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:	Wexford General Hospital
Centre ID:	OSV-0001108
	Newtown Road Wexford Co Wexford
Type of Inspection:	Announced
Date of Inspection:	04/02/2026 and 05/02/2026
Inspection ID:	NS_0186

About the healthcare service

Model of hospital and profile

Wexford General Hospital is a model 3* HSE public hospital. It is a member of and is managed by the Health Service Executive (HSE) Dublin and South East (DSE) Regional Health Area† (RHA). Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- critical care
- maternity care
- general paediatrics
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	222 inpatient beds 55 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 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)
04/02/2026	*09:00 – 17:20*	Laura Byrne	Bairbre Moynihan Elaine Egan Liz Maume Martina Glynn
05/02/2026	*09:00 – 15:45*	Laura Byrne	Bairbre Moynihan Elaine Egan Liz Maume Martina Glynn

Information about this inspection

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

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

The inspection team visited four clinical areas:

- Emergency department (ED) including the Acute Medical Assessment Unit (AMAU)
- Surge 1 (Surge capacity)
- Patrick's ward (Medical and Surgical)
- Florence ward (Medical)

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

Acknowledgements

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

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

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

Inspectors spoke with a number of patients throughout the two days of inspection. Patients described their care in a positive manner, for example that staff were very friendly and helpful. Patients commented that staff responded promptly when assistance was required. Patients in the ED described staff as "terrific" and "lovely". Patients accommodated in the wards described staff as "kind" and "very friendly".

Patients who spoke with inspectors described their wait in the ED and their experience ranged from those waiting 10 minutes to a patient waiting overnight in the chair area. Inspectors observed that the main ED was busy but calm. Patients were accommodated in rooms, and three patients were on trolleys in the ED corridor. As discussed later in this report, some patients accommodated in trolleys or surge areas did not have access to call-bells. Patients who spoke with inspectors did not have any concerns with this arrangement and said they would call a member of staff if they needed assistance.

Patients who spoke with inspectors were not aware of how to make a complaint. One patient commented that they would speak with a nurse if they needed to make a complaint.

Capacity and Capability Dimension

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

Wexford General Hospital was substantially compliant in one national standard (5.5) and partially compliant in three national standards (5.2, 5.8 and 6.1).

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

The hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. However, high risks were identified in relation to governance, oversight and management of Surge 1. In addition, some

committees were not meeting at the frequency outlined in their terms of reference (TOR). This was also a finding on the inspection in March 2024.

During this inspection, inspectors identified high risks that had the potential to present serious risk to the health and welfare of people who use the service. Risks were identified in relation to Surge 1, specifically:

- the governance, management and oversight of the ward
- inadequate space and facilities to support adherence to infection prevention and control guidelines including lack of access to hand hygiene sinks due to inappropriate bed placement, shared toilet and shower facilities for patients requiring contact and droplet precautions. The patient shower, located within a staff area, contained a staff toilet, lockers and staff belongings including coats on chairs and shoes on top of lockers. However, management stated that the lockers and patient shower were not in use by staff at the time of inspection. In addition, there was lack of and inappropriate storage of patient belongings and inappropriate storage of staff belongings in the clinical area. No environmental audits had been completed to identify areas for action
- lack of oversight of infection prevention and control (IPC) audits and no IPC risk assessment was completed to identify controls and additional actions required to manage and mitigate the risks
- lack of access to emergency call systems in "Office 1" and the shower room located within the staff changing area
- early warning score and identify, situation, background, assessment and result (ISBAR) audits were requested, and inspectors were informed they were not completed
- the impact of the deficits in the ward environment had not been risk assessed through the lens of the deteriorating patient to control and address the lack of space for managing a deteriorating patient, cardiac resuscitation of a patient and completing clinical examinations
- sustainable staffing model in line with the bed capacity
- security of the ward with an entrance and or exit door located on the ward used for accessing outpatient clinics
- unsecured storage of healthcare records on the ward corridor.

Though assurances were provided by management in response to each risk identified at the time of inspection, adequate oversight of Surge 1 was not in place on the days of inspection. After the inspection, HIQA wrote to hospital management outlining the specific risks outlined above in Surge 1 and requested detail on how they had addressed or intend to address them, including the intended time frame for action. HIQA also sought assurance on the governance, management and oversight of Surge 2, 3 and 4. Assurances were provided by management in response to each risk identified at the time of inspection. Risks relating to national standard 5.2 are

described here and further risks and assurances provided are detailed under national standards 5.5, 5.8, 6.1, 2.7 and 3.1. Management provided assurances on the governance, management and oversight of all surge areas in use in the hospital.

Organisational charts detailed the direct reporting arrangements of various governance and oversight committees to hospital management, which aligned with what inspectors were told. Since the inspection in March 2024, the hospital had transitioned to a new governance structure in line with the establishment of the HSE regional health areas (RHA). The hospital was part of the Dublin and South East (DSE) RHA. The hospital manager was the senior accountable officer with overall responsibility and accountability for the quality and safety of the healthcare services delivered in the hospital. The hospital manager reported to and was accountable to the integrated health area (IHA) manager for Waterford and Wexford. They in turn were accountable to the regional executive officer (REO) for the Dublin and South East RHA.

The reporting relationships for the Executive Management Team (EMT) and the Quality and Safety Committee (QSC) were unchanged since the last inspection. These committees were assigned the responsibility for ensuring the quality and safety of healthcare services at the hospital. The EMT met monthly and updates were provided at this meeting from relevant hospital departments, for example from the clinical director and nursing department. Meetings were well attended. Though due to be reviewed annually, the terms of reference (TOR) had not been reviewed since approval in 2023. In addition, actions from meetings had responsible persons identified but were not time bound.

The QSC had met in July 2024, May 2025, and July 2025. This seven-month gap to the time of the inspection was not in line with the TOR which outlined quarterly meetings. Although fully staffed at the time of inspection, management described how gaps in staffing in the quality and patient safety (QPS) and consumer affairs department had impacted the QSC function throughout 2025. Hospital management assured HIQA that they had oversight of any issues in this interim period and a meeting was planned for February 2026 and a schedule of meetings put in place for the year. QPS department update reports were provided for meetings of the EMT in July, October and November 2025. Actions from QSC meetings were not time-bound and this was a finding on the previous inspection in March 2024.

Committees reporting to the QSC related to the areas of focus for this inspection included, the Infection Prevention and Control Committee (IPCC), Drugs and Therapeutics Committee (DTC) and Deteriorating Patient (DP) committee. Minutes requested for the most recent three meetings showed that the DP committee met in August 2024, June 2025 and October 2025. This 10-month gap was not in line with the meeting frequency outlined in the TOR. Management responded that deficits in staffing in the QPS and consumer affairs department had led to these gaps. All

committees had oversight of items relating to their areas such as audits, key performance indicators (KPIs), training and incidents. Inspectors were shown a QPS meeting schedule that outlined the planned meeting dates for each committee in 2026.

A Clinical Governance Operational Team (CGOT) had been established since the last inspection and reported to the EMT. Monthly meetings were chaired by the clinical director and had oversight of staffing, quality and safety. Minutes of the monthly meetings showed that meetings were action-oriented however, actions were not time-bound.

The Unscheduled Care Committee (USCC), chaired by the hospital manager, reported to the CGOT and had oversight of patient flow, hospital activity and delayed transfers of care. However, this committee had met twice in 2025 and the most recent meeting prior to the inspection was June 2025. This was not in line with the TOR which outlined bi-monthly meetings. A bed management committee met monthly and had oversight of patients with delayed transitions of care.

