Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Regional Hospital Mullingar
Address of healthcare service:	Longford Road Mullingar Co. Westmeath N91 NA43
Type of inspection:	Announced
Date of inspection:	6 and 7 December 2022
Healthcare Service ID:	OSV-0001072
Fieldwork ID:	NS_0019

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

The Regional Hospital Mullingar is a Model 3* acute teaching hospital. It is a member of and is managed by Ireland East Hospital Group† on behalf of the Health Service Executive (HSE). Services provided by the hospital to the population in the counties of Westmeath and Longford include:

- acute medical inpatient services
- elective surgery
- emergency care
- obstetrics and gynaecology care
- maternity
- paediatrics
- critical care unit
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	234 inpatient beds
Number of inpatients on day one of inspection	234

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a two-day

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

† The Ireland East Hospital Group comprises eleven hospitals. These are the Mater Misericordiae University Hospital, St Vincent's University Hospital, Cappagh National Orthopaedic Hospital, the Royal Victoria Eye and Ear Hospital, the National Maternity Hospital, St Columcille's Hospital, Loughlinstown, St Michael's Hospital, Dún Laoghaire, the Midland Regional Hospital, Mullingar, St Luke's General Hospital, Kilkenny, Wexford General Hospital, Wexford, National Rehabilitation Hospital, Dún Laoghaire and Our Lady's Hospital, Navan. The hospital group's academic partner is University College Dublin (UCD).

announced inspection at the Regional Hospital Mullingar to assess compliance with a number of standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, healthcare inspectors‡ reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and Ireland East Hospital Group, unsolicited information§ and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- 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
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

A summary of the findings and a description of how the hospital performed in relation to the national standards assessed during the 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 at a particular point in time — before, during and following the on-site inspection at the hospital.

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality

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

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

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.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how the service performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
06 December 2022	09.00 – 17.30hrs	Emma Cooke	Lead
		Denise Lawler	Support
07 December 2022	09.00 – 15.45hrs	Danielle Bracken	Support

Background to this inspection

This inspection focused on 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 three clinical areas:

- Emergency department
- Surgical 1 (surgical and medical ward)
- Medical 1 (general medical ward)

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

- Representatives of the hospital's Executive Management Group:
  - Hospital Manager
  - Director of Nursing (DON)
  - Director of Midwifery
  - Clinical Director
- Clinical Risk Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager, Regional Hospital Mullingar
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics

** The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

†† 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. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Deteriorating Patient
- Unscheduled Care.

Acknowledgements

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

What people who use the emergency department told inspectors and what inspectors observed in the emergency department

Inspectors visited the emergency department and the Acute Medical Assessment Unit (AMAU) during the course of the inspection. The hospital's emergency department provides undifferentiated care for adults and children.

The emergency department has a total planned capacity for 25 treatment areas comprising:

- an eight-bedded open planned area located near the nurses station (inclusive of two isolation rooms)
- a two-bedded resuscitation area
- a three-bedded resuscitation area for COVID-19 patients (red zone)
- a two-bedded advanced nurse practitioner (ANP)[§§] area
- a five-bedded paediatric assessment area
- one negative pressure isolation room with en-suite bathroom facilities
- a designated area on the main corridor that could accommodate four trolleys.

On the first day of inspection, at 11am, the emergency department was overcrowded relative to its intended capacity. A total of 48 patients were accommodated in the department. Seventeen (35%) patients were accommodated on trolleys and six (13%)

[§§] Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

patients were accommodated on chairs — throughout the department, including on the main corridor, which was a public thoroughfare.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment (PPE), in line with public health guidelines at the time of inspection.

Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of receiving care in the department. Staff were described as *'busy', 'lovely', 'kind' and 'helpful'.* However, when asked what could be improved about the care received, some patients reported that they would like to *'be kept updated about test results'* and recognised that while staff were busy, they *'could listen more'.* Patients accommodated on trolleys on a corridor described their experiences as *'not good, not ideal' and* the hospital *'needs more beds'.* They explained how they were '*unable to sleep'* and how they had *'no call bell'* to call for help if needed.

The experiences recounted by patients in the emergency department were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey,*** where the hospital scored lower than the national average in the following areas:

- getting answers to important questions from doctors and nurses in the emergency department — the hospital scored 7.8 (national score 8.2)
- waiting time before being admitted to a ward — the hospital scored 6.1 (national score of 6.8).

Patients in the emergency department who spoke with inspectors said they would speak with a member of staff or the nurse in charge if they wanted to make a complaint. Patients that spoke to inspectors were not provided with information leaflets about the HSE's complaints process *'Your Service, Your Say.'* Inspectors observed information on *'Your Service, Your Say'* displayed in the emergency department during the inspection.

What people who use the service told inspectors and what inspectors observed in the two inpatient clinical areas visited

Medical 1 was a 28-bedded general medical ward comprising five four-bedded multi-occupancy rooms, two two-bedded multi-occupancy rooms and four single rooms with en-

*** The National Care Experience Programme, was a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

suite bathroom facilities. There were an additional three unfunded beds on Medical 1 giving it a total of 31 beds. One bed was located in the treatment room and two beds were located in the day room. Additional bed spaces were not dedicated, fully equipped spaces for an inpatient bed and therefore were not conducive to the delivery of high-quality, safe healthcare.

Surgical 1 was a 28-bedded ward which primarily accommodated surgical patients but also accommodated some medical patients. There was an additional one unfunded bed on Surgical 1 giving it a total of 29 beds. The additional bed was located in the treatment room. The ward comprised two two-bedded rooms with en-suite bathroom facilities, five four-bedded rooms with en-suite bathroom facilities and four single rooms with en-suite bathroom facilities. All 29 beds were occupied on the day of inspection.

Patients who spoke with inspectors described staff in the two inpatient clinical areas visited as *'beautiful' 'great' and 'you couldn't find better'*.

When asked what was good about the service or care received, some patients responded by saying *'you could not ask for better care', 'everyone is as good as each other', 'when you call the bell, they [nurses] come straight away.'* In general, patients' experiences recounted on the days of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 85% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, above the national average of 82%.

Patients in the two inpatient clinical areas visited who spoke with inspectors described how they would speak to a staff member or go online if they wanted to make a complaint. Inspectors observed patient information leaflets about the HSE's complaints process '*Your Service, Your Say'* displayed along with comment boxes in the clinical areas visited.

Overall, while patients were very complimentary about the staff and of the care received in the two inpatient clinical areas visited, the experience of patients in the emergency department was different. Patients in the emergency department identified areas for improvement, such as the need to be kept up-to-date with their plan of care and how providing care on trolleys in a corridor was not person centred and did not support the delivery of high-quality, safe care. Patients' experiences in the emergency department were consistent with what inspectors observed on the first day of inspection and with the findings from the 2022 National Inpatient Experience Survey. However, the experiences of patients in the two inpatient clinical areas visited were more positive than the survey findings.

Capacity and Capability Dimension

Inspection findings from the wider hospital and two inpatient clinical areas visited related to the capacity and capability dimension are presented under three national standards (5.2, 5.5, and 5.8) from the theme of leadership, governance and management. Key inspection findings leading to these judgments are described in the following sections.

Inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. Key inspection findings leading to these judgments 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.

Corporate and clinical governance arrangements were in place at the hospital. However, HIQA found that governance arrangements need to be strengthened to further improve the oversight of the quality and safety of healthcare services provided at the hospital.

An organisational chart submitted to HIQA detailed the direct reporting arrangements of the hospital's senior management team to the Chief Executive Officer of the Ireland East Hospital Group. During the inspection, hospital management outlined the reporting structures for other committees within the hospital which were consistent with those reported by committee representatives, however, reporting arrangements for oversight committees were not represented in the organisational chart submitted to HIQA.

The hospital was governed and managed by the Hospital Manager who was supported by the Executive Management Group. The Hospital Manager reported to the Chief Executive Officer of the Ireland East Hospital Group.

The hospital's Clinical Director provided overall clinical oversight and leadership at the hospital and was a member of the hospital's Executive Management Group. There was evidence of devolved responsibility and accountability according to clinical specialty, with the oversight and management of clinical services arranged into four clinical directorate structures:

- Women's Health Directorate
- Medicine and Emergency Department Directorate
- Perioperative Directorate (including Radiology Department)
- Paediatric Directorate.

Each clinical directorate had a designated clinical lead who was responsible and accountable for their specialty. The clinical leads reported to and were accountable to the hospital's Clinical Director.

The hospital's DON was responsible for the organisation and management of nursing services at the hospital. The hospital's Director of Midwifery was responsible for the organisation and management of midwifery services at the hospital. Both directors were members of the hospital's Executive Management Group. Both directors reported to the Hospital Manager and had a close working relationship with the Chief Director of Nursing and Midwifery for the Ireland East Hospital Group.

Hospital management told inspectors that they had commissioned an independent review of current governance structures and arrangements at the hospital to identify areas that was working well and areas for improvement. The review was supported by the Ireland East Hospital Group and was due to start in early 2023.

Executive Management Group

The hospital's Executive Management Group was the main governance structure assigned with responsibility for the governance and oversight of healthcare services at the hospital. Chaired by the Hospital Manager, the group were accountable to the Chief Executive Officer of the Ireland East Hospital Group. Membership of the hospital's Executive Management Group included the four clinical leads for each directorate, the Clinical Director, the DON, Director of Midwifery, Operations and Clinical Services Manager, Finance Manager, Human Resources Manager, Facilities and Safety Manager, and Quality and Patient Safety Manager.

The group met monthly, in line with its terms of reference. Minutes submitted to HIQA showed that the group had effective oversight of the hospital's performance against set quality indicators, and the overall quality and safety of services provided at the hospital. Meetings of the group followed a structured agenda, were action-orientated and progress with implementation of agreed actions was monitored from meeting to meeting.

The Hospital Manager attended monthly performance meetings between the hospital and the Ireland East Hospital Group, where items such as finance, workforce, quality and safety risks, scheduled and unscheduled care access and activity were reviewed and discussed. Minutes of these performance meetings submitted to HIQA demonstrated that the hospital group had effective oversight of the quality and safety of healthcare services at the hospital and the implementation of actions agreed at meetings was progressed from meeting to meeting.

Clinical Governance Quality and Patient Safety Committee

The hospital's Clinical Governance Quality and Patient Safety Committee was the main committee assigned with overall responsibility for the governance of and oversight for improving the quality and safety of healthcare services at the hospital. The committee,

chaired by the hospital's Clinical Director, met every two months in line with the committee's terms of reference and had multidisciplinary membership with representatives from all hospital departments. The committee's terms of reference submitted to HIQA did not outline who the committee reported and were accountable to. However, committee representatives who met with inspectors during inspection said that the committee reported and were accountable to the Executive Management Group.

Minutes of meetings submitted to HIQA were comprehensive and meetings followed a standard agenda. The committee had effective oversight of the hospital's risk management processes, complaints process, performance against established quality indicators, and of the quality improvement initiatives implemented to improve the quality and safety of healthcare services at the hospital. Meetings were action-orientated and progress with the implementing of agreed actions was monitored from meeting to meeting.

At operational level, HIQA was satisfied that the hospital had clear lines of accountability with devolved autonomy and decision-making for three of the four areas of known harm assessed during inspection — infection prevention and control, medication safety and the deteriorating patient. The hospital had the following three committees in place, all reported and were operationally accountable to the hospital's Clinical Governance Quality and Patient Safety Committee:

- Infection Prevention and Control Committee
- Drugs and Therapeutics Committee
- Deteriorating Patient Committee.

At the time of inspection, the hospital did not have a Bed Management and or Discharge Committee.

Healthcare Associated Infections and Antimicrobial Stewardship Committee (HCAI AMS Committee).

The hospital's multidisciplinary Healthcare Associated Infections and Antimicrobial Stewardship Committee was responsible for the governance and oversight of infection prevention and control and antimicrobial stewardship activities at the hospital. Chaired by the Hospital Manager, the committee reported to the Clinical Governance Quality and Patient Safety Committee and the Executive Management Group. The committee also had a communicating relationship with the sepsis lead and the Chief Director of Nursing at Ireland East Hospital Group level. Reporting structures of the committee were outlined in an organisational chart submitted to HIQA, however, it did not include additional sub groups that report into the committee as set out in terms of reference.

Terms of reference submitted to HIQA outlined that the committee met quarterly. Minutes of meetings reviewed showed that the committee, to date, had met three times in 2022. Minutes submitted to HIQA were comprehensive and showed that meetings

followed a structured agenda and were action-orientated, with the implementation of agreed actions monitored from meeting to meeting.

It was evident from minutes that the committee had effective oversight of the implementation of the hospital's infection and prevention control programme, the hospital's compliance with key infection prevention and control performance indicators, relevant audit findings, patient-safety incidents and risks, the development and implementation of relevant policies, procedures and guidelines, and staff education and training.

Operational responsibility for implementing the hospital infection prevention and control plan was assigned to the hospital's infection prevention and control team. The programme is discussed further in national standard 5.5.

Antimicrobial stewardship was a standing agenda item at meetings of the HCAI AMS Committee. The hospital had an antimicrobial stewardship programme,[†††] however, HIQA were not assured that there was effective oversight of antimicrobial stewardship at the hospital. This was further compounded by the lack of an on-site consultant microbiologist at the hospital and the absence of antimicrobial pharmacist at the hospital up until May 2022 when a full time antimicrobial position commenced. Minutes of meetings of the HCAI AMS Committee submitted to HIQA for 2022 did not provide assurance that updates relating to antimicrobial stewardship were sufficiently provided to the committee. There was documented evidence that updates related to the hospital's antibiotic consumption rates were provided to the Drugs and Therapeutics Committee.

Drugs and Therapeutics Committee

The hospital's Drugs and Therapeutics Committee were responsible for the governance and oversight of medication safety practices at the hospital. The committee, chaired by the Clinical Director, was operationally accountable and reported to the Clinical Governance and Quality Patient Safety Committee and the Executive Management Group.

According to the committee's terms of reference, the committee should meet four times a year, however, minutes of meetings submitted to HIQA indicated that the committee had, to date, met twice in 2022 (March and October). The multidisciplinary committee comprised representation from the four clinical directorates, nursing and midwifery department, quality and patient safety department and a community pharmacist.

It was evident from minutes submitted to HIQA that meetings of the committee were well attended and followed a defined agenda, which included items such as medication safety, medication process issues, medication selection issues, antimicrobial stewardship and nurse prescribing. Meetings were action-orientated and progress with the implementation of agreed actions was monitored from meeting to meeting.

[†††]Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

The Drugs and Therapeutics Committee had effective governance and oversight of the hospital's medication safety programme. A medication safety strategy, which comprised short-, medium- and long-term objectives to support safe medication practices at the hospital was developed by the Chief Pharmacist and approved by the committee. Operational implementation of the strategy was supported by an annual medication safety plan which outlined the key areas of focus and resources required to support safe medication practices at the hospital. This plan focused on a number of key areas including the governance of medication safety, medication risk management, high-risk medications, monitoring and evaluation of medication practices and medication related staff education and training. The plan is discussed further in national standard 5.5.

Medication Safety Committee

The hospital's Medication Safety Committee was responsible for supporting the implementation of safe medication practices at the hospital. The committee oversaw the implementation of the hospitals' medication safety programme and provided progress updates to the Drugs and Therapeutics Committee.

Terms of reference outlined that the committee were due to meet three times a year, however, no meetings occurred in 2021. At the time of the inspection, the committee had met twice with a further meeting planned by the end of the year. Minutes of these meetings demonstrated that the committee had effective oversight of medication safety practices and were action-orientated and progress in implementing agreed actions was monitored from meeting to meeting.

The Deteriorating Patient Improvement Programme Committee

Hospital management had established a Deteriorating Patient Improvement Programme Committee in July 2022. This committee was the result of the merger of three committees — the Sepsis Committee, Early Warning Score Committee and Resuscitation Committee. The committee was responsible for the implementation of national guidance in relation to sepsis management, early warning systems and resuscitation. Chaired by a consultant anaesthesiologist the newly convened committee met every three months in line with its terms of reference and reported to the hospital's Clinical Governance and Quality and Patient Safety Committee. Minutes of meetings submitted to HIQA were comprehensive and meetings followed a structured agenda, were action-orientated and the implementation of agreed actions was monitored from meeting to meeting.

Unscheduled Care Committee

The hospital's Unscheduled Care Committee had oversight of activity and performance within the emergency department including patient flow through the department and surge capacity at the hospital. Chaired by the hospital's operations and clinical services manager, the committee reported and was accountable to the hospital manager. Inspectors were informed that the committee were due to meet monthly, however, the committee were not meeting as planned in 2022 and inspectors were informed that

meetings had only recently reconvened in October 2022. The minutes of the committee's most recent meeting (November 2022) submitted to HIQA showed that the committee had effective oversight of the emergency department's attendance, patient experience times, patient flow through the department, implementation and effectiveness of winter planning measures, integrated care pathways and access to diagnostics. Collated information on scheduled and unscheduled care activity and inpatient bed capacity was discussed at meetings of the Executive Management Group and reviewed at monthly performance meetings with the Ireland East Hospital Group. Unscheduled care activity was also discussed at meetings of the Ireland East Hospital Group Unscheduled Care Integrated Steering Group. This group had oversight and management of the measures to support integration across the community and hospitals within the Ireland East Hospital Group.

In summary, while the hospital had defined corporate and clinical governance arrangements in place, HIQA found that governance arrangements required strengthening to ensure consistent and effective oversight of the quality and safety of healthcare services at the hospital. A number of committees responsible for the quality and safety of services had not met as planned. While HIQA acknowledges that some of these committees had recently reconvened and other committees had reconfigured, the role, effectiveness and function of committees needs to be assessed and reviewed to ensure they are operating in line with their terms of reference and providing the necessary oversight arrangements. Hospital management needs to use the findings and recommendations from the planned independent review of governance arrangements to at the hospital to strengthen and formalise governance structures and reporting arrangements at the hospital.

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.

Findings relating to the emergency department

Attendees to the hospital's emergency department presented by ambulance, were referred directly by a general practitioner (GP) or were self-referred. In 2021, the overall attendance rate at the emergency department was 36,074 which represents a 7% decrease on 2019 attendances (33,400) (the last full year before the COVID-19 pandemic) and a 6% decrease on the 2020 (33,819) attendances to the department. The attendance rate in 2021 equated to an average attendance rate of 3,000 people each month or 99 attendances daily. As of

October 2022, the attendance rate at the department was 30,153, which when compared to 2022 attendance rates at other Model 3 hospitals,[‡‡‡] was generally lower.

