to implement findings in order to improve the quality and safety of the services provided.

Judgment: Partially Compliant

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

Overall, while the hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services on a day to day

basis, these systems were not fully effective in providing assurances to hospital management on the quality and safety of care, including in relation to medication safety, deteriorating patient and, delivery of care in line with their assessed needs. As discussed under national standard 5.2, following inspection, HIQA engaged with hospital management in relation to these issues.

Patients who spoke with inspectors were positive about their experience of care in Medical 1 Ward, however, inspectors identified that care was not always planned and delivered to these patients in line with their ongoing assessed needs. Medical 1 Ward was an assigned cardiology and general surgical ward. These patients had a higher level of dependency in terms of their individual care needs as evidenced by documentation reviewed by inspectors and conversations with staff. Risks identified on inspection which were discussed with hospital management were included in the correspondence to hospital management following inspection.

Inspectors observed that a range of healthcare professionals were involved in assessing the needs of patients on Medical 1 Ward for example, doctors, nurses and health and social care professionals. A sample of documentation in relation to the patients with higher levels of dependency on Medical 1 Ward was reviewed by inspectors. This included notes in the healthcare records, nursing assessments, care plan documentation, and healthcare assistant care checklists. Inspectors observed that assessments were completed on food records, stool charts, fluid balance charts, and care plans which referenced self-care activities. Inspectors identified that care was not always planned and delivered to meet the patient's initial and ongoing assessed healthcare needs in relation to:

- nutrition and hydration
- care plans
- patient toileting
- oral hygiene
- continence management.

These findings were escalated to hospital management on the morning of day two of inspection and at the feedback meeting at the end of the inspection.

As discussed under national standard 5.2, following the inspection, HIQA sought assurances from hospital management on the governance, management and oversight of patient care in Medical 1 Ward.

Additional specific assurances were sought on how the assessment, treatment and nursing care of patients in Medical 1 Ward was in line with their prioritised needs and delivered in a timely and appropriate way. Findings included:

- nutrition and hydration — incomplete patient intake and output records were noted, patients were not receiving fluids in line with recommendations from a dietitian
- care plans — care plans did not include instructions in relation to a patient's continence management and diet and fluid requirements
- patient toileting — a stool chart was not completed on a daily basis as advised by a dietitian
- oral hygiene — records did not reflect that a patient's oral hygiene was being attended to regularly
- continence management — documentation indicated that a patient's continence needs were not being met at night.

Inspectors were informed that safety huddles took place daily. An inspector attended one of these huddles in the Slievenamon Unit East on day one of inspection at 12.19pm. The huddle was attended by nursing staff and healthcare assistants and topics discussed included recent patient observations, and patient plans, including discharge plans. A safety huddle took place in the emergency department four times a day between the consultant, senior registrar and CNM 3, other staff members were present at two of these huddles (12pm and 4pm). The huddles were documented using a set template, with a completed copy from the 9am huddle for the emergency department on the first day of inspection provided to inspectors. This showed that patients of concern, staffing and skill mix, and delays in care and or services (such as diagnostic scans or laboratory results) were discussed.

A local risk register was in place in the emergency department. The risks associated with overcrowding in the department were documented. Controls to minimise these included a hospital escalation policy and surge plans. A paediatric risk register included the risks associated with medication errors in paediatric patients, controls to minimise the risk included information on weight-based dosing.

Three high-rated risks were on the hospital risk register related to infection prevention and control (IPC), these risks had last been reviewed in March and April 2025. The risks associated with aging infrastructure had documented controls such as building project team meetings between hospital management and HSE estates, and environmental cleanliness audits. To minimise the risk of hospital-acquired infection, controls included an IPC risk assessment on new admissions and the provision of isolation facilities within the hospital. The risk of Carbapenemase Producing *Enterobacterales* (CPE) exposure was a new risk, which was entered on the risk register in December 2024 in response to a CPE outbreak which is discussed further below. Controls to minimise this risk included screening patients for CPE in line with national guidance, carrying out CPE testing on drains and convening CPE outbreak control meetings.

The infection prevention and control (IPC) team carried out surveillance in relation to healthcare associated infection, oversaw the placement of patients requiring transmission-based precautions and oversaw infection outbreaks. Patients were screened for multidrug resistant organisms (MDROs) on admission, this included CPE screening for admitted patients in line with national guidelines. Inspectors were told by the IPC team that patients were screened for CPE on admission, weekly and on discharge in outbreak wards. Screening for Vancomycin-Resistant *Enterococci* (VRE) and Methicillin-Resistant *Staphylococcus Aureus* (MRSA) was in line with national guidance and local IPC risk assessment. Patients symptomatic for influenza and or Covid-19 were also screened, with point of care testing available in the emergency department.

Inspectors were told by staff in the clinical areas inspected, that the IPC team visited daily. Patients requiring transmission-based precautions were isolated as per the advice of the infection prevention and control team. Inspectors observed appropriate signage on doors where patients were isolated. It was noted by inspectors that signage with information on what precautions to use was turned inwards with 'check at nurses station before entering the room' visible. This was in line with local policy.

At the time of inspection there was an active outbreak of norovirus on Medical 3 Ward, resulting in restrictions to visitors. The outbreak report was provided to inspectors following the inspection. This showed that the outbreak was declared on 6 May 2025 and closed on 12 May 2025. The report included actions taken, lessons identified and recommendations. An outbreak of norovirus had occurred the previous month on Medical 2B Ward. The outbreak was declared open on 14 April 2025 and closed on 1 May 2025, with similar recommendations made and this included the correct use of personal protective equipment (PPE). According to the 2024 report on the implementation of the infection prevention and control programme, there had been no norovirus outbreaks in the hospital in 2024. A CPE outbreak had been declared in September 2024 on Medical 5 Ward. A number of measures were taken in response to this outbreak which included environmental testing.

As discussed under national standard 5.5, a limited clinical pharmacy service was provided at the hospital, pharmacy-led medication reconciliation was not undertaken in all clinical areas, and was available on a prioritised basis only in line with the hospital's standard operating procedure for medication reconciliation. Samples of healthcare records reviewed by inspectors confirmed this, with the majority of patient administration and prescribing records reviewed showing no evidence of medication reconciliation or clinical pharmacist review. Additionally, a number of records reviewed had no patient weight recorded and one had no allergy status recorded, these were in line with findings from hospital audits as discussed in national standard 2.8. Information on high risk medicines and the '10 rights of medication administration' was displayed in clinical areas. Information on sound-

alike, look-alike drugs (SALADS) posters were not displayed in clinical areas, although these posters were available. Staff in the emergency department addressed this during the inspection.

The main emergency department had two resuscitation rooms, one adult, one paediatric. On day one of inspection doors to presses containing medicines and syringes in the resuscitation rooms were not securely locked. Due to the location of these rooms, this meant that syringes and medicines could potentially be inappropriately accessed. These issues were raised during the inspection. Inspectors rechecked the rooms on day two of inspection and the issues raised had not been addressed. HIQA sought assurances from hospital management following the inspection. As part of their response, a quality improvement plan was submitted to HIQA by hospital management which included a review of current infrastructure and a review of custody of medicines in the hospital.

An automated dispensing machine in pharmacy allowed for controlled access to medicines outside normal working hours. Inspectors were told that medication stock control was carried out by pharmacy technicians every week. Inspectors identified issues with medication custody and storage and stock control in a number of clinical areas, including the emergency department, Medical 1 Ward and Slievenamon Unit East. The issues related to medicines not being stored securely, overstock of medicines, a lack of stock checking procedures such as no accurate or up to date quantity of stock medication, and full pharmacy return trays that had not been emptied. Additionally, inspectors found pre-diluted potassium of two different strengths stored together in two clinical areas. The bags of potassium looked identical which could lead to the wrong strength being chosen. This had not been identified as a risk by the hospital. These issues were brought to the attention of CNMs and or senior management.

As discussed under national standard 5.2 correspondence was sent to the interim hospital manager requesting assurances in relation to the governance, management and oversight of medication safety in the emergency department, Slievenamon Unit East and Medical 1 Ward. Management outlined the measures taken in their response to the correspondence.

The relevant national early warning systems — Irish National Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS), and Paediatric Early Warning System (PEWS) were implemented in the hospital. These systems were used to facilitate the recognition and response of acutely deteriorating patients. The Emergency Medicine Early Warning System (EMEWS) was not implemented, however, INEWS was used in the emergency department for both admitted and non-admitted patients. Inspectors were told that an Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication sticker was used to

document escalations of care, however, there was no evidence in healthcare records reviewed of this sticker being used. As discussed earlier in the report, from a review of healthcare records, inspectors found instances of non-adherence to local and national guidance in relation to INEWS. Patient observations were not carried out at the required frequency, healthcare records were not updated following medical review, including modified escalation parameters not being documented.

As discussed under national standard 5.2 HIQA engaged with hospital management to seek assurances in relation to the governance, management and oversight of the deteriorating patient.

Daily operational patient flow meetings took place in the hospital to discuss capacity, demand, and the use of surge beds. These included an 8am handover meeting from the night supervisor, followed by a meeting at 8.30am, attended by patient flow staff, the hospital manager and director of nursing. At this meeting the demand for beds, measures implemented in response to overcrowding in the emergency department, and plans for discharge were discussed. Inspectors were informed that the hospital manager gave a status update on capacity and demand to the integrated healthcare area (IHA) manager or representative at 10am each day. Additional meetings were held throughout the day to reassess capacity and demand and these included meetings involving the infection prevention and control team and with senior staff in the emergency department. Staff at ward level were involved in discharge planning and attended multidisciplinary team meetings and delayed transfer of care meetings. Transfer of care from one clinical area to another was verbal.

A number of person-centred initiatives were implemented in the hospital to avoid an unnecessary admission and support safe discharge. These included the Frail Intervention Therapy Team (FITT), and use of the Community Intervention Team (CIT) and Outpatient Parenteral Antimicrobial Therapy (OPAT).

At 11am on the first day of inspection,

- six (33%) of the eighteen patients in the department were admitted and waiting on a bed
- three of these patients were waiting in excess of 24 hours, which is not in line with the HSE target outlined below, these patients were all under 75 years of age.

Data on the emergency department patient experience times (PETs) at 11am showed that the hospital was compliant with five of the HSE's targets, with one target not met:

- 83% of attendees to the emergency department were admitted or discharged within 24 hours of registration (HSE target of 97%).

Waiting times for patients on day one of inspection were as follows:

- registration to triage ranged from 5 to 27 minutes (average 13 minutes, which is within the HSE National Emergency Medicine Programme's target of 15 minutes).

The AMAU saw a mixture of direct referrals from general practitioners (GPs) (up to six patients a day) and patients from the emergency department (approximately 10 patients a day). Patients not referred by a GP were triaged in the emergency department first before being seen. Patients awaiting a CT scan that were stable were not admitted and could return home and come back the following morning for the scan and medical review. The average patient experience time in the acute medical assessment unit (AMAU) on the first day of inspection was 3.25 hours which met the HSE target of six hours.

Staff had access to policies, procedures, protocols and guidelines (PPPGs) on computers in clinical areas. A number of PPPGs were overdue for review or had not been reviewed since 2022. For example, infection prevention and control PPPGs related to equipment decontamination, environmental cleaning and infection outbreak management. Information displayed in clinical areas relating to the deteriorating patient, such as cardiac arrest guidelines, and information in relation to medicines, such as intravenous drug guidelines were not up to date. Copies of prescribing guidelines for adults and paediatric patients, which provide information about prescribing of medicines, were available in clinical areas.

Inspectors identified that patients were not protected from the risk of harm in relation to the four areas of focus on this inspection. As evidenced in this standard, the following was identified:

- gaps were found in relation to nursing assessments, provision of care, and documentation in the following areas: nutrition and hydration, care plans, patient toileting, oral hygiene, and continence management documentation. Furthermore, gaps in documentation in healthcare assistant care checklists were identified
- medicines in a number of clinical areas were not stored securely, there was a lack of stock check systems and overstock of medicines was observed
- instances of non-adherence to INEWS guidelines included observations not being carried out at the required frequency, and medical reviews and modified escalation parameters not being recorded

- a small number of patients were waiting in excess of 24 hours to access an inpatient bed
- PPPGs, including information on display in a number of areas were overdue for review or had not been reviewed in some time.

Judgment: Non-Compliant

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

Systems and processes were in place in the hospital to ensure that patient-safety incidents were identified, managed, reported and responded to effectively. Incidents were entered on to the National Incident Management System (NIMS).[††††] The HSE target for entering patient-safety incidents into NIMS had been consistently achieved in 2024 and year to date 2025. For example, compliance in quarter one 2025 was 99.1%. The hospital was compliant with serious incident reviews being completed within 125 days of notification.