Hospital management through the compliance plan committed to actioning the findings from the inspection in March 2024. It was identified that some findings were actioned for example, the recruitment of an antimicrobial stewardship pharmacist and the filling of vacancies in the QPS and consumer affairs department. However, other findings from the March 2024 inspection were also found on this inspection such as workforce deficits, mandatory training compliance not within the expected target and, as discussed earlier in this standard, findings relating to time-bound actions arising from meetings.

Overall, while there were a number of formalised governance arrangements in place at the hospital, the following was identified;

- high risks as outlined in this national standard were identified in the governance, management and oversight of Surge 1
- the QSC, USCC and DP committees were not meeting at the frequency outlined in the TOR
- assigned time-bound actions were not identified by some committees and this was a finding on the previous inspection
- findings from the inspection in March 2024 had not been actioned.

Judgment: Partially Compliant

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

The hospital had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. However, as discussed above, management arrangements were not in place in Surge 1 at the time of the inspection.

Management arrangements were in place to monitor issues that impacted on the effective and safe transitions of care. The patient flow team, led by an ADON, had oversight of patient flow and discharge processes seven days a week and supported clinical areas with safe discharge. A daily operational hub meeting was held with members of the hospital management team and the patient flow team which reviewed hospital activity including patient transfers, inpatient and ED activity, IPC issues, staffing, hospital capacity and patient waiting times. A daily patient flow huddle was in place on Florence ward and Patrick's ward which was attended by members of the patient flow team and ward management. On the days of inspection, the hospital was at red escalation level on the internal escalation plan, which meant that the emergency department was over capacity and there was limited bed availability in the hospital. Management confirmed that plans for an interim solution to bed capacity deficits had been developed and was under appraisal by HSE Capital and Estates. Longer term actions required included the construction of a new medical block providing 97 beds and inspectors were informed that this infrastructure development was not due for completion until 2028.

The hospital's pharmacy service was led by the pharmacy executive manager. There were arrangements in place to provide a clinical pharmacy service. A pharmacy technician service managed stock control to ward areas. Arrangements were in place for out-of-hours access to medications. An antimicrobial stewardship (AMS) pharmacist had recently commenced in post with AMS rounds due to commence however, rounds were not taking place at the time of the inspection. An annual medication safety programme was developed with defined goals with target implementation dates.

The infection prevention and control (IPC) advisory team had responsibility for IPC activity, and a quarterly IPC advisory team report was compiled. This detailed healthcare associated infection surveillance, audit results, outbreaks and incidents. An action log with identified responsible persons was included. The IPC team comprised a 0.5 WTE consultant microbiologist and a CNM2 and arrangements were in place for out-of-hours telephone support with University Hospital Waterford. Staffing deficits in this team are discussed under national standard 6.1. Inspectors were informed that the IPC link nurse programme was in place to support staff in the ward areas. The hospital had a documented overarching infection prevention and control programme. Microbiology laboratory services were provided in University Hospital Waterford.

Samples were transported twice daily on weekdays and once daily on weekends and inspectors were informed that this sometimes resulted in delays that could impact on patient flow. The hospital had access to point of care testing for respiratory viral illnesses to counteract delays in testing for symptomatic patients.

Consultants were supported by non-consultant hospital doctors (NCHDs). There was 24/7 access to an anaesthesiology consultant and two registrars on site at all times. Out of hours a consultant on-call service was in place in addition to two registrars on site. There was 24/7 access to an ED consultant who was on site during the day and on Saturdays and an on-call arrangement at night and on Sundays. There was 24/7 access to a registrar grade in the ED. Hospital management assured HIQA that there was adequate access to a senior decision maker at all times in the ED.

Nursing services in the hospital were managed and organised by a director of nursing (DON) who was supported in the role by assistant directors of nursing (ADONs). Clinical nurse managers (CNMs) of different grades were responsible for the management and oversight of the clinical areas and were operationally accountable to a CNM3 and upwards to the ADONs. A clinical director had responsibility for medical services at the hospital and had a 0.5 whole time equivalent (WTE) allocation for this role. A site manager CNM3 had responsibility for the service outside normal working hours. A clinical nurse manager 3 (CNM3) position for medical services was vacant. Senior nursing management oversight of Surge 1 was allocated to an identified assistant director of nursing (ADON) which varied each day. Management outlined that a CNM2 position to upgrade the CNM1 role had been approved but this was not in place on the day of inspection. In their response to the request from HIQA after the inspection, the service provided assurances on the immediate commencement of a CNM2 to provide governance, management and oversight of Surge 1 and clarified the reporting relationship to nursing management.

In summary, the hospital had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. However, deficits in the management arrangements for Surge 1 were identified. Specifically;

- a CNM3 position for medical services was vacant
- a CNM2 position to upgrade the CNM1 role in Surge 1 had been approved but this was not in place on the days of inspection.

Judgment: Substantially Compliant

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

While the hospital had systematic arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of health care services, deficits were identified in the oversight of audit activity in Surge 1.

Incident Management

Incidents were logged on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework (IMF). The serious incident management team (SIMT) had oversight of patient safety incidents. Separate meetings were held for the general and maternity service incidents. Patient-safety incidents were discussed at EMT and QSC. Hospital management reported on the number of serious reportable events (SREs) reported to NIMS and submitted data monthly at performance meetings with the IHA. Evidence was provided that incidents were tracked and trended and this was shared with CNMs. This is further discussed under national standard 3.3.

Monitoring Performance

Performance data was discussed at performance meetings between the hospital and IHA manager for Waterford and Wexford. Information on a range of performance indicators and data related to the quality and safety of healthcare services was collected and reported in line with the HSE's reporting requirements. A collated 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, workforce and infrastructure.

Risk Management

Formalised risk management structures and processes were in place to proactively manage and minimise risks at the hospital. Risks in relation to transitions of care, quality and safety and workforce were recorded on the hospital's corporate risk register. However, some risks that had the potential to impact on the quality and safety of patient care had not been fully assessed or managed by the service. These are further discussed under national standards 6.1, 2.7 and 3.1. There was evidence that the risk register was reviewed in January 2026. Existing and additional controls were documented on the risk register along with action due dates. Inspectors were informed that risks that could not be managed at hospital level were escalated to the regional IHA risk register. Staff on Patrick's ward had good knowledge on risk identification and escalation.

Audit

The service was completing regular audits in a number of areas related to the focus of this inspection including Irish National Early Warning System (INEWS), medication safety and sepsis audits. There was evidence that governance committees had oversight of audit results relevant to their area of focus, for example hand-hygiene audit results were reviewed at the IPCC. There was no audit plan in place, but management told inspectors that this was being compiled. Staff were informed of audit findings through the use of quality boards in the ward area.

Environmental audits were carried out regularly in AMAU, Florence ward and Patrick's ward with scores above 93% for the most recent three audits in each area. Each audit had an improvement plan with actions assigned to responsible persons. Some of the audits provided did not have total compliance calculated for example hand hygiene and IPC equipment audits in Patrick's ward and medication management audits in AMAU. Actions plans were not provided for these audits. In ED the most recent three hand-hygiene audits were requested but only three individual staff checks were provided dating from June 2025, July 2025 and January 2026. Nursing quality care metrics were completed monthly in each ward visited and included medication safety audits. Quality improvement plans with responsible persons and time-bound actions were developed in response to quarterly INEWS audits. For example, Patrick's ward had a QIP after an escalation and response audit in quarter four 2025 showed compliance of 65% which had dis-improved from 82% in quarter three. However, a recent audit on Florence ward showed compliance of 15% with the use of the ISBAR sticker for escalation of a deteriorating patient. Although areas for improvement were identified from this audit, no time-bound action plan was provided. Some of the issues identified were also identified by inspectors during the inspection which are discussed further under national standard 3.1.

There were no environmental, infection prevention and control, medication safety, deteriorating patient or transition of care audits taking place in Surge 1. In response to the identification of this risk, assurances were sought from the service after the inspection as described under national standard 5.2. Hospital management provided assurances that environmental and infection prevention and control (IPC) audits were completed after the inspection and that an ongoing audit schedule was now in place. The service also outlined that INEWS and Identify, Situation, Background, Assessment and Result (ISBAR) audits were undertaken, QIPs developed and an ongoing schedule for audit outlined.

Quality Improvement

The service had implemented a quality improvement plan in response to the findings of the 2024 National Inpatient Experience Survey. This had led to the introduction of a snack trolley that was being trialled on three wards, and this was observed by

inspectors. Actions that were planned for early 2025 in relation to a welcome leaflet and discharge information for patients had not yet been actioned and were planned for 2026. Inspectors were informed that these initiatives had been delayed due to resource constraints in the QPS and consumer affairs department as previously discussed.

Overall, while there were processes in place for incident management, risk identification and performance monitoring, gaps were identified in the audit process. Specifically;

- there were no environmental, infection prevention and control, medication safety, deteriorating patient or transitions of care audits taking place in Surge 1
- limited hand hygiene audits were provided for ED and a sample of audits reviewed from Patrick's and AMAU did not have compliance totals calculated or associated action plans provided
- QIPs planned by the service in response to the NIES had not been implemented.

Judgment: Partially Compliant

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

Overall, while some workforce arrangements in the hospital were planned, organised and managed to provide high-quality, safe and reliable services in the hospital, staffing deficits identified in Surge 1, ED and the IPC team had the potential to impact on the quality and safety of care. These are similar to findings on the previous inspection in March 2024.

Although there were minimal deficits in staffing from the 23 allocated NCHD posts in ED, management informed HIQA that significant agency cover was required to maintain the NCHD roster in ED, which can affect sustainability. On a review of rosters for the weeks prior to the inspection, it was found that, from 12 January 2026 to the day of inspection, 71 of a total of 296 shifts were covered by agency NCHDs. Six shifts were not covered in that timeframe. Staff reported that this could negatively affect skill mix. When this was discussed with hospital management, they outlined that they had identified a need for more senior decision makers and had increased ED consultant posts by two to eight. 0.2 WTE of this allocation was assigned to University Hospital Waterford. All posts were filled at the time of inspection either through permanent, temporary or agency contracts. Following inspection, it was confirmed

that recruitment for the vacant posts had commenced. Hospital management confirmed that the consultant rota was fully covered with the use of locum consultants but that this arrangement impacted consultant availability. 20 ED consultant shifts from a total of 111 were covered by agency staffing in the month prior to the inspection. The lack of consultant staffing was a risk recorded on the ED risk register.

Included in the ED staffing complement were eight CNM2 grades and seven CNM1 grades. A minimum of 13 staff nurses were rostered on days and 10 on night duty for the adult ED. Five of the allocated 77 WTE staff nurse positions were vacant, and this was being managed through the use of agency staff. ED management outlined that recruitment delays were impacting on the filling of these posts. Two staff nurses on day shift and one on night duty were allocated to the paediatric ED. A review of rosters showed that these staffing levels were in place in the four weeks leading up to the inspection. Two HCAs were allocated on each shift from a total of 10 WTE, and this was in place on the day of inspection.

Since the inspection in March 2024 the hospital had recruited an additional four anaesthesiologists to bring the total complement to eight. However, in order to provide the '2 plus 2' model[§§] of emergency cover recommended for hospitals with co-located obstetrics units, the hospital had identified that a total of twelve anaesthesiologists were required. At the time of the inspection the '2 plus 2' model was not in place. Hospital management reported that this had been escalated to the IHA manager but that no immediate plans were in place to address this. This issue was recorded on the corporate risk register.

Hospital management confirmed that medical and surgical consultants were on the relevant specialist division of the specialist register with the Irish Medical Council (IMC) with minimal exceptions. The clinical director confirmed that they had oversight of consultants not on the specialist register.

The QPS and consumer affairs department was fully staffed with a QPS manager, clinical risk manager, a quality co-ordinator and a maternity clinical risk services officer. This was an improvement from the previous inspection but staffing gaps prior to the inspection had affected the functioning of the QSC as discussed under national standard 5.2.

The IPC team comprised a CNM2 and a consultant microbiologist who had a 0.5 WTE allocation to the service. An ADON position was vacant, and a recruitment process was underway. Another CNM2 position in the team was also vacant due to statutory leave. Management outlined some supports that had been provided by other acute and community services and that they were liaising with regional structures for support. Inspectors were informed that the deficit had an impact on IPC support for clinical areas, surgical site surveillance and audit activity. For example, the team were unable

[§§]Model of Care for Anaesthesiology, National Clinical Programme for Anaesthesia 2019

to visit clinical areas and were providing phone support. Staffing deficits in this team impacted on IPC oversight of Surge 1 as discussed in national standards 5.8 and 2.7. IPC staffing was recorded as a risk on the IPC risk register.

A review of rosters in Surge 1 showed that three staff nurses were rostered on day and night shifts plus a CNM1 on day shift from Monday to Friday. As discussed earlier in the report, inspectors were informed that approval had been granted for the upgrade of this CNM1 post to a CNM2 position and recruitment had commenced however, this was not in place on the day of inspection. Inspectors were informed while onsite that approval was granted to fill the post immediately. In their response to the request from HIQA after the inspection, the service provided assurances on the immediate commencement of a CNM2. A total of 11 WTE staff nurses including the CNM1 had been allocated as the total resource for 11 beds. However, no HCAs or additional permanent staffing were in place for the additional two beds that were regularly in use and three trolleys. Additional agency staffing was sought when needed for these beds. On the second day of inspection two agency nurses had been allocated to cover deficits from short term leave which resulted in total staffing of three agency nurses and one staff nurse on the day shift plus the CNM1. No HCA was allocated on the day. From 12 January 2026 to the day of inspection, 21 of 132 nursing shifts were unfilled in Surge 1. In the assurances provided by the service regarding a sustainable staffing model they outlined that a business case would be submitted to secure approval for permanent staffing for Surge 1.

In Florence ward a review of rosters showed three staff nurses on day and night shifts and one HCA. Inspectors were informed that the allocation for Florence ward under the safer staffing initiative was four staff nurses on days, but one nurse had been redeployed on the day of inspection leaving three staff nurses on the ward. Patrick's ward had approval for six staff nurses and two HCAs on day shifts. At night, four staff nurses and one HCA were allocated. No deficits in staffing were identified in Patrick's ward on the day of inspection.

Pharmacy staffing included the pharmacy executive manager, three advanced specialist pharmacists, a senior AMS pharmacist, 2.5 WTE staff grade pharmacists, four senior pharmaceutical technicians and five staff grade pharmaceutical technicians. One staff grade post was vacant at the time of inspection. Inspectors were informed that staffing impacted on the ability of the pharmacy team to cover all clinical areas and a prioritised service for medicines reconciliation was in place. This and other findings from this inspection in relation to prescription charts are further discussed under national standard 3.1.