The hospital could also refer eligible patients to a Minor Injury Unit and Rapid Assessment Clinic. This clinic was located off site and healthcare services were provided by a private facility. The arrangement was underpinned by a service level agreement and a formalised pathway from the emergency department.

The hospital's conversion rate (rate of admission of patients to an inpatient ward) for the emergency department year to date in 2022 was 20%, which suggested that the remaining patients attending the hospital's emergency department completed their episodes of care in the department.

On the days of inspection, hospital management told inspectors they had implemented the hospital's escalation plan in response to overcrowding in the emergency department. On the first day of inspection there was evidence that controls had been implemented as part of the hospital's escalation protocol to respond to overcrowding in the emergency department. For example, inspectors were informed that escalation meetings had taken place with bed management, nursing management, consultant leads and senior hospital management. Inspectors were also informed that next day diagnostic appointments were being made for suitable patients.

On the day of inspection, there was evidence of strong clinical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the on-site consultant in emergency medicine. Outside core working hours,[§§§] clinical oversight of the emergency department was provided by the consultant in emergency medicine on call. Operational issues affecting the day-to-day workings of the emergency department, such as patient flow, activity, staffing, patient safety, risks and audit activity, were discussed at meetings of the Emergency Department Workflow Group every month. The meetings of the group were chaired by a consultant for emergency medicine and a sample of meeting minutes reviewed by inspectors showed that there was a structured agenda and the implementation of agreed actions was monitored from meeting to meeting. Risks related to the emergency department and the measures and controls implemented to mitigate the potential patient safety risk were discussed at the emergency department daily operational and safety huddles ('EDOSH')[****] which occurred twice daily at 11am and 4pm.

On the days of inspection, the majority of attendees to the department were self-referrals. At 11am, the emergency department was overcrowded and very busy relative to its intended

[‡‡‡] Other hospitals used as comparisons include: Midland Regional Hospital Tullamore, Midland Regional Hospital Portlaoise, Regional Hospital Mullingar, St Luke's General Hospital, Kilkenny, Cavan General Hospital, Mayo University Hospital, Portiuncula University Hospital, Sligo University Hospital, Tipperary University Hospital and University Hospital Kerry.
[§§§] Core working hours is considered Monday to Friday 9.00am to 5.00pm.
[****]Huddles are brief (usually 15-20 minutes) and routine meetings for sharing information about potential or existing safety and operational problems.

capacity and function. Patients experienced lengthy waiting times to be triaged, medically reviewed and assessed, and while waiting for an inpatient bed. A total of 48 patients were in the department. Of the 48 patients, eight patients (17%) were aged 75 years or older. Inspectors observed that the spacing between the majority of trolleys and chairs in the department was not always one metre. This was not in line with national guidance in relation to the management and control of COVID-19 in place at the time of inspection and posed a cross infection risk.

On arrival to the emergency department, all attendees were promptly assessed for signs and symptoms of COVID-19 and streamed to the most appropriate care pathway, in line with national guidance. The emergency department had four designated waiting areas located in the main hospital reception. There was a:

- designated waiting area for patients with suspected COVID-19. Inspectors observed that one metre physical spacing could not always be maintained in this waiting area
- designated waiting area for patients confirmed COVID-19
- designated waiting area for paediatric patients. At the time of inspection, there was no audio-visual separation of children from adult emergency care as recommended in the national model of care for paediatric healthcare services
- designated waiting area, situated at the hospital's main reception for patients with no signs and symptom of COVID-19.

All patients were triaged and prioritised in line with the Manchester Triage System.[††††] On the first day of inspection, the average waiting time from registration to triage was 35 minutes, which falls short of the 15 minutes recommended by the HSE's emergency medicine programme. Fourteen (29%) patients were prioritised as orange category (priority level 2, review within 10 minutes, very urgent cases) and a further 14 patients were prioritised as yellow category (priority level 3, review within 30 minutes, less urgent cases). The remaining patients were categorised as green (priority level 4, review within 120 minutes) or blue (priority level 5, non-urgent, review within 240 minutes). Staff could view the status of all patients in the department — their prioritisation category levels and waiting times via the hospital's electronic emergency department dashboard.

Continuous and effective flow of patients within and out of the hospital is essential for optimal service delivery in an emergency department. Patient flow within the hospital was challenged by bed capacity and staffing resources. On the first day of inspection, 10 of the 234 inpatient beds, (one clinical area) were closed because of staff resourcing issues. Inspectors were informed that these 10 beds were only used when additional dedicated nursing staff were available and assigned to care for patients in the clinical area.

[††††] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

Collectively, the mismatch between availability and demand for inpatient beds, as evident on the first day of inspection, impacted the flow of patients through the emergency department and contributed to the boarding of admitted patients in the department. This in turn impacted on patient experience times.[‡‡‡‡] At 11am on the first day of inspection, the waiting time from:

- registration to triage ranged from seven minutes to two hours one minute. The average waiting time was 34 minutes
- triage to medical review ranged from 23 minutes to 15 hours 30 minutes. The average waiting time was two hours 11 minutes
- decision to admit to actual admission in an inpatient bed ranged from one hour 14 minutes to 31 hours 47 minutes. The average waiting time was six hours and six minutes.

Other systems and processes in place at the hospital to manage the demand in activity and to support continuous and effective patient flow through the emergency department were not functioning as they should be. On the days of inspection, the hospital's Acute Medical Assessment Unit (AMAU) was not functioning as an alternate flow pathway for patients in order to take pressure from the emergency department. The AMAU opened from 8.30am to 8pm, but in effect, the unit was used to accommodate admitted patients from the emergency department while awaiting an inpatient bed.

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care at the hospital. However, HIQA was not assured that these arrangements were fully effective in addressing issues evident in the department on the first day of inspection. Operationally, the emergency department was not functioning as effectively as it should be, was overcrowded and had significant issues with patient flow within the hospital, which collectively posed a patient-safety risk and was a concern to HIQA. Other findings related to the emergency department are discussed further in the emergency department section of this report under national standards 6.1, 1.6 and 3.1.

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.

Findings relating to the wider hospital and other clinical areas

The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and two inpatient clinical areas visited on the days of inspection, and these are discussed in more detail below.

[‡‡‡‡] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

Infection, prevention and control

The hospital had an infection prevention and control team comprising;

- one whole-time equivalent (WTE)[§§§§] assistant director of nursing (ADON)
- 2.5 WTE clinical nurse manager grade 2 (CNM2)
- one WTE surveillance scientist
- one WTE antimicrobial pharmacist.

Previous HIQA inspections highlighted the lack of a comprehensive consultant microbiology service at the hospital. At the time of this inspection, inspectors found that there was no consultant microbiologist available on site at the Regional Hospital Mullingar. Inspectors were informed that the hospital had approval for one WTE consultant microbiologist, but the post was unfilled at the time of inspection. Hospital management told inspectors that staff had access to an off-site consultant microbiologist available by phone or email. Similar to previous inspections, HIQA was concerned about this arrangement. When discussed with hospital management, inspectors were told that the patient safety risk associated with this arrangement was assessed and had been escalated to the Ireland East Hospital Group. Inspectors were not assured that the existing controls introduced to address any patient safety risk were effective. For example, inspectors were concerned that the consultant microbiologist did not have access to the hospital's computer system to access test results and or relevant hospital policies, procedures and guidelines, and that on a limited number of occasions, as told to inspectors the consultant microbiologist was not immediately available when contacted by staff. Following this inspection, HIQA issued a high-risk letter to hospital management seeking further information and assurances on the effectiveness of controls and measures in place to address the patient safety risks associated with the lack of an on-site consultant microbiologist at the hospital. In their response, hospital management set out the additional measures and controls taken while progressing the recruitment campaign to appoint a permanent consultant microbiologist at the hospital. HIQA was assured that appropriate measures and controls outlined in the response from hospital management addressed the concerns identified by HIQA. However, notwithstanding this, hospital management need to progress the appointment of a permanent on-site consultant microbiologist in order to ensure the provision of safety, quality healthcare.

The hospital did not have an overarching infection prevention and control programme[*****] as per national standards.[†††††] However, the infection prevention and control team had

[§§§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

[*****] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out a clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

[†††††] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health

developed an infection prevention and control plan that set out the objectives to be achieved in relation to infection prevention and control yearly at the hospital. The 2022 plan reviewed by inspectors was comprehensive and focused on:

- improving hand hygiene compliance
- improving compliance with infection prevention and control guidelines
- managing patients identified with resistant organisms
- managing infection outbreak
- risk register management
- invasive devices
- staff education and training
- surveillance activity
- audit activity.

It was evident from documents reviewed by inspectors that the infection prevention and control team reported on progress in implementing the objectives and actions in the annual plan to the Infection Prevention and Control Committee. The team also submitted a comprehensive annual report, which detailed the activities completed and the quality improvement initiatives put in place to minimise the transmission of healthcare-acquired infections to patients and staff, to the Infection Prevention and Control Committee.

Medication safety

The hospital did not have a comprehensive clinical pharmacy service.[‡‡‡‡‡] The hospital were approved for:

- 11 WTE pharmacists comprising of one WTE chief pharmacist, eight WTE senior pharmacists and two WTE basic grade pharmacists
- 8.2 WTE pharmacy technicians.

At the time of inspection, 6.6 WTE pharmacist's positions were filled, which equated to a variance of 4.4 WTE (40%). However, inspectors were informed that a number of pharmacist's positions were due to be filled in January 2023, which when filled would equate to a variance of 1.8 WTE (16%). All pharmacy technician posts were filled at the time of inspection. The lack of a comprehensive clinical pharmacy service at the hospital resulted in a number of clinical areas not having a sufficient clinical pharmacy service. Pharmacist-led medication reconciliation was not carried out for all patients, but inspectors were informed that pharmacist-led medication reconciliation was prioritised for vulnerable patients.

Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

[‡‡‡‡‡] 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.

The hospital's medication management strategy and annual medication safety plan outlined key areas of focus to support safe medication practices at the hospital. The 2022 plan reviewed by inspectors was comprehensive and focused on:

- ensuring governance arrangements are robust and fit for purpose
- reporting medication patient-safety incidents
- high-risk medicines and situations
- empowering patients to be involved with their medicines through the provision of medicines information and engagement
- expanding clinical pharmacy services to include medication reconciliation on admission
- providing up-to-date evidence-based policies, procedures and guidelines
- assessing the safety culture within the hospital through survey and audit activity
- staff education and training on medication safety.

Deteriorating patient

The hospital's newly established deteriorating patient improvement committee was responsible for progressing the hospital's deteriorating patient improvement programme. At the time of inspection, a clinical lead had each been appointed for sepsis management, and resuscitation, however, the lead position for the early warning system was unfilled but a person was due to resume post shortly. In the interim, it was explained that updates in respect of the early warning system were provided by clinical skills facilitators at relevant meetings. The hospital was using the appropriate national early warning systems for the various cohorts of patients — INEWS),[§§§§§] the Irish Maternity Early Warning System (IMEWS)[******] and the Irish Paediatric Early Warning System (IPEWS). However, at the time of inspection, the hospital had not implemented version 2 of the INEWS. Inspectors were informed that there was a requirement to modify INEWS version 2 for local hospital use and this had resulted in a delay in implementing the latest version of the INEWS guidance and observation chart, but a plan was in place for this version to be introduced in the hospital on a phased basis in quarter one of 2023. Hospital management should progress with the implementation of version 2 of the INEWS and ensure compliance with the guideline is monitored and evaluated.

Transitions of care

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

[******] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

Transitions of care incorporates internal transfers, shift and interdepartmental handover, external transfer of patients and patient discharge. The hospital's patient flow department was responsible for monitoring and overseeing the safe transitions of care within and from the hospital. The department comprised one WTE ADON (bed management), one WTE CNM3 (bed management), one ADON (emergency department patient flow) which was vacant at the time and one CNM2 (emergency department admitted patients).

At the time of inspection, the average length of stay for medical patients was nine days, which was above the HSE's target of seven days or less. The average length of stay for surgical patients was 13 days, which is significantly greater than the HSE's target of 5.2 days or less.

The hospital had implemented a number of hospital admission avoidance pathways and measures to improve patient flow and the safe transfers of patients within and from the hospital. These included:

- Community Intervention Team pathway — a nurse led team, supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.
- Home Support Service for Older People — this pathway provides help and support to older persons living at home. The supports are provided by the HSE or external providers that have service level agreements with the HSE.
- Linking in with the Integrated Care Programme for Older Persons — this is a national initiative that integrates primary and secondary care services for older people, especially those with more complex needs.[††††††] In this pathway, care is provided by a multidisciplinary team under the clinical governance of a consultant geriatrician.

A number of systems were also in place to enhance the safe transfer of patients within and from the hospital. These included:

- the visual hospital programme with the Ireland East Hospital Group
- accessing and transferring eligible patients for transitional, rehabilitation and step down care in community hospitals in Community Health Organisation 8 (CHO 8)
- daily bed management meetings
- weekly multidisciplinary meetings to discuss complex cases and all patients who have been admitted longer than seven days
- nurse manager forums
- reviewing inpatient bed capacity, patient discharge and transfers into and out of the hospital at daily multidisciplinary meeting.

[††††††] Health Service Executive. Integrated Care Programme for Older Persons. Dublin, Health Service Executive. 2022. Available online from: https://www.hse.ie/eng/about/who/cspd/icp/older-persons/

- nursing huddles
- using the SAFER[‡‡‡‡‡‡]patient flow bundle in all clinical areas.

Hospital management had identified delays in issuing discharge letters to patients' GPs as a risk to the safe transitions of care and recorded it as a high-rated risk on the hospitals' corporate risk register. A number of measures and controls were implemented to manage the risk to patient safety which included the installation of additional mobile and fixed computers for non-consultant hospital doctors (NCHDs) to use. It was evident from documentation reviewed by inspectors that the effectiveness of measures and controls introduced to reduce the delay in issuing discharge letters were discussed and evaluated at senior management meetings.

Overall, HIQA found that the hospital had systems and processes in place to support the safe transitions of patients out of the hospital. It was clear that initiatives in place to support the transition of patients out of the hospital were having a positive impact as evident by only one episode of delayed discharges on both days of inspection and the low numbers of delayed discharges at the hospital (average one) per month, which is commendable. Inspectors were informed that access to convalescence and long-term care facilities in the community was challenging at times and hospital management told inspectors that the recent closure of some nursing homes in the surrounding areas may have an impact on the hospital's ability to discharge patients requiring further care and support. Notwithstanding this, it was evident that measures to support the safe transition of care within the hospital, particularly from the emergency department to the main hospital, were not always effective and that the mismatch between supply and demand remains challenging for the hospital.

Nursing, medical and support staff workforce arrangements

The human resource department was responsible for workforce management in the hospital. The department tracked and trended staffing levels and absenteeism rates, which were reported at monthly performance meetings with the Ireland East Hospital Group. Inspectors were informed that absenteeism rates at the hospital for the year to date (2022) were 6.8%, which was significantly above the HSE's target of 4% or less.

The hospital's total approved complement of nursing and midwifery staff was 436.33 WTE. At the time of inspection, 384 WTE positions were filled, which represented a variance of 52.33 WTE (12%) between the approved and actual nursing and midwifery staff complement.

The hospital had a total approved complement of 43.5 WTE medical consultant staff and had approval for an additional nine consultants to cover specific contracts and explicit leave

[‡‡‡‡‡‡] The SAFER patient flow bundle is a practical tool comprising five elements to reduce delays for patients in adult inpatient wards (excluding maternity). S - Senior Review - all patients have a senior review by a consultant or by a registrar enabled to make management and discharge decisions. A - All patients have a predicted discharge date. F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. E - Early discharge - patients discharged from inpatient wards early in the day. R – Review - a systematic multidisciplinary team review of patients with extended lengths of stay.

resulting in a total of 52.5 WTE medical consultants in place at the time of inspection. While the hospital were not experiencing a deficit in medical consultant staff, documentation reviewed by inspectors showed that hospital management was awaiting approval to appoint 12 permanent consultants across various specialities. At the time of inspection, all 12 positions were filled by temporary or locum consultants.

The hospital had a total approved complement of 123 WTE NCHDs. At the time of inspection, 118.8 WTE NCHD positions were filled, which represented a variance of 3.4%.

The hospital's inability to recruit suitably qualified medical, nursing and midwifery staff was a high-rated risk recorded on the hospital's corporate risk register. Hospital management had implemented controls and measures to mitigate the risk, which were reviewed and updated at meetings of the Executive Management Group and at Ireland East Hospital Group level. Regional Hospital Mullingar in conjunction with the Ireland East Hospital Group had developed a workforce plan for 2021 – 2024, but there was no evidence that a time-bound action plan was developed to enable the implementation of the plan.

Staff training and education

There was no central process or system to record and monitor staff attendance at and uptake of mandatory and essential training at the wider hospital level. This was a high-rated risk recorded on the hospital's corporate risk register. Heads of departments maintained a paper based record of staff attendance at and uptake of essential and mandatory training. Some electronic systems recorded the uptake of staff training but these were not centrally controlled and access was limited for all staff.

Attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at clinical area level by CNMs. The hospital had mandatory training programmes for infection prevention and control, medication safety and the national early warning system. Nursing, medical and support staff who spoke with inspectors confirmed to HIQA that they had received induction training and had completed training on a variety of topics on the HSE's online learning and training portal (HSELanD). A greater level of oversight of staff uptake of mandatory and essential training is needed by the senior management team.

The attendance at and uptake of training for hand hygiene by nursing and midwifery staff was above the HSE target of 90% but was below the target for medical staff and healthcare assistants. From the information provided to HIQA, the attendance at and uptake of training in standard and transmission-based precautions by nursing and midwifery staff, medical staff and healthcare assistants could be significantly improved. Attendance at and uptake of training for IMEWS was very good for nursing and midwifery staff but required improvement for medical staff. Attendance at and uptake of basic life support training could also be improved across all staff groups.

Overall, HIQA identified opportunities for improvement in relation to the management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services. While the hospital had a number of overarching plans in place to

support infection prevention and control, medication safety and deteriorating patient activities at the hospital, HIQA was not assured that there were adequate management arrangements to manage any increase in service demand, especially in emergency care. Hospital management had implemented a number of hospital admission avoidance pathways however, more innovative measures to support patient flow within the hospital is required. HIQA acknowledges hospital management's efforts to recruit medical, nursing and midwifery staff. Nevertheless, at the time of inspection there were deficits across nursing and midwifery staff and clinical pharmacy services. Systems and processes in place to support medication safety at the hospital will continue to be impacted by a lack of clinical pharmacy services. Furthermore, the continued absence of an on-site consultant microbiologist is a concern to HIQA.

HIQA recognises the efforts made by hospital management to provide mandatory training over the period of the COVID-19 pandemic. Notwithstanding this, staff attendance at and uptake of mandatory and essential training requires significant improvement. It is essential that hospital management have a greater level of oversight of staff attendance at and uptake of mandatory and essential training and ensure that all clinical staff receive training appropriate to their scope of practice and at the required frequency, in line with national standards.

Judgment: Partially compliant

Inspection findings relating to the Emergency Department

The following section outlines findings from the inspection as they related to the emergency department. Findings and judgments are presented under three (6.1, 1.6 and 3.1) national standards from the *National Standards for Safer Better Healthcare* relating to the themes of: workforce; person-centred care and support; and safe care and support.

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

A senior clinical decision-maker§§§§§§ at consultant level was on site in the emergency department each day, with availability on a 24/7 basis. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

Medical staffing levels in the emergency department were maintained at levels to support the provision of 24/7 emergency care. At the time of inspection, the emergency department had four WTE consultants in emergency medicine — two WTE appointed on a permanent basis and two WTE appointed on a locum basis. Hospital management had received approval to appoint an additional one WTE consultant in emergency medicine on a temporary contract to support the COVID-19 service. The person recruited to this position was due to finish at the end of December 2022. One of the two permanent consultants in emergency medicine was the assigned clinical lead for the emergency department and was responsible for the day-to-day operational functioning of the department. The consultants were operationally accountable and reported to the hospital's Clinical Director. All permanent consultants in emergency medicine were on the specialist register with the Irish Medical Council.

The hospital was an approved training site for non-consultant hospital doctors on the basic specialist training in emergency medicine. Consultants in the emergency department were supported by 14 NCHDs at registrar and senior house officer grades — eight registrars and six senior house officers, providing 24/7 medical cover in the department. Inspectors were informed that the hospital was reliant on the use of agency staff to fill vacant NCHD positions in the emergency department. The use of agency staff is not a sustainable solution in the long-term for covering vacancies.

The emergency department's approved nursing staff (excluding management grades) complement was 33.9 WTE. At the time of inspection, the department's actual complement of nursing staff was 25.9 WTE. This represented a variance of eight WTE (23%) between the approved and actual nursing staff complement. Hospital management were managing the deficit in nurse staffing levels through an ongoing recruitment campaign, the use of an internal bank of nurses and redeployment of nursing staff.

Inspectors reviewed nursing staff rosters from the emergency department for the preceding four-week period to HIQA's inspection. During this period, the department had not experienced any shifts where there was a significant shortfall in rostered nurse staffing levels. There were some occasions where there was a shortfall of one staff member on days or nights. However, this was occasional and a member of staff from the hospital's internal relief panel who was known to the emergency department filled the shortfall.

§§§§§§ Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

A CNM3 had overall nursing responsibility for the emergency department and was rostered on duty Monday to Friday during core working hours. A CNM2 was rostered on each shift (day and night).

Through the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*, launched by the Minister of Health in June 2022[*******] the hospital had approval to increase the nursing staff complement in the emergency department by 16.5 WTE, 11 WTE to the core roster and 5.5 WTE for admitted patients. Hospital management were working to progress the recruitment campaign to fill these new positions at the time of inspection. Other members of the multidisciplinary team in the emergency department included:

- one ADON for patient flow
- two advanced nurse practitioners (ANPs)
- one clinical skills facilitator
- 11 healthcare assistants
- one pharmacy technician.

Uptake of mandatory and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. However, HIQA found that significant improvement was required in relation to staff attendance and uptake at mandatory and essential training.

Training records for nursing staff in the emergency department showed that:

- 19.14% of nurses were compliant with hand hygiene practices – significantly below the HSE's target of 90%
- 51% of nurses were up to date in basic life support training
- 21.27% of nurses were up to date with training on the NEWS
- 2.12% of nurses and midwives were up to date with the Irish Maternity Early Warning System (IMEWS)
- 42.5% of nurses were up to date in training on the Manchester Triage System.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. However, the hospital were reliant on agency

[*******] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

staff to maintain the NCHD staff roster, which is not sustainable in the long-term. Furthermore, attendance at and uptake of mandatory and essential training for nursing staff in the emergency department was sub-optimal and requires significant improvement. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement efforts following HIQA's inspection.

Judgment: Partially compliant

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[†††††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department, and to be responsive to their individual needs. Staff provided assistance and information to patients in a kind and caring manner.

Privacy and dignity in the emergency department was supported for patients accommodated in single bays. However, it was clear to inspectors that the privacy, dignity and confidentiality of patients accommodated on trolleys and chairs in the corridor and multi-occupancy areas was severely compromised. Consultations and clinical assessment was carried out wherever the patient was located, this included the multi-occupancy eight-bedded open planned area at the nurses' station and on the corridor. In this setting, it was impossible to maintain the patient's privacy and confidentiality. Others (patients, visitors and staff) could overhear patient-clinician conversations and the exchange of personal information between patients, medical and nursing staff. This was not consistent with a human rights-based approach to healthcare promoted and supported by HIQA. These findings were consistent with the hospital's findings from the 2022 National Inpatient Experience Survey, where with regard to:

[†††††††] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

- privacy when being examined or treated in the emergency department, the hospital scored 7.5 (national average score – 8.1)
- being treated with respect and dignity in the emergency department, the hospital scored 8.6 (national average score – 8.7).

During the inspection, inspectors observed multiple patient healthcare records contained in an open, unlocked trolley that were easily accessible on a public corridor in the emergency department. Inspectors brought this to the attention of the CNM on the first day of inspection for remedy. However, the same issue was observed on the second day of inspection and was brought to the attention of the CNM again. Healthcare records should be managed and stored in line with national standards and relevant general data protection and regulation legislation.

Over the course of the two day inspection, inspectors observed the severe difficulty caused by the overcrowding and trolley congestion in the emergency department. It was clear that the privacy, dignity and confidentiality of patients accommodated on trolleys and chairs in the corridor was severely compromised. HIQA did not find sufficient evidence that actions taken at the hospital were effective in respecting, promoting and protecting the dignity, privacy and autonomy of patients receiving care in the emergency department at the time of inspection. The situation in the department significantly impacted on the meaningful promotion of the patient's human rights.

Judgment: Non-compliant

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

Data on a range of different quality and safety indicators related to the emergency department was collected at the hospital, in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times. Collated performance data and compliance with national key performance indicators for the emergency department were reviewed at monthly meetings of the emergency department workflow group, Unscheduled Care Committee, Executive Management Group and the Ireland East Hospital Group.

Data on patient experience times collected on the first day of inspection, showed that at 12pm the hospital was non-compliant with national key performance indicators on patient experience times set by the HSE. At that time, 46 patients were in the emergency department, of them:

- 18 (39%) patients were in the emergency department for more than six hours after registration — not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 18 (39%) patients were in the emergency department for more than nine hours after registration — not in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- Four (9%) patients were in the emergency department for more than 24 hours after registration — not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- Seven (13%) attendees to the emergency department were aged 75 years and over and were in the emergency department greater than nine hours of registration - not in line with national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.
- Only two (25%) of attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration — significantly short of the national target that 99% of patients aged 75 years and over are discharged or admitted to a hospital bed within 24 hours of registration.

Similar to other emergency departments inspected by HIQA, the hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In 2021, 21% of ambulances that attended the hospital's emergency department had a time interval of 30 minutes or less, which suggests that ineffective patient flow in the emergency department affects the timely offload of patients arriving to the department via the national ambulance service. For the year to date, in 2022, 17% of ambulances that attended the department had an ambulance turnaround time interval of 30 minutes or less.

Risk management

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Emergency department related risks were managed at department level with oversight of the process assigned to the CNM3 and assistant director of nursing for the emergency department.

At the time of inspection, four high-rated risks recorded on the hospital's corporate risk register were related to the emergency department — increased emergency department attendances, cardiac telemetry, limited paediatric nurse staffing levels and inadequate isolation facilities. Other high-rated risks on the risk register that also impacted the emergency department included: inability to maintain a basic pharmacy service due to unfilled pharmacy posts and the risk to patient safety due to non-compliance with national guidance on sepsis management.

The hospital had limited number of inpatient beds to accommodate patients needing heart monitoring (cardiac telemetry) which was a high-rated risk on the hospital's corporate risk register. Two beds in the eight-bedded open plan area in the emergency department were used regularly for inpatients admitted to the hospital for cardiac telemetry. These patients were reviewed daily by the cardiology team but nursing care was provided by the complement of rostered nurses in the emergency department. Inspectors observed documented controls in place to mitigate this risk in place on the day of inspection. For example, staff responding to alerts from monitors and reviewing patients and request forms for placing patients on waiting lists for telemetry beds in the intensive care unit. Hospital management also told inspectors that a recruitment campaign was underway at the time of inspection to recruit extra nursing staff to support the opening of a Telemetry Hub which will increase the number of remotely monitored inpatient beds from two to ten.

Inspectors noted that one risk relating to the emergency department recorded on the hospital's corporate risk register was overdue for review and this was not in keeping with effective risk management processes.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were promptly screened for signs and symptoms of COVID-19 and streamed to the most appropriate care pathway, in line with national guidance in place at the time of inspection. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to single bays. A nurse from the infection prevention and control team was accessible to staff in the emergency department during core working hours. Staff had access to a consultant microbiologist over the telephone but as outlined in national standards 5.5, this arrangement was not sustainable or reliable.

Patients attending the emergency department were also screened for Carbapenemase-producing *Enterobacterales* (CPE) in line with national guidance at the time of inspection.

The emergency department environment was generally clean and well maintained however, significant opportunities for improvement were noted in relation to the cleanliness of the treatment room. Inspectors observed a box of intravenous fluids leaking on the floor, medication on the floor and no healthcare waste bin (yellow bin) for safe disposal of clinical waste. These findings were brought to the attention of the CNM on the day of inspection for remedy.

Staff confirmed that terminal cleaning[‡‡‡‡‡‡‡] was carried out following suspected or confirmed cases of COVID-19. Environmental and equipment hygiene audits were carried out in the department monthly. The department scored 85% in an environmental audit

[‡‡‡‡‡‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

carried out in November 2022. There was evidence that a quality improvement plan was developed to improve compliance with hygiene standards in the emergency department. This is discussed further in national standard 2.8.

Medication safety

There was no clinical pharmacist assigned to the emergency department but inspectors were informed that a pharmacist came to the department when available or requested. Pharmacist-led medication reconciliation did not take place for all patients on admission or discharge. A pharmacy technician did visit the emergency department every Monday, Wednesday and Friday to replenish pharmacy stock. Inspectors observed a high-risk medication list and a SALAD§§§§§§§ list displayed in the treatment room in the emergency department. Documentation reviewed by inspectors showed that medication safety practices were audited in the department and quality improvement plans were developed to improve areas of non-compliance. This is discussed further in national standard 2.8.

Deteriorating patient

The emergency medicine early warning system was not used in the emergency department. The department was using INEWS and IMEWS, but were not using the most up-to-date version of the INEWS (2.0) observation chart to support the recognition and response to a deteriorating patient. Inspectors were told of plans to implement the latest version (version 2) of INEWS in January 2023 and two CNMs were trained by the clinical skills facilitator to support the implementation process. It was explained to inspectors that auditing of compliance with national guidance on INEWS and IMEWS was not carried out in the emergency department as the hospital was scheduled to implement the latest version of INEWS.

The hospital had a specific system for requesting medical review for patients whose clinical condition was deteriorating. Inspectors were informed that the Identify, Situation, Background, Assessment and Recommendation (ISBAR)******** communication tool was used when requesting a medical review.

Compliance with national clinical guidance on sepsis management in the emergency department was audited as part of a national HSE audit. Overall findings from the audit indicated areas of non-compliance with the national guidance. This was a high-rated risk recorded on the hospital's corporate risk register and an action plan, which included

§§§§§§§ SALADS are 'Sound-alike look-alike drugs'. The existence of similar drug and medication names is one of the most common causes of medication error and is of concern worldwide. With tens of thousands of drugs currently on the market, the potential for error due to confusing drug names is significant.

******** Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

increasing staff education and awareness about antibiotic guidelines was developed to bring the emergency department into compliance with national guidance on sepsis management. Documentation reviewed by inspectors outlined that an audit was due to take place in December to evaluate progress against this action plan and audit compliance with national sepsis guidelines.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers from the emergency department. However, inspectors were informed that it was not consistently used amongst all medical teams and that there was some variance in use.

Management of patient-safety incidents and serious reportable events

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported to the National Incident Management System (NIMS),[††††††††] in line with the HSE's Incident Management Framework. The hospital's Serious Incident Management Team (SIMT) and Executive Management Group had oversight of the management of serious reportable events and serious incidents that occurred in the emergency department. Feedback on emerging trends and themes from patient-safety incidents was provided to the CNM3 by the Clinical Risk Manager and shared with staff in the emergency department during clinical handover, daily safety huddles and via a staff communication book.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally, in line with the hospital's complaints policy by the CNM with oversight from the CNM3. Complaints relating to the department were tracked and trended by the complaints manager and feedback on emerging trends and themes was provided to the CNM. Inspectors were informed that there was a 30% increase in the overall numbers of complaints in 2021 at the hospital. This increase was mainly related to complaints about the emergency department. Information about complaints and the resolution of complaints was shared with staff in the emergency department at clinical handover, daily safety huddles and via a staff communication book.

Overall, HIQA found that while the hospital had structures and systems in place to protect patients from the risk associated with the design and delivery of the service, these were not always effective. The high number of patients boarding in the department on the first day of inspection was symptomatic of ineffective patient flow and limited surge capacity at the hospital. This impacted on patients waiting times, especially for patients over the age of 75 years. Considering the increase in morbidity and mortality association with prolonged

[††††††††] 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).

waiting times in the emergency department, this was a concern for HIQA. Hospital management need to introduce sustainable improvements to protect patients receiving care in the emergency department from harm and hospital management need to be supported to do this from hospital group and national HSE levels. The hospital needs to ensure that plans outlined to implement the most up to date versions of early warning systems are progressed and that action plans to bring the emergency department into compliance with national guidance on sepsis management are effectively implemented.

Judgment: Non-compliant

Inspection findings relating to the wider hospital and clinical areas

This section of the report describes findings relating to the wider hospital and two inpatient clinical areas visited during the inspection. It sets out the judgments against selected national standards from the themes of leadership, governance and management (5.8), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3).

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

The hospital had monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. However, HIQA found that not all monitoring arrangements were operating effectively with opportunities for improvement identified in relation to the monitoring of risks and incident management

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). Collated performance data was reviewed at meetings of the Clinical Governance Quality and Patient Safety Committee and the Executive Management Group.

Risk management

The hospital had risk management structures and processes in place to proactively identify, analyse, manage and minimise identified risks. Each clinical directorate had their own risk register and risks that could not be managed at directorate level were escalated to senior management and recorded on the hospital's corporate risk register.

The Executive Management Group and Clinical Governance Quality and Patient Safety Committee had oversight of the management of identified risks. Risks were also discussed at monthly meetings of the hospital's SIMT. High-rated risks not managed at hospital level were escalated to the Ireland East Hospital Group.

Inspectors were not fully assured that all risks were appropriately reviewed and evaluated at executive management level. It was noted that one risk and the effectiveness of measures and controls to mitigate the risk recorded on the hospital's risk register needed to be reviewed. The management of reported risks related to the four areas of known harm is discussed further in national standard 3.1.

Audit activity

There were processes and structures in place to monitor all clinical audit activity carried out across the hospital. The Clinical Governance Quality and Patient Safety committee had oversight of all clinical audit activity carried out at the hospital. The hospital had a clinical audit facilitator at CNM2 level who reported to and was accountable to the Director of Nursing and the Clinical Governance Quality and Patient Safety Committee.

Management of serious reportable events

The hospital's SIMT were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. The team had oversight of the reporting and management of category one serious reportable events and serious incidents that occurred in the hospital. Documentation reviewed by inspectors demonstrated that serious reportable events and incidents were reviewed, tracked and trended by the risk manager and discussed and updated at the meetings of the SIMT. Notwithstanding this, HIQA was concerned that not all incidents were managed in line with the HSE's Incident Management Framework. A serious incident that had occurred in quarter three of 2022 was reviewed at hospital level and there was evidence of some learning shared with clinical staff. However, there was no evidence that a quality improvement plan was developed in response to the findings of the preliminary review into the incident at the time of this inspection. Therefore, inspectors were not assured that learning opportunities and recommendations from the incident had been appropriately addressed and effectively implemented.

Management of patient-safety incidents

There were effective systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. The Executive Management Group and the Clinical Governance Quality and Patient Safety Committee had governance and oversight of reported patient-safety incidents. Patient-safety incidents were also discussed at performance meetings with the Ireland East Hospital Group. The hospital's quarterly average rate from July 2021 to June 2022 of

reporting clinical incidents to the NIMS within 30 days of date of notification was 53%. This is significantly less than the HSE's target of 70%. Inspectors were informed that this was mainly due to staff resourcing issues in the quality and patient safety department. Patient-safety incidents related to the four areas of known harm are discussed further in national standard 3.3.

Feedback from people using the service

Findings from National Inpatient Experience Surveys were reviewed at meetings of the Clinical Governance and Quality and Patient Safety Committee and updates were provided to the Executive Management Group. The hospital had developed a quality improvement initiative in response to the National Inpatient Experience Survey findings (2022). The quality improvement plans focused on:

- addressing long waiting times for inpatient beds in the emergency department
- providing information to patients on discharge.