A monthly quality report was submitted for review at meetings of the executive management team where an overview of patient-safety incidents was provided. Incidents were discussed at the quality risk patient safety governance group (QRPSGG). A separate quality and patient safety report was submitted for review at monthly performance meetings with the HSE Dublin and South-East health region. This report provided an overview of the number and severity of incidents per month, and performance in achieving NIMS reporting and incident review completion timelines.

Relevant patient-safety incidents were discussed at the infection prevention and control committee and the drugs and therapeutics committee. There was no evidence of discussion of relevant patient-safety incidents at the deteriorating patient and transition of care group, nor did they feature as part of the committee's agenda.

Staff were knowledgeable in relation to the hospital's incident reporting process and with how to report incidents directly into NIMS. Staff were receiving trended information in relation to patient-safety incidents from the quality and patient-safety department. Inspectors were told by staff that information in relation to patient-safety incidents was discussed at safety huddles.

[††††] 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).

There were systems in place at the hospital to manage patient-safety incidents, with the following identified:

- relevant patient-safety incidents were not being discussed at committee meetings of the deteriorating patient and transition of care group.

Judgment: Substantially Compliant

Conclusion

An unannounced two-day inspection of Tipperary University Hospital was conducted 7 and 8 May 2025.

This inspection focused on 11 national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. Governance and management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services were not fully effective. High risks were identified on this inspection, which included oversight of medication safety, the deteriorating patient and ensuring the assessed needs of patients on Medical 1 Ward were met. Immediately following this inspection, HIQA sent a high-risk letter to the interim hospital manager seeking assurance around the governance, management and oversight of medication safety, the deteriorating patient and patient care in Medical 1 Ward. Hospital management responded with information on governance and oversight arrangements provided, along with a time-bound quality improvement plan to address the findings. HIQA further engaged with hospital management in relation to nutrition and hydration, care plans, patient toileting, oral hygiene, and continence management. Hospital management responded with immediate actions they had taken to address concerns.

The hospital's escalation plan and surge capacity plan had not alleviated overcrowding in the emergency department at the time of this inspection, as a result there was a mismatch in capacity and demand. However, the acute medical assessment unit was unaffected and was functioning as intended. The monitoring arrangements at the hospital were not fully successful in identifying areas for improvement. Minimal gaps were identified in staffing with the exception of vacant pharmacist positions and assurances were provided that the backfill of these posts was approved. Staff deficits in the infection prevention and control team which were impacting on monitoring activity and the ability to provide sufficient oversight of these areas.

Staff working in the hospital were committed to promoting a person-centred approach to care. Patients who spoke with inspectors were positive about the care

they received in the hospital and complimentary of staff. Staff were aware of and generally respected and promoted the dignity, privacy and autonomy of patients. However, privacy in particular was a challenge to maintain for patients on trolleys in the emergency department and in ward areas. Systems and processes within the hospital to respond effectively to patient-safety incidents and complaints were in place, although complaints response timelines were not being met.

The physical environment did not fully support the delivery of high quality, safe, reliable care. Some areas visited as part of this inspection had issues with infrastructure, storage, and environmental cleanliness. Findings from environment audits where clinical areas had achieved high scores did not align with inspectors' findings of levels of cleanliness in those areas. Audits did not always have an associated quality improvement plan in place to implement findings.

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 implementing actions to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	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	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for Tipperary University Hospital

Inspection ID: NS_0147

Date of inspection: 7 and 8 May 2025

Compliance plan provider's response:

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

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

1.

Deficits in Governance Management and oversight of patient care on Medical 1, Deteriorating patient and Medication safety

A. Governance Management

a) Formal Governance

Tipperary University Hospital has a formal governance reporting structure for all disciplines.

Committees:

There is a formal Governance Group Structure and pathway for reporting of each group to Hospital Manager who reports to and can escalate to the Integrated Health Area Manager and Dublin South East Region REO.

Care Management

Each patient in Tipperary University Hospital is admitted under a designated Primary Consultant who oversees their medical care. Safe and effective care is delivered through a multidisciplinary team approach.

Care Plan and Assessments

Nursing Care Management is assessed, evaluated and reassessed via the Tipperary University Hospital "Patient Nursing Notes".

Plan:

(i) Nursing metrics data will be presented monthly at the Quality Risk and Patient Safety Governance Group (QRPSGG) monitoring, ward, scores, sections, issues identified, close out and trending for Governance, outstanding issues will be escalated to Executive Management team, Hospital Manager and are reported at monthly IHA performance meetings.

(ii) External accreditation – TippUH will continue to participate in external accreditation to include:

- NMBI inspections based on NMBI student national quality clinical learning environment audit tool. NMBI accreditation as adaptation site for oversees nursing.

- Irish National Accreditation Board for laboratory accreditation inspected annually for compliance. Medical 1 was the ward selected by INAB on most recent visit and excellent compliance was noted for Haemovigilance care and management of a patient on a blood transfusion was noted.
- RCPI Site Visit 16-19 September 2025.
- HSE National Audit Schedules.

(iii) Risk Register.

- Each clinical area holds their own risk register. These risks are monitored and escalated as required to the hospital Risk Register Committee.

Training on risk awareness is carried out at mandatory training days and induction.

(iv) Formal Governance

- Formal annual review of governance arrangements will be undertaken by Hospital Manager

B. Deteriorating Patient

Plan:

- Training: -Additional specific training sessions provided to staff on Medical 1 by TippUH Practice development team / Sepsis Nurse lead/ Clinical Nurse Specialists. Clinical skills facilitators working with staff at ward level, promote, educate, train and assess competencies of skills. "Lunch and Learn" hosted on wards on a rotational basis to include simulation sessions. – complete.
- Audits: ISBAR Audit of Communication + Clinical Handover + Deterioration are ongoing. Audit of ISBAR handover on Medical 1 to monitor Medical 1 compliance with best practice in line with National Clinical Effective Committee NCG 11 for handover of care - complete.
  ED majors' safety huddle audit ongoing.
  EWS /IMEWS/ PEWS audits escalation and response monthly audits continue feedback to relevant governance group.

Results of all the above audits inclusive of DNACPR audits are presented at Deteriorating Governance Group Committee for appropriate actions plan, recommendations, monitoring and feedback.