HIQA were informed that staffing deficits of three grade IV posts in the human resources function were impacting on the recruitment efficiency for the hospital. A

workforce plan for 2026 outlined the key areas of focus for staff recruitment and retention.

The human resource department tracked staff absenteeism rates. This was reported as 8.5% in December 2025 which was above the HSE target of 4% or less. Figures reviewed for 2025 showed that the rate was above 5% monthly. Management stated that back-to-work interviews were conducted with staff on return from unplanned leave.

Gaps were identified in relation to compliance with mandatory training. For example, basic life support (BLS) training compliance was 27% for HCAs and 47% for doctors. This was also a finding on the previous inspection in 2024. Mandatory training compliance varied in the clinical areas visited. For example, training compliance for staff nurses in BLS was 38% in Surge 1, 50% in Florence ward, 61% in Patrick's ward and 82% in ED. Other areas had high compliance for example, medication safety education compliance for nurses on Patrick's ward and Florence ward was 100%. Training in the INEWS ranged from 64% for nurses in Patrick's ward to 76% on Surge 1 and 100% for HCAs on Patrick's. Sepsis training compliance in the ED was 94% for nurses. Standard and transmission-based precautions training compliance for HCAs was 30% and 64% for nurses in ED. Hand hygiene training ranged from 76% on Surge 1 to 97% on Patrick's ward. CNMs had oversight of mandatory training compliance in the clinical areas and described initiatives to improve compliance.

In summary, deficits in workforce arrangements in place had the potential to impact on the quality and safety of services delivered at the hospital. These included;

- no permanent nursing staffing were in place for the additional two beds that were regularly in use and three trolleys in Surge 1
- deficits in staffing were identified in the IPC team which impacted on the service provided
- the '2 plus 2' model of anaesthesiology care was not in place
- medical staffing rosters in the ED were reliant on agency staff
- deficits were identified in compliance with mandatory training compliance, for example BLS training. This is a repeat finding from the inspection in March 2024.

Judgment: Partially Compliant

Quality and Safety Dimension

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

Wexford General Hospital was substantially compliant in three national standards (1.6, 1.8 and 3.3) and partially compliant in two national standards (2.7 and 3.1).

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

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

Patients were cared for in mixed gender bays on Florence ward and on Patrick's ward. No patients identified a concern with this arrangement; however, management had not identified this as impacting on patient's dignity and privacy as a risk and assessed it. A risk assessment was requested by HIQA and completed while inspectors were onsite. This detailed existing control measures and additional actions required with action owner and due dates documented. Curtains were in use in multi-occupancy bays to maintain privacy. Evidence of this was observed by inspectors for example, the use of a privacy screen to surround an additional bed in a multi-occupancy room on Florence ward. One patient accommodated in an additional bed did not report any issues with privacy to inspectors. In Surge 1, although curtains were placed in between each bay to increase privacy, there was limited space and staff commented that the ward could get very crowded at times. The space in front of the nurses' station was a narrow thoroughfare with staff and patients having to pass by other patients' beds to access the area.

In ED three patients were accommodated on trolleys in the ward corridor on the day of inspection. Patients who were accommodated on these trolleys did not express any concerns regarding privacy. A sensory room was located within the paediatric ED area.

A family room was available on Florence and Patrick's wards for use by families of patients receiving end-of-life care and for communication requiring privacy. A ward mission statement and philosophy of care was on display on Florence ward.

On Florence ward and Patrick's ward healthcare records were stored on the ward corridor in trolleys that were not locked. In Surge 1 some healthcare records were stored on a table on the corridor. After the inspection hospital management informed

HIQA that a secure cabinet had been ordered for this area. Inspectors observed patient names above bed spaces which did not promote privacy and confidentiality.

A number of patients commented that they were kept informed of the plan for their care. A patient information booklet was available which detailed discharge information for patients. An equality review of the hospital's services for individuals who are deaf and use Irish Sign Language had been carried out and a QIP developed with actions due for implementation throughout 2026. Information on independent advocacy services was on display in the ED, but it was not on display in all the ward areas. It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. However, the following was identified:

- although information on independent advocacy services was on display in the ED, it was not on display in all the ward areas
- patients were accommodated in mixed gender bays.

Judgment: Substantially Compliant

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

The hospital had systems in place to respond effectively to complaints. The hospital had a designated complaints officer assigned with responsibility for managing complaints. Formal complaints received by hospital management were managed in line with the HSE's complaints management policy '*Your Service Your Say*'.

A complaints officer position, which had been vacant at the time of the last inspection in 2024, had been filled since July 2025. Hospital management formally reported on the number and type of complaints received to the HSE annually and was tracking compliance with the HSE KPI of percentage of complaints closed within 30 days of being acknowledged by the complaints officer. In 2025, 66% of complaints were resolved within 30 working days which had improved from the 2024 inspection when this was 59%. However, this still did not meet the HSE's target of 75%.

Complaints trending was completed and common themes identified. An annual report was produced outlining complaints KPI's. Trends and complaints were discussed at the EMT and QSC meetings. CNMs received an annual communication on complaints and compliments for the hospital. However, CNMs did not report receiving a breakdown of trended complaints for their own individual clinical area. Staff in the clinical areas reported the communication of individual complaints and compliments at daily huddles.

A quality improvement plan to increase service user feedback had been undertaken. Among the actions that had been implemented by the service was the development a feedback poster with a QR code that linked directly to an email address for the patient services department. This was observed in clinical areas visited. Quality improvement plans (QIPs) arising from complaints trends were implemented for example, upgrades to the seating area in the ED waiting room and access to snacks. Another identified trend in the theme of communication had resulted in a campaign to increase availability of communication training for staff. Meeting minutes indicated that The National Healthcare Communication modules 1, 2 and 3 were available for staff to attend onsite. Complaints information leaflets were available in the ED. Some patients who spoke with inspectors were not aware of how to make a complaint but reported they would speak with a nurse, and none wished to make a complaint at the time. Comment boxes were noted in Surge 1 and in ED.

Overall, the hospital had systems in place to effectively manage and respond to complaints. However,

- compliance with the HSE KPI for complaints investigated within 30 working days of being acknowledged by the complaints officer was below the target of 75%
- CNMs did not report receiving a breakdown of trended complaints for their own individual clinical area.

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.

Inspectors observed that in most of the clinical areas visited the physical environment supported the delivery of high-quality, safe, reliable care with the exception of Surge 1. Significant infrastructure issues were identified there which had the potential to impact on the safety of patient care in that area.

Surge 1 had five single isolation pods and three single rooms, one of which had en-suite toilet and shower facilities. These pods were small in size which necessitated the beds to be placed along the wall. In the main area of the ward five beds were accommodated in individual bays. Beds were placed against a wall which divided each bay. There were no doors to these bays and they were not large enough to accommodate a bed, chair, tray table and patient belongings and so chairs were placed at the end of the beds which reduced the available corridor space in front of the nurses' station for staff attending to patients. The limitation on space meant that

each bed was in contact with the hand hygiene sink in place in each bay and therefore the sinks could not be accessed for hand hygiene purposes. Household staff confirmed a flushing routine was in place for these out-of-use sinks although records show that flushing was completed generally on the ward and individual sinks not recorded.