Overall, the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. However, HIQA was not fully assured that all risks were appropriately reviewed and evaluated at executive management level. HIQA was not satisfied that a serious incident that occurred at the hospital was managed appropriately and an action plan developed as recommended following a review of the incident. This is an area that needs to be improved following this inspection. Hospital management should ensure and enable a proactive approach to the learning from findings of patient-safety incidents, and the timely implementation of recommendations to support patient safety at the hospital. In addition, opportunities for improvement were identified in relation to the reporting of clinical incidents at the hospital. Furthermore, hospital management must ensure that systems in place to monitor, manage and evaluate risk are effective and operating in line with the hospital's risk management processes in order to provide assurance that risks are being managed appropriately.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings related to the two inpatient clinical areas visited and wider hospital in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.
Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. Inspectors observed staff offering assistance to patients with their individual needs and protecting their privacy. Nursing staff were observed helping patients who needed assistance to mobilise. For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, inspectors observed privacy curtains drawn in multi-occupancy rooms when patients were being assessed and receiving personal care. The isolation rooms and multi-occupancy rooms in the inpatient clinical areas visited had en-suite bathroom facilities. Notwithstanding this, some patients accommodated in extra beds requiring isolation had to use commodes, which had the potential to impact on their privacy and dignity. Patient's personal information in the clinical areas visited, during the inspection was not always protected and stored appropriately. Inspectors observed whiteboards being used to record key information about patient care. Patients' names were clearly visible on whiteboards in the clinical areas inspected which is not consistent with general data protection and regulation standards. This was brought to the attention of the CNM for remedy at the time of inspection. Findings were consistent with the overall findings from the 2022 National Inpatient Experience Survey, where with regard to privacy in the clinical area and staff introducing themselves when treating and examining patients, the hospital scored above the national average. Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity and privacy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. However, opportunities for improvement were identified in relation to the storage and protection of patients' personal information. Patients' personal information should be protected at all times and hospital management needs to ensure that systems and processes are in place to achieve this and ensure compliance with relevant data protection legislation.
Judgment: Substantially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. For example, staff were observed responding in a timely and calm way to a patient who was confused and offered reassurance and support. There was evidence that staff supported a person-centred approach to care, especially for vulnerable patients. In one clinical area visited, there were two 'end-of-life' rooms which enabled families of a patient receiving end of life care to stay at the hospital, if they wished. Notwithstanding this, in one of the clinical areas visited, inspectors noted that a concern raised by patients relating to draught windows that caused them to feel cold had not been managed appropriately by hospital management. A risk assessment was completed at clinical area level and the issue was escalated to senior management. However, it was unclear to staff how the discomfort for patients was being addressed by management and what remedial actions had been taken to address concerns about the draught windows. Inspectors raised this with senior management and were informed that the hospital had requested funds to have windows replaced but there was no agreed timeframe as to when this would happen. Overall, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. However, listening to and acting on patient experiences is an area identified for improvement following this inspection.
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.

There were systems and processes in place at the hospital to respond to complaints and concerns received from patients and their families. The complaints manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was oversight and monitoring of the timeliness of responses and the management of complaints by the relevant governance structures — Clinical Governance and Quality and Patient Safety Committee, the Executive Management Group and SIMT. However, inspectors noted that terms of reference for the SIMT submitted to HIQA did not outline reporting and accountability arrangements for the SIMT.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*'.[‡‡‡‡‡‡‡‡] There was evidence that hospital management supported and encouraged point of contact complaint resolution in line with national guidance, whereby informal and formal complaints were managed at local clinical area level by the CNM. Informal and formal complaints were also managed by the designated complaints officer.

The hospital formally reported on the number and type of complaints, verbal and written, received annually. In 2021, hospital management received 164 formal complaints (excluding withdrawn or anonymous complaints). Just over half (59%) of the complaints were resolved within 30 working days, which was significantly below the national HSE target of 75% for investigating complaints. Delays in achieving the HSE's target for complaints resolution was often attributed to the complexity of the complaint and the workload of those involved with providing information to resolve the complaint. When this occurred, the complainant was informed of the reason for the delay.

Complaints were tracked and trended to identify the emerging themes, categories and departments involved. Safe and effective care, communication and information and access to care and facilities were the top three themes arising from the tracking and trending of complaints in 2021.

There was some evidence that quality improvement initiatives were developed and implemented to improve services and care also as a result of complaints received. For example, improvements were made to the maternity unit and a specific room was created for the purpose of having private and sensitive conversations.

Staff who spoke with inspectors in the clinical areas visited received limited feedback on complaints received and the complaints resolution process. This is a missed opportunity that could be addressed following inspection.

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

Inspectors observed information about the HSE's '*Your Service Your Say'* displayed in all the clinical areas visited on the days of inspection. The majority of patients who spoke with inspectors were not provided with information on the hospital's complaints process, but all said that they would speak with a nurse or a member of staff if they wanted to raise a concern.

Patients and staff who spoke with inspectors were not aware of any independent advocacy services available to patients who may need the service. Inspectors were informed that plans were in place to facilitate training for staff by the National Advocacy Office in January 2023 as part of an action identified in response to the 'Learning To Get Better'§§§§§§§§ recommendations.

Overall, the hospital had systems and processes in place to respond to complaints and concerns raised by people who use their services. Hospital management should continue to implement measures to support the prompt, open and effective resolution of complaints within national HSE targets so as to improve the experience of people using the service. Patients receiving care at the hospital should be provided with information on the hospital's complaints process and on any independent advocacy services available to them. A formal standardised system should also be implemented at the hospital to facilitate the sharing of learning from complaints and the complaints resolution process to help reduce reoccurrence of the same issues for people using their services.

Judgment: Substantially compliant

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

During inspection, inspectors observed that, the physical environment was generally well maintained and clean with few exceptions in the clinical areas visited. There was evidence of general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning and posed an infection prevention and control risk. The inpatient clinical areas visited had adequate communal toilet and bathroom facilities for patient use.

Environmental cleaning was provided by the support services department within the hospital. Cleaning supervisors and CNMs had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal cleaning was carried out by designated cleaning staff. CNMs who spoke with inspectors were

§§§§§§§§ An investigation by the Office of the Ombudsman that looks at how public hospitals in Ireland handle complaints about their services. in particular, it looks at how well the HSE and public
hospitals listen to feedback and complaints and whether the HSE and public hospitals are learning from complaints to improve the services they provide.

satisfied with the level of cleaning resources in place during and outside core working hours for their areas of responsibilities.

Cleaning of equipment was assigned to healthcare assistants and a tagging system was used to identify clean equipment. Hazardous material and waste was safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

CNMs who spoke with inspectors stated they were generally satisfied with the maintenance services at the hospital. However, the timeliness to resolve maintenance issues was an identified area of improvement.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available in all clinical areas visited. Hand hygiene signage was also clearly displayed throughout the clinical areas visited. Hand hygiene sinks throughout the hospital conformed to requirements.********* Infection prevention and control signage in relation to transmission-based precautions was displayed in all clinical areas visited.

Supplies and equipment were stored adequately and appropriately in all clinical areas visited. However, in one of the clinical areas inspected, inspectors observed that not all sterile products were stored above floor level. This was brought to the attention of staff on the day of inspection for immediate remedy.

PPE was available outside isolation rooms where patients with confirmed or suspected infections were accommodated. Staff were also observed wearing appropriate PPE, in line with public health guidelines at the time of inspection. Physical spacing of one metre was observed to be maintained between beds in multi-occupancy rooms in the inpatient clinical areas visited. However, this was not the case for trolleys and chairs on the corridor in the emergency department.

There were processes in place to prioritise and ensure appropriate placement and management of patients with suspected or confirmed communicable disease, which was underpinned by a formalised prioritisation criteria and was overseen by the infection prevention and control team. However, it was noted that there were insufficient isolation facilities in both inpatient clinical areas visited. Inspectors were informed that cohorting of patients with the same microorganism is facilitated following consultation with the infection control team and based on a risk assessment.

In summary, the physical environment and patient equipment in the clinical areas inspected was observed to be generally clean and well maintained with few exceptions. However, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care at all times noting the insufficient number of isolation rooms available at

********* Department of Health, United Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

the hospital and the challenges some clinical areas faced as a result of issues identified with windows.
Judgment: Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.
HIQA found that the hospital had monitored and reviewed information from multiple sources including: patient-safety incident reviews, complaints, risk assessments, quality nursing and midwifery metrics, quality and safety performance metrics and national inpatient experience surveys. **Infection prevention and control monitoring** HIQA was satisfied that the Infection Prevention and Control Committee had oversight of the monitoring of infection prevention and control practices at the hospital. Monthly environment, equipment and hand hygiene audits were undertaken at the hospital using a standardised approach. Monthly environment and equipment audits were undertaken at clinical area level by multi-task attendants and trained auditors. Environmental hygiene audits submitted to HIQA showed that the inpatient clinical areas visited achieved a high level of compliance ranging from 90.8% (medical 1) to 92.2% (surgical 1) in October 2022. Inspectors noted that recommendations were not identified and or time-bound action plans developed for all completed equipment hygiene audits to improve equipment hygiene standards. Not all clinical areas visited were compliant with the HSE's target of 90% for effective hand hygiene practices. Hand hygiene audit results for December 2022 ranged from 86.7% to 93.3%. There was evidence that time-bound action plans were developed when hand hygiene standards fell below acceptable levels. Audit findings and the learnings from audit activity were shared with staff in the clinical areas through the use of information boards and at clinical handover. Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection.[†††††††††] The infection prevention and control team submitted a comprehensive infection prevention

[†††††††††] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf

and control report to the Infection Prevention and Control Committee annually. The report detailed all the activities put in place during the year to minimise the transmission of healthcare associated infections at the hospital

In line with HSE's national reporting requirements, the hospital reported on rates of:

- *Clostridioides difficile* infection
- CPE
- hospital-acquired *Staphylococcus aureus* blood stream infections
- hospital-acquired COVID-19 and outbreaks.

For year to date in 2022, the hospital's rate of new cases of:

- hospital-acquired *Clostridioides difficile* was above the national HSE's target of less than 2 per 10,000 bed days in one month only (July).
- hospital-acquired *Staphylococcus aureus* blood stream infection was above the national HSE's target of less than 0.8 per 10,000 bed days for four non-consecutive months (February, March, May and August).

The infection prevention and control report demonstrated that outbreaks in relation to *Clostridioides difficile* were being monitored and managed by the hospital outbreak control team. However, inspectors were unclear what action or actions had been introduced at the hospital in response to *Clostridioides difficile* outbreaks in 2021.

The hospital had two confirmed outbreaks of CPE in February and May of 2022. There was no evidence that outbreak reports were completed for the outbreaks of CPE in line with national guidelines. Minutes of outbreak meetings submitted to HIQA showed that actions required to reduce the risk of further CPE outbreaks were discussed at those meetings.

Antimicrobial stewardship monitoring

There was limited evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. With no on-site consultant microbiologist, hospital management must ensure that there is adequate oversight of antimicrobial stewardship activities at the hospital.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication audits were carried out in the following areas:

- medication reconciliation
- venous thromboembolism prophylaxis†††††††††
- custody and storage of controlled drugs

- prescribing, dispensing, storage and administration of insulin
- compliance with completion of medication prescription administration record (MPAR).

There was evidence that quality improvement initiatives were introduced following audit activity to improve medication safety practices at the hospital. For example, green bags for identifying and safely transferring patients' own medications.

Deteriorating patient monitoring

The hospital took part in the HSE's national sepsis management audit carried out in July 2022 and were found to be non-compliant with clinical guidelines for sepsis management. This was identified as a high-rated risk recorded on the hospitals' corporate risk register. The hospital had developed a quality improvement plan to implement the seven key recommendations from this audit. Actions included face to face training on the management and escalation of sepsis and skills and drills training for doctors. While training records provided to HIQA indicated that this was being implemented for nursing staff, inspectors were not assured that these actions were being implemented for doctors. The re-audit of compliance with national guidelines on sepsis management was due to be carried out in December 2022.

Compliance with national guidance on the use of ISBAR was audited at the hospital. A snapshot audit on the use of ISBAR for nursing shift handover in 12 clinical areas was completed in November 2022. Findings identified that the ISBAR tool was not routinely used for clinical handover, only 17% of clinical areas were using a template that was aligned with the ISBAR format and 33% of clinical areas did not use a template for clinical handover. A time-bound action plan had been developed to improve compliance with ISBAR use across the hospital.

Transitions of care monitoring

The hospital tracked the number of new attendances to the emergency department, patient experience times, the average length of stay of a medical and surgical patient and the rate of delayed transfer or discharge every month. At the time of inspection, there was only one episode of delayed transfers of care.

Staff spoke about quality improvement initiatives implemented in response to findings from the National Inpatient Experience Survey and examples such as those outlined in national standard 2.8 were observed in clinical areas inspected. Overall, HIQA found that the hospital had effective systems in place to monitor and evaluate healthcare services provided at the hospital. However, all information from monitoring activities was not being used to improve practices in relation to the four areas of known harm. Opportunities for improvement were identified in relation to the need to re-audit the effectiveness of measures introduced in relation to audit findings. Furthermore, hospital management need to ensure that outbreak management review reports are completed in

line with national guidelines so that recommendations to reduce the risk of infection transmission to patients are identified and effectively implemented.

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.

The hospital had systems in place to identify, evaluate and manage risks to people using the service in the four areas of known harm, however, HIQA found that the monitoring and evaluating of controls and actions to mitigate the identified risks could be improved. Each clinical directorate had their own risk register and there was evidence that risks not managed at directorate level were escalated to senior management and recorded on the hospital's corporate risk register. The Clinical Governance and Quality and Patient Safety Committee, Executive Management Group and SIMT had oversight of the risks, controls and corrective actions to mitigate the risks on the hospital's corporate risk register.

At the time of inspection, six high-rated risks related to the four areas of known harm were recorded on the hospital's corporate risk register. These included risks related to:

- increased emergency department attendances
- lack of isolation facilities in the emergency department
- staffing recruitment
- delays in issuing discharge letters
- non-compliance with national guidance on sepsis management.

CNMs were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential patient safety risks in their clinical areas.

HIQA was not assured that all risks were being formally reviewed in line with the hospital's risk management processes outlined to inspectors on the day. For example, a number of risks documented on the risk register were overdue for review and status updates in relation to the effectiveness of corrective actions and controls in place were not documented. Furthermore, findings on the days of inspection would suggest that control measures implemented to address two identified risks recorded on the corporate risk register — lack of on-site consultant microbiology and sedation administered for endoscopy procedures, were not fully effective in mitigating the actual and potential risk to patient safety. This was discussed with hospital management during the inspection. Following the inspection, a high-risk letter was issued to hospital management seeking assurances on the further measures implemented to ensure that any patient safety risks arising from the lack of on-site consultant microbiology and sedation administered for endoscopy procedures were appropriately managed and mitigated. HIQA was assured by

the hospital management's response that the immediate risks identified to patient safety had been appropriately addressed.

Infection outbreak preparation and management

Patients were screened for multi-drug resistant organisms. Patients who were suspected or symptomatic for COVID-19 were promptly screened at point of entry to the hospital in line with guidance in place at the time of inspection. The patient's infection status was also recorded on a sample of healthcare records reviewed by inspectors.

In 2021, the hospital had outbreaks in COVID-19, CPE, *Clostridioides difficile* and norovirus. The process of managing an infection outbreak was underpinned by a formalised up-to-date policy. HIQA found the approach to outbreak management was not comprehensive as outbreak review management reports were not always completed. Furthermore actions arising from outbreak meetings were not time-bound and did not identify persons responsible for implementing agreed actions. This is an area for improvement that could be addressed after this inspection.

The hospital were screening for CPE in line with national guidelines. However, the total number of patients screened for CPE in 2021 had decreased to 2,421, compared to 2,593 in 2020 and 3,264 in 2019. When discussed with hospital management, inspectors were told that the redeployment of staff during the COVID-19 pandemic had impacted on the screening for CPE. At the time of inspection, monthly audits of compliance with CPE screening were being carried out and compliance rates were reported to be 90%. Inspectors were told that when compliance rates are less than 100%, the frequency of audits of compliance with CPE screening are increased, with audits carried out weekly instead of monthly. Due to limited numbers of single isolation rooms at the hospital, all patients with an infective status were not isolated within 24 hours of admission or diagnosis as per national guidance. Potential risks were mitigated by the cohorting of patients suspected or confirmed with infection in multi-occupancy rooms.

Medication safety

There were limited clinical pharmacy services at the hospital and pharmacy-led medication reconciliation was not undertaken for all patients. Medication stock control in the clinical areas visited was carried out by pharmacy technicians every week.

HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications underpinned by a formalised policy which was represented by the acronym 'A PINCH'.[‡‡‡‡‡‡‡‡‡] Inspectors observed the use of risk reduction strategies to support the safe use of medicines in relation to anticoagulants, insulin, opioids and potassium. The hospital had a list of sound-

[‡‡‡‡‡‡‡‡‡] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

alike look-alike medications (SALADs). Prescribing guidelines, including antimicrobial guidelines and medication information was available and accessible to staff at the point of care in hard copy format, and through an application for smart mobile phones.

Deteriorating patient

The hospital had implemented the INEWS version 1 guideline and observation chart and staff had received training to support the introduction of INEWS version 2 in January 2023. Staff in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient. There were systems in place to manage patients with a triggering early warning system. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. The ISBAR communication tool was used when requesting a patient review. Inspectors reviewed a sample of healthcare records and found that the majority of INEWS charts were completed and calculated correctly in line with the INEWS escalation protocol. Issues identified were brought to the attention of the CNM on the day of inspection.

Safe transitions of care

The hospital had some systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services, and to support safe and effective discharge planning. A CNM2 was appointed for admitted patients in the emergency department and the hospital's bed manager supported safe and effective discharge planning.

Staff used a number of transfer and discharge forms to support the exchange of information, which is imperative to the safe transition of care. Notwithstanding this, inspectors were informed that there was often delays with issuing transfer letters and discharge summaries to primary healthcare services. This was an identified high-rated risk recorded on the hospital's corporate risk register and had the potential to impact on the timely provision of information relating to the patients medication, infection control status and plan of care. A rapid improvement event was introduced at the hospital to improve the timely completion of discharge letters at the hospital which involved the installation of additional computers and inspectors were informed that this had a positive impact on the timely issuing of discharge letters to GPs, but that further work was still required.

Policies, procedures and guidelines

The hospital had a suite of infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, managements of patients in isolation and equipment decontamination. The hospital also had a suite of medication policies, procedures, protocols and guidelines. However, some locally developed policies were overdue for review at the time of inspection. The hospital used national policies on INEWS, IMEWS

and PEWS. All policies, procedures, protocols and guidelines were accessible to staff via the hospital's intranet.