C. Medication Safety

Plan:

Medication Management Audit scheduled for Medical 1- 2nd October 2025

Medication safety training compliance overview. At time of compliance plan completion:

- Medical 1: 100% staff have had this training, 96.4% in the last 3 years
- SMU East: 100% staff have had this training, 100% in the last 3 years
- SMU West: 100% staff have had this training, 94.1% in the last 3 years
- Emergency Department: 81.9% staff have had this training, 44.4% completed in the last 3 years

Medication Management Study Day (Staff only required to attend once)

- Medical 1: 100% staff have attended this study day
- SMU East: 100% staff have attended this study day
- SMU West: 100% staff have attended this study day
- Emergency Department: 87% have attended this study day

Additional compliance plan -TippUH will:

(i) Review medication top up list and storage facilities for Med 1, Emergency Department & SMU. Completed and actioned appropriately -Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations - completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & Medical 1 to identify those requiring additional security measures – Review Completed and actioned accordingly 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL – Completed additional alert sent to HPRA & [external company].

(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications. Completed and in place 09/09/2025

(vi) Additional medication management updates continuing scheduled for completion October 2025

(vii) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area – Completed

(viii) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols – Completed and rechecked 09/09/2025

(ix) Secure storage press in adult resus room in ED- Completed

(x) Review of controlled access to Resus Rooms in Emergency Department – approval to proceed granted, currently awaiting date for installation from Technical Services Department.

2.

- Nursing Metrics, deteriorating patient and medication safety will be standing items included on the agenda of the Quality Risk & Patient Safety Governance group. Template for Nursing Metrics include ward, month, score, section, issues actions close out and trending. Terms of reference amended. Approved at QRPSGG meeting 10/09/2025.
  Nursing Metrics, deteriorating patient and medication safety discussed at QRPSGG meeting 10/09/2025, and at relevant governance groups.

3.

- Formal Quality and Patient Senior Management Safety Walkarounds to recommence October 2025.

Timescale (T/S) 1,

A Governance Management

(i) Nursing metrics data will be presented monthly at the Quality Risk and Patient Safety Governance Group (QRPSGG) monitoring, ward, scores, sections, issues identified, close out and trending for Governance, included on agenda for QRPSGG
T/S Complete- included on QRPSGG & TOR approved September 2025

(ii) External accreditation –
T/S Ongoing as identified.

(iii) Risk register. Each clinical area holds their own risk register. Training on risk awareness is carried out at mandatory training days and induction. Training updates provided on clinical areas
T/S Q2 2026.

(iv) Formal annual review of governance arrangements will be undertaken by Hospital manager
T/S January 2026

B Deteriorating Patient

Training: -Additional specific training sessions provided to staff on Medical 1.
T/S Complete July 2025.

Audits: ISBAR audit of Communication + Clinical Handover + Deterioration are ongoing. Audit of ISBAR handover on Medical 1 to monitor Medical 1 compliance with best practice in line with National Clinical Effective Committee NCG 11 for handover of care
T/S Complete May 2025

C Medication Safety

Medication Management audit scheduled for Medical 1
T/S 2nd October 2025

Medication safety training compliance overview.
T/S complete.

Additional Med Safety Compliance plan:

(i) Review medication top up list and storage facilities for Med 1, Emergency department & SMU.
T/S -Complete: Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations –
T/S scheduled completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & medical 1 to identify those requiring additional security measures –
T/S Complete -checked 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL –
T/S Complete additional alert sent to HPRA & [external company].

(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications in place
T/S Complete 09/09/2025

(vi) Additional medication management updates continuing scheduled for completion T/S Scheduled October 2025

(vii) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area – T/S Complete

(viii) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols –
T/S Complete -rechecked 09/09/2025

(ix) Secure storage press in adult resus room in ED-
T/S Complete

(x) Review of controlled access to adult resus in Emergency Department – approval to proceed
T/S awaiting date for installation of same.

2

- Nursing Metrics, deteriorating patient and medication safety standing items included on the agenda of the Quality Risk & Patient Safety Governance group.
  T/S Approved at QRPSGG meeting 10/09/2025. Complete.

3

- Quality and Patient Senior Management safety walkarounds to recommence October 2025
  T/S October 2025

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

Outline how you are going to improve compliance with this national standard.
A (i) *Gaps in relation to management of medication safety or deteriorating patient in ED SMU East Med 1 & Gynae*

Plan:

(a) Training: -Additional specific training sessions provided to staff on SMU East, Med 1, Gynae & ED by TippUH Practice development team / Sepsis Nurse lead/ Clinical Nurse Specialists.

(b) Clinical skills facilitators working with staff at ward level, promote, educate, train and assess competencies of skills. "Lunch and Learn" hosted on wards on a rotational basis with MDT involvement as relevant– complete.

(c) Audits: ISBAR Audit of Communication + Clinical Handover + Deterioration are ongoing. Audit of ISBAR handover on SMU East, Med 1, Gynae & ED to monitor compliance with best practice in line with National Clinical Effective Committee NCG 11 for handover of care - Completed.
ED majors' safety huddle audit May 2025.
EWS /IMEWS/ PEWS audits escalation and response monthly audits continue with feedback to relevant governance groups.

Results of all the above audits inclusive of DNACPR audits are presented at Deteriorating Governance Group Committee for appropriate actions plan, recommendations, monitoring and feedback.

(d) Medication Management audit scheduled for October 2025

Med 1	02/10/2025
ED	09/10/2025
AMAU & Gynae	16/10/2025
SMU East	23/10/2025
Paeds & PAU	30/10/2025

(e) Medication safety training compliance overview. At time of compliance plan completion:

- Medical 1: 100% staff have had this training, 96.4% in the last 3 years
- SMU East: 100% staff have had this training, 100% in the last 3 years
- SMU West: 100% staff have had this training, 94.1% in the last 3 years
- Emergency Department: 81.9% staff have had this training, 44.4% in the last 3 years

Medication Management Study Day (Staff only required to attend once)

- Medical 1: 100% staff have attended this study day
- SMU East: 100% staff have attended this study day
- SMU West: 100% staff have attended this study day
- Emergency Department: 87% have attended this study day

Additional compliance plan -TippUH will:

(i) Review medication top up list and storage facilities for Med 1, Emergency department & SMU. -Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations - completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & medical 1 to identify those requiring additional security measures – checked 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL – complete additional alter sent to HPRA & [external company].
(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications in place 09/09/2025
(vi) Additional medication management updates continuing scheduled for completion October 2025
(vii) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area – complete
(viii) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols – complete rechecked 09/09/2025
(ix) Secure storage presses in adult resus room in ED- complete
(x) Review of controlled access to adult resus in Emergency Department – approval to proceed awaiting date for installation of same.

A (ii) Patient care Medical 1

(a) Nursing metrics data will be presented monthly at the Quality Risk and Patient Safety Governance Group (QRPSGG) monitoring, ward, scores, sections, issues identified, close out and trending for Governance, included on agenda for QRPSGG
T/S Complete- included on QRPSGG & TOR approved September 2025
(b) Oversight of, review and update if required of care plans by CNMs, ADONs, Practice Development.
(c) Additional staff training on safe care protocols & documentation
(d) Noted key challenges include inconsistent documentation. SCA representatives coming onsite 23rd October to highlight importance of (i) documentation, (ii) consent, (ii) deteriorating patient, (iv) Medication Safety, (v) clinical handover
(e) Introduction of " Care checklist for patients under increased level of observation" with accompanying policy for " Increased levels of observation Role expectations of staff"
(f) TippUH and Medical 1 now one of 2 hospitals in the country participating in the urinary output measurement quality improvement initiative " Improving documentation of urinary output for patients requiring fluid balance monitoring"
(g) Continue monthly audits of care plans and protocols to monitor compliance. Action plans to be closed out within 21 days not exceeding 1 month. Presentation of Nursing metrics to QRPSGG monthly.
(h) Monthly audits of EWS on Medical 1 via "Patient monitoring and Surveillance" audits by auditors independent to Medical 1 with action plans as required signed off by ADON.
(i) Ongoing review of training and knowledge through formal and informal assessments, identify and addressing any training deficits.

A (iii) IPC

IPC Nursing WTE compliment returned to full capacity on 15/09/2025

A (iv) Environmental cleaning

(a) Governance – review of current structures plan to commence Operational Hygiene meetings monthly and Hygiene Governance quarterly.
Governance and oversight of environment to remain under the Governance of the Hygiene Governance Group. Schedule of environmental audits, findings issues, close out, trending monitored by this committee.
(b) Reaudit of ED, SMU East, ED, AMAU by Senior auditors October 2025
Management, Staff Support & Development
(c) Support Services Manager and management team will review documentary evidence that cleaning has been completed by monitoring of checklists, cleaning records
(d) Allocation of staff specific for cleaning on areas.
(e) Program for retraining of cleaning staff.

B
Alleviate overcrowding mismatch between capacity and demand for inpatient beds.

B (i) Review of escalation plans and surge capacity plan for Tipperary University hospital.

B (ii) Acute Inpatient Hospital Bed Expansion Plan (May 2024) identified that TippUH required additional 48 inpatient beds, this is included in the National Capital Plan (2024-2031)

Timescale:
A.
(a) Training: -Additional specific training sessions provided to staff on SMU East, Med 1, Gynae & ED
T/S complete.
(b) Clinical skills working with staff
T/S complete
(c) Audits: ISBAR Audit of Communication + Clinical Handover + Deterioration on SMU East, Med 1, Gynae & ED
T/S completed.
ED majors' safety huddle audit May 2025 completed.

(d) Medication Management audit scheduled for October 2025

Med 1	02/10/2025
ED	09/10/2025
AMAU & Gynae	16/10/2025
SMU East	23/10/2025
Paeds & PAU	30/10/2025

T/S Oct 2025

(e) Medication safety training compliance overview.
T/S Completed

Additional compliance plan -TippUH will:

(i) Review medication top up list and storage facilities for Med 1, Emergency department & SMU. –
T/S Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations –
T/S completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & medical 1 to identify those requiring additional security measures –
T/S Completed review 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL
T/S Completed additional notification for awareness sent to HPRA & [external company].

(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications
T/S Completed and in place 09/09/2025

(vi) Additional medication management updates
T/S October 2025

(vii) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area – T/S completed

(viii) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols –
T/S completed reviewed09/09/2025

(ix) Secure storage press in adult resus room in ED
T/S - completed

(x) Review of controlled access to Resus Rooms in Emergency Department – approval to proceed granted currently awaiting date for installation. T/S Q4 2025

A (ii) Patient Care Medical 1

(a) Nursing metrics data will be presented monthly at the Quality Risk and Patient Safety Governance Group (QRPSGG) monitoring, ward, scores, sections, issues identified, close out and trending for Governance, included on agenda for QRPSGG
T/S Completed- included on QRPSGG & TOR approved September 2025

(b) Oversight of, review and update if required of care plans by CNMs, ADONs, Practice Development.
T/S ongoing

(c) Additional staff training on safe care protocols & documentation
T/S ongoing

(d) SCA representatives coming onsite to highlight importance of (i) documentation, (ii) consent, (ii) deteriorating patient, (iv) Medication Safety, (v) clinical handover

T/S 23rd Oct 2025

(e) Introduction of " Care checklist for patients under increased level of observation" with accompanying policy for " Increased levels of observation Role expectations of staff"
T/S Completed August 2025

(f) TippUH (Medical 1 ward) is now one of 2 hospitals in the country participating in the urinary output measurement quality improvement initiative " Improving documentation of urinary output for patients requiring fluid balance monitoring"
T/S Completed in Medical 1 and further roll out to all Clinical areas throughout September 2025 T/S October 2025

(g) Continue monthly audits of care plans and protocols to monitor compliance. Action plans to be closed out within 21 days not exceeding 1 month. Presentation of Nursing Metrics to QRPSGG monthly.
T/S Completed and ongoing – included on QRPSGG agenda & TOR September 2025

(h) Monthly audits of EWS on Medical 1 via "Patient monitoring and Surveillance" audits by auditors independent to Medical 1 with action plans as required signed off by ADON.
T/S ongoing.

(i) Ongoing review of training and knowledge through formal and informal assessments, identify and addressing any training deficits.
T/S ongoing

A (iii) IPC

IPC Nursing WTE compliment returned to full capacity.
T/S Completed and in situ 15/09/2025

A (iv) Environmental Cleaning

(a) Governance – review of current structures plan to commence Operational Hygiene meetings monthly and Hygiene Governance quarterly.
T/S Q 4 2025.

(b) Environmental Reaudit of ED, SMU East, ED, AMAU by Senior auditors
T/S October 2025

Management, Staff Support & Development

(c) Support Services Manager and management team will review documentary evidence that cleaning has been completed
T/S Daily
monitoring of checklists, cleaning records
T/S Daily

(d) Monitoring of assigned cleaners and staffing allocations
T/S Daily

(d) Program for retraining of cleaning staff.
T/S Q4 2025

B

B (i) Review of escalation plans and surge capacity plan for Tipperary University hospital. T/S 30/10/2025

B (ii) Acute Inpatient Hospital Bed Expansion Plan (May 2024) identified that TippUH required additional 48 inpatient beds, this is included in the National Capital Plan (2024-2031) T/S 2032

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

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

(a) In additional to current schedule for Environmental audits a full Environmental Audit by senior auditors using the National MEG environmental audit tool, of ED, SMU East, ED, AMAU- T/S October 2025

(b) Management, Staff Support & Development
Support Services Manager and management team will review:

- documentary evidence that cleaning has been carried out,
- monitor checklists,
- cleaning records,
- assigned cleaners

A Multiple instances of an unclean environment

(c) Support Services management complete a walk round of all clinical areas monitoring environment and cleaning.

(d)Retraining of cleaning staff and training for new staff at commencement of employment.

(e) Replacement of Robotic laser decontamination unit & Training onsite provided, 23rd June 2025

(f) Communication by Hospital Management to all Heads of Department on the following:

- Need to ensure good housekeeping within own Department
- Importance of reporting any issues identified to Household Services
- Any Maintenance Issues to be reported to Technical Services Department

T/S Completed September 2025

B Lack of oversight of cleaning checklists

(g) Daily walkrounds by Support Services Manager and supervisors to ensure cleaning checklists and sink flushing records are completed. Importance of record keeping verified with support services staff. Support services management to continue to review cleaning checklists track and trend data from same. Follow up with staff involved for accountability, learning and close out of issues.

C Inappropriate storage of staff personal items

(h) Communication issued to staff on appropriate storage of personal belongings, hygiene and security risks of inappropriate storage of personal belongings.
(i) Additional lockers provided.
(j) Designated locker rooms with shower facilities provided for staff on first floor.

D Some equipment was observed as being unclean and or rusty.

Equipment identified as rusty on ward assessment process Environmental audits included wheels on trolleys. This was due to effect of a cleaning agent on wheels and wheel covers.

(k) A schedule maintenance programme to replace new covers /wheels is underway
(l) New chlorine wipes now in use which do not affect or cause rust on stainless steel equipment.

E Not all handwashing sinks were compliant

(m) Sink replacement schedule in progress and managed by Technical Services subject to relevant AMRIC funding.

Paediatric refurbishment completed all sinks are now compliant in this Department

F Issues with general wear and tear found on Medical 1 and Paediatric Unit
(n) Refurbishment of Paediatric Unit Completed September 2025
(o) Medical 1 on maintenance schedule for completion Q4 2025.

Timescale (T/S):

(a) In additional to current schedule for Environmental audits a full Environmental Audit by senior auditors using the National MEG environmental audit tool, of ED, SMU East, ED, AMAU-
T/S October 2025

(b) Management, Staff Support & Development

Support Services Manager and management team will review:

- documentary evidence that cleaning has been carried out,
- monitor checklists,
- cleaning records,
- assigned cleaners

T/S In progress at time of completion of compliance plan

A Multiple instances of an unclean environment

© Support Services management complete a walk round of all clinical areas monitoring environment and cleaning.

T/S in progress since inspection

(d) Retraining of cleaning staff and training for new staff at commencement of employment.
T/S Q1 2026

(e)Replacement of Robotic laser decontamination unit & Training onsite provided.
T/S completed 23rd June 2025

(f) Communication by Hospital Management to all Heads of Department on the following:

- Need to ensure good housekeeping within own Department
- Importance of reporting any issues identified to Household Services
- Any Maintenance Issues to be reported to Technical Services Department

T/S Completed September 2025

B Lack of oversight of cleaning checklists

(g)Daily walkrounds by Support services managers and supervisors to ensure cleaning checklists and sink flushing records completed. Follow up with staff involved for accountability, learning and close out of issues.
T/S Complete -in place at time of compliance plan

C Inappropriate storage of staff personal items

(h) Communication issued to staff on appropriate storage of personal belongings, hygiene and security risks of inappropriate storage of personal belongings.
T/S Complete

(j) Additional lockers provided.
T/S complete Q 3 2025

(k) Designated locker rooms with shower facilities provided for staff on first floor.
T/S Complete

D Some equipment was observed as being unclean and or rusty.

Equipment identified as rusty on ward assessment process Environmental audits included wheels on trolleys.

(l) A schedule maintenance programme to replace new covers /wheels
T/S Q4 2025

(m) New chlorine wipes now in use which do not affect or cause rust on stainless steel equipment.
T/S Complete in situ at time of compliance plan

E Not all handwashing sinks were compliant

(n) Sink replacement schedule in progress and managed by Technical Services.
Paediatric refurbishment complete sink removed.
T/S Q4 2026 subject to AMRIC funding

F issues with general wear and tear found on Medical 1 and Paediatric Unit

(o) Refurbishment of Paediatric Unit
T/S Completed September 2025

(p) Medical 1 on maintenance schedule
T/S for completion Q4 2025

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

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

A *TippUH QIPs for compliance with EWS audits issues persist.*

(a) Findings continue to be brought to attention of CNM and practice development. CNM alerts staff of findings and action plan for compliance, inclusion of ADON over area sign off of results, action plans and timely close out of QIPs. Issues / trending as relevant reviewed at monthly CNM meetings.

(b) Training included within the "Deteriorating Patient Study Day"

© Issues relating to requirement regarding documentation of modified parameters escalated to Clinical Director DSE.

B *Sepsis form completion not meeting targets*

QIP in place and submitted for regional sepsis audits to DSE Sepsis lead, and reviewed at Regional Deteriorating Patient GG committee. TippUH piloted new sepsis form for Dublin SE rapid update to NCG 26 -sepsis September 2025, Plan roll out of implementation of rapid update to the National Clinical Guideline No 26 presented and accepted by Deteriorating patient TOC/ Sepsis Group meeting on 10th Sept. Implementation plan for October 2025 agreed. Forms currently being printed. Training to commence October 2025 for implementation of new forms Nov 1st 2025. Subsequent audit plan following implementation.

C *Medication Management audits findings reoccurring, findings by inspectors not identified through medication management audits*

(c) Plan additional questions within Medication management audit. Reaudit October schedule:

Med 1	02/10/2025
ED	09/10/2025
AMAU & Gynae	16/10/2025
SMU East	23/10/2025
Paeds & PAU	30/10/2025

Figure 1 TippUH Audit schedule Oct 2025

Additional actions for Medication management compliance included within standard 5.2

D *Findings from environmental audits did not align with inspectors' findings*

(d) Full Environmental Audit by senior auditors using the National MEG environmental audit tool, of clinical areas visited by HIQA. *See figure 1 TippUH audit schedule October 2025*

E Hand hygiene audits by IPC not reaudited within timely manner
Return to full WTE complement of staff 15/09/2025, plan to address audits and training deficits Q4 2025.

***F** Audits did not always have an associated QIP timebound.*
All QIPs identified following audits will have a timebound QIP with responsible person identified and reported to relevant Governance Group.

Timescale:

***A** TippUH QIPs for compliance with EWS audits issues persist*

(a) Findings brought to attention of CNM and practice development, ADON oversight & signoff.
T/S Sept 2025

(b) Training included within the "Deteriorating patient study Day"
T/S Complete

© Issues relating to requirement regarding documentation of modified parameters escalated to Clinical Director DSE.
T/S Complete (at DSE Deteriorating patient GG) awaiting response.

***B** Sepsis form completion not meeting targets*

(c) Roll out of implementation of rapid update to the National Clinical Guideline No 26
T/S Implementation plan for October 2025 agreed.
Forms currently being printed.
Training to commence October 2025 for implementation of new forms Nov 1st 2025.

***C** Medication Management audits findings reoccurring, findings by inspectors not identified through medication management audits*

(d) Plan additional questions within Medication management audit. Reaudit October schedule:

Med 1	02/10/2025
ED	09/10/2025
AMAU & Gynae	16/10/2025
SMU East	23/10/2025
Paeds & PAU	30/10/2025

Figure 1 TippUH Audit schedule Oct 2025

T/S October 2025
Additional actions for Medication management compliance included within standard 5.2

***D** Findings from environmental audits did not align with inspectors' findings*

(e) Full Environmental Audit by senior auditors using the National MEG environmental audit tool of clinical areas visited by HIQA. *See figure 1 TippUH audit schedule October 2025*
T/S Oct 2025

E *Hand hygiene audits by IPC not reaudited within timely manner*
Return to full WTE complement of staff 15/09/2025, plan to address audits and training deficits Q4 2025.
T/S Q4 2025

F *Audits did not always have an associated QIP timebound.*
All QIPs identified following audits will have a timebound QIP with responsible person identified & oversight of department heads.
T/S Q 4 2025

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

Outline how you are going to improve compliance with this national standard.
1. *Gaps in Nursing assessments, provision of care, & documentation*

(i) Target all clinical and care staff, including Nurses, Care Assistants, and HSCPS.
(ii) Oversight of, review and update if required of care plans by CNMs, ADONs, Practice Development.
(iii) Additional staff training on safe care protocols & documentation
(iv) Noted key challenges include inconsistent documentation. SCA representatives providing training in TippUH 23rd October to highlight importance of documentation, consent, deteriorating patient, Medication Safety, clinical handover
(v) Introduction of " Care checklist for patients under increased level of observation" with accompanying policy for " Increased levels of observation Role expectations of staff"
(vi) TippUH now one of 2 hospitals in the country participating in the urinary output measurement quality improvement initiative " Improving documentation of urinary output for patients requiring fluid balance monitoring"
(vii) Continue monthly audits of care plans and protocols to monitor compliance Action plans to be closed out within 21 days not exceeding 1 month. Presentation of Nursing metrics to QRPSGG monthly. Monthly audits of EWS on all clinical areas via "Patient monitoring and Surveillance" audits by auditors independent to area with action plans as required signed off by ADON.
(viii) Introduce Nutrition & Hydration mealtime MEG audit in line International Dysphagia Diet Standardisation Initiative (IDDSI) guidance via MEG audit tool on clinical areas. Pilot complete August 2025
(ix) Ongoing review of training and knowledge through formal and informal assessments, identify and address if any training deficits

(x) Inconsistent audit quality -training for new auditors and utilisation of standardised audit tool via Meg qcm.

Risk management-

(xi) Flexible risk management training sessions times will be provided.

Governance:

(xii) Cascade of audit findings reported via line management e.g., ↑ADON, ↑DON, ↑Hospital management, Pharmacy technician, Pharmacist, PEM2, QM, Hospital management.

(xiii) Reporting of audit results monthly via QRPSSG - template inclusive of ward, scores, issues, actions, close out, trending

Communication:

(xiv) Monthly staff feedback at department meetings to update on progress

(xv) Quarterly reports shared with Governance groups.

2.

Medicines not stored correctly

(i) Review medication top up list and storage facilities for Med 1, Emergency department & SMU. -Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations - completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & medical 1 to identify those requiring additional security measures – reviewed 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL – completed, additional alert sent to HPRA & [external company].

(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications in place 09/09/2025 Completed

(vi) Additional medication management updates continuing scheduled for completion October 2025

(vii) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area

(viii) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols – complete rechecked 09/09/2025

(ix) Secure storage press in adult resus room in ED- complete

(x) Review of controlled access to adult resus in Emergency Department – approval to proceed awaiting date for installation of same.

(xi) Medication management audits continue to be presented at Drugs & Therapeutic Committee with issues identified and actions noted.

(xii) Safe management & storage of chemical to be included within Health & Safety audits carried out by Health and Safety Manager.

3.

Non adherence to INEWS guidelines

a) In addition to scheduled monthly audits of EWS on clinical areas via "Patient monitoring and Surveillance" audits by auditors independent to area with action plans as required signed off by ADON. There is Bi annual formal audit by Practice

Development and Quality Manager of compliance with INEWS, data presented at Deteriorating Patient GG, QRPSGG and EMT with issues and actions outlined. Feedback provided to all staff by CNM & ADON, with ADON signoff of QIP.

b) Escalation at Dublin & South East Deteriorating patient group currently being addressed by Clinical Director Dublin & South East regarding difficulty in documentation of modified escalation parameters by medical teams in line with NCG. Prioritisation given to care of deteriorating patients, care delivery reviewed, patient safety prioritised and maintained.

4.
Small number of patients waiting in excess of 24 hours to access inpatient bed.
Ongoing monitoring of bed capacity by Patient Flow team and hospital management with oversight by Regional Access and Performance Unit Dublin and South East.

5.
PPPGs and information on display overdue / not reviewed for some time.
a) List of PPPGs on HCI knowledge that are overdue have been forwarded to the relevant persons for review and updating.
b) Senior Managers reviewing information displayed on Clinical areas.

Timescale:
1 *Gaps in Nursing assessments, provision of care, & documentation*
(i) Target all clinical and care staff, including Nurses, Care Assistants, and HSCPs. Clinical Skills provision of "lunch & learn" to target areas/ topics.
T/S In progress at time of compliance plan.

(ii) Oversight of, review and update if required of care plans by CNMs, ADONs, Practice Development.
T/S In progress - ongoing development with local/ group and National teams, oversight & support provided by CNMs & ADONS.

(iii) Additional staff training on safe care protocols & documentation
T/S Complete -as issues arise targeted by "lunch & learn" training sessions

(iv) State Claims Agency Training onsite in TippUH to highlight importance of documentation, consent, deteriorating patient, Medication Safety, clinical handover
T/S 23rd Oct 2025

(v) Introduction of " Care checklist for patients under increased level of observation" with accompanying policy for " Increased levels of observation Role expectations of staff"
T/S Completed

(vi) Introduce Nutrition & Hydration mealtime MEG audit in line International Dysphagia Diet Standardisation Initiative (IDDSI) guidance via MEG audit tool on clinical areas
T/S October 2025

(vii) TippUH now one of 2 hospitals in the country participating in the urinary output measurement quality improvement initiative " Improving documentation of urinary output for patients requiring fluid balance monitoring"
T/S Completed across all clinical wards in TippUH

(vii) Continue monthly audits of care plans and protocols to monitor compliance Action plans to be closed out within 21 days not exceeding 1 month. Presentation of Nursing metrics to QRPSGG monthly.
T/S In progress

(viii) Ongoing review of training and knowledge through formal and informal assessments, identify and address if any training deficits. Mandatory training compliance rates monitored and reported as relevant at Deteriorating patient governance group e.g. sepsis, BLS, EWS, ACLS.
T/S Ongoing

(ix)Inconsistent audit quality -training for new auditors and utilisation of standardised audit tool via Meg qcm.
T/S Completion Q 4 2025

Risk management-
(x) Flexible risk management training sessions times will be provided
T/S Risk staff providing support & training for all staff on request and is a continuous process.

Governance:
(x) Cascade of audit findings reported via line management e.g., ↑ADON, ↑DON, ↑Hospital management, Pharmacy technician, Pharmacist, PEM2, QM, Hospital management.
T/S Completed – audit findings escalated to all relevant stakeholders

(xi) Reporting of audit results monthly via QRPSSG - template inclusive of ward, scores, issues, actions, close out, trending
T/S Completed included on QRPSGG agenda & TOR Sept 2025

Communication:
(xii) Monthly staff feedback at department meetings to update on progress
T/S Completed – provided by CNMs & supported by ADONS monthly CNM2 meetings in progress.

(xiii) Quarterly reports shared with Governance groups.
T/S Completed – reports and trending of data findings distributed and presented to Deteriorating Patient GG & Risk Management.

2.
Medicines not stored correctly

(i) Review medication top up list and storage facilities for Med 1, Emergency department & SMU.
T/S Complete -Med 1 12/09/2025, ED 15/09/2025, SMU East 19/09/2025.

(ii) Planned review of medication stock top-up list and storage facilities in outstanding clinical locations
T/S completion Q4 2025

(iii) Review of all drug storage presses in ED, SMU & Medical 1 to identify those requiring additional security measures
T/S Complete & checked 10/09/2025

(iv) Addition of question within Medication Management audit to include segregation of Potassium 40 & 20 mmols in 1 Litre NACL
T/S Completed additional notification submitted to HPRA & [external company].

(v) Review of custody of medications in each clinical area – streamlined process for enhanced custody of CD4 medications
T/S Review Completed, in place 09/09/2025

(xiv) Additional medication management updates continuing scheduled
T/S Completion October 2025

(xv) Segregation of Potassium 40 & 20 mmols in 1 Litre NACL on each clinical area
T/S Completed

(xvi) Specific SALAD warnings alert to be displayed in Clean Utility rooms to highlight similarity between potassium 40 & 20 mmols
T/S Completed rechecked 09/09/2025

(ix) Secure storage press in adult resus room in ED
T/S Completed

(xvii) Review of controlled access to Resus Rooms in Emergency Department
T/S – approval to proceed granted, currently awaiting date for installation.

(xviii) Medication management audits continue to be presented at Drugs & Therapeutic Committee with issues identified and actions noted.
T/S complete process in situ.

(xix) Safe management & storage of chemical to be included within Health & Safety audits carried out by Health and Safety Manager.
T/S Q4 2025

3.
Non adherence to INEWS guidelines

(xx) In addition to scheduled monthly audits of EWS on clinical areas of random sample of 25% of patient compliment on ward via "Patient monitoring and Surveillance" audits by auditors independent to area with action plans as required signed off by ADON. TippUH performs Bi annual formal audit by Practice Development and Quality Manager of compliance with INEWS, data presented at Deteriorating Patient GG, QRPSGG and EMT with issues and actions outlined. Feedback provided to all staff by CNM & ADON, with ADON signoff of QIP.

T/S process in situ.

(xxi) Escalation at Dublin & South East Deteriorating patient group currently being addressed by Clinical Director Dublin & South East regarding difficulty in documentation of modified escalation parameters by medical teams in line with NCG. Prioritisation given to care of deteriorating patients.

T/S completed – awaiting response

4.

Small number of patients waiting in excess of 24 hours to access inpatient bed.

Ongoing monitoring of bed capacity by Patient Flow team and hospital management with oversight by Regional Access and Performance Unit Dublin and South East

T/S ongoing

5.

PPPGs and information on display overdue.

(xxii) List of PPPGs on HCI knowledge that are overdue have been forwarded to the relevant persons for review and updating.

T/S Completed June 2025

(xxiii) Senior Managers reviewing information displayed on Clinical areas.

T/S Q4 2025.