An additional three trolleys were accommodated in a room called "Office 1" in Surge 1, one of which was occupied on the day of inspection. This room was previously an office, and it did not have call-bells, piped oxygen or suction. A portable oxygen cylinder was available in the bay. One shower was available for the 15 patients accommodated on Surge 1. This shower was located in an area that was until recently a staff changing area and co-located with the staff toilet. Lockers with staff belongings remained in this area which did not have any call-bell access. Although one patient reported that staff had assisted them to shower, another patient commented that they had not had a shower and were not aware of where to access one.

HIQA wrote to senior hospital management after the inspection seeking assurances on the lack of access to emergency call systems in "Office 1" and the shower room located within the staff changing area. The response included a risk assessment of these spaces on Surge 1 which outlined existing controls and outlined a planned action to install call-bells in these areas with an action due date of February 2026. The surge spaces on Florence ward and some of the surge spaces on Patrick's ward did not have access to a call-bell. Staff outlined that a dynamic risk assessment was carried out with regard to appropriate patient placement in these beds. No criteria for patients accommodated in this area was available on the day of inspection. Patients accommodated in these beds commented that they had no call-bell but that they could call a nurse if they needed anything.

No risk assessment had been completed for Surge 1 layout and infrastructure with respect to IPC, managing a deteriorating patient or cardiac arrest. This was communicated to the ADON on the day of inspection. HIQA wrote to hospital management after the inspection outlining the high risks identified in relation to IPC and deteriorating patient management in Surge 1 as discussed previously in this report. The service carried out and submitted risk assessments as part of their response. Each risk had an action plan, owner and action due date.

The ED comprised: two triage rooms, two resuscitation bays, one generally used for adults and the other for paediatric patients, two assessment rooms, which were also used for review clinics, 12 adult treatment rooms, one psychiatric assessment room, one family room, one procedure room and one plaster room, a minor injury area containing two treatment rooms and a surgical streaming unit with one treatment room. The acute medical assessment unit (AMAU) had eight cubicles and had 16 patients in attendance on the day of inspection. Three patients were admitted and lodged in the ED awaiting beds in the hospital on the morning of the inspection. Three patients were accommodated on trolleys in the ward corridor on the day of

inspection. Due to space limitations these trolleys were not spaced one metre apart as advised in national guidance. This also impacted on available private space, for example when a patient was changing their clothing. This was brought to the attention of management in the ED.

The paediatric ED had seven treatment rooms and its own waiting area that was located in a corridor off the main ED. One paediatric patient was accommodated in this area at the time of the inspection.

Inspectors visited Florence ward and Patrick's ward, a 19-bedded general medical ward and 32-bedded surgical and general medical ward respectively. Both wards contained multi-occupancy rooms with four and five single en-suite rooms on each ward. Each multi-occupancy area had a toilet and shower. Additional surge capacity was allocated via three additional beds on Florence ward and four additional beds on Patrick's ward. One of these spaces on Florence ward was occupied on the day of inspection. Surge 1 was a 13-bedded area with a mix of five isolation pods, three single rooms and five beds in the main ward area. Three additional trolley spaces were accommodated in a multi-occupancy room that was previously used as an office space.

A door on Surge 1 was used by the public accessing an outpatient's service and this door exited to the road outside the hospital. Although staff said that no patients with exit seeking behaviours were accommodated on the ward, this was not supported by defined admission criteria. After the inspection, hospital management confirmed that outpatients attending the service would be re-directed to the main hospital entrance and that use of this door remained for emergency access only.

Patients were isolated for infection control purposes where possible. The hospital was challenged due to an insufficient number of isolation rooms that had en-suite facilities. On the day of inspection patients with the same infection were cohorted together in multi-occupancy bays in Florence ward and Patrick's ward. Appropriate isolation signage was in use. A quick reference guide for multi drug resistant organism's patient placement was dated 2024 and did not align with practices at the hospital. For example, it outlined that one toilet should be available for every four patients cohorted with an MDRO however this was not in place. Appropriate personal protective equipment was available. A quick reference guide to decontamination of non-invasive and non-critical medical device was in draft format. Practices outlined aligned to what inspectors observed, for example the appropriate use of PPE and cleaning solutions.

Inspectors observed that sharps waste material was correctly stored and there were appropriate segregation and storage of linen and waste. Stock and equipment were stored appropriately in most cases; however, there were some exceptions. For example, on Florence ward patient belongings were stored on the floor in the multi-occupancy rooms and in a dirty utility area. In Patrick's ward some boxes were stored

on the floor of the clean utility and patient moving and handling equipment was stored in a shower room. Some boxes were stored on the store room and corridor floor in ED although inspectors noted these areas were tidy. Inappropriate storage of staff belongings was noted in the cleaner's room, stock room and in the nurses' station where staff were completing documentation on Surge 1. Not all hand-hygiene sinks in the clinical area met the required specifications. For example, hand-hygiene sinks in one room on Patrick's ward, Florence ward and in AMAU. Staff had access to wall-mounted alcohol-based hand sanitiser dispensers throughout the ward areas.

Routine environmental cleaning was completed by cleaning staff from 8am to 8pm. A phone number was available for out-of-hours cleaning requests. Terminal cleaning was carried out as required. A system was in place to identify equipment which had been cleaned, for example, the use of checklists and these were kept up to date. The cleaning supervisor had oversight of this checklist. Ward environments were clean with few exceptions. HCAs were assigned with responsibility for cleaning equipment. Inspectors observed that equipment was clean in the clinical areas visited with the exception of a medication trolley and medication equipment on Patrick's ward that was not included on a cleaning schedule. HIQA highlighted in the 2019 and 2020 inspections the hospital's practice of decontamination of integrated sharps trays in the washer disinfectors in the dirty utility. On discussion with staff, it was evident that this practice remained in place in Patrick's ward. This was not aligned to the local hospital guidance with regard to the cleaning of low or semi-critical medical devices. Florence ward staff were unaware of policy to guide the frequency of curtain changing although they outlined a process of changing these as required after a patient with an infection. In Patrick's ward the curtain changing frequency aligned with the policy.

Staff reported that they had access to maintenance services and clinical areas visited were generally well maintained. Security staff were allocated to the ED during the day, and HIQA were informed that this was due to become a 24/7 allocation soon after the inspection.

Overall, although the clinical areas in the hospital were clean and, in most cases, items were stored appropriately, significant infrastructure challenges and storage issues were identified which did not support the delivery of high quality, safe, reliable care.

Specifically;

- the design and layout of the environment in Surge 1 was not in line with national guidance for example, lack of access to hand hygiene sinks, lack of storage space for personal belongings and proximity of bed spaces to hand-hygiene sinks
- no call-bell access in the shower and "Office 1" of Surge 1 or for additional beds placed in Florence ward

- trolley's accommodated on the ED corridor did not allow for one metre distance in between each trolley
- no defined criteria were in place for patient placement on Surge 1
- an exit door from Surge 1 was leading directly on to a road
- the cleaning of sharps trays in bed pan washers did not align with local policy
- inappropriate storage was noted in multiple ward areas.

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

Risks in relation to transitions of care, quality and safety and workforce were recorded on the hospitals corporate risk register. However, some risks that had the potential to impact on the quality and safety of patient care had not been fully assessed or managed by the service. For example, the infrastructure in Surge 1 and the placement of patients in mixed gender bays. During the inspection, a risk assessment for the use of surge areas was requested and detailed existing control and additional actions each with an action owner and due date. However, the additional actions required included the construction of a new medical block providing 97 beds and this infrastructure development was not due for completion until 2028.

Inspectors were informed that a lack of single room availability throughout the hospital impacted on patient flow and some patients needed to remain in the ED while awaiting a suitable isolation space. This was recorded on the hospital's risk register. Other issues impacting on patient flow had been identified, for example, a delay with inpatient specialities reviewing patients in the ED. An additional registrar for medicine had been allocated in recent months which had eased the delays but overall, the waiting times had increased from the previous inspection. Inspectors were informed that access to diagnostics impacted on patient flow in the ED. A business case had been submitted by the service for additional radiography staffing to support the on-call service by having two on call. Access to diagnostics impacted by lack of staff on call was listed on the top five risks in the service's monthly performance report.

All patients in the ED were triaged and prioritised in line with the Manchester Triage System. The hospital was monitoring activity in relation to the ED and AMAU. On the day of inspection there were no 24-hour Patient Experience Time (PET) breaches. However, on the day of inspection the service was not meeting the HSE targets for six and nine hours PETs which were 32% (target 70%) and 68% (target 85%) respectively. The hospital was not meeting the national KPI for 6-hour PET times for patients over 75 which was 66% with the target of 99%. The year to date (YTD)

average PET was 5.7 hours which was below the national average of 7.17 hours. On the first day of inspection the average waiting time from registration to triage was 17 minutes, this was an increase from an average waiting time of five minutes during the inspection in March 2024. Average waiting time from triage to medical assessment was 48 minutes, and at the time of inspection in 2024 this was 15 minutes. The range of waiting times from decision to admit to admission to an inpatient bed was three hours and 30 minutes to 18 hours, an increase from a range of one hour to 12 hours in 2024.

On the day of inspection, the hospital was in red escalation in line with their internal escalation framework. As discussed earlier in the report four additional beds and four trolleys were placed on four wards across the hospital as well as surge capacity in Surge 1. In the main ED 47 patients were present, at various stages of treatment.

The AMAU operated 8:30am to 9:30pm Monday to Friday, had defined inclusion and exclusion criteria for accepting patients and was functioning as an alternative pathway of care for ED presentation at the time of the inspection. AMAU had accepted 11.19% of ED admissions in January 2026. There were pathways in place to facilitate ED flow. For example, an advanced nursing practitioner (ANP) service comprised 4.28 WTE in ED and one paediatric ANP who reviewed patients in their referral criteria. A frailty intervention therapy team comprised a clinical nurse specialist, physiotherapist, and occupational therapist, operated Monday to Friday 9am to 5pm and reviewed adults over 75 years to optimise referral pathways and discharge planning. A new general practitioner (GP) liaison nurse service had commenced in January 2026, and this role focussed on improving communication for GPs and patients in the ED.

The discharge lounge which had been in use at the time of the last inspection was no longer operational and hospital management cited that space limitations had led to this closure. On the first day of inspection, there were seven beds subject to delayed discharge in the hospital.

In line with national guidance and based on a risk assessment, patients were screened for multidrug-resistant organisms (MDROs) on admission to the hospital. The hospital's information technology system alerted staff to patients who had previously been admitted and had a confirmed MDRO. However, in two records in ED, no IPC status was recorded on the ED care plan. The hospital was monitoring KPIs such as hospital acquired infection rates. For example, a trend of increased vancomycin resistant *enterococcus (VRE)* infections linked to one ward had been noted in March and April 2025. A process audit and action plan had been completed and improvements noted in quarter three 2025. Rates of *Clostridioides difficile* were not within national parameters in 2025. A plan was developed including recommendations for decontamination of equipment and the environment. Antimicrobial stewardship was monitored by the IPCC and monthly antimicrobial consumption data recorded. On the day of inspection there were active outbreaks of influenza and COVID-19.

Inspectors noted that there had been several outbreaks of COVID-19 and influenza throughout 2025. Outbreak reports were completed that detailed contributing factors and learnings. The hospital had identified that the lack of single room availability was a factor in the spread of healthcare associated infections and this was identified in a outbreak report reviewed and listed on the corporate risk register.

Emergency equipment was available in each clinical area and there was evidence of appropriate checks. As discussed previously the room accommodating trolleys in Surge 1 (Office 1) did not have piped oxygen or suction. A portable oxygen cylinder had been placed in the room. As discussed under national standard 2.7, space was limited on the ward. The impact of the space and infrastructure deficits in the ward environment had not been risk assessed through the lens of the deteriorating patient to control and address the lack of space for managing a deteriorating patient, cardiac resuscitation of a patient and completing clinical examinations. In response to the request for assurance from HIQA, hospital management completed risk assessments for this risk. Each risk assessment had identified controls and additional actions required with due dates recorded. Hospital management also assured HIQA that deteriorating patient and cardiac arrest simulations were carried out after the inspection and scheduled to take place monthly thereafter. Emergency call response system information was on display in the ward area and in ED.

Inspectors were informed that the hospital was following national guidelines for Irish National Early Warning System (INEWS) and Emergency Medicine Early Warning System (EMEWS). All staff in the general hospital spoken with were knowledgeable about the INEWS and the escalation and response protocol to ensure timely management of patients with a raised early warning score. Inspectors reviewed a sample of INEWS charts. It was observed that, while the many of entries reviewed were appropriately recorded and adhered to the required observation frequency there were some examples where national guidance was not followed. For example, for a score of five, observations were not repeated at the required one-hour interval, and no review had been carried out by a doctor.

EMEWS had been introduced at the hospital in quarter three 2025. ED had an allocated staff nurse dedicated to completing EMEWS. On the day of inspection, a sample reviewed showed that EMEWS was in place for patients requiring it. In two healthcare records checked the repeat EMEWS scores were not recorded in the timeframe required by the policy. Monthly EMEWS audits were carried out and showed an improvement from 30.6% in November 2025 to 44.4% in December 2025. This improvement continued to 51.8% in January 2026. One issue identified was the format of the current EMEWS form and an action plan was in place to address this.

The ISBAR communication tool was in use for transitions of care. For example, an ISBAR form was included on the ED chart for handover to the inpatient wards for both adults and paediatric patients. The nursing shift handover in Surge 1 was in ISBAR

format. A nursing patient transfer tool in use was in ISBAR format. The ISBAR communication tool was used for the escalation of a raised INEWS score and recorded on a sticker in the chart. On the day of inspection, there was evidence that ISBAR was in use for a patient requiring escalation of care on Florence ward and there was evidence of appropriate review by medical staff.

Medicines reconciliation was performed in some wards and not on all patients, for example, no medicines reconciliation was completed on Surge 1 or for any patients whose charts were reviewed by inspectors on Florence and Patrick's wards. This was supported by the hospital policy which stated that medicines reconciliation was dependant on staffing levels and prioritised for high-risk patients. Patrick's ward had an allocated pharmacist; however, Florence ward did not have allocated pharmacy staffing. There was no section on the medication prescription and administration record in use in Florence ward for recording medicines reconciliation, however, inspectors were informed that the communication section of the medication record was used if required by pharmacists to communicate concerns. Of the sample reviewed in Florence ward there was no evidence of this being used. A new medication prescription form had been recently introduced at the hospital with the aim of improving practice. However, this project was still ongoing and in some clinical areas both the new and the previous version of the prescription were in use simultaneously. This was highlighted to hospital management at the time of the inspection. Gaps were identified in the documentation of medication prescriptions, for example, patients' weights were not recorded in any of the three records checked in Florence ward, and one record in Surge 1 and on one record in ED. Patient allergy status was not documented in four records reviewed from ED and Surge 1. Similar issues had been identified from medication safety nursing metrics and were discussed at the November 2025 meeting of the DTC. Planned actions included regular audits and feedback to staff however these actions were not assigned to a named person or time bound.

Medications were appropriately stored in locked medication rooms in each ward with keypad access. The lock on one medication press on Patrick's ward was not working, and this was brought to the attention of ward management. Staff had access to a medication fridge in each clinical area and temperatures were monitored. Controlled medications were appropriately stored and there was evidence of appropriate checks. A sample of these were reviewed and were observed as accurate. However, there were some examples of poor medication management practices. For example, in Patrick's and Florence wards the date of opening had not been recorded on a multi-dose prefilled medication pen that was currently in use, and a high-risk medication was not labelled. In Florence ward no patient name or date of opening had been recorded on an open medication in the fridge.

Up-to-date medicines information, intravenous medication information and information such as posters on time critical medicines were available. Sound-alike look-alike (SALAD) medications and high-risk medications information was on display. However, some information was out of date such as a medication formulary in ED dated 2023 and intravenous medication monographs that were due for review in 2025. The pharmacy department had undertaken number of high-risk drug reviews for individual high-risk medicines that identified known risks from literature, local incidents and measures to reduce the risk including a list of risk reduction strategies. A medication safety programme outlined key goals and target implementation dates for 2026.

A number of policies, procedures and guidelines were available to guide staff and many of these were up to date. However, there were a small number of policies which were not up to date, and this was also a finding on the previous inspection. For example, the guideline for transferring critically ill patients which was due for review in 2021, and the Ely campus policy and procedure was due for revision in 2022.

Overall while the service had systems in place to protect service users from the risk of harm, the following was identified;

- access to medicines reconciliation was limited and provided to patients on a prioritised basis
- the hospital had not identified a risk in relation to emergency equipment in Surge 1
- the impact of the space and infrastructure deficits in Surge 1 had not been risk assessed through the lens of the deteriorating patient to control and address the lack of space for managing a deteriorating patient, cardiac resuscitation of a patient and completing clinical examinations
- there were examples where national guidance was not followed in relation to INEWS and EMEWS escalation and response protocols and audit findings for the EMEWS and ISBAR showed low compliance
- gaps were identified in the documentation of patients' weight and allergy status on medication prescriptions
- there were two different versions of medication prescription form in use simultaneously
- some PPPGs had not been reviewed in line with their planned review dates
- patient experience times in ED had disimproved from the last inspection and were impacted by patient flow from the ED to inpatient wards.

Judgment: Partially Compliant

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

There were effective systems and processes in place in the hospital to proactively identify and manage patient-safety incidents. Incidents were recorded on a national incident report form and sent to the risk manager. As discussed in national standard 5.8, patient-safety incidents were logged on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework (IMF). As discussed in national standard 5.8, the SIMT had oversight of patient safety incidents. Separate meetings for the general hospital and maternity service were held, met every two months and were chaired by the hospital manager.

Staff in the clinical areas were aware of the process for the reporting of incidents and confirmed that incidents were discussed at safety pauses. Medical staff reported getting feedback on incidents at weekly meetings. Feedback was provided to CNMs and staff in the clinical areas were aware of their incident trends.

The hospital reported on incident management KPIs at monthly performance meetings with the IHA. External patient-safety reviews carried out in response to serious incidents were not completed in line with the HSE KPI of 125 days throughout 2025 due to deficits in the QPS and consumer affairs department as outlined earlier in the report. This was also a finding on the inspection in March 2024. The QSC had oversight of incidents and QIPs. Governance committees had oversight of incidents in their relevant areas. Overall, inspectors found there was a system in place at Wexford General Hospital to identify, report, manage and respond to patient-safety incidents. However, the following was identified;

- incident reviews were not carried out in the timeframe in line with the HSE KPI of 125 days.

Judgment: Substantially Compliant

Conclusion

The hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. These findings were not consistent across all clinical areas however, as high risks were identified in relation to governance, oversight and management of Surge 1. These were escalated to hospital management after the inspection and assurances received as outlined in the report regarding the governance of Surge 1.

Effective management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare services, however deficits in management arrangements were identified in Surge 1. While some workforce arrangements in the hospital were planned, organised and managed to provide high-quality, safe and reliable services in the hospital, staffing gaps were identified including those in Surge 1 and the IPC team. These had the potential to impact on the quality and safety of care. Gaps were identified in compliance levels with mandatory training.

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. The hospital had systems in place to effectively manage and respond to complaints. Significant infrastructure issues were identified in Surge 1 which had the potential to impact on the safety of patient care in that area. Risks in relation to transitions of care, quality and safety and workforce were recorded on the corporate risk register. However, not all risks identified during the inspection had been identified or managed by the service. Inspectors found there was a system in place at Wexford General Hospital to identify, report, manage and respond to patient-safety incidents.

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 being employed to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance Classifications

An assessment of compliance with 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.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	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
Theme 3: Safe Care and Support	

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance plan for: Wexford General Hospital

Inspection ID: NS_0186

Date of inspection: 4 and 5 February 2026

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

Area for improvement	Recommendation
High risks as outlined in this National Standard were identified in the governance, management and oversight of Surge 1	The appointment of a CNM2 and a CNM3 with management, governance and oversight for Surge 1 has been complete and staff now in post. Timescale: Complete
The QPS, USCC and DP committees were not meeting at the frequency outlined in the TOR	See below schedule for QPS and DP 2026. The USCC has been stood down.

DP 12th March 2026	Complete
DP 21st May 2026	Complete
DP 1st Sept 2026	Scheduled
DP 24th Nov 2026	Scheduled
QPS Exec 24th Feb 2026	Complete
QPS Exec 21st April	Complete
QPS Exec 16th June	Complete
QPS Exec 11th Aug	Scheduled
QPS Exec 20th Oct	Scheduled
QPS Exec 15th Dec	Scheduled

Assigned time-bound actions were not identified by some committees and this was a finding on previous inspection	EMT members have been requested to ensure that all committees/meetings under their remit include timeframes within the action plans. QPS to monitor. Timescale: Complete 8.6.26
Findings from the inspection in March 2024 had not been actioned.	Timebound actions plans - see above recommendation BLS training - See Standard 6.1 compliance plan Out of date PPPGs - See Standard 3.1 compliance plan Electronic document management system - See Standard 3.1 compliance plan

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.	Partially Compliant

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

Area for improvement	Recommendation
There were no environmental, IPC, medication safety, DP or transitions of care audits taking place in surge 1	A schedule of audits is now in place. Environmental, sharps and equipment audits continue monthly, hand hygiene audits continue quarterly and IPC audits as per the yearly schedule. INEWS escalation and response, chart completion and ISBAR audits continue quarterly and are reported to the Deteriorating Patient (DP) committee. Nursing Quality Care Metrics are completed monthly which include medication safety audits. These are reported to the QPS executive, IPC and DP committees. Timescale: Complete and Ongoing
Limited hand hygiene audits were provided for ED and a sample of audits reviewed from Patrick's ward and AMAU did not	The importance of ongoing hand hygiene audits has been raised at the CNM meetings. The senior nursing team in all ward areas including ED, Patricks and AMAU have provided a specific focus

have compliance totals calculated or associated actions plans provided	ensuring that hand hygiene audits have been undertaken with compliance totals calculated and actions plans developed. Findings will be presented at the next IPC committee meeting. The IPC team will also undertake yearly (at least) hand hygiene audits in all clinical areas. Timescale: Complete and Ongoing
QIPs planned by the service in response to the NIES had not been implemented	The Consumer Affairs and the QPS Department have met to focus on the QIP progression and its implementation. Timeframe: 30th September 2026

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

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

Area for improvement	Recommendation
No permanent nursing staffing were in place for the additional 5 beds that were regularly in use in Surge 1	Additional staff requirements have been escalated to the IHA Manager Waterford Wexford for attention and progression. Discussions are ongoing. Timescale: 30th September 2026
Deficits in staffing were identified in the IPC team which impacted on the service provided	The vacant post (CNS IPC) is in preclearance. The ADON IPC is in post since April 2026. Timescale: As soon as possible ensuring compliance with recruitment processes
The '2 plus 2' model of anaesthesiology care was not in place	An additional four WTE are required to facilitate implementation of the '2 plus 2' model. This has been escalated to the Regional Clinical Director for approval. To date approval has not been received to progress. Timescale: Dependant on approval being secured

Medical staffing rosters in the ED were reliant on agency staff	Deficits in the medical staffing roster in ED remains reliant on agency staff. Approval is pending for additional NCHDs posts. This has been escalated to the regional Clinical Director and IHA Manager Waterford Wexford for approval to progress. Timescale: Approval awaited
Deficits were identified in compliance with mandatory training compliance, for example BLS training. This is a repeat finding from the inspection in March 2024.	The need has been identified for additional nursing staff to support the training needs and demands of the hospital for BLS training. This is a work in progress. There are two midwifery staff in place currently to support this. BLS compliance rates are monitored through the Deteriorating Patient committee. Other training data that is validated, monitored and reported to the DP committee is sepsis, INEWS, EMEWS, PEWS, IMEWS, BLS and ACLS. It is acknowledged that there are deficits in compliance with specific mandated training courses. The governance for monitoring compliance of staff training is with line managers who submit the data to the database. A hospital wide database is in place which is updated quarterly and findings reported to EMT. Compliance will continue to be monitored through EMT. Timescale: Ongoing

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.

Area for improvement	Recommendation
The design and layout of the environment in Surge 1	Surge 1 is due to close in July for window replacement, energy efficient works (National Pathfinder Project). The

	was not in line with National guidance for example, lack of access to hand hygiene sinks, lack of storage space for personal belongings and proximity of bed spaces to hand hygiene sinks	sinks that currently are at the end of the bed spaces will be removed at this time. There is access to sinks for hand hygiene purposes and Spirogel is available at every bed space. The staff lockers have been removed from the shower space. A working group will assess and review appropriate safe utilisation of the space prior to reopening including storage space. Upgrade works will include new windows, blinds, flooring and light fittings. Perspex screens erected during Covid will be removed in this area which will improve the overall environment. The EMT continue to work with HSE Capital and Estates and the IHA Manager to explore solutions to bed capacity deficits. Timeframe: 30th September 2026
	No call bell access in the shower and 'Office 1' of Surge 1 or for additional beds placed in Florence ward	Patients are accompanied by staff for the duration of a shower. When patients are admitted to 'Office 1' a third nurse is allocated to remain with and care for patients in this area. WGH are working with maintenance to upgrade the area subject to funding approval and this area will take priority. This will require a full upgrade to update the existing system and the additional upgrades that are required. The existing system cannot be expanded to include the additional requirements. A dynamic risk assessment (utilising the 'criteria for placement guideline) is completed prior to placement of any patient in the Surge area and also additional beds in Florence to minimise the risk of immobile, deteriorating patient allocation to these areas. Timeframe: 30th September subject to funding approval

Trolleys accommodated on the ED corridor did not allow for one meter distance in between each trolley	ED staff have been reminded that trolleys are to be maintained at one meter distance. Timescale: Complete
No defined criteria was in place for patient placement in Surge 1	A PPPG including criteria for placement in Surge 1 is now in place. Timescale: Complete
An exit door from Surge 1 was leading directly onto a road	This is fire exit door. This will change to swipe access only and will be on a lock system at night. The door is swipe access from outside presently. Risk assessment of all patients placed in surge 1 continues with due consideration for those patients identified as a potential flight risk. Timeframe: 31st July 2026
The cleaning of sharps trays in bed pan washers did not align with local policy	This practice has ceased following notification from the IPC team to all clinical areas. Timescale: Complete
Inappropriate storage was noted in multiple ward areas	QPS and Nurse management Quality and Safety walk rounds will be scheduled for 2026 and will include a focus on storage and audit of inappropriate storage. Senior nursing staff, as part of regular ward visits, have reiterated to ward staff the importance of appropriate storage for personal, patient and staff belongings. Timescale: Complete

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

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

Area for improvement	Recommendation
Access to medication reconciliation was limited	Two additional pharmacists have completed induction and are now undertaking medication reconciliation. A

	and provided to patients on a prioritised basis	third pharmacist will shortly complete induction and will be completing medication reconciliation also. A 4th pharmacist is returning from statutory leave in July and will also participate in medication reconciliation. This will improve compliance and access for all patients to medication reconciliation. Timescale: 31st July 2026
	The hospital had not identified a risk in relation to emergency equipment in Surge 1	A risk assessment has been completed. This has also been incorporated into the hospital risk register. Additional simulation with the MDT has been completed June 2026 in relation to the deteriorating/cardiac arrest patients. Timescale: Complete
	The impact of the space and infrastructure deficits in the ward environment had not been risk assessed through the lens of the DP to control and address the lack of space for managing the DP, cardiac resuscitation of a patient and completing clinical examinations	A dynamic risk assessment (utilising the 'criteria for placement' guideline) is completed prior to placement of any patient in the Surge area to minimise the risk of cardiac arrests/deterioration in this area. Compliance with allocation of low-risk patients is monitored through the quarterly INEWs audits and completion of clinical incidents for deteriorating patient requiring transfer form Surge 1. Additional simulation with the MDT has been completed in June 2026 in relation to the deteriorating/cardiac arrest patients. An MDT team (ED, Medical, Anaesthetic and site management) are participating in the RCPI 'Being safe together programme' which facilitates awareness and early identification and intervention of deteriorating patients throughout the hospital including Surge. Timescale: Complete and ongoing
	There were examples where national guidance was not followed in relation to INEWS and EMEWS escalation and response protocols and	The DON, Clinical Practice Development team and CNM2s of each ward area continue to ensure completion of INEWS and EMEWS audits and associated Quality Improvement Plans. INEWS, ISBAR and EMEWS training compliance is reported to and monitored by the Deteriorating Patient Committee. Clinical simulations

	audit findings for EMEWS and ISBAR showed low compliance	continue and incorporate the use of ISBAR for communicating concerns. Timescale: Complete
	Gaps were identified in the documentation of patient weight and allergy status on medication prescriptions	A recent audit (24.4.26) has been undertaken by the QPS and Practice Development team in conjunction with the Medication Safety committee. A QIP is in place with a plan for further audit. Timescale: Complete
	There were 2 different versions of medication prescription form in use simultaneously	Only one version of the Medication Prescription and Administration Record is in use currently within WGH. Timescale: Complete
	Some PPPGs had not been reviewed in line with their planned review dates	QPS Department are working through the files in WGH publisher with relevant HODs to archive and update relevant PPPGs. The QPS Department continue to work with local IT and regional QPS team to explore financially viable options for an electronic document management system. Timescale: 31st December 2026
	PET in ED had disimproved from the last inspection and were impacted by patient flow from ED to inpatient wards.	PET is discussed at the twice daily huddles and the acute floor huddle (new initiative) to focus and drive awareness and improvement of PET. Timescale: Ongoing