In summary, while the hospital had systems in place to identify potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care — HIQA found that risk management processes required strengthening in order to provide adequate oversight of potential and actual risks to patient safety identified at the hospital. Hospital management must ensure that identified risks are being appropriately managed, evaluated and updated in line with the hospital's risk management processes. Furthermore, the hospital were not completing outbreak management review reports, in line with national guidelines. This was also a finding from HIQA's previous inspection in 2020, which had not been progressed despite it being a documented objective in the hospital's infection prevention and control plan 2022. It is imperative that an outbreak management review occurs after each infection outbreak so that learning can occur and a time-bound action plan be developed to implement the various recommendations from the review, so as to mitigate any risk to patient safety in the medium- and longer-term, and to sustain safe, high-quality healthcare services.

Judgment: Partially compliant

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

There were systems in place at the hospital to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Patient-safety incidents were discussed at meetings of the SIMT with oversight provided by The Clinical Governance and Quality and Patient Safety Committee and Executive Management Group.

The hospital reported clinical incidents through the NIMS. In 2021, a total of 2,123 patient-safety incidents were reported to NIMS. The hospital's average of clinical incidents reported to NIMS for 2022 was 16.0 per 1,000 bed days. Overall, HIQA identified opportunities for improvement in relation to the numbers of clinical incidents reported at the hospital. Higher reporting rates of clinical incidents generally means there is a good reporting culture and greater visibility of risk at the hospital, which are key determinants for safer healthcare services.

Documentation submitted to HIQA showed that for quarter one 35% of the clinical incidents that occurred in the hospital were reported within 30 days of date of notification which is lower that the HSE's target of 70%, however, this had increased to 81% in quarter two which was above target. Hospital management, identified that the under

resourcing of the quality and patient safety department was a major contributor to the hospital's non-compliance with the rate of reporting to NIMS.

Staff who spoke with HIQA were knowledgeable about how to report and manage a patient-safety incident and were aware of the most common patient-safety incidents reported — slips, trips and falls, pressure ulcers and medication errors.

Patient-safety incidents were tracked and trended, according to numbers, location and severity. A summary report on patient-safety incidents was compiled for relevant governance committees with a reporting arrangement to the Clinical Governance and Quality and Patient Safety Committee.

The hospital's SIMT met monthly to review new patient-safety incidents, the status of any patient-safety incident reviews in progress and the implementation of recommendations from other reviews. Eight serious reportable events were reported in 2021. Every year, the SIMT compiled a comprehensive summary report detailing the serious incidents and serious reportable events and the recommendations arising from each of these reviews. The Clinical Governance and Quality and Patient Safety Committee had oversight of the management of patient-safety incidents.

Infection prevention and control patient-safety incidents

Patient-safety incidents related to healthcare-acquired infections were reported to NIMS. Inspectors were informed that the infection prevention and control team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective action or preventative measures. Reported infection prevention and control patient-safety incidents were tracked and trended monthly by the infection prevention and control team.

Infection prevention and control related patient-safety incidents were reported to the Infection Prevention and Control Committee who had oversight of the effectiveness of any corrective actions and measures introduced to mitigate any patient safety risk. However, there was limited evidence from minutes of meetings of the Infection Prevention and Control Committee reviewed by inspectors, that infection prevention and control incidents were discussed at committee meetings.

Medication patient-safety incidents

Medication patient-safety incidents were reviewed by the chief pharmacist in collaboration with a senior pharmacist who categorised the incidents in terms of severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. In 2021, 181 medication patient-safety incidents were reported in the hospital, an increase on the number of incidents reported when compared to 2020 and 2019. This demonstrates an improved reporting culture amongst staff as higher incident reporting rates are generally indicative of a positive medication

safety culture. Key trends to emerge from medication safety patient-safety incidents in 2021, included:

- errors associated with pre-admission and discharge prescribing
- antithrombotic medications
- administration of antibiotics to patients with known allergies
- inappropriate self-administration of medications.

Quality improvement initiatives targeted at improving medication safety practices at the hospital arising from patient-safety incidents were implemented and evidence of these were noted in the hospital's medication safety annual plan and observed by inspectors during inspection.

Deteriorating patient-safety incidents

Patient-safety incidents relating to the deteriorating patient were reported to the Deteriorating Patient Committee. Inspectors were informed of an incident that had occurred at the hospital in August 2022. While a preliminary assessment of the review had been completed, a formalised quality improvement plan had not been put in place to address learning opportunities identified at the time of inspection. This is a missed opportunity and was discussed with hospital management during inspection.

Feedback relating to patient-safety incidents was provided informally by CNMs, clinical pharmacists and the infection prevention and control team. The risk manager also discussed findings and learning opportunities from patient-safety incidents at grand rounds.§§§§§§§§§

Overall, HIQA found that the hospital had systems in place to identify and report, patient-safety incidents, however, opportunities for improvement were identified in relation to the appropriate management and oversight of all incidents. Furthermore, learning opportunities and quality improvement initiatives arising from the review of patient-safety incidents should be formally documented, implemented and evaluated in line with best practice guidelines.

Judgment: Partially compliant

Conclusion

§§§§§§§§§ Grand rounds: are formal meetings where physicians and other clinical support and administrative staff discuss the clinical case of one or more patients. Grand rounds originated as part of medical training.

HIQA carried out an announced inspection of Regional Hospital Mullingar to assess compliance with national standards from the *National Standards for Safer Better Healthcare.* The inspection focused on a selection of the national standards, and as part of the same inspection HIQA placed a particular focus on measures the hospital had put in place to manage four areas of known potential patient safety risk — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, HIQA found the hospital to be:

- substantially compliant in three national standards (1.6, 1.7, 1.8).
- partially compliant in nine standards (5.2, 5.5 (ED), 5.5 (wider hospital), 6.1, 5.8, 2.7, 2.8, 3.1, 3.3).
- non-compliant with two national standards (1.6, 3.1).

Opportunities for improvement were identified across a number of areas.

Capacity and Capability

The Regional Hospital Mullingar had defined corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, HIQA found that governance arrangements could be strengthened to further improve the effective oversight of the quality and safety of healthcare services provided at the hospital. Furthermore, hospital management need to ensure that committees are operating in line with their terms of reference in order to provide adequate oversight of quality and safety at the hospital.

There was evidence of devolved accountability and responsibility within the emergency department. Operationally, there was evidence that hospital management had implemented a range of measures to improve the flow of patients in the emergency department and increase surge capacity at the hospital, but it was evident from findings on the first day of inspection that the department was not functioning as effectively as it should be.

Hospital management were working to actively recruit medical, nursing and midwifery staff to fill vacant positions. Notwithstanding this, there are notable deficits in the hospital's approved and actual rostered complement of medical, nursing and midwifery staff. The lack of an on-site consultant microbiologist at the hospital remains a concern for HIQA. Hospital management should progress with the recruitment to fill the position permanently and in the interim continue to progress actions outlined to HIQA to address the related patient safety risk. Staff attendance at and uptake of mandatory and essential training was suboptimal and could be significantly improved. The senior management team also need to have a greater level of oversight of staff attendance at and uptake of mandatory and essential training. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice, and at the required frequency, in line with national standards.

The hospital had systems in place to monitor and evaluate healthcare services provided at the hospital. However, opportunities for improvement were identified to ensure that all information from monitoring activities was being used to improve practices. Hospital management must ensure that outbreak management review reports are completed following infection outbreaks in line with national guidance.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. There was variance in the care experienced by patients receiving inpatient care and those receiving care within the emergency department. Patients' privacy, dignity and confidentiality were severely compromised in the emergency department, especially for patients accommodated on trolleys and chairs on the corridor.

The physical environment in the clinical areas visited did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of isolation and en-suite bathroom facilities particularly in the emergency department, which has the potential to increase the risk of cross infection. Furthermore, not all healthcare records were managed and stored in line with national standards.

There were systems in place at the hospital to proactively identify, manage and minimise unnecessary or potential risk of harm to people receiving care at the hospital. However, HIQA found that the oversight of risks required improvement. Hospital management need to ensure that identified risks are managed appropriately and that corrective controls in place to mitigate identified risks are regularly evaluated and updated to determine their effectiveness.

HIQA was satisfied that there was a system in place at the hospital to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm. Notwithstanding this, HIQA found evidence of missed opportunities for learning and improving services in relation to findings from a patient-safety incident.

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 the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to properly address HIQA's findings at the hospital, in the best interest of the patients that the hospital serves.

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 of Regional Hospital Mullingar 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 standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital 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 hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Judgments relating to overall inspection findings	
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
Judgments relating to Emergency Department findings only	
Theme 5: Leadership, Governance and Management	
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
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
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-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

Capacity and Capability Dimension
Judgments relating to wider hospital and inpatient clinical areas findings only

National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
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.	Partially compliant
Quality and Safety Dimension	
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.	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
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant
Quality and Safety Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	

National Standard	Judgment
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.	Partially compliant

Compliance Plan for Regional Hospital Mullingar

Inspection ID: NS 0019

Date of inspection: 6 and 7 of December 2022

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

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

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

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

Standard Number and Name	5.2 Leadership , Governance and Management	Document Title: Standard 5.2 Item 1 Action Plan
Directorate/Department/Speciality	Oversight of the quality and safety of healthcare	
Date of Action Plan	13/03/2023	
Document Owner		
HIQA Finding/Summary	Reporting arrangements for oversight committees were not represented in the Organisational Chart submitted to HIQA (p9)	
Action Required		**Timeframe (delete as appropriate)**

A new Regional Hospital Mullingar Committee Governance Structures CHART-M/HOSPQ/17, is currently being *drafted and will be submitted with this action plan.*	– **Immediate (0-1month)**
The draft CHART-M/HOSPQ/17 will be presented to and ratified by Hospital Executive Management Group and Hospital Clinical Governance and Quality and Patient Safety Committee.	– **Short term (0-3 months)**
Revision 1 of the approved Chart will be distributed to all relevant Staff Revision 1 of the approved Chart will be uploaded to Shared Electronic Folder	– **Short term (0-3 months)**

Standard Number and Name	5.2 Leadership , Governance and Management	Document Title: Standard 5.2 Item 2 Action Plan
Directorate/Department/Speciality	Oversight of the quality and safety of healthcare	
Date of Action Plan	13/03/2023	
Document Owner		
HIQA Finding/Summary	The role, effectiveness and function of committees needs to be assessed and reviewed to ensure they are operating in line with their terms of reference and providing the necessary oversight arrangements (p14)	

Action Required	**Timeframe (delete as appropriate)**
A communication to request a review will be circulated to ensure all committees have Terms of Reference in place. This will include a terms of reference template.	– **Short term (0-3 months)**
Each committee is requested to include review of Terms of Reference as an agenda item at their next meeting and confirm compliance with Terms of Reference to QPS Manager. A checklist may be drafted to ensure the effectiveness and function of committees are periodically reviewed to ensure they are operating in line with the agreed terms of reference. The following are examples which may be included on the Checklist:- • Does the Meeting meet at the frequency set out in the TOR? • Is there representation from all required areas across Clinical and Management/Administration? • Is it confirmed that there is no Conflict of Interest by participants at the meeting? • Is Quality and Safety a standard item on the Agenda? • Are minutes and action points distributed to all relevant staff in a timely manner? • Are action points captured, time bound and completed in a timely manner? • Is there an escalation procedure if the meeting cannot resolve an item(s)	– **Medium term (3-6 months)**
Oversight arrangements should be provided to the QPS manager for inclusion on the Organisation Committee organogram.	– **Medium term (3-6 months)**

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

Inspection Finding: Clinical Governance Quality and Patient Safety Committee.

The committee's terms of reference submitted to HIQA did not outline who the committee reported and were accountable to (p10)

Action: Refer to Appendix 3; Updated *Meeting Terms of Reference Hospital Clinical Governance Quality and Patient Safety Committee*

Standard Number and Name	Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Document Title: Standard 5.2 Item 4 Action Plan
Directorate/Department/Speciality	Clinical Governance Quality and Patient Safety Committee: Bed Management/ Patient Flow	
Date of Action Plan	09/02/2023	
Document Owner		
HIQA Finding/Summary	The hospital did not have a Bed Management and or Discharge Committee. (p11)	

Action Required	**Timeframe (delete as appropriate)**
RHM to form a Multidisciplinary Bed Management / Patient Flow committee which will focus on all aspects of admission and discharge processes at the hospital. This will include the creation of terms of reference clearly outlining its operational function and the reporting relationship of this committee will be to Unscheduled Care Governance Committee who report to Hospital Executive Management Group.	– **Short term (0-3 months)**
The review of current PPPGs and the development of additional ones as required to inform and guide the Multidisciplinary team on matters pertinent to this area of hospital activity.	– **Medium term (3-6 months)**
The committee will be responsible for developing an audit schedule in relation to patient flow activity in partnership with the Clinical Audit Facilitator	– **Long-term (6 months+)**

Standard Number and Name	Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Document Title: Standard 5.2 Item 6 Action Plan
Directorate/Department/Speciality	Antimicrobial Stewardship Monitoring / Pharmacy	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital had an antimicrobial stewardship programme, however, HIQA were not assured there was effective oversight of antimicrobial stewardship at the hospital. (p12)	

Action Required	**Timeframe (delete as appropriate)**

Antimicrobial pharmacist (appointed 2022) currently finalising annual service plan, which sets out details of proposed stewardship activities, audits, education and training, targets (e.g. reductions in antimicrobial consumption) and other foci for the year.	**Immediate (0-1month)**
A summary of stewardship activities and progress on service plan to be brought to bi-monthly HCAI AMS committee meetings and quarterly meetings of the Drugs and Therapeutics committee.	**Short term (0-3 months) (and ongoing)**
The clinical director, general manager and director of nursing are members of the Drugs and Therapeutics committee and the Hospital Executive Management Group. Where appropriate, they will relay or escalate matters relating to antimicrobial stewardship activities from the Drugs and Therapeutics committee to the Hospital Executive Management Group for action.	**Medium term (3-6 months) (and ongoing)**

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

Inspection Finding: Lack of an on-site consultant microbiologist at the hospital identified during inspection as high risk. (p12)

Action: Immediate action implemented by hospital: refer to Appendix 1; *QIP No.2 HIQA Inspection December 2022 - Consultant Microbiologist*

Standard Number and Name	5.2 Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Document Title: Standard 5.2 Item 8 Action Plan
Directorate/Department/Speciality	Healthcare Associated Infections and Antimicrobial Stewardship Committee	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	Minutes of the Infection Prevention and Control Committee submitted to HIQA for 2022 did not provide assurance that updates relating to antimicrobial stewardship were sufficiently provided to the committee. (p12)	

Action Required	**Timeframe (delete as appropriate)**
Antimicrobial Pharmacist (appointed 2022) to provide detailed updates regarding antimicrobial stewardship activities to HCAI AMS committee at bi-monthly meetings, including: • Antimicrobial consumption • Antimicrobial activities, e.g. stewardship rounds • Education and training provided • Antimicrobial audits • Updates to antimicrobial guidelines, where applicable	**Short term (0-3 months)**

Standard Number and Name	5.2 Service providers have formalised governance arrangements for assuring	Document Title: Standard 5.2 Item 9 Action Plan

	the delivery of high-quality, safe and reliable healthcare.	
Directorate/Department/Speciality	Drugs and Therapeutics committee	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	According to the committee's terms of reference, the committee should meet four times per year, however, minutes of the meetings submitted to HIQA indicated that the committee had, to date, met twice in 2022 (March and October). (p12)	

Action Required	**Timeframe (delete as appropriate)**
Chairperson and committee secretary to ensure that meetings are scheduled and go ahead quarterly. • The recently launched meeting room booking system has made scheduling meetings much more efficient • A teleconference option will be made available for committee members unable to attend in person. Meetings have been scheduled for the following dates: 1. 29th March 2023 2. 27th June 2023 3. 4th October 2023 4. 6th December 2023	**Immediate (0-1month)**

Standard Number and Name	5.2 Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Document Title: Standard 5.2 Item 10 Action Plan
Directorate/Department/Speciality	Medication Safety committee	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	Terms of reference outlined that the committee was due to meet three times a year, however, no meeting took place in 2021. At the time of the inspection, committee had met twice with a further meeting planned by the end of the year. (p13)	

Action Required	**Timeframe (delete as appropriate)**
Medication Safety committee chairperson to ensure that meetings of the Medication Safety committee are scheduled and go ahead three time a year. The recently launched meeting room booking system has made scheduling meetings more efficient. A teleconference option will be made available for committee members unable to attend in person. Meetings have been scheduled for the following dates: 1. 1st March 2023 (has already taken place) 2. 13th June 2023 3. 12th September 2023	**(0-1month)**

Standard Number and Name	5.2 Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Document Title: Standard 5.2 Item 11 Action Plan

Directorate/Department/Speciality	Unscheduled Care Committee
Date of Action Plan	12/03/2023
Document Owner	
HIQA Finding/Summary	HIQA were informed that the committee were due to meet monthly, however, the committee were not meeting as planned in 2022 and inspectors were informed that meetings had only recently reconvened in October 2022 (p13)

Action Required	**Timeframe (delete as appropriate)**
The Unscheduled Care Committee meet monthly and have oversight of activity and performance within the Emergency Department including patient flow and surge capacity at the hospital. The below dates have been scheduled for 2023: 25/01/23 – occurred and well attended 22/02/23 - occurred and well attended 22/03/23 26/04/23 24/05/23 28/06/23 26/07/23 23/08/23 27/09/23 25/10/23 22/11/23 27/12/23 The Unscheduled Care is a fixed item at the hospital monthly performance meetings with the Ireland East Hospital Group.	– **Immediate (0-1month)**

Timescale: **Long-term (6 months+)**

National Standard	**Judgment**
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 standard. This should clearly outline:

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

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

Findings relating to the emergency department

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 ED Item 12 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	Spacing between the majority of trolleys and chairs in the department was not always one metre. This was not in line with national guidance in relation to the management and control of COVID-19 in place at the time of inspection and posed a cross infection risk. (p15)	

Action Required	**Timeframe (delete as appropriate)**
Re-measure all areas between trolleys and chairs and ensure 1-meter distance.	– **Immediate (0-1month)**
Memo/communication to all staff in ED to re-emphasise the importance of adhering to the national guidance in relation to the management and control of COVID-19	– **Immediate (0-1month)** –
Development of acute floor for additional assessment spaces for the Emergency Department.	**Long-term (6 months+)**

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 ED Item 13 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	Operationally, the emergency department was not functioning as effectively as it should be, was overcrowded and had significant issues with patient flow within the hospital, which collectively posed a patient-safety risk and was a concern to HIQA. (p17)	

Action Required	**Timeframe (delete as appropriate)**
Opening of ward 4 which is a 10 bedded ward to facilitate short stay patient from ED. Open since 16th January 2023	– **Immediate (0-1month)**
Continuous communication to Staff and the general public regarding the additional facility to assess and treat adult minor injuries in the offsite minor injuries unit	– **Immediate (0-1month)**

Attend the Visual Boards meetings at the allocated times for the Emergency Department staff. Ensure rotation of staff attending meetings to raise awareness of the process.	– **Immediate (0-1month)**
Review of team rosters to achieve maximum staffing and skill mix per shift	– **Immediate (0-1month)**
Additional resourcing to the Community Intervention team (CIT) to improve the service including but not limited to Physiotherapist and OT.	– **Short term (0-3 months)** –
Introduction of Twilight shifts to support nurses in Triage and Paediatrics to assist with patient flow for peak periods of attendances i.e. afternoons and evenings	– **Short term (0-3 months)** –
Reconfiguration of Triage area to accommodate support Nurse in Triage	– **Short term (0-3 months)**
Appointment of ADON for admitted patients Interview dates to be confirmed	– **Short term (0-3 months)**
Promote and continue awareness of ongoing EDOSH huddles in ED.	– **Short term (0-3 months) Ongoing**
Rostering of an Adult phlebotomist in the Emergency Department to assist with patient flow. This is a work in progress. In the interim agency staff are employed to provide Phlebotomy service in the ED	– **Medium term (0-3 months)**
Development of acute floor for additional assessment spaces for the Emergency Department.	**Long-term (6 months+)**
Appointment of 5 nurses for admitted patient team within the emergency department.	– **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

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

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

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

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

Standard Number and Name	Standard 6.1. Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Document Title: Standard 6.1 ED Item 23 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	14/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital was reliant on the use of agency staff to fill nearly a third of the NCHD positions in the ED. The use of agency staff is not a sustainable solution for the future. (p25)	

Action Required	Timeframe (delete as appropriate)
Commence earlier recruitment campaign for July intake – closing date was 2 Dec 2022 Conduct earlier interviews and improve the processing of offers by using the online Equitas system. Use of Rezoomo system for offering of posts which is streamlining the process.	– **Immediate (0-1month)**
Advance plans and explore feasibility to be included in Basic Specialist Training in EM training schemes Participate in overseas rotation scheme such as *International Medical Graduate Training Initiative* / RHM Romanian Blueprint / IEHG Italian Scheme.	**Long-term (6 months+)**

Standard Number and Name	Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Document Title: Standard 6.1 ED Item 24 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	Attendance at and uptake of mandatory and essential training for nursing staff in the emergency department was sub-optimal and requires significant improvement. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. (p26)	

Action Required	Timeframe (delete as appropriate)
The Divisional Nurse Manager and CNM 111 for the Emergency Department are to review current status and develop an action plan to improve the attendance at both face to face training and to increase the uptake and participation in on line training programmes which are mandatory available on HSELand.	– **Immediate (0-1month)**
RHM to develop an audit schedule to monitor compliance with all mandatory and essential training in the Emergency Department in collaboration with the Clinical Audit Facilitator.	– **Short term (0-3 months)**
RHM to develop a central system with associated work processes supported by relevant systems and personnel to record and monitor staff attendance at mandatory and essential training throughout the hospital amongst all staff grades. Refer to Standard 5.5 WH Item 20 Action Plan	– **Medium term (3-6 months)**

Timescale: **Long-term (6 months+)**

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

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

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

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

Standard Number and Name	Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Document Title: Standard 1.6 ED Item 25 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	The privacy, dignity and confidentiality of patients accommodated on trolleys and chairs in the corridor and multi-occupancy areas was severely compromised. Consultations and clinical assessment was carried out wherever the patient was located, this included the multi-occupancy eight bedded open planned area at the nurses' station and on the corridor. In this setting, it was impossible to maintain the patient's privacy and confidentiality. Others (patients, visitors and staff) could overhear patient-clinician conversations and the exchange of personal information between patients, medical and nursing staff. (p27)	

Action Required	**Timeframe (delete as appropriate)**
Memo/communication to all staff in ED to re-emphasise the importance of privacy, dignity and confidentiality of patients in line hospital policy and HIQA standards.	– **Immediate (0-1month)**
Propose inclusion of additional field to EDOSH (Emergency Department Safety Huddle) regarding need for staff to undertake risk assessment to identify an appropriate clinical space to speak with patients and maintain privacy and dignity at all times	– **Immediate (0-1month)**
Daily risk assessment to be undertaken by senior management in ED to identify patients that can possibly be moved out of Resus/main area to the corridor to allow for examination and to ensure privacy and dignity when assessing/examining patients.	– **Immediate (0-1month)**
Appointment of ADON Patient Flow ED for admitted patients	– **Short term (0-3 months)**
Development of acute floor for additional assessment spaces for the Emergency Department.	– **Long-term (6 months+)**

Standard Number and Name	Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Document Title: Standard 1.6 ED Item 27 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	Inspectors observed multiple patient healthcare records contained in an open, unlocked trolley that were easily accessible on a public corridor in the emergency department. Healthcare records should be managed and stored in line with	

	national standards and relevant general data protection and regulation legislation. (p27)

Action Required	Timeframe (delete as appropriate)
Remove trolley from public area and locate in private area with access to healthcare professionals only	– **Immediate (0-1month)**
Review locked trolleys currently in use on ward in RHM. Order new locked trolley for ED based on review.	– **Immediate (0-1month)**
Liaise with Estates Dept regarding allocation of a designated nurse's station for the corridor.	– **Short term (0-3 months)**

Timescale: **Long-term (6 months+)**

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

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

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

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

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 28 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	Data on patient experience times collected on the first day of inspection, showed that at 12pm the hospital was non-compliant with any of the national key performance indicators on patient experience times set by the HSE. Seven (15%) attendees to the emergency department were aged 75 years and over and were in the emergency department greater than nine hours of registration - not in line with national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration. Only two (4%) of attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration — significantly short of the national target that 99% of patients aged 75 years and over are discharged or admitted to a hospital bed within 24 hours of registration. (p28)	

Action Required	Timeframe (delete as appropriate)
Liaise with CNM 2 for admitted patients to establish patient pathways and communication strategies developed since commencement in her post in late 2022	– **Immediate (0-1month)**

e. g Meetings with local PHNs every Mon, Wed and Friday. Development of direct link with Community Intervention Teams etc.	
Establishment of the Over 75yrs working group: MDT committee including but not limited to ED Consultant, Clerical rep, DNM ED, CNM3 ED, MFIT Rep, and Dementia CNS. This working group will be responsible for creating awareness and fostering a culture of prioritising care of the over 75yrs including but not limited to : ▪ Placing Purple stickers on ED Cards at registration to highlight patients over the age of 75 **will continue indefinitely** – In place since 1st September, 2022 ▪ Daily monitoring of over 75 ED attendances for each month and recording the required information to review performance as close as possible to real time ▪ 9:15am huddle (EDOSH) - CNM2 will liaise with MFIT regarding prioritising frailty positive patients suitable for discharge. ▪ Communication and updating all staff regarding action items and providing feedback on PET performance. ▪ Introduction of the Dementia friendly cubicle in main ED including introduction of Dementia friendly clocks and signage	– **Immediate (0-1month)**
Continuous MFIT service to the ED with appointment of a Physiotherapist to cover a temporary post.	– **Immediate (0-1month)**
Efficient use of the AMAU and CIT referral pathways to optimise care for >75yrs Identification of 6 protected beds in AMAU for ED use only. Establish AMAU pathway to manage number of daily GP referrals to the AMAU	– **Immediate (0-1month)**
Appointment of Frailty at the front door CNS to prioritise care of the Frail attending ED	– **Short term (0-3 months)** –
Appointment of ADON for admitted patients in the emergency department. Date of Interviews to be confirmed	– **Short term (0-3 months)**
Development of acute floor for additional assessment spaces for the Emergency Department.	– **Long-term (6 months+)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 29 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	10/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. For the year to date, in 2022, 17% of ambulances that attended the department had an ambulance turnaround time interval of 30 minutes or less (p29)	

Action Required	**Timeframe (delete as appropriate)**
Contact Ambulance Area Coordinator to discuss the implementation of a roster for Ambulance tactile officer with contact details on this document. Ensure shift leader knows who is on call and has a phone number to contact daily. This will be recorded in the CNM2 office on the noticeboard.	– **Immediate (0-1month)**
Memo/communication to all staff in ED to re-emphasise the fit to sit policy. Display the Fit to Sit policy in the Ambulance bay for reference purposes.	– **Immediate (0-1month)**

Allocate an Ambulance Nurse on each shift when possible. Initial plan will be to implement this Monday to Friday 1400-2200hrs as staff resources permits. A review of the availability of staff for this role will be undertaken weekly by the DNM and CNM3. This will be recorded on the ED roster by the CNM3 for each shift	– **Short term (0-3 months)** –
Request quarterly reports from NAC on our compliance with Ambulance turnaround times and provide this information to staff at department level with a focus on improvements	– **Medium term (3-6 months)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 30 Action Plan
Directorate/Department/Speciality	Risk Management	
Date of Action Plan	20/03/2023	
Document Owner		
HIQA Finding/Summary	Inspectors noted that some risks relating to the Emergency Department recorded on the hospital's Corporate Risk Register were overdue for review and this was not in keeping with effective risk management processes (p29) Inspectors were not fully assured that all risks were appropriately reviewed and evaluated at Executive Management level. It was noted that some risks and effectiveness of measures and controls to mitigate the risk recorded on the hospital's risk register needed to be reviewed. (p33)	

Action Required	**Timeframe (delete as appropriate)**
Immediate review and updating of Risk Register	– **Immediate (0-1month)**
As part of the review, it was noted that the HSE Excel Template used for recording the RHM Corporate Risk Register requires further development. This has commenced with assistance requested from HSE Corporate ICT (designers of the Excel template)	– **Short term (0-3 months)**
Once a stable Risk Register template is in place, implement a quarterly Risk Register management and monitoring process in line with HSE Procedure for Managing and Monitoring Risk Registers Service Template.	**- Medium term (3-6 months)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 31 Action Plan
Directorate/Department/Speciality	Emergency Department – Infection, prevention and control	
Date of Action Plan	12/03/2023	
Document Owner		
HIQA Finding/Summary	Significant opportunities for improvement were noted in relation to the cleanliness of the Treatment Room. Inspectors observed a box of intravenous fluids leaking on the floor, medication on the floor and no healthcare waste bin (Yellow Bin) for safe disposal of clinical waste (p30)	

Action Required	**Timeframe (delete as appropriate)**
A clinical waste bin (yellow bin) has been placed in the Treatment Room for the safe disposal of clinical waste.	– **Immediate (0-1month)**

Continue twice daily bin checks (9am and 8pm) and ensure completion of the cleaning schedule which is returned to the Support Services Offices on a weekly basis.	– **Immediate (0-1month)**
MTA's, General Services Manager and Assistant Managers will monitor to ensure bins are empty promptly so that staff using intravenous fluids have appropriate space for the disposal of waste items To monitor compliance with intermittent bin emptying throughout the day and night, spot checks by support services may be commenced.	– **Short term (0-3 months)**
Discussions regarding additional resourcing to the Support Services Dept to increase support services in the Emergency Dept is ongoing.	- **Long-term (6 months+)**

Standard Number and Name	3.1 Service providers protect service users from harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 32 Action Plan
Directorate/Department/Speciality	Emergency Dept: Medication Safety/Pharmacy	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	There was no clinical pharmacist assigned to the emergency department. (p30)	

Action Required	**Timeframe (delete as appropriate)**
Current practice: Clinical pharmacy support is currently provided to the emergency department by the dispensary team. Each day a pharmacist is rostered to provide clinical support to the duty pharmacist. The clinical support pharmacist visits and attends wards and departments (including the emergency department) as necessary, on the direction of the duty pharmacist. The duty pharmacist is prompted to seek the assistance of the clinical support pharmacist by various means, e.g. a complex medication regimen on a requisition book, a clinical query that cannot be resolved from the dispensary, a telephone request from a ward or department to undertake medication reconciliation or counsel a patient on medication. The Chief Pharmacist will issue a memorandum to the Emergency department advising them of the availability of a pharmacist to attend the department on an as needed basis to review patients with complex pharmaceutical care needs and/or to provide counselling to patients on their medications. The Chief Pharmacist will attend the next CNM meeting (14th March) to advise of same in person.	**Short term (0-3 months)**
The Chief Pharmacist will prepare a business case for submission to the ED and Medical directorate for a dedicated senior pharmacist post to be assigned to the emergency department. Should this business case be successful, a recruitment campaign to fill a senior pharmacist (Emergency Department) post will be held in 2023/2024.	**Long-term (6 months+)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 33 Action Plan
Directorate/Department/Speciality	Emergency Department	
Date of Action Plan	15/03/2023	
Document Owner		

HIQA Finding/Summary	The emergency medicine early warning system was not used in the emergency department. Auditing of compliance with national guidance on INEWS and IMEWS was not carried out in the emergency department. The hospital needs to ensure that plans outlined to implement the most up to date versions of early warning systems are progressed and that action plans to bring the emergency department into compliance with national guidance on sepsis management are effectively implemented. (p30)

Action Required	**Timeframe (delete as appropriate)**
Training in use of the INEWS observation chart is currently in progress and the Clinical Skills Facilitators/ INEWS trainers have met with the Clinical Audit CNM2 to review national audit tools for audit and the audit cycle will commence once sufficient training saturation is obtained.	– **Immediate (0-1month)**
INEWS V2 Observation chart has been ratified by the DPIP committee. The observation chart will be sent for printing with full implementation of the chart on 27th March 2023	– **Short term (0-3 months)**
The emergency medicine early warning system is due for implementation in the Emergency Department commencing 27th March 2023. A plan for audit will be formulated with the Clinical audit CNM2 and ED Stakeholders including but not limited to ED CNM3, ED Clinical Skills Facilitator. This audit will be scheduled for Q3 2023	**Short term (0-3 months)**
Maintain a schedule of audit and re audit for both INEWS. IMEWS and EMEWS in the ED	– **Long-term (6 months+)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 ED Item 35 Action Plan
Directorate/Department/Speciality	Transitions of care	
Date of Action Plan	15/03/2023	
Document Owner		
HIQA Finding/Summary	The ISBAR communication tool was used for internal and external patient transfers from the emergency department. However, inspectors were informed that it was not consistently used amongst all medical teams and that there was some variance in use. (p31)	

Action Required	**Timeframe (delete as appropriate)**
To increase the use of the ISBAR tool to facilitate effective communication by medical staff. Grand Rounds presentation to be arranged regarding use of ISBAR tool	– **Immediate (0-1month)**
ISBAR tool to be added to daily admission list as a reminder	– **Immediate (0-1month)**
Liaise with ED regarding their documented use of the tool	– **Immediate (0-1month)**
ISBAR stickers to be put on/next to hospital phones to facilitate usage	– **Short term (0-3 months)**
Enlist NCHD leads in promoting tool usage	– **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

National Standard	**Judgment**

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 standard. This should clearly outline:

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

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

Findings relating to the wider hospital and other clinical areas

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

Inspection Finding: At the time of this inspection, inspectors found that there was no consultant microbiologist available on site at the Regional Hospital Mullingar. Inspectors were informed that the hospital had approval for one WTE consultant microbiologist, but the post was unfilled at the time of inspection. (p18)

Action: Immediate action implemented by hospital: refer to Appendix 1; *QIP No.2 HIQA Inspection December 2022 - Consultant Microbiologist*

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 15 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital did not have an overarching infection prevention and control programme as per national standards (p18)	

Action Required	**Timeframe (delete as appropriate)**
HCAI committee to report to the Quality & Patient Safety Committee with updates.	– **Short term (0-3 months)**
RHM HCAI committee in partnership with members of the Hospital Executive Management Group should develop an interim overarching IPC programme to provide guidance to all hospital departments as a risk mitigation measure due to the current absence of a QPS manager.	– **Short term (0-3 months)**
Quality & Patient Safety Committee to outline an overarching infection prevention & control programme for Regional Hospital Mullingar annually in line with national standards.	**Long-term (6 months+)**

Standard Number and Name	5.5 Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 16 Action Plan

Directorate/Department/Speciality	Medication Safety/Pharmacy
Date of Action Plan	09/03/2023
Document Owner	
HIQA Finding/Summary	The hospital did not have a comprehensive clinical pharmacy service (p19)

Action Required	**Timeframe (delete as appropriate)**
Following the recruitment of 2.6 WTE pharmacists in mid-January 2023, a clinical pharmacy service to adult in-patient wards has been re-established in a limited capacity since 27th February 2023. (A clinical pharmacy service to the paediatric ward is already established).	**Immediate (0-1month)**
Due to varying levels of hospital experience across the pharmacist complement, a pharmacy team-based approach is employed. This comprises 2 or more pharmacists (one senior) being rostered together for clinical pharmacy duties on adult in-patient wards on a given day (where staffing numbers allow), focusing on: 1. Medication reconciliation 2. Prescription chart review 3. Preventing, identifying and recording medication errors and incidents 4. Documentation 5. Audit Due to the relatively small number of pharmacists available for these duties daily, the inclusion criteria for patients to be reviewed are as follows: • Adult in-patients ≥65 years admitted acutely during the preceding 24 hours (or longer where appropriate, e.g. on Monday). A bespoke IPMS report allows pharmacists to access the patient lists and identify those for review. • Younger patients with complex pharmaceutical care needs identified or highlighted to pharmacists by nursing or medical colleagues. Exclusions include: Patients in paediatric ward or women's health (supported separately), patients in ICU (supported separately), patients in ED awaiting admission to ward (catered for on an as needed basis by dispensary team). An initial training period is required for new pharmacists, which is anticipated to take approx. 6 weeks.	**Short term (0-3 months) and ongoing**
Challenges around recruitment and retention of pharmacists remain at Regional Hospital Mullingar. Two senior pharmacist campaigns were held in 2022, and further campaigns will be considered in 2023/2024. It is hoped that with the implementation of the revised career structure for pharmacists, supported education and training opportunities, and our participation in the APPEL training programme for undergraduate pharmacists, we may be more successful in recruiting and retaining pharmacists in the future, which would enable us to seek funding for and expand our clinical pharmacy service, e.g. enabling us to review and undertake medication reconciliation for all or most adult in-patients.	**Long-term (6 months+)**

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 17 Action Plan

Directorate/Department/Speciality	Deteriorating Patient Improvement Programme Committee
Date of Action Plan	09/02/2023
Document Owner	
HIQA Finding/Summary	Hospital management should progress with the implementation of version 2 of the INEWS and ensure compliance with the guideline is monitored and evaluated. (p20)

Action Required	**Timeframe (delete as appropriate)**
Review terms of reference of DPIP committee to ensure clear oversight and reporting responsibility is as below: The DPIP reporting relationship is to the QPS committee who report to Hospital Executive Management Group. Ensure reporting structures are clearly outlined on Hospital Oversight Committee Organogram.	– **Immediate (0-1month)**
The RHM Deteriorating Patient Improvement Programme Committee (DPIP) will continue with the implementation of National Clinical Guideline (NCG) No.1, INEWS 2 (2020) to all relevant clinical personnel at RHM. This involves the use of HSELand training modules and face to face opportunities to educate staff.	– **Immediate (0-1month)**
The DPIP are to review the feedback on the draft INEWS 2 observation chart and arrange for the printing of the finalised document for use in clinical practice at RHM.	– **Short term (0-3 months)**
The DPIP are responsible for establishing an audit schedule in partnership with the Clinical Audit Facilitator to monitor compliance with NCG No.1 for 2023.	– **Short term (0-3 months)**
The DPIP will contribute to reviews of near misses or incidents in relation to any non-compliance issues with NCG No. 1 that arise at RHM.	– **Medium term (3-6 months)**

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 18 Action Plan

Directorate/Department/Speciality	Transitions of Care: Bed Management / Patient Flow
Date of Action Plan	09/03/2023
Document Owner	
HIQA Finding/Summary	It was evident that measures to support the safe transition of care within the hospital, particularly from the emergency department to the main hospital, were not always effective and that the mismatch between supply and demand remains challenging for the hospital. (p22) Hospital management had implemented a number of hospital admission avoidance pathways however, more innovative measures to support patient flow within the hospital is required.(p23)

Action Required	**Timeframe (delete as appropriate)**
RHM have engaged with Charter Medical with the recent opening of the Minor Injuries Unit (MIU) in Q4 2022. There is a requirement for continuation of the close monitoring of throughput and key performance indicators to optimise the utilisation of this service to further ease pressure within RHM's Emergency Department. This data is discussed at RHM's monthly Unscheduled Care Governance meeting which reports to Hospital Executive Management Group.	– **Immediate (0-1month)**
RHM is currently participating in a patient flow improvement initiative - Visual Hospital Programme in partnership with a service improvement lead from the Ireland East Hospital Group and an external company Operasee. The key objectives of this work are to :	– **Medium term (3-6 months)**

✓ Create a sustainable Visual Hospital platform at RHM ✓ Improve Patient Flow ✓ Focus on the levelling of discharges at RHM over 7 days This work flow programme reports monthly to the Unscheduled Care Governance Committee which reports to Hospital Executive Management Group.	
Recruitment of the vacant Assistant Director of Nursing, Emergency Department, Patient Flow position. Interviews dates to be confirmed.	– **Medium term (3-6 months)**
The establishment of a Transit Lounge at RHM will serve a dual purpose of accommodating patients appropriately within criteria either at their entry or egress point on the care management journey. It will facilitate: 1: The transfer of discharged patients from inpatient areas who are awaiting discharge letter/ prescription or collection from RHM. 2: The transfer of admitted patients from the Emergency Department who are awaiting their assigned inpatient bed. The Transit Lounge will come under the Governance of the Bed Management/Patient Flow Team. Its performance will be monitored by RHM's Unscheduled Care Governance committee which reports to Hospital Executive Management Group.	– **Medium term (3-6 months)**
RHM are currently engaged with Charter Medical Private Hospital (CMPH) in relation to the proposed development of a service level agreement for a pilot period with associated processes for access to inpatient beds at CPMH within defined criteria to alleviate pressure on the acute bed stock at RHM with resulting easing of pressure on flow processes within and external to RHM.	– **Medium term (3-6 months)**
RHM to establish a Telemetry Hub to increase the number of inpatients that can have their cardiac status monitored remotely from a central hub. Currently there is only the capacity to monitor 2 patients, the plan is to increase to 10. This will mitigate against one of the main reasons for a delay in accessing a bed for an admitted patient who requires remote monitoring. This requires the reconfiguration of existing clinical space and the recruitment of an addition 6 WTE Staff Nurses with relevant experience / qualifications.	– **Medium term (3-6 months)**
RHM is currently working on developing a sustainable model with appropriate staffing for the Mullingar Frailty Intervention Team (MFIT). This team is based in the Emergency Department and is proactive in undertaking a prompt comprehensive geriatric assessment. This informs the clinical team with regards to the care needs required to support admission avoidance and has also the potential to reduce the length of these patients in the event they are admitted.	– **Medium term (3-6 months)**
RHM is engaged with the Integrated Care Programme for Older People at CHO8 to improve access and services to this vulnerable group. There is work in progress to develop work streams and pathways to ensure this cohort of patients attend the most appropriate service and to reduce the attendances and admissions via the Emergency Department.	**Long-term (6 months+)**
RHM has plans to increase the capacity of the Rehabilitation Beds from 10 -15 when the existing Rehabilitation Unit transfers to its new accommodation. This will provide RHM with the ability to increase the throughput in the unit which will release acute medical beds for utilisation thus improving patient flow pathways.	**Long-term (6 months+)**
Full implementation of Phase 2 of the Safe Staffing Framework for ED; 11 WTE for the core roster and 5.5 WTE for the admitted patient cohort.	**Long-term (6 months+)**
Development of the Acute Floor following completion of the Outpatient Department Build at RHM. This will provide opportunity for RHM to increase capacity for the Acute Medical Assessment Unit which is operational in a restricted space. It will also facilitate the development of an Acute Surgical Assessment Unit & Gynaecological Assessment Unit. This development will have a positive impact on the all aspects of patient flow at RHM.	– **Long-term (6 months+)**

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 20 Action Plan
Directorate/Department/Speciality	Staff Training and Education; Hospital Wide	
Date of Action Plan	08/03/2023	
Document Owner		
HIQA Finding/Summary	There was no central process or system to record and monitor staff attendance at and uptake of mandatory and essential training at the wider hospital level. Some electronic systems recorded the uptake of staff training but these were not centrally controlled and access was limited for all staff. (Standard 5.5 Staff Training and Education p23) It is essential that hospital management have a greater level of oversight of staff attendance at and uptake of mandatory and essential training and ensure that all clinical staff training appropriate to their scope of practice and at the required frequency, in line with National Standards. (Standard 5.5 Staff Training and Education p24)	

Action Required	**Timeframe (delete as appropriate)**
To set up a subcommittee to review the recording of mandatory hospital training at RHM. The purpose of this subcommittee is to improve the recording process as RHM have a good culture of training but are currently underreporting mandatory training attendance. The terms of Reference of this committee will be established at the first meeting to include who the committee reports to. Committee to include:- • *Clinical Operations Manager* • *Laboratory Manager/Quality Manager* • *Director of Midwifery* • *Director of Nursing* • *RHM Safety Officer* • *Secretary to facilities Manager* • *Core Trainers for example in Fire, Haem vigilance & infection control*	– **Immediate (0-1month)**
To implement the new training recording process throughout the hospital to include • Clear Working Instruction • Training Policy outlining responsibilities of trainer, trainee & Dept manager • Training for Relevant Staff on recording training information • Communication to all Relevant Staff	– **Medium term (3-6 months)**
Increased administration support to coordinate and manage the Mandatory Hospital Training Records	– **Long-term (6 months+)**
Quarterly reports will be provided/available to all trainers/educators for feedback to relevant committees and to provide oversight of training provided to Hospital Executive Management Group.	– **Long-term (6 months+)**

Standard Number and Name	Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Document Title: Standard 5.5 WH Item 22 Action Plan
Directorate/Department/Speciality	Staff Training and Education; Wider Hospital	
Date of Action Plan	14/03/2023	

Document Owner	
HIQA Finding/Summary	The attendance at and uptake of training for hand hygiene by nursing and midwifery staff was above the HSE target of 90% but was below the target for medical staff and healthcare assistants. From the information provided to HIQA, the attendance at and uptake of training in standard and transmission-based precautions by nursing and midwifery staff, medical staff and healthcare assistants could be significantly improved. Attendance at and uptake of training for IMEWS was very good for nursing and midwifery staff, exceeding the HSE target of 85%, but required improvement for medical staff. Attendance at and uptake of basic life support training could also be improved across all staff groups (p23)

Action Required	**Timeframe (delete as appropriate)**
The Clinical Director will ensure that all NCHDs attend skills /drills training that is developed and scheduled at RHM in respect of National Clinical Guidelines for example NCG No.1 and 26 and others as programs evolve. This is to compliment any eLearning programmes.	– **Short term (0-3 months)**
Monitor NCHD compliance via the NCHD National Employment Record (NER) in respect of mandatory training for National Clinical Guidelines. Communicate with NCHDs on a monthly basis via email to provide assurance to RHM that they are compliant with the mandatory training.	– **Short term (0-3 months)**
Ensure NCHDs are accommodated with paid day of study leave as per IMO / HSE agreement to complete necessary mandatory training.	– **Short term (0-3 months)**

Refer also to document title: *Standard 5.5 WH Item 22 Action Plan*

Timescale: **Long-term (6 months+)**

National Standard	**Judgment**
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 standard. This should clearly outline:

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

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

Standard Number and Name **Item 36**	Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to	Document Title: Standard 5.8 Item 36 Action Plan

	continually improve the quality, safety and reliability of healthcare services.	

Directorate/Department/Speciality	Risk Management
Date of Action Plan	13th March 2023
Document Owner	
HIQA Finding/Summary	Inspectors were not fully assured that all risks were appropriately reviewed and evaluated at executive management level. It was noted that some risks and the effectiveness of measures and controls to mitigate the risk recorded on the hospital's risk register needed to be reviewed. (p34)

Action Required	**Timeframe (delete as appropriate)**
Immediate review of Hospital Risk Register to identify outstanding risks and update measures and controls to mitigate risk as required	– **Immediate (0-1month)**
Hospital Executive Management Group Meeting Agenda to include: Risk Register – Review of risks, measures and controls.	– **Short term (0-3 months)**
Hospital Clinical Governance and Quality Patient Safety Meeting Agenda to include: Risk Register – Review of risks, measures and controls.	– **Short term (0-3 months)**

Standard Number and Name	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.	Document Title: Standard 5.8 Item 38 Action Plan

Directorate/Department/Speciality	Management of Patients Safety Incidents
Date of Action Plan	14/03/2023
Document Owner	
HIQA Finding/Summary	The hospital's quarterly average rate from July 2021 to June 2022 of reporting clinical incidents to the NIMS within 30 days of date of notification was 53%. This is significantly less than the HSE's target of 70%. Inspectors were informed that this was mainly due to staff resourcing issues in the quality and patient safety department. This is an area that needs to be improved following this inspection. (p34)

Action Required	**Timeframe (delete as appropriate)**
Await update of the 30 days KPI's from NIMS for Q3 & Q4 2022. This review of statistics for Q3 and Q4 will establish if this remains an issue as Q2 demonstrated good compliance (see Feedback document).	– **Immediate (0-1month)**
Consider increase hours for NIMS data upload from 0.5 WTE (current).	– **Short term (0-3 months)**
Work towards a long term solution which would require introduction of electronic point of entry incident reporting.	- **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

National Standard	**Judgment**

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

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

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

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

Standard Number and Name	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	Document Title: Standard 2.7 Item 43 Action Plan
Directorate/Department/Speciality	Maintenance	
Date of Action Plan	13th March 2023	
Document Owner		
HIQA Finding/Summary	The timeliness to resolve maintenance issues was an identified area of improvement. There was evidence of general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning and posed an infection prevention and control risk. (p39)	

Action Required	**Timeframe (delete as appropriate)**
Review and prioritisation of Maintenance Worklist completed on a monthly basis in consultation with Maintenance Manager, Facilities Manager and Hospital Manager. Items of highest risk are prioritised in terms of both risk and cost	– **Short Term (0-3 months)**
The Maintenance Staffing Structure has been under review and business case submitted to IEHG to address the staffing gaps. Additional resources are required to meet the staffing deficit. Discussions are at an advanced stage.	– **Long-Term (6 months+)**

Standard Number and Name	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	Document Title: Standard 2.7 Item 44 Action Plan
Directorate/Department/Speciality	Hospital Wide	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	In one of the clinical areas inspected, inspectors observed that not all sterile products were stored above floor level. This was brought to the attention of staff on the day of inspection for immediate remedy.(p39)	

Action Required	**Timeframe (delete as appropriate)**

Communication to issue from the Hospital Managers office advising all departments to ensure that all sterile products are stored above floor level in line with Infection & Prevention Control Guidelines.	– **Immediate (0-1month)**
There will be a focus on this aspect of product storage at RHM and any deviation will be captured in the environmental audit schedule and also the unannounced spot checks that are undertaken. Action plans will be developed in partnership with department heads if there is non-compliance with specific actions and assigned responsibility which are time bound. Results of the audits and unannounced spot checks are discussed at the Hospital Hygiene Committee which reports to the Healthcare Associated Infection Committee (HCAI). The HCAI committee reporting relationship is to Quality & Patient Safety who report to Hospital Executive Management Group.	– **Short term (0-3 months)**

Standard Number and Name	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	Document Title: Standard 2.7 Item 45 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	It was noted that there were insufficient isolation facilities in both inpatient clinical areas visited. (p39)	

Action Required	**Timeframe (delete as appropriate)**
Ensure appropriate use of isolation rooms using Lewisham tool to prioritise	– **Immediate (0-1month)**
IPC team to liaise with bed management team to advise re isolation rooms	– **Immediate (0-1month)** –
Priority to include isolation rooms in any future clinical renovations or new builds at Regional Hospital Mullingar	– **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

National Standard	**Judgment**
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 standard. This should clearly outline:

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

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

Standard Number and Name	Standard 2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 46 Action Plan
Directorate/Department/Speciality	Non-Clinical Services	

Date of Action Plan	12/03/2023
Document Owner	
HIQA Finding/Summary	Inspectors noted that recommendations were not identified and/or time bound action plans developed for all completed equipment, hygiene audits to improve equipment hygiene standards (p40)

Action Required	**Timeframe (delete as appropriate)**
On each report there is a note outlining the timeline for return of the audit paperwork to the General Services Office. Hygiene Audit Supervisor will continue to track that the reports are returned and issues highlighted are signed off as corrected within the allocated timeframe. Items which are highlighted as "dusty" and marked cleaned will be accepted.	– **Immediate (0-1month)**
Hygiene Audit Supervisor will carry out spot checks monthly and record action to MEG IT Audit System Hygiene Audit Supervisor will add action to MEG IT Audit System to action "clean" / "remove" be added to the report	– **Medium term (3-6 months)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 47 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	Inspectors were unclear what action or actions had been introduced at the hospital in response to clostridium difficile outbreaks in 2021.(p41)	

Action Required	**Timeframe (delete as appropriate)**
Conduct Outbreak Control Team meetings for all outbreaks of infection at Regional Hospital Mullingar	– **Immediate (0-1month)**
Outbreak Reports will be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Short term (0-3 months)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 48 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital had two confirmed outbreaks of CPE in February and May of 2022. There was no evidence that outbreak reports were completed for the outbreaks of CPE in line with national guidelines. Hospital management need to ensure that outbreak management review reports are completed in line with national guidelines so that recommendations to reduce the risk of infection transmission to patients are identified and effectively implemented.(p41)	

Action Required	Timeframe (delete as appropriate)
Outbreak Reports will be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Immediate (0-1month)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 49 Action Plan
Directorate/Department/Speciality	Antimicrobial Stewardship Monitoring / Pharmacy	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	There was limited evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. With no on-site consultant microbiologist, hospital management must ensure that there is adequate oversight of antimicrobial activities at the hospital. (p42)	

Action Required	Timeframe (delete as appropriate)
Antimicrobial pharmacist (appointed 2022) currently finalising annual service plan, which sets out details of proposed stewardship activities, audits, education and training, targets (e.g. reductions in antimicrobial consumption) and other foci for the year.	**Immediate (0-1month)**
A summary of stewardship activities and progress on service plan to be brought to bi-monthly HCAI AMS committee meetings and quarterly meetings of the Drugs and Therapeutics committee.	**Short term (0-3 months) (and ongoing)**
The clinical director, general manager and director of nursing are members of the Drugs and Therapeutics committee and the Hospital Executive Management Group. Where appropriate, they will relay or escalate matters relating to antimicrobial stewardship activities from the Drugs and Therapeutics committee to the Hospital Executive Management Group for action.	**Medium term (3-6 months) (and ongoing)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 50 Action Plan
Directorate/Department/Speciality	Deteriorating Patient Monitoring	
Date of Action Plan	14/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital took part in the HSE's national sepsis management audit carried out in July 2022 and were found to be non-compliant with clinical guidelines for sepsis management. This was identified as a high-rated risk recorded on the hospitals' corporate risk register. The hospital had developed a quality improvement plan to implement the seven key recommendations from this audit. Actions included face to face training on the management and escalation of sepsis and skills and drills training for doctors. While training records provided to HIQA indicated that this was being implemented for nursing staff, inspectors	

	were not assured that these actions were being implemented for doctors. The re-audit of compliance with national guidelines on sepsis management was due to be carried out in December 2022. Opportunities for improvement were identified in relation to the need to re-audit the effectiveness of measures introduced in relation to audit findings (p42)

Action Required	**Timeframe (delete as appropriate)**
The Clinical Director will ensure that all NCHDs attend skills /drills training that is developed and scheduled at RHM in respect of National Clinical Guidelines for example NCG No.1 and 26 and others as programs evolve. This is to compliment any eLearning programmes.	– **Short term (0-3 months)**
Monitor NCHD compliance via the NCHD National Employment Record (NER) in respect of mandatory training for National Clinical Guidelines. Communicate with NCHDs on a monthly basis via email to provide assurance to RHM that they are compliant with the mandatory training.	– **Short term (0-3 months)**
Ensure NCHDs are accommodated with paid day of study leave as per IMO / HSE agreement to complete necessary mandatory training.	– **Short term (0-3 months)**

Timescale: **Medium term (3-6 months)**

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

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

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

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

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 WH Item 51 Action Plan
Directorate/Department/Speciality	Risk Management	
Date of Action Plan	20/03/2023	
Document Owner		
HIQA Finding/Summary	HIQA found that the monitoring and evaluating of controls and actions to mitigate the identified risks could be improved. (p43) HIQA was not assured that all risks were being formally reviewed in line with the hospital's risk management processes outlined to inspectors on the day. For example, a number of risks documented on the risk register were overdue for review and status updates in relation to the effectiveness of corrective actions and controls in place were not documented. (p44)	

Action Required	Timeframe (delete as appropriate)
Immediate review and updating of Risk Register	– **Immediate (0-1month)**
As part of the review, it was noted that the HSE Excel Template used for recording the RHM Corporate Risk Register requires further development. This has commenced with assistance requested from HSE Corporate ICT (designers of the Excel template)	– **Short term (0-3 months)**
Once a stable Risk Register template is in place, implement a quarterly Risk Register management and monitoring process in line with HSE Procedure for Managing and Monitoring Risk Registers Service Template.	- **Medium term (3-6 months)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Document Title: Standard 3.1 WH Item 52 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	HIQA found the approach to outbreak management was not comprehensive as outbreak review management reports were not always completed. Furthermore actions arising from outbreak meetings were not time-bound and did not identify persons responsible for implementing agreed actions. This is an area for improvement that could be addressed after this inspection.(p44)	

Action Required	Timeframe (delete as appropriate)
Conduct Outbreak Control Team meetings for all outbreaks of infection at Regional Hospital Mullingar	– **Immediate (0-1month)**
Responsible person and a time-frame for actions to be clearly outlined and documented at Outbreak Control Team meeting	– **Immediate (0-1month)**
Outbreak Reports should be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Short term (0-3 months)**
Outbreak action plans are an agenda item at HCAI meetings to facilitate the monitoring of status of actions and to ensure all actions are implemented.	– **Short term (0-3 months)**
Outbreak Recommendations are an agenda item at HCAI meetings to generate a repository for RHM in respect of recurring issues that may require action by the HCAI committee	– **Short term (0-3 months)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	3.1 Service providers protect service users from harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 WH Item 53 Action Plan
Directorate/Department/Speciality	Policies, procedures and guidelines	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital had a suite of IPC policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, management of patients in isolation and equipment decontamination. However, a number of these policies were overdue for review at the time of inspection. The hospital also had a suite of medication policies, procedures, protocols and	

	guidelines. However, some of these policies were overdue for review also. (p46)

Action Required	Timeframe (delete as appropriate)
Chief Pharmacist, with the assistance of senior pharmacist colleague, will identify medication policies due or overdue for review.	**Immediate (0-1month)**
Will bring overdue policies to the attention of document owner(s) or relevant directorate.	**Short term (0-3 months)**
Will agree a time frame with document owner or directorates for overdue policies to be reviewed and updated, with the aim of having updates completed within 3 - 6 months. Pharmacy will provide assistance to document owners or directorates where needed, e.g. around medication preparation, administration, monitoring and disposal.	**Medium term (3-6 months)**
Where necessary or appropriate, pharmacy will bring PPPGs forward to relevant committee(s) for approval, e.g. Drugs and Therapeutics, PPPG committee. Will aim to have all policies updated and approved by mid-September 2023, to be brought to Drugs and Therapeutics committee meeting for consideration and approval on 4th October 2023.	**Medium term (3-6 months)**

Timescale: **Medium term (3-6 months)**

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

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

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

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

Standard Number and Name	Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Document Title: Standard 3.1 WH Item 56 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	There was limited evidence from minutes of meetings of the Infection Prevention and Control Committee reviewed by inspectors, that infection prevention and control incidents were discussed at committee meetings (p48)	

Action Required	Timeframe (delete as appropriate)

There will be a detailed record and discussion in respect of all IPC incidents in the preceding quarter under the agenda item "IPC Incidents" at the HCAI meeting.	– **Immediate (0-1month)**
The IPC team will complete an action plan in partnership with relevant stakeholders pertinent to IPC incidents that arise outlining specific actions with assigned responsibilities which are time bound. These will be presented and recorded at the HCAI meetings under the agenda item IPC incidents.	– **Short term (0-3 months)**

Timescale: **Short term (0-3 months)**

National Standard	Judgment
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 standard. This should clearly outline:

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

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

Standard Number and Name **Item 36**	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.	Document Title: Standard 5.8 Item 36 Action Plan
Directorate/Department/Speciality	Risk Management	
Date of Action Plan	13th March 2023	
Document Owner		
HIQA Finding/Summary	Inspectors were not fully assured that all risks were appropriately reviewed and evaluated at executive management level. It was noted that some risks and the effectiveness of measures and controls to mitigate the risk recorded on the hospital's risk register needed to be reviewed. (p34)	

Action Required	**Timeframe (delete as appropriate)**
Immediate review of Hospital Risk Register to identify outstanding risks and update measures and controls to mitigate risk as required	– **Immediate (0-1month)**
Hospital Executive Management Group Meeting Agenda to include: Risk Register – Review of risks, measures and controls.	– **Short term (0-3 months)**
Hospital Clinical Governance and Quality Patient Safety Meeting Agenda to include: Risk Register – Review of risks, measures and controls.	– **Short term (0-3 months)**

Standard Number and Name	Standard 5.8: Service providers have systematic monitoring arrangements for	Document Title: Standard 5.8 Item 38 Action Plan

	identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	

Directorate/Department/Speciality	Management of Patients Safety Incidents
Date of Action Plan	14/03/2023
Document Owner	
HIQA Finding/Summary	The hospital's quarterly average rate from July 2021 to June 2022 of reporting clinical incidents to the NIMS within 30 days of date of notification was 53%. This is significantly less than the HSE's target of 70%. Inspectors were informed that this was mainly due to staff resourcing issues in the quality and patient safety department. This is an area that needs to be improved following this inspection. (p34)

Action Required	**Timeframe (delete as appropriate)**
Await update of the 30 days KPI's from NIMS for Q3 & Q4 2022. This review of statistics for Q3 and Q4 will establish if this remains an issue as Q2 demonstrated good compliance (see Feedback document).	– **Immediate (0-1month)**
Consider increase hours for NIMS data upload from 0.5 WTE (current).	– **Short term (0-3 months)**
Work towards a long term solution which would require introduction of electronic point of entry incident reporting.	- **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

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

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

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

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

Standard Number and Name	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	Document Title: Standard 2.7 Item 43 Action Plan

Directorate/Department/Speciality	Maintenance
Date of Action Plan	13th March 2023
Document Owner	
HIQA Finding/Summary	The timeliness to resolve maintenance issues was an identified area of improvement. There was evidence of general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning and posed an infection prevention and control risk. (p39)

Action Required	Timeframe (delete as appropriate)
Review and prioritisation of Maintenance Worklist completed on a monthly basis in consultation with Maintenance Manager, Facilities Manager and Hospital Manager. Items of highest risk are prioritised in terms of both risk and cost	– **Short Term (0-3 months)**
The Maintenance Staffing Structure has been under review and business case submitted to IEHG to address the staffing gaps. Additional resources are required to meet the staffing deficit. Discussions are at an advanced stage.	– **Long-Term (6 months+)**

Standard Number and Name	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	Document Title: Standard 2.7 Item 44 Action Plan
Directorate/Department/Speciality	Hospital Wide	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	In one of the clinical areas inspected, inspectors observed that not all sterile products were stored above floor level. This was brought to the attention of staff on the day of inspection for immediate remedy.(p39)	

Action Required	Timeframe (delete as appropriate)
Communication to issue from the Hospital Managers office advising all departments to ensure that all sterile products are stored above floor level in line with Infection & Prevention Control Guidelines.	– **Immediate (0-1month)**
There will be a focus on this aspect of product storage at RHM and any deviation will be captured in the environmental audit schedule and also the unannounced spot checks that are undertaken. Action plans will be developed in partnership with department heads if there is non-compliance with specific actions and assigned responsibility which are time bound. Results of the audits and unannounced spot checks are discussed at the Hospital Hygiene Committee which reports to the Healthcare Associated Infection Committee (HCAI). The HCAI committee reporting relationship is to Quality & Patient Safety who report to Hospital Executive Management Group.	– **Short term (0-3 months)**

Standard Number and Name	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	Document Title: Standard 2.7 Item 45 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	It was noted that there were insufficient isolation facilities in both inpatient clinical areas visited. (p39)	

Action Required	Timeframe (delete as appropriate)
Ensure appropriate use of isolation rooms using Lewisham tool to prioritise	– **Immediate (0-1month)**
IPC team to liaise with bed management team to advise re isolation rooms	– **Immediate (0-1month)** –

Priority to include isolation rooms in any future clinical renovations or new builds at Regional Hospital Mullingar	– **Long-term (6 months+)**

Timescale: **Long-term (6 months+)**

National Standard	Judgment
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 standard. This should clearly outline:

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

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

Standard Number and Name	Standard 2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 46 Action Plan
Directorate/Department/Speciality	Non-Clinical Services	
Date of Action Plan	12/03/2023	
Document Owner		
HIQA Finding/Summary	Inspectors noted that recommendations were not identified and/or time bound action plans developed for all completed equipment, hygiene audits to improve equipment hygiene standards (p40)	

Action Required	**Timeframe (delete as appropriate)**
On each report there is a note outlining the timeline for return of the audit paperwork to the General Services Office. Hygiene Audit Supervisor will continue to track that the reports are returned and issues highlighted are signed off as corrected within the allocated timeframe. Items which are highlighted as "dusty" and marked cleaned will be accepted.	– **Immediate (0-1month)**
Hygiene Audit Supervisor will carry out spot checks monthly and record action to MEG IT Audit System Hygiene Audit Supervisor will add action to MEG IT Audit System to action "clean" / "remove" be added to the report	– **Medium term (3-6 months)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 47 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	Inspectors were unclear what action or actions had been introduced at the hospital in response to clostridium difficile outbreaks in 2021.(p41)	

Action Required	**Timeframe (delete as appropriate)**

Conduct Outbreak Control Team meetings for all outbreaks of infection at Regional Hospital Mullingar	– **Immediate (0-1month)**
Outbreak Reports will be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Short term (0-3 months)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 48 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital had two confirmed outbreaks of CPE in February and May of 2022. There was no evidence that outbreak reports were completed for the outbreaks of CPE in line with national guidelines. Hospital management need to ensure that outbreak management review reports are completed in line with national guidelines so that recommendations to reduce the risk of infection transmission to patients are identified and effectively implemented.(p41)	

Action Required	**Timeframe (delete as appropriate)**
Outbreak Reports will be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Immediate (0-1month)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	2.8 The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 49 Action Plan
Directorate/Department/Speciality	Antimicrobial Stewardship Monitoring / Pharmacy	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	There was limited evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. With no on-site consultant microbiologist, hospital management must ensure that there is adequate oversight of antimicrobial activities at the hospital. (p42)	

Action Required	**Timeframe (delete as appropriate)**
Antimicrobial pharmacist (appointed 2022) currently finalising annual service plan, which sets out details of proposed stewardship activities, audits, education and training, targets (e.g. reductions in antimicrobial consumption) and other foci for the year.	**Immediate (0-1month)**
A summary of stewardship activities and progress on service plan to be brought to bi-monthly HCAI AMS committee meetings and quarterly meetings of the Drugs and Therapeutics committee.	**Short term (0-3 months) (and ongoing)**

The clinical director, general manager and director of nursing are members of the Drugs and Therapeutics committee and the Hospital Executive Management Group. Where appropriate, they will relay or escalate matters relating to antimicrobial stewardship activities from the Drugs and Therapeutics committee to the Hospital Executive Management Group for action.	**Medium term (3-6 months) (and ongoing)**

Standard Number and Name	Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Document Title: Standard 2.8 Item 50 Action Plan
Directorate/Department/Speciality	Deteriorating Patient Monitoring	
Date of Action Plan	14/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital took part in the HSE's national sepsis management audit carried out in July 2022 and were found to be non-compliant with clinical guidelines for sepsis management. This was identified as a high-rated risk recorded on the hospitals' corporate risk register. The hospital had developed a quality improvement plan to implement the seven key recommendations from this audit. Actions included face to face training on the management and escalation of sepsis and skills and drills training for doctors. While training records provided to HIQA indicated that this was being implemented for nursing staff, inspectors were not assured that these actions were being implemented for doctors. The re-audit of compliance with national guidelines on sepsis management was due to be carried out in December 2022. Opportunities for improvement were identified in relation to the need to re-audit the effectiveness of measures introduced in relation to audit findings (p42)	

Action Required	**Timeframe (delete as appropriate)**
The Clinical Director will ensure that all NCHDs attend skills /drills training that is developed and scheduled at RHM in respect of National Clinical Guidelines for example NCG No.1 and 26 and others as programs evolve. This is to compliment any eLearning programmes.	– **Short term (0-3 months)**
Monitor NCHD compliance via the NCHD National Employment Record (NER) in respect of mandatory training for National Clinical Guidelines. Communicate with NCHDs on a monthly basis via email to provide assurance to RHM that they are compliant with the mandatory training.	– **Short term (0-3 months)**
Ensure NCHDs are accommodated with paid day of study leave as per IMO / HSE agreement to complete necessary mandatory training.	– **Short term (0-3 months)**

Timescale: **Medium term (3-6 months)**

National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Outline how you are going to improve compliance with this standard. This should clearly outline:	

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

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

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 WH Item 51 Action Plan
Directorate/Department/Speciality	Risk Management	
Date of Action Plan	20/03/2023	
Document Owner		
HIQA Finding/Summary	HIQA found that the monitoring and evaluating of controls and actions to mitigate the identified risks could be improved. (p43) HIQA was not assured that all risks were being formally reviewed in line with the hospital's risk management processes outlined to inspectors on the day. For example, a number of risks documented on the risk register were overdue for review and status updates in relation to the effectiveness of corrective actions and controls in place were not documented. (p44)	

Action Required	**Timeframe (delete as appropriate)**
Immediate review and updating of Risk Register	– **Immediate (0-1month)**
As part of the review, it was noted that the HSE Excel Template used for recording the RHM Corporate Risk Register requires further development. This has commenced with assistance requested from HSE Corporate ICT (designers of the Excel template)	– **Short term (0-3 months)**
Once a stable Risk Register template is in place, implement a quarterly Risk Register management and monitoring process in line with HSE Procedure for Managing and Monitoring Risk Registers Service Template.	- **Medium term (3-6 months)**

Standard Number and Name	Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Document Title: Standard 3.1 WH Item 52 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	HIQA found the approach to outbreak management was not comprehensive as outbreak review management reports were not always completed. Furthermore actions arising from outbreak meetings were not time-bound and did not identify persons responsible for implementing agreed actions. This is an area for improvement that could be addressed after this inspection.(p44)	

Action Required	**Timeframe (delete as appropriate)**
Conduct Outbreak Control Team meetings for all outbreaks of infection at Regional Hospital Mullingar	– **Immediate (0-1month)**

Responsible person and a time-frame for actions to be clearly outlined and documented at Outbreak Control Team meeting	– **Immediate (0-1month)**
Outbreak Reports should be generated following the closure of an Outbreak and the findings then shared with key stakeholders at appropriate forums	– **Short term (0-3 months)**
Outbreak action plans are an agenda item at HCAI meetings to facilitate the monitoring of status of actions and to ensure all actions are implemented.	– **Short term (0-3 months)**
Outbreak Recommendations are an agenda item at HCAI meetings to generate a repository for RHM in respect of recurring issues that may require action by the HCAI committee	– **Short term (0-3 months)**
Outbreak & surveillance data to be reviewed by HCAI & Quality & Patient Safety Committee and specific action plans established	– **Medium term (3-6 months)**

Standard Number and Name	3.1 Service providers protect service users from harm associated with the design and delivery of healthcare services	Document Title: Standard 3.1 WH Item 53 Action Plan
Directorate/Department/Speciality	Policies, procedures and guidelines	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	The hospital had a suite of IPC policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, management of patients in isolation and equipment decontamination. However, a number of these policies were overdue for review at the time of inspection. The hospital also had a suite of medication policies, procedures, protocols and guidelines. However, some of these policies were overdue for review also. (p46)	

Action Required	**Timeframe (delete as appropriate)**
Chief Pharmacist, with the assistance of senior pharmacist colleague, will identify medication policies due or overdue for review.	**Immediate (0-1month)**
Will bring overdue policies to the attention of document owner(s) or relevant directorate.	**Short term (0-3 months)**
Will agree a time frame with document owner or directorates for overdue policies to be reviewed and updated, with the aim of having updates completed within 3 - 6 months. Pharmacy will provide assistance to document owners or directorates where needed, e.g. around medication preparation, administration, monitoring and disposal.	**Medium term (3-6 months)**
Where necessary or appropriate, pharmacy will bring PPPGs forward to relevant committee(s) for approval, e.g. Drugs and Therapeutics, PPPG committee. Will aim to have all policies updated and approved by mid-September 2023, to be brought to Drugs and Therapeutics committee meeting for consideration and approval on 4th October 2023.	**Medium term (3-6 months)**

Timescale: **Medium term (3-6 months)**

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

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

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

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

Standard Number and Name	Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Document Title: Standard 3.1 WH Item 56 Action Plan
Directorate/Department/Speciality	Infection Prevention & Control	
Date of Action Plan	09/03/2023	
Document Owner		
HIQA Finding/Summary	There was limited evidence from minutes of meetings of the Infection Prevention and Control Committee reviewed by inspectors, that infection prevention and control incidents were discussed at committee meetings (p48)	

Action Required	**Timeframe (delete as appropriate)**
There will be a detailed record and discussion in respect of all IPC incidents in the preceding quarter under the agenda item "IPC Incidents" at the HCAI meeting.	– **Immediate (0-1month)**
The IPC team will complete an action plan in partnership with relevant stakeholders pertinent to IPC incidents that arise outlining specific actions with assigned responsibilities which are time bound. These will be presented and recorded at the HCAI meetings under the agenda item IPC incidents.	– **Short term (0-3 months)**

Timescale: **Short term (0-3 months)**