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:	Cork University Hospital
Centre ID:	OSV-0001024
Address of healthcare service:	Wilton Cork T12 DFK4
Type of Inspection:	Unannounced
Date of Inspection:	19/03/2025 and 20/03/2025
Inspection ID:	NS_0119

About the healthcare service

Model of hospital and profile

Cork University Hospital (CUH) is a Model 4* public acute, tertiary referral centre and university teaching hospital managed by the Regional Health Area South West (RHA SW)† on behalf of the Health Service Executive (HSE). CUH provides care for people in the catchment area of the HSE South and supra-regional areas of Limerick, Kerry, Tipperary, Waterford and Kilkenny. The hospital is one of two designated Level 1 trauma centres‡ in the country, one of two 24 hours, seven days a week neurosurgical and stroke thrombectomy centres, one of five 24 hours, seven days a week primary percutaneous coronary intervention (PPCI) centres, one of four cardiothoracic surgical centres, one of two comprehensive coagulation and haemophilia centres, and a cystic fibrosis centre. CUH is also one of eight cancer centres aligned with the HSE National Cancer Control Programme (NCCP).

Services provided by CUH include:

- all major medical specialities
- a range of surgical specialities including cardiothoracic, neurosurgical, orthopaedic, plastic and reconstructive, maxillofacial, breast and colorectal
- interventional radiology, interventional pain management and palliative care
- emergency care
- diagnostic services
- outpatient care.

* A model-4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, which is open on a continuous basis (24 hours, every day of the year) and an emergency department.

† The Regional Health Area HSE South West provides health and social care services to Cork and Kerry. HSE South West includes all hospital and community healthcare services in the region. This includes South / South West Hospital Group and Cork Kerry Community Healthcare.

‡ The establishment of the major trauma centres represents the first phase in the development of the acute hospital trauma services as set out in the National Trauma Strategy. The services comprise regional trauma networks each with a major trauma centre, the Mater Misericordiae University Hospital in Dublin and Cork University Hospital, which provide specialist trauma care in the one hospital to the most severely injured patients.

The following information outlines some additional data on the hospital.

Number of beds	645 inpatient beds 41 day care beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[§] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

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

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
19/03/2025 20/03/2025	*08:30 – 18:30* *08:15 – 16:30*	Mary Flavin	Marguerite Dooley Rosie O'Neill Eileen O'Toole

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes[**] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited six clinical areas:

- Emergency Department (ED), including the Geriatric Emergency Medicine Service (GEMS) and the Clinical Decision Unit (CDU)
- 4B Ward (surgical ward)
- 5B Ward (medical respiratory ward)
- Ladybird Ward (paediatric ward)
- Acute Medical Assessment Unit (AMAU)
- Paediatric Emergency Department.

During this inspection, the inspection team spoke with representatives of the hospital management team, quality patient safety, human resources, and medical staff. Inspectors also spoke with representatives from:

- Infection Prevention and Control
- Drugs and Therapeutics
- Acutely Unwell Adult Patient
- Delayed Discharge and Bed Management.

Acknowledgements

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

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

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

Over the course of the inspection, inspectors visited the emergency department, which included the GEMS, the AMAU, and the CDU, in addition to the paediatric emergency department, 4B Ward, 5B Ward and Ladybird Ward. The emergency department had a total planned capacity of 86 treatment areas, which included:

- 12 major treatment cubicles
- four resuscitation spaces
- three isolation spaces
- a Rapid Assessment Streaming Triage Treatment Area (RASTTA), which consisted of three triage rooms and a total of 54 areas where ambulatory care*** was provided, comprising of individual booths and cubicles
- a CDU which contained 12 trolleys
- six single rooms with beds where older persons attending the emergency department were medically reviewed and treated — GEMS.

People who attended the emergency department arrived through various pathways, including by ambulance, direct referral from their general practitioner (GP), self-referral, or via the Urgent Virtual Care navigation hub. During the inspection, the emergency department was experiencing high levels of activity and, in accordance with the hospital's escalation plan, was classified as being in red escalation.

At the time of inspection, the Blackwater AMAU had been temporarily relocated to facilitate renovation works aimed at increasing its capacity from eight to 14 assessment rooms, with the newly refurbished unit scheduled to open in April 2025. In the interim, the AMAU had five spaces available for patient assessment and review. This included two single rooms, one room containing two trolleys and one bed, as well as a waiting area with 20 chairs. At the time of inspection, there were 10 patients in the unit. The unit operated five days a week, Monday to Friday (7.45am to 8.30pm), with a designated consultant on call each day for the AMAU, and a separate consultant managing ED referrals. They were supported by non-consultant hospital doctors (NCHDs) and nursing staff. Referral pathways for patients meeting AMAU inclusion criteria included ED referrals, direct GP referrals, teams from the Outpatients Department, and the Urgent Virtual Care navigation hub. The CDU operated under the governance of the ED and included two en-suite single rooms, one en-suite two-bedded room, and two four-bedded rooms with access to a shared toilet. Inspectors also noted the presence of a wheelchair-accessible shower and toilet located along the corridor. In addition, there was a designated family room available.

*** Ambulatory care refers to medical and healthcare services provided by healthcare professionals on an outpatient basis, without admission to hospital.

The paediatric emergency department operated under the governance of the main ED and accepted children up to the age of 16 years. Upon arrival at the hospital, children were registered and triaged in the main ED before being transferred to the paediatric emergency department. The department consisted of seven treatment cubicles (one of which included a toilet), two procedure rooms, and two rapid assessment rooms. An additional toilet was also available within the department. The waiting area featured 10 single pods, 23 double seats, and a toilet. A designated consultant was assigned to the paediatric emergency department from Monday to Friday, (8am and 5pm). A consultant was also on-site Saturday (8am to 6pm) and Sunday (8am to 1pm). Outside of these hours, an on-call consultant provided cover for both emergency departments. The consultant team was supported by NCHDs and nursing staff. The total planned capacity for the department was nine. At the time of inspection there were seven patients in the department.

The 4B Ward was a 35-bedded surgical ward comprising four six-bedded multi-occupancy rooms, one four-bedded multi-occupancy room, one two-bedded multi-occupancy room and five single rooms (four of the single rooms had en-suite bathroom facilities). The ward had adequate communal toilet and shower facilities for patients use. At the time of inspection, 33 of the 35 beds on the ward were occupied, with two additional admissions expected. One patient was accommodated on a trolley within the ward. Inspectors observed that the four-bedded multi-occupancy room was mixed gender. This area served as the observational section of the ward for recovering patients, from 24 to 72 hours post-operation, and risk assessments were completed based on clinical need.

The 5B Ward was a 20-bedded medical respiratory ward, comprising of three four-bedded multi-occupancy rooms and eight single rooms. All single rooms were negative pressure rooms and included en-suite facilities. At the time of inspection, all beds were occupied, and one patient was accommodated on a trolley within the ward.

The Ladybird Ward was a 21 bedded paediatric ward, comprising of one six-bedded bay and 15 single rooms, all with en-suite facilities. At the time of inspection, 15 beds were occupied.

Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to them. Staff were observed promoting and protecting patients' privacy and dignity when delivering care. Patients who spoke with inspectors shared their experience of the care they received in the hospital. One patient described staff as "fantastic", while another referred to them as "exceptional and courteous". Inspectors observed staff in the clinical areas responding promptly to patients in need of assistance, with one patient noting that staff responded very quickly whenever they used their call-bell. All patients interviewed reported that they were kept informed and up to date regarding their care during their hospital stay. All patients expressed satisfaction

with the food provided, describing it as "great" and "very good". When asked about making a complaint, patients told inspectors that they had no complaints. One patient mentioned that they were very happy and felt the care was good. Another patient said that staff listen attentively and demonstrate great empathy. Additionally, one patient shared that during a previous admission, they had made a complaint, which was resolved locally by the nurse manager. Overall, patients were very complimentary about the staff and the care they received in the hospital, and this feedback was consistent with what inspectors observed throughout the inspection.

Capacity and Capability Dimension

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

Cork University Hospital was found to be substantially compliant with two national standards (5.2 and 5.5) and partially compliant with two national standards (5.8 and 6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

In general, inspectors found that CUH had established formal corporate and clinical governance arrangements to ensure the quality and safety of healthcare services provided. Organisational charts submitted to HIQA clearly outlined the responsibilities, accountability and oversight arrangements for management structures and governance committees. This aligned with the information provided by both management and staff during inspection.

The hospital was under the governance and management of the interim chief executive officer (CEO) who had been in the post since September 2024. The interim CEO was the senior accountable officer (SAO) with overall responsibility for the governance of the hospital. Updated reporting structures to the integrated healthcare area (IHA) manager and subsequently to the regional executive officer (REO) of the HSE South West Health Region had only recently been introduced, prior to the inspection. These changes were reflected in the organisational charts. The director of nursing (DON) was responsible for

the organisation and management of nursing services within the hospital and had an operational reporting line to the interim CEO. The site clinical lead for CUH provided clinical leadership and oversight to consultants and NCHDs within the hospital.

Clinical services at the hospital were delivered under the leadership and oversight of six clinical directorates: medicine, perioperative, children's services, diagnostics and therapeutics, cancer services, and emergency acute care. Each clinical directorate had a management team comprising a clinical director (CD), business manager (BM), assistant director of nursing (ADON), and was expected to include a quality and patient safety (QPS) lead. At the time of inspection, three quality and patient safety lead roles had not yet been approved and, as a result, remained vacant in three of the clinical directorates (emergency and acute medicine; diagnostics and therapeutics; and peri-operative). This is discussed further under national standard 6.1. This team had oversight of risk management, complaints, as well as the quality and safety of the clinical services within its remit. The interim CEO had proactively sought approval for these posts; however the necessary authorisation had not been granted at the time of inspection. Despite this, efforts were being made to ensure appropriate oversight of quality and safety within the affected clinical directorates by the Directorate Management Team (DMT), with the support of the of the hospital's quality and patient safety (QPS) manager. Each clinical directorate had a defined reporting relationship to the Executive Management Team (EMT).

The EMT, chaired by the interim CEO, served as the senior executive decision-making body with overarching responsibility for the effective management and oversight of CUH. In line with the terms of reference, the EMT met on a weekly basis. The first three meetings each month were dedicated to operational matters, while the fourth meeting focused on strategic issues. Membership of the EMT was multidisciplinary and included the site clinical lead, operations manager, finance manager, DON, head of information and communication technology, clinical directors, site director, QPS manager, health and social care professional (HSCP) lead, business manager, head of support services, HR representative, capital and estates manager, and the lead from the project and portfolio management office. Minutes from meetings reviewed by inspectors demonstrated that EMT meetings were action-oriented, with clear mechanisms in place to monitor the implementation of agreed actions, from one meeting to the next. The interim CEO also participated in a monthly group performance meeting, chaired by the REO for the HSE South West Health Region. These meetings were conducted in accordance with the HSE performance and accountability framework 2023. In addition, senior management advised inspectors that the Quality, Safety and Risk Committee (QSRC) reported to the EMT on a monthly basis, thereby supporting the governance of quality and patient safety within the hospital.

The QSRC, chaired by the CD, provided the EMT with assurance regarding the quality and safety of healthcare services delivered at the hospital. In accordance with the terms of reference, the committee met on a monthly basis. Membership of the committee was multidisciplinary and comprised of key stakeholders involved in the governance and operational oversight of quality, safety, and risk within the hospital. The committee submitted both monthly reports and an annual report to the EMT to ensure continued oversight and accountability. Minutes of meetings reviewed by inspectors indicated that the committee's work was action-orientated, with agreed actions monitored and followed up from meeting to meeting. At the time of inspection, thirteen subcommittees reported formally to the QSRC. These included the Infection Prevention and Control, Drugs and Therapeutics, the Acutely Unwell Adult Patient, and the Serious Incident Management Team.

The Infection, Prevention and Control Committee (IPCC), chaired by the DON, reported directly to the QSRC. In line with the terms of reference, the committee met on a monthly basis. Its membership was multidisciplinary and included key stakeholders involved in the governance and operational management of infection prevention and control within the hospital. Members included representatives from the Antimicrobial Stewardship Committee (ASC), the chief medical scientist, a consultant microbiologist, surveillance scientist, and members of the Infection Prevention and Control Team. The committee submitted biannual reports to the QSRC and an annual report to the EMT, supporting ongoing oversight and accountability. Inspectors reviewed minutes of meetings which indicated that the committee's activities were action-orientated, with a designated individual assigned responsibility for each action. However, it was noted that not all actions were consistently time-bound, and some actions remained overdue. According to the committee's terms of reference and the organogram provided to inspectors, a number of subcommittees and teams reported monthly to the IPCC. These included the Care Bundle Committee, Sharps Committee, Outbreak Management Team, Decontamination Committee, Reusable Invasive Medical Devices Team, Health Services Team, Hand Hygiene Working Group, Infection Prevention and Control Team, and ASC.

The Drugs and Therapeutics Committee (DTC), chaired by the site CD, reported directly to the QSRC. In accordance with its terms of reference, the committee met on a bi-monthly basis. Membership was multidisciplinary and included key stakeholders responsible for the governance and oversight of medication management and therapeutic practices within the hospital. The committee submitted reports twice a year to the QSRC, providing assurances on the safe and effective use of medicines. Minutes of meetings reviewed by inspectors indicated that the committee's activities were action-orientated, with a designated individual assigned responsibility for each action. However, it was noted that the actions were not time-bound. Subgroups reporting to the DTC included, the Multidisciplinary Medication Safety Working Group, and the

Nurse Midwife Prescriber Working Group. The ASC had a linear reporting relationship with the DTC, providing monthly updates. However, its formal reporting line was directly to the QSRC. Upon review of the committee's terms of reference, inspectors noted that the document pertained to the hospital group and identified the reporting relationship of the DTC was to the Executive Quality and Safety Committee. However, this committee was no longer in operation at the time of inspection. Senior hospital management confirmed, and the current organogram also reflected, that the DTC now reports directly to the QSRC. Accordingly, the terms of reference for the DTC will require amendment to accurately reflect the current reporting structure and governance arrangements.

The Steering Committee for the Acutely Unwell Adult Patient provided governance and oversight of the systems and processes in place for recognising and managing the deteriorating patient, including sepsis management. The committee was chaired by a medical consultant and reported directly to the QSRC. In line with its terms of reference, the committee met on a monthly basis. Membership was multidisciplinary and included representation from medical and surgical consultants, ADONs, physiotherapists, the centre of nurse education, the deteriorating patient nurse service, resuscitation officer, and QPS manager. The committee submitted bi-annual reports to the QSRC. Minutes of meetings reviewed by inspectors indicated that the committee's activities were action-orientated, with actions tracked and monitored from meeting to meeting. However, on review of the committee's terms of reference, inspectors noted that it identified the reporting relationship was to the Executive Quality and Safety Committee, which was no longer in operation at the time of inspection. The organogram reviewed by inspectors indicated that the committee now reports directly to the QSRC. This was confirmed by senior hospital management. As such, the terms of reference for the Steering Committee for the Acutely Unwell Adult Patient require revision to accurately reflect the current reporting structure and governance arrangements.

At the time of inspection, there was no transition of care committee in place within the hospital. However, data relating to scheduled and unscheduled care activity, inpatient bed capacity, and compliance with defined key performance indicators (KPIs) was reviewed and discussed at the monthly meetings of the Unscheduled Care Programme Board (USCPB) and during monthly performance meetings between CUH and the South West Region. The USCPB reported directly to the EMT through the emergency and acute care director, who also served as chair of the board. USCPB also reported, as appropriate, to relevant regional and national urgent and emergency care forums. In line with the terms of reference, the board met on a monthly basis. Membership was multidisciplinary and included representatives from both CUH – acute and Community services. Minutes of meetings reviewed by inspectors indicated that the board's activities were action-orientated, with a designated individual assigned responsibility for each action. However, it was noted that not all actions were consistently time-bound.

There was evidence of improvement since the previous HIQA inspection in July 2023, with new reporting structures under the HSE South West Health Region in place at the time of inspection. However:

- terms of reference for several committees need to be revised to accurately reflect the hospital's restructured governance arrangements; for example, the Drugs and Therapeutics Committee, and the Steering Committee for the Acutely Unwell Adult Patient
- agreed actions aimed at improving the quality and safety of healthcare services must be time-bound across a number of committees to ensure accountability and effective follow-through.

Judgment: Substantially Compliant

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

Inspectors found that there was effective management arrangements in place to support and promote the delivery of high quality, safe, and reliable healthcare services within CUH.

The Infection Prevention and Control Committee provided oversight, and support for the infection prevention and control team in the implementation of the infection prevention and control programme for 2024-2025. This programme set out the goals and objectives for the two year period. The actions within the programme are aligned with the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017). In addition, the committee had developed a draft annual plan for 2025. This plan outlined key areas of focus, including surveillance activities, outbreak management, auditing and monitoring, education, policies procedures protocols and guidelines (PPPGs), healthcare-associated infections, and risk. Inspectors reviewed a draft version of the infection prevention and control 2024 annual report. The report highlighted key findings, including surveillance data on healthcare-associated infections and the measures implemented to prevent their occurrence.

The hospital's pharmacy was led by an executive pharmacy manager, and the drugs and therapeutic committee provided oversight of medication safety and associated risks. The committee played an active role in the development and review of relevant policies, procedures and guidelines within the hospital. It provided governance and oversight in

line with key national initiatives, including the nurse prescribing initiative, and medication risk management. Although the committee submitted bi-annual reports to the QSRC, there was no report available for 2024, nor was there a formal annual plan for medication safety or a medication safety programme developed for 2025. Inspectors were informed that pharmacy-led medication reconciliation was carried out within 24 hours of admission, however, there was no dedicated pharmacist assigned to the paediatric ED or AMAU. Hospital pharmacy services were available on site during core working hours, and nursing administration had access to the pharmacy stock outside of these hours. The ASC was multidisciplinary, with membership including microbiologists, pharmacists, a representative from infectious diseases, and nursing staff. The hospital had two dedicated antimicrobial pharmacists in place, and a clinical microbiologist was available 24 hours a day, which included out-of-hours cover.

The hospital had implemented a deteriorating patient improvement programme, aligned with national best practice guidelines. National early warning systems (EWS)[†††] – such as the Irish National Early Warning Score (INEWS) and Paediatric Early Warning Score (PEWS) were in use for the appropriate patient cohorts. Clinical communication was supported through the use of the Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk (ISBAR3)[‡‡‡] tool to ensure clear and structured handover of risk. At the time of inspection, inspectors were told that there was no designated clinical lead for EWS used in the hospital. Oversight of the effectiveness of systems to recognise and manage the deteriorating patient was maintained by the Steering Committee for the Acutely Unwell Adult Patient. This committee was responsible for monitoring compliance with national standards, including EWS usage, and sepsis management protocols. Since HIQA's last inspection in 2023, the hospital had implemented a 'Deteriorating Patient' nurse-led service. This service, consisting of four dedicated nurses, operates from Monday to Friday (7am to 6pm). Training on the use of EWS, including sepsis management, is delivered by the deteriorating patient nursing service in conjunction with the hospital's clinical facilitators.

Safe transitions of care were supported through three key structures: bed management team, discharge coordinators, and scheduled care or bed-booking system. These functions worked collaboratively to ensure timely patient flow, appropriate bed allocation, and effective discharge planning. Daily calls were held with community services to discuss and review all delayed transfers of care (DTOC) and complex discharge patients. Oversight of these functions was provided by the head of bed management, who

[†††] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient

[‡‡‡] Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk (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.

reported directly to the interim CEO. The REO was kept informed of complex discharge cases through a weekly regional call, which included representatives from other hospitals.

There were established management arrangements in place to monitor hospital activity and address factors impacting healthcare service demand and the safe and effective transition of care. Key aspects such as hospital activity levels, patient acuity, bed capacity, and the hospital's responsiveness to service demand were reviewed and managed on a daily and weekly basis through a series of formalised meetings. These included handover meetings, demand and capacity site review meetings, infection prevention and control meetings, ED planning meetings, and escalation meetings. In addition, a Clinical Operations Group (COG), chaired by the clinical lead in emergency and acute medicine, convened weekly to review and discuss the functioning of the department. Topics addressed at these meetings included operational issues, performance analysis, audit findings, and risk management. This forum supported ongoing oversight, collaboration, and decision-making in response to emerging clinical and operational pressures. Oversight was provided by the emergency and acute care directorate, chaired by the clinical director, which met monthly and, reported to the interim CEO.

Clinical and operational oversight of the ED was maintained seven days a week by a consultant in emergency medicine, supported by a clinical nurse manager 3 (CNM) or an ADON. The consultant in emergency medicine reported to the clinical director for emergency and acute care. The CNM 3 reported to the ADON for unscheduled care, who in turn reported to the DON.

At 11am on the first day of inspection the hospital was in red escalation with 99 patients registered in the ED, 33 of whom were aged over 75 years. Of these patients, 36 had been referred by a GP, 40 had arrived by ambulance, and 23 had self-referred. A total of 36 (36%) patients had been admitted and were boarding in the ED while awaiting the availability of an inpatient bed. This represented a slightly higher rate than observed during HIQA's previous inspection in 2023, when 31% of patients were found to be boarding in the ED. While the hospital was operating under red escalation status, inspectors found that the actions taken by the EMT to manage patient flow were aligned with the actions outlined in the hospital's escalation plan. Actions taken included:

- convening escalation meetings with hospital executive, and nursing management to review activity levels in ED and across the wider hospital, and to authorise the opening of surge capacity beds
- the AMAU was fully operational as an alternative care pathway for patients in the ED
- the GEMS was partially functioning, as it was being used to accommodate admitted patients
- surge areas within the ED were activated

- additional surge capacity was opened within the main hospital to accommodate patients on trolleys.

Staff informed inspectors that the hospital faced several ongoing challenges impacting patient flow and service delivery. These included an increase in ED attendances, with a notable number of patients requiring mental health services, limited inpatient bed capacity, a lack of single isolation rooms, and the absence of a dedicated high dependency unit (HDU). Additional challenges included limited availability of suitable community rehabilitation, transitional, and step-down beds, as well as challenges in securing adequate home-care support in the community. This was consistent with HIQA's previous inspection in 2023. As a result, 25 patients experienced delays in their transfer of care on the day.

In summary, at the time of inspection, it was evident to inspectors that the EMT was responsive and reactive, demonstrating a strong operational grasp of the issues affecting patient flow and discharge planning. However, a significant mismatch between the demand for health services and the availability of beds at the hospital, adversely impacted patient flow on the day of inspection and contributed to a high number of delayed transfers of care. An area for further focus includes:

- the hospital had no formal annual plan for medication safety or a medication safety programme developed for 2025.

Judgment: Substantially Compliant

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

While the hospital had systematic monitoring arrangements in place to identify and act on opportunities to improve the quality, safety and reliability of healthcare services, there was scope for improvement.

The hospital collected and collated data relating to patient safety incidents, complaints and compliments, workforce metrics, risk management, and a range of national KPIs associated with the quality and safety of services provided. Collated performance data and KPIs were reported to the QSRC, as well as at the monthly EMT strategic meetings.

At the time of inspection, the risk manager and assistant risk manager positions were vacant. While the hospital had formalised risk management structures and processes in place to proactively identify, assess, manage, monitor and escalate risks, it was not as effective as it should be. Risks identified at the clinical area level were managed and monitored by the CNM and the ADON. The CNMs had implemented corrective actions to mitigate actual or potential risks to patient safety. Where appropriate, risks were escalated up through the relevant clinical directorates.

Where a clinical directorate was supported by a designated QPS lead, oversight of risk was maintained within their respective areas. The clinical directorates that did not have an appointed QPS lead resulted in a gap in oversight. This gap was managed collaboratively by the business manager, the ADON, and the clinical director for each affected directorate, with support from the QPS manager.

Risks within each directorate were reviewed and discussed on a monthly basis at the QSRC meetings. High-rated or serious risks that could not be managed at clinical area or directorate level were escalated to the hospital's corporate risk register. The hospital's corporate risk register was presented quarterly to the EMT through the QSRC. Oversight of the hospital's corporate risk register was the responsibility of the interim CEO.

At the time of inspection, there was no centralised governance or oversight mechanism in place for managing audit findings, required actions, or associated recommendations within the hospital. Hospital management told inspectors that staffing deficits within the QPS department had adversely impacted the completion of follow-up audits to assess compliance with the implementation of recommendations. The Clinical Audit Committee had not convened since November 2024, due to a vacancy in the quality manager position. As a result, audit activity was conducted in isolation within individual clinical areas and by their respective representative committees. Each of these committees managed their own clinical audits and reported to the QSRC, where audit remained a standing agenda item. However, the lack of central coordination limited the hospital's ability to systematically track and ensure the implementation of audit recommendations across services. Addressing the vacancies within the QPS department will enhance the conduct, coordination, and oversight of audit activities across the hospital.

The hospital had established systems and processes to proactively identify and manage patient safety incidents. Clinical directorates, in collaboration with assigned QPS leads, were responsible for overseeing the timely and effective management of adverse events and patient safety incidents reported within their respective areas. In directorates where a QPS lead had not been appointed, this responsibility was assumed collectively by the business manager, ADON, and the clinical director. However, this gap created challenges in effectively tracking and tending patient safety incidents, as well as ensuring consistent feedback was provided to clinical areas on incidents.

The Senior Incident Management Team (SIMT), chaired by the operations manager reported directly to the QSRC. In accordance with the draft terms of reference provided to inspectors, the SIMT met on a monthly basis to provide assurance to the interim CEO that all Serious Reportable Events (SREs) and serious incidents were appropriately reported to the National Incident Management System (NIMS) and managed in line with the HSE Incident Management Framework (IMF, 2020). In addition to its scheduled monthly meetings, the SIMT was convened within one working week of any category 1 occurrence. Membership of the team included the operations manager, CDs, QPS manager, and the DON. The SIMT submitted biannual reports and a more comprehensive annual report to the QSRC to support oversight and governance of serious incident management within the hospital. Learnings from SREs, serious incidents, and patient safety incidents were communicated to clinical staff through clinical handover and multidisciplinary safety huddles.

The QPS department was responsible for monitoring and responding to findings from the National Inpatient Experience Survey (NIES) 2024. In response to the survey findings, three quality improvement initiatives were implemented, relating to promotion of the National Healthcare Communication Programme to all staff involved in patient care, promotion of the national HSE 'Your Service Your Say' (YSYS) complaints and feedback process throughout the hospital, and the development of a visual identifier on patient files to highlight additional needs for patients with long-term conditions or disabilities. In addition, the hospital participated in the first annual National End-of-Life Survey conducted in 2023. Four key areas for improvement were identified relating to communication with families and relatives, coordination between the hospital and community services, provision of practical information to support end-of-life care in the hospital, and overall experience of end-of-life care delivery. Findings from both surveys were reviewed by the QSRC, with relevant updates subsequently communicated to the EMT.

Overall, the hospital had established effective systematic monitoring arrangements to monitor and evaluate the quality, safety and reliability of care. There was structured oversight of performance against key indicators, particularly in the four areas of known harm. Evidence demonstrated that data from these monitoring processes was actively used to inform quality improvement initiatives and enhance both patient safety and the overall care experience. However:

- improvements are required to strengthen the oversight and governance of audit activity to ensure compliance with the implementation of audit recommendations
- the implementation of quality improvements initiatives should be systematically monitored and tracked to provide assurance to the EMT that all opportunities to enhance the quality and safety of healthcare services are being fully acted upon
- improvements are required to progress the recruitment of approved vacant posts.

Judgment: Partially Compliant

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

Workforce arrangements at the hospital were planned, organised, and managed with the objective of ensuring the delivery of high-quality, safe, and reliable care. However, at the time of inspection, several positions across various professional disciplines remained unfilled. These staffing shortfalls, along with the associated mitigation measures, were reflected in six workforce-related risks recorded on the hospital's risk register. Inspectors were informed and minutes from meetings confirmed that workforce issues were actively discussed at EMT meetings and remained a standing item on the agenda for monthly regional performance meetings, where concerns regarding staffing deficits was formally escalated to regional management.

At the time of inspection, the hospital provided workforce figures for nursing staff, pharmacists, pharmacy technicians, and microbiologists. These figures were subsequently revised by the hospital in its factual accuracy feedback submission. The variation between the two sets of data was discussed with the hospital during the factual accuracy process. For the purpose of accuracy and consistency, the final report reflects the workforce figures provided in the factual accuracy feedback, rather than those submitted to inspectors at the time of inspection.

Medical workforce in the ED

Data provided to inspectors during the inspection, along with post-onsite documentation, contained conflicting figures for certain staffing posts across the hospital. The adult ED had 16 approved whole-time equivalent (WTE)[§§§] consultant posts, all of which were filled. There was 15 approved WTE registrar posts, with 13 of these filled, resulting in a short fall of two WTE registrars. However, inspectors were informed by staff that six WTE registrars were awaiting registration at the time of inspection. There was 14 approved WTE senior house officer (SHO) posts, but a total of 24 SHOs were in place. A consultant in emergency medicine was on-site from Monday to Friday (from 8am to 10pm). Outside of these hours, a consultant was available on-call at all times. At weekends, a consultant in emergency medicine was on-call, with a second consultant rostered on-site (from 8am to 6pm) on Saturdays and (from 8am to 1pm) on Sundays.

[§§§] 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.

The paediatric ED had three approved WTE consultant posts, two of which were filled at the time of inspection, with the third at interview stage. Of the five approved WTE registrar posts, four were filled. Seven SHO WTE posts were approved, with five filled at the time of inspection. A consultant in emergency medicine specialised in paediatrics was present on-site in the paediatric ED from Monday to Friday (from 8am to 5pm). Outside of these hours, cover for the paediatric ED was provided by the ED consultant on call.

Nursing workforce in the ED

The hospital's approved funded complement for nursing staff in the adult ED, including management and other grades, was 174.47 WTE. Overall nursing responsibility for the ED was held by the ADON. A senior nurse manager (ADON, patient flow, or CNM 3) was rostered and assigned to the ED on-site seven days a week (from 8am to 8pm). In addition, a CNM 2 was rostered each shift (day and night) to provide nursing leadership and support. Inspectors were informed that while the number aligned with the staffing requirements set out in the *Framework for Safer Nurse Staffing and Skill Mix in Adult Emergency Settings in Ireland*,[****] the approved WTE nursing complement had not included staffing requirements for the CDU, paediatric ED, ambulance triage, and the GEMS unit. As such, there remained a gap between the actual staffing resources and the department's service demands.

At the time of inspection, there was a deficit of 23 WTE nursing positions in the adult ED. Post onsite documentation provided to inspectors indicated a number of additional vacancies, including one WTE ADON, four WTE CNM 2 positions, four WTE CNM 1 positions, and two clinical nurse specialist (CNS) posts. In addition, two advanced nurse practitioners (ANPs) and one WTE clinical skills facilitator (CSF) posts were vacant at the time of inspection due to leave. The overall 13% nursing shortfall represented a notable deterioration from the 10% deficit identified during the previous HIQA inspection. The ED was supported by 20.54 WTE working healthcare assistants (HCAs). However, the total approved WTE for HCA posts was not provided to inspectors.

In the paediatric ED, the WTE staff nurse allocation was included within the overall 174.47 WTE nursing staff assigned to the adult ED. Inspectors were informed by staff that, when the paediatric service transferred to CUH, the full complement of staff did not transfer with the service. One approved CNM 1 post was filled, and of the 5.6 WTE approved CNM 2 posts, only 3.6 WTE were in post-leaving two WTE positions vacant.

[****] The Framework for Safer Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland and the Framework for Safe Nurse Staffing and Skill-Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

While 5.6 WTE HCA posts were approved for the paediatric ED, the actual number of HCAs in post at the time of inspection was not provided to inspectors.

Workforce in the wider hospital

The wider hospital was funded for 309 WTE consultant posts across various specialities. While inspectors were informed that all posts were filled, documentation provided to inspectors following inspection highlighted a shortfall in consultant staffing within the AMAU. Consultant staff were supported by NCHDs at registrar and SHO grades, ensuring 24/7 medical cover. The hospital had approved funding for 309 WTE registrar posts, with 299 WTE posts filled at the time of inspection. Of the 160 approved WTE SHO posts, 158 WTE posts were filled.

The hospital was funded for 1,835 WTE nursing posts, inclusive of management and other grades. At the time of inspection, 90.72 WTE nursing positions remained unfilled. Shortfalls between the approved nursing establishment and the number of filled posts were observed across the clinical areas reviewed during the inspection. Nursing staff were supported by HCAs. At the time of inspection, 206.52 WTE HCA positions were filled. The total number of approved HCA posts could not be confirmed, as a process of agency conversion to permanent roles was ongoing.

AMAU had an approved staffing complement of 12 WTE staff nurse positions, of which 11.2 WTE were filled. The unit also had a CNM2 and ANP in post, however, one CNM 3 position and one CNM 1 position remained vacant at the time of inspection. Seven WTE consultant posts were approved for the AMAU of which six WTE posts were filled. There were no vacancies in NCHD positions. However, one approved dietitian post and one approved speech and language therapist post remained unfilled.

The 4B Ward had an approved staffing complement of 30 WTE staff nurse positions; however, 32.8 WTE staff nurses were in post at the time of inspection. One approved WTE position for an ANP, clinical skills facilitator (CSF), and one CNS post was vacant. Six WTE HCA positions were filled, however, the total number of approved HCA posts was not defined.

The 5B Ward had an approved staffing complement of 27 WTE staff nurse positions, with 25.52 WTE in post at the time of inspection. One approved WTE CNM 2 position was filled, while the approved CNM 1 position remained vacant. A total of 2.6 WTE HCA positions were filled, however, the total number of approved HCA posts was not defined.

The Ladybird Ward had an approved staffing complement of 29.5 WTE staff nurse positions, with 25.6 in post at the time of inspection. A CNM 3, CNM 2, and CNM 1 were in post. An approved 0.5 WTE ADON post was also filled. Of the two approved WTE HCA posts, one was filled, while the second post remained vacant due to long-term leave.

The hospital was funded for a total of 73.25 WTE pharmacy staff, representing an increase of 27.65 WTE since HIQA's previous inspection. This complement of staff included posts allocated to support wider pharmacy services beyond the hospital itself. The total comprised 47 WTE pharmacist posts and 26.25 WTE pharmacy technician posts. At the time of inspection 11 WTE pharmacist posts and nine WTE pharmacy technician posts were unfilled. This shortfall in pharmacy staffing impacted the delivery of clinical pharmacy and medication reconciliation services across the hospital. Senior management, including the EMT, were aware of the risks associated with these shortfalls, and pharmacy staffing was recorded as a high-rated risk on the hospital's corporate risk register.

The hospital's Infection Prevention and Control team was comprised of one WTE ADON and 12 WTE CNM2 posts, four of which were on leave at the time of inspection. Inspectors were told that an additional CNM 2 post had been approved and was pending advertisement. One WTE CNM 3 decontamination lead position remained vacant. Four WTE surveillance scientist posts were approved and filled, but there remained vacancies due to leave. Two WTE antimicrobial pharmacist posts were approved and both were filled. The hospital was funded for 4.1 WTE consultant microbiologist posts, of which 0.7 WTE were filled by locums at the time of inspection.

During interviews, inspectors were informed that of the approved 14 posts in the QPS department, six were vacant at the time of inspection. Documentation submitted, and data reviewed by inspectors confirmed the following vacant WTE posts:

- risk manager
- assistant risk manager
- quality manager
- grade VI data analyst
- section officer
- perioperative directorate QPS lead.

The absence of key personnel within the QPS department was reported to be negatively impacting it's capacity to deliver its full range of functions. It is essential that these vacant positions are supported and filled. In addition, the hospital had submitted requests for the approval of three directorate QPS lead posts, as well as a dedicated complaints manager post. Support for the approval and recruitment of these posts are considered necessary to strengthen the hospital's quality and safety governance structures, and to ensure effective oversight, governance, and coordination of quality and patient safety functions at both directorate and hospital-wide levels. Additionally, hospital staff who spoke with inspectors reported that the vacant medical manpower manager post (Grade 8) posed significant operational challenges. This was further compounded by a large number of vacant administrative positions, many of which were being filled by agency staff. However, this presented a challenge, as agency staff could

only be appointed at the maximum of Grade 3. These challenges had been escalated to regional level, and were recorded as a high-rated risk on the hospital's corporate risk register under workforce.

The hospital's absenteeism rate in January 2025 was 6.6%, representing an increase from 6.07% in January 2024 and a significant rise compared to the 4.7% reported at the time of the previous HIQA inspection. The current rate remains above the HSE's target absenteeism rate of ≤4%. Staff who spoke with inspectors were aware of, and had access to, occupational health services and the employee assistance programme. Inspectors were informed that back-to-work interviews were being conducted by CNMs at ward level. HR had commenced the process of carrying out exit interviews, however, this had not yet been implemented across all staff disciplines at the time of inspection.

CNMs and clinical facilitators had oversight of staff attendance and uptake of mandatory and essential training within their areas of responsibility. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) System.[††††] Staff who spoke with inspectors confirmed that they had received formal induction training upon commencing employment at the hospital. Training records provided to inspectors during the inspection, as well as through documentation submitted post-onsite, indicated that compliance with essential and mandatory training remained sub-optimal. For example, the overall hospital compliance rate for training on standard and transmission-based precautions among nursing staff was 81%, with HCAs' attendance recorded at 87.5%. Hand hygiene training compliance was 77.98% for nursing staff, 87.5% for HCAs, and significantly lower among NCHDs at 43.2%. Compliance with basic life support training was recorded as 81.58% for nursing staff and 60% for HCAs. Overall hospital medication education compliance among nursing staff was particularly low at 40.92%, however, areas visited by inspectors such as ED, AMAU and Ladybird Ward had a compliance rate of over 90%. Compliance with training in the use of the INEWS among nursing staff was 83.42%. Similarly, training compliance with national clinical handover guidance (ISBAR) was also 83.42% for nursing staff. These findings were consistent with those noted during the previous HIQA inspection. Accessing training records required manual data extraction at the time of inspection. The QPS department had been exploring the use of a module within the Q-Pulse system to log and monitor mandatory training compliance. However, this initiative had not progressed due to the vacancies within the QPS department.

In summary, several positions across various professional disciplines within the hospital remained unfilled at the time of inspection. Recruitment efforts by hospital management to address staffing gaps in the ED and other areas of the hospital were ongoing but

[††††]The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

required support from the regional service. The safety of services was being maintained through the use of agency staff, local staff working additional hours, use of locums, and use of the hospital 'bank' pool of staff. While this ensured continuity of care, it placed an additional burden of responsibility and workload on existing staff, which was not considered sustainable. Hospital management were actively working to resolve these staffing challenges but faced difficulties in progressing recruitment across professional groups, largely due to delays associated with the approval process.

In summary, to address areas requiring action on inspection, management should;

- address the vacancies within the QPS department
- address the vacancies across the various professional and administrative disciplines
- review approved staffing levels within the paediatric ED, separate from the staff allocation of the adult ED
- address vacant pharmacy positions in the hospital
- address deficits in essential and mandatory training compliance
- review actions to address the hospital's absenteeism rate to align with the HSE's target of 4%.

Judgment: Partially Compliant

Quality and Safety Dimension

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

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

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

Inspectors noted that staff adopted a person-centred approach to care, treating patients with respect while upholding their dignity, privacy, and autonomy. Staff interactions with patients were observed to be kind and respectful. All of the inpatient clinical areas visited during this inspection contained a number of single rooms, ensuring privacy for patients. Privacy curtains were used to maintain patients' privacy in multi-occupancy rooms. Inspectors identified that some rooms were mixed gender to facilitate enhanced care, with appropriate risk assessments carried out. Inspectors observed patients' mobilising around the clinical areas with staff support, promoting their independence. They also noted posters displayed, highlighting the HSE slogan '*Get up, Get dressed, Get moving*,' emphasising the importance of mobilisation to clinical outcomes. For patients unable to get out of bed, call-bells were provided at their bedside. Healthcare records and personal information was protected in ward areas visited. Thank you cards were displayed in a number of areas.

On day one of the inspection, the emergency department was in red escalation, with 99 registered patients present at 11am. While privacy and dignity was upheld for patients accommodated in individual cubicles and pods within the department, this was not the case for patients placed on trolleys in the corridor of the emergency department. Staff informed inspectors that if a patient on a trolley required assessment, they would be moved into a cubicle to ensure privacy during the provision of care. In the 2024 National Inpatient Experience Survey, the hospital received a score of 7.9, which aligned with the national average for patient experience in the emergency department, specifically relating to privacy when being examined or treated. This represented an improvement from the 2022 National Inpatient Experience Survey, where CUH scored below the national average.

The newly purpose-built paediatric emergency department provided a dedicated space for children up to the age of 16, ensuring their care while promoting privacy and dignity. The child-friendly individual bays further supported this by offering a private and respectful environment for treatment. Additionally, the department featured an outdoor play area and inspectors observed that toys were available in the waiting area. A sensory room was also available to accommodate the individual needs of children requiring a more tailored environment. A dedicated single room was available for sudden end-of-life situations, and memory boxes were provided within the department. Inspectors observed healthcare records and personal information was protected and stored securely within the paediatric emergency department and the AMAU. However, inspectors identified whiteboards being used to record relevant clinical information and personal identifiable information in two areas of the emergency department, which was viewable by others.

Hospital management was aware of this and were seeking to procure an interactive electronic system to address this issue. Inspectors were shown a family room comfortably furnished with couches, providing a quiet space where staff could speak privately with patients and their families. Patient information leaflets on the HSE 'Your Service Your Say', along with a poster titled 'We Would Like To Hear From You', were displayed on the wall of the paediatric emergency department. Volunteers were available at the main hospital reception to assist service users with queries. Inspectors were informed that the hospital had access to translator services to accommodate specific patient needs.

In summary, there was evidence that hospital management and staff recognised the importance of respecting and promoting the dignity and privacy of patients receiving care within the hospital. Areas for focused improvement:

- review the appropriateness of accommodating patients on trolleys in the emergency department corridor
- assess the use of whiteboards in the emergency department to ensure patient confidentiality is maintained.

Judgment: Substantially Compliant

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

There was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for patients receiving care in the clinical areas visited during inspection. Inspectors observed staff actively listening and effectively communicating with patients in a kind and sensitive manner, taking into account their individual expressed needs and preferences. For example, an inspector noted a staff member creating a calm environment for a visibly upset child while also providing support to the accompanying parent. Staff were also observed responding promptly to patients and demonstrating attentiveness to their individual needs. For instance, an inspector witnessed a nurse patiently explaining to a patient how to fill their prescription, doing so with kindness and genuine concern. Kind and respectful interactions between staff and patients were also observed. Patients who spoke to inspectors were complimentary of the staff and the care provided to them. Inspectors noted that patients appeared comfortable discussing any issues or concerns with staff. The hospital's mission statement was displayed in one of the clinical areas visited.

Judgment: Compliant

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

Overall, the hospital had systems and processes in place to support the management of complaints, however, some areas required further improvement and follow-up action.

At the time of inspection, the hospital did not have an approved, designated complaints officer with overall responsibility for managing complaints and implementing recommendations arising from complaint reviews. In the absence of a complaints officer, the QPS lead for each directorate acted as the designated complaints officer, within their respective areas. In directorates without a QPS lead, complaints were jointly managed by the business manager, the ADON, and the clinical director, with support from the QPS manager. Complaints were escalated through the directorate structure to the QSRC, and formal complaints were also discussed at EMT meetings. Minutes of meetings reviewed by inspectors showed that the request for quarterly and six-monthly complaints data reports to be provided to directorates from the QPS department were put on hold due to the staffing shortages within the QPS department. Inspectors were informed by hospital management that the need for three additional QPS leads posts had been escalated to regional level, and was also recorded as a high risk on the hospital's corporate risk register.

Complaints received at the hospital were managed in accordance with the HSE's 'Your Service Your Say' management policy. Verbal complaints were addressed at local clinical level by the CNMs, and escalated to the ADON if unresolved. Written complaints were managed by the ADON within their respective areas of responsibility, with further escalation to the relevant directorate where required. All complaints were logged onto the HSE's complaints management system (CMS). The adult ED maintained a log of verbal complaints. However, this practice was not applied consistently across all areas of the hospital. Information on how to make a complaint, including how to give compliments, was available on the hospital's website. Patient advocacy service details were also accessible on-line. However, inspectors noted that information on how to make a complaint was not available in the clinical areas visited, with the exception of Ladybird Ward where, 'Your Service Your Say' and 'We Would Like to Hear From You' posters were on display. A suggestion box was also present. Additionally, inspectors were provided with evidence of quality improvement plans (QIP) in response to complaints for both the adult and paediatric ED. Staff in the clinical areas visited by inspectors reported

that feedback and learning from complaints was communicated verbally, typically during clinical handovers or patient safety huddles. All staff received training on complaints management during formal induction to the hospital.

There was one patient advocacy and liaison service (PALS) manager and one patient experience coordinator in place at the hospital to support and advocate for patients attending the hospital. Inspectors also noted the commencement of a patient volunteer service on the first day of inspection. At the time of inspection, the patient experience committee was paused and the patient experience coordinator was responsible for tracking and trending complaints by theme, and for monitoring the implementation of related recommendations.

Patients who spoke with inspectors stated that they had not received information about the hospital's complaints process or how to access independent advocacy services. They reported that, if they wished to make a complaint, they would speak directly to a member of staff. However, patients expressed that they were very satisfied with the care they were receiving. One patient noted that they had previously made a complaint, which had been resolved locally by the CNM.

Post-onsite documentation reviewed by inspectors showed that the hospital received 617 formal complaints in 2024, with 107 complaints received year-to-date at the time of inspection in 2025. All complaints received in both years were acknowledged within five days, in line with HSE policy. However, only 65% of complaints in 2024 and 54% in 2025 year-to-date were resolved within the HSE's target timeframe of 30 working days. This performance fell short of the national KPI, which sets a target of 75% resolution within 30 working days, and represented a significant decline compared to the findings of HIQA's previous inspection in 2023. QPS management were aware of this shortfall and had acknowledged it as a challenge linked to ongoing staffing deficits.

Overall, the hospital had systems and processes in place to respond openly and appropriately to complaints and concerns raised by people using the service; however, areas requiring action were identified:

- the hospital did not have a designated complaints officer in place
- ensure 'Your Service Your Say' leaflets and patient advocacy service information are readily available to patients in clinical areas
- regional services to consider approval for QPS leads for a number of clinical directorates
- address non-compliance in meeting national KPI target of 75% for resolving complaints within 30 working days
- address the risk posed due to inability of QPS department to furnish data reports relating to complaints to clinical directorates.

Judgment: Partially Compliant

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

During the inspection, the inspectors observed that the physical environment in the clinical areas visited was secure, well maintained, and clean. There was evidence of some wear and tear. The inpatient ward areas visited by inspectors had adequate shower and toilet facilities, but patients attending the paediatric ED had no access to shower facilities within the department and had to go to the adult ED to access a shower. All bays within the paediatric ED were observed to be child friendly. Patients who spoke with inspectors in the adult ED stated that the area was very clean. However, some patients reported that the chairs in the pods within the RASTA area, used for sleeping, were 'very uncomfortable'.

CNMs who spoke with the inspectors expressed satisfaction with the cleaning resources in place, with the exception of two areas. Inspectors were informed that there were ongoing challenges faced due to staffing within hygiene services which included a high turnover of staff within the previous three months. Inspectors were told that a meeting had been scheduled to address these issues on the first day of inspection. Hygiene supervisors and CNMs maintained oversight of cleaning standards and daily cleaning schedules within their respective areas of responsibility. Cleaning of patient equipment was assigned to HCAs. Inspectors observed that patient equipment was clean and noted the use of a green tagging system to identify and indicate equipment that had been cleaned across the clinical areas visited. The CNM had oversight of the standard of patient equipment cleaning in the respective areas. Terminal cleaning was carried out by designated household staff, and hygiene staff were contactable out of hours via the bleep system. Environmental and patient equipment audits were conducted and are discussed further in national standard 2.8.

Hazardous materials and waste were observed to be stored safely and securely. Sharps were disposed of in a safe manner, and sharps boxes were observed to be kept in the temporary closed position when not in use. Medications were securely stored within the clinical areas. Clean and used linen were appropriately segregated, and supplies and equipment were stored appropriately. However, inadequate storage space was noted in some of the clinical areas visited during the inspection. For example, one clinical area did not have a designated storage area, and clean equipment was observed stored in the lobby and anterooms. Additionally, equipment was seen stored in the corridor of the

adult ED. Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms in the clinical areas visited. However, in the ED, trolleys observed along the corridor did not always maintain the required minimum distance of one meter.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for both staff and visitors. Inspectors observed that one dispenser in a clinical area was empty; however, once it was brought to the attention of the management, it was replaced promptly. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Hand hygiene sinks in these areas were compliant with national requirements.[‡‡‡‡]

Appropriate infection prevention and control signage related to transmission-based precautions was observed in the clinical areas visited. Personal protective equipment (PPE) was readily available outside single rooms where patients requiring transmission-based precautions were accommodated, as well as along the corridors in clinical areas.

A formalised process was in place to ensure the appropriate placement of patients requiring transmission-based precautions, with oversight provided by the IPC team. Staff informed inspectors that a member of the IPC team visited clinical areas daily and attended hospital huddles, where patients requiring isolation could be identified and prioritised, and any issues related to cleaning and housekeeping could be raised and addressed. A significant challenge for the hospital was the limited availability of isolation rooms, which was identified as a risk and placed on the hospital's corporate risk register. At the time of inspection, senior management informed inspectors that a strategic plan was in place to provide an additional 342 beds for the CUH campus by 2032. In the interim, capital works were ongoing to increase overall bed capacity and expand the number of isolation rooms. Risk assessments relevant to these building works were provided to inspectors for review and included the risk of aspergillosis, which was being closely monitored.

Overall, at the time of inspection, the physical environment and patient equipment was observed to be clean and well maintained. The environment supported the delivery of high-quality, safe, reliable care and contributed to protecting the health and welfare of patients receiving care in the hospital. However:

- physical distancing of one meter between trolleys in the adult ED was not maintained due to overcrowding
- storage issues were identified in two clinical areas.

Judgment: Substantially Compliant

‡‡‡‡ 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.

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

The hospital had systems and processes in place to monitor, analyse, evaluate, and respond to information from a variety of sources (including KPIs, audit findings, risk assessments, patient safety incident reviews, complaints, and patient experience surveys) in order to support the continuous improvement of services and to compare and benchmark the quality of services provided against other model four hospitals.

A 2024 annual report reviewed by inspectors demonstrated that the IPCC was actively monitoring and evaluating infection prevention practices in clinical areas. Inspectors were also provided with the IPC annual plan for 2025, which outlined planned audit and surveillance activities for the year. Hospital management monitored and regularly reviewed compliance with KPIs related to the prevention and control of healthcare-associated infections.[§§§§] The IPC team submitted a healthcare-associated infection surveillance report to the IPCC at monthly meetings. As per the HSE's reporting requirements, hospital management reported on rates of *Clostridioides difficile* infection, healthcare-associated *Staphylococcus aureus* blood stream infections, and *Carbapenemase-Producing Enterobacterales* (CPE) on a monthly basis.

In 2024, the hospital's rate of new *Clostridioides difficile* cases ranged from 0.5 to 8.1 per month. In January 2025, the hospital recorded 3.1 new cases. The hospital exceeded the HSE's target of fewer than 2 cases per 10,000 bed days in 10 of the 12 months of 2024, as well as in January 2025. This represented an increase of *Clostridioides difficile* rates compared to the findings from HIQA's previous inspection in 2023.

Healthcare-associated *Staphylococcus aureus* blood stream infections ranged from 0 to 2.8 new cases per month in 2024. The hospital exceeded the HSE target of fewer than 0.8 cases per 10,000 bed days in 10 of the 12 months, though the rate was 0.5 in January 2025. This also reflects an increase in infection rates since HIQA's last inspection.

The rate of new cases of CPE ranged from five to 19 cases per month in 2024, with nine new cases reported in January 2025. Quality improvement plans (QIPs) submitted to inspectors as part of the post-onsite documentation identified specific actions aimed at reducing rates of *Clostridioides difficile*, *Staphylococcus aureus*, and CPE. These actions were assigned to a responsible person and included time-bound targets to support effective implementation and monitoring. Hospital patients were screened for multi-drug resistant organisms (MDROs) including CPE and Methicillin-resistant *Staphylococcus*

[§§§§] 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. .

aureus (MRSA) in line with national guidance. Screening compliance was audited twice a year through MDRO screening audits. Audit results for 2024 indicated that 85.3% of patients were screened for CPE within 24 hours of admission. This indicated that improvement was required to ensure 100% compliance with CPE screening for all eligible patients across the hospital.

The IPCC had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. The frequency of environmental and equipment cleaning audits submitted to inspectors was not consistent across all clinical areas visited at the time of inspection. Additionally, not all areas achieved the hospital's audit target of 85% compliance. For example, audit results for Ladybird Ward and 5B Ward showed compliance rates of 81%. Audit results for the adult ED showed lower compliance rates of 79% and 77% respectively. Audit findings were shared with clinical staff, and QIPs were developed at a local level by the CNM in response to audit findings. However, QIPs reviewed by inspectors did not always include clearly defined actions or assign responsibility to an individual for their implementation, limiting their effectiveness.

Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices, with the exception of the combined adult and paediatric ED, which reported compliance rates of 68.4% in January and 80% in March of 2025. The overall hospital compliance for 2024 was 92%. QIPs were developed to address deficits, outlining actions to be implemented. However, QIPs reviewed by inspectors did not always include a designated responsible person or time-bound actions, which may impact effective follow-through.

The ASC reported to the QSRC. Information on antimicrobial consumption in the hospital was submitted monthly to the health protection surveillance centre (HPSC). An antimicrobial update was also provided at the DTC. Inspectors were informed by staff that education and training initiatives were in place to support and improve antimicrobial stewardship practices within the hospital.

There was evidence of ongoing monitoring and evaluation of medication safety practices at the hospital. Medication audits were conducted using the HSE's 'Test Your Care' nursing and midwifery quality care metrics,***** with findings reported to the DTC. Audits carried out in the clinical areas visited by inspectors at the time of inspection showed good levels of compliance, ranging from 86% to 100%. QIPs were developed when audit results fell below the expected standards. QIPs reviewed by inspectors were action-orientated, assigned to responsible individuals, and time-bound. Common areas identified for improvement included the documentation of patient weight and allergy status on medication records. Medication storage and custody practices were also audited through medication nursing metrics, with overall hospital compliance rates

ranging from 90% to 100%. Inspectors were informed by staff that audit feedback was shared with staff during ward meetings, safety huddles, and clinical handover.

The Steering Committee for Acutely Unwell Adult Patient had oversight of the hospital's compliance with national guidance on the use of INEWS, PEWS, ISBAR communication tool, and sepsis management. Performance data relating to the escalation protocol for the deteriorating patient was collected through the 'Test Your Care' nursing and midwifery metrics system. The frequency of audits submitted to inspectors was not consistent across all clinical areas visited at the time of inspection. Audits reviewed by inspectors for INEWS and ISBAR communication tool demonstrated compliance rates between 90% and 100% for wards 4B and 5B. However, audit results in the adult ED ranged from 62% to 84.3%. In response, QIPs were developed locally by clinical facilitators. QIPs reviewed by inspectors were action-based, assigned to responsible individuals, and were time-bound. PEWS audits submitted for Ladybird Ward showed 100% compliance for September and November 2024. However, compliance dropped to 77% in February 2025. The corresponding QIP reviewed by inspectors was also action-oriented, assigned responsibility, and time-bound. Audits reviewed for escalated care using sepsis forms, showed 100% compliance. Inspectors were informed by staff that audit feedback was shared locally through clinical handovers, multidisciplinary safety huddles, and CNM meetings. Inspectors observed quality care boards displayed in some of the clinical areas visited, which provided visible information on compliance with the 'Test Your Care' nursing and midwifery metrics and audit results.

Safe transitions of care at the hospital were supported through the bed management team, discharge coordinators, and a scheduled care bed booking system. Discharge planning audits were conducted throughout the hospital, using the HSE's 'Test Your Care' nursing and midwifery quality care metrics. Audit results reviewed by inspectors showed 100% compliance for wards visited at the time of inspection. QIPs were submitted for other clinical areas that did not achieve full compliance. QIPs reviewed by inspectors

were action-orientated, time-bound, and assigned to responsible individuals. Audits on discharge planning were not provided for the ED. However, inspectors reviewed a quality improvement toolkit for clinical handover, developed in January 2025, aimed at improving compliance with structured nursing documentation and the use of the ISBAR clinical handover tool within the ED department. In line with HIQA's previous inspection in 2023, the hospital continued to monitor key metrics in the ED. A patient flow plan and bed utilisation document submitted to inspectors outlined a series of daily multidisciplinary meetings designed to facilitate effective patient flow throughout the hospital. In addition, a daily situational report and a DTOC report were provided to hospital management, offering a real time overview of bed status and delayed

***** Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

discharges. A daily call with community services was held to review all delayed transfers of care and complex discharges, ensuring appropriate planning for safe and timely patient transitions.

Staff in one of the clinical areas visited by inspectors were aware of the hospital's findings from the National Inpatient Experience Survey and were able to provide examples of changes in practice that had been introduced in response to patient feedback, with the aim of improving the overall experience of people receiving care in the hospital.

Overall, assurance systems were in place to monitor and evaluate healthcare services within the hospital. However, areas for improvement were identified:

- improve compliance with CPE screening protocols
- address rates of healthcare-associated infection that remain above national targets
- improve compliance in areas where audit results do not meet expected standards, including environmental hygiene, hand hygiene, and PEWS
- ensure the frequency of audits is consistent across all clinical areas.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to identify, evaluate, and manage immediate and potential risks to people using the service. However, at the time of inspection, both the risk manager and assistant risk manager positions were vacant. In the absence of these roles, risks identified at clinical area level were managed and monitored by the CNM and the ADON. In the clinical areas visited, CNMs were responsible for implementing corrective actions to address actual or potential patient safety risks. When necessary, risks were escalated to the relevant clinical directorate.

A number of clinical directorates had a QPS lead responsible for overseeing risk management within their respective areas. Where this role was not in place, risk oversight was handled by the directorate management team, supported by the QPS manager. Every directorate maintained its own risk register, which was reviewed and discussed monthly at the QSRC meetings. Serious or high-rated risks that could not be managed at the directorate level were escalated to the EMT and recorded on the hospital -wide risk register. Risks related to the ED, were discussed weekly at the clinical operation group meetings. At the time of inspection, the hospital risk register included high-rated risks related to infrastructure and space constraints across the hospital,

admitted patients waiting in ED for an inpatient bed, non-compliance with PET indicators, staffing resource shortages across all professional disciplines, lack of isolation rooms, insufficient critical care bed capacity, and no high dependency unit. Inspectors observed that all risks were assigned to a responsible person, had time-bound actions, and were regularly reviewed.

Patients were screened on admission to the hospital for MDROs. The hospital's patient information management system supported the identification and appropriate management of patients requiring MDRO screening, by alerting staff to patients who had been previously admitted with known MDROs. A sample of patient healthcare records and transfer documentation reviewed by inspectors, showed that the patient's MDRO or other transmissible infection status was appropriately recorded. Patients were screened for CPE in line with national guidance, and compliance with this guidance was audited twice a year within the hospital. According to the infection prevention and control annual report for 2024, the hospital's compliance with CPE screening for 2024 was reported at 85.3%. Inspectors were informed by staff that there was an IPC nurse linked to all wards in the hospital, and staff had access to a microbiologist on a 24/7 basis. A member of the IPC team attended ED at 8am each morning to review and discuss any potential IPC issues with the shift leader. Staff told inspectors that patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. If an isolation room was not available, a risk assessment was conducted, and suitable patients were cohorted in multi-occupancy rooms. Inspectors observed that a patient isolation prioritisation risk assessment tool had been approved in June 2024. However, the standard operating procedure for the management of patients who require contact precautions when a single room is not available, was due for renewal in January 2025.

On the day of the inspection, there were no infection outbreaks in the hospital. The Outbreak Committee, chaired by the operations manager, met every two weeks, or more frequently if required. Outbreak reports submitted to inspectors for review were detailed and comprehensive, outlining the control measures implemented to mitigate actual and potential risks to patient safety. The reports also included analysis of the challenges and contributing factors, as well as recommendations to reduce the risk of recurrence. Findings from these reports were shared with staff in the clinical areas by the IPC team.

At the time of the inspection, pharmacy resources had been escalated as a risk to the hospital's risk register, therefore, the pharmacy service delivered was not consistent across all clinical areas within the hospital. A clinical pharmacy service was available in most areas of the hospital, however, some key areas did not have dedicated pharmacy support. For example, there was no clinical pharmacy service in the AMAU or the paediatric ED. This represents a service gap.

Inspectors were told by staff that a pharmacist was available in the adult ED each morning for one to two hours, prioritising medication reconciliation for admitted patients and providing advice for other patients when requested by staff. In clinical areas with a dedicated pharmacy service, pharmacy- led medication reconciliation was routinely completed within 24 hours of a patient's admission. However, this process was not undertaken for patients in the AMAU or the paediatric ED. Additionally, some clinical areas were supported by a pharmacy technician who restocked medications throughout the week. This practice was not consistently implemented across all clinical areas within the hospital. Staff were observed using risk-reduction strategies to support the safe use of high-risk medicines. Inspectors observed a list of high-risk medications, which aligned with the acronym 'A PINCH'[†††††]. In addition, a sound-alike look-alike medications (SALADs) list was also available in the clinical areas. A guide on the use of SALAD drugs was approved in November 2024. The hospital's medication management policy was dated June 2018 and was noted to be due for review and updating since June 2020. The hospital provided access to an online application that contained guidelines and training resources. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of prescribing.

The INEWS and the Sepsis 6 care bundle were in place to support staff in recognising and responding to the deterioration of patients. At the time of the inspection, the Emergency Medicine Early Warning System (EMEWS) had not been implemented in the ED. Inspectors were informed by staff that all adult patients in the ED were commenced on the INEWS chart following triage. In the paediatric ED and Ladybird Ward, the Paediatric Early Warning System (PEWS) was used to support the recognition and escalation of care for deteriorating paediatric patients. PEWS review stickers were placed in the patient's healthcare record to document this process. In the clinical areas inspectors visited, staff demonstrated a good understanding about the INEWS and PEWS escalation process. The ISBAR3 communication tool was used when requesting a medical review of a deteriorating patient, and staff reported that they did not experience difficulties in accessing medical support when required. A sample of healthcare records reviewed by inspectors showed that the escalation protocol for the deteriorating patient was in line with the EWS policy. The records also demonstrated that the ISBAR3 communication tool had been used appropriately to support the escalation process. However, inspectors noted that the use of this tool was not consistently applied across all clinical areas for the purpose of clinical handover. The deteriorating patient nurse service team plays a key role in promoting patient safety by participating in daily ward safety huddles and attending the hospital's operational hub meetings to escalate any concerns regarding patients showing signs of clinical deterioration. Inspectors were told that since HIQA's last inspection, an outreach critical care team had been established to

[†††††]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

review patients discharged from the intensive care unit, providing follow-up support and oversight.

The hospital had management arrangements in place to monitor issues that impacted the effective and safe transitions of care, as well as patient flow. As previously discussed under national standard 5.5, the safe transfer of care was supported through three key structures: the bed management team, the discharge coordinators, and the scheduled care bed booking system. As part of the integrated discharge process, discharge coordinators maintained regular engagement with community services to support safe and timely transitions of care. This included bi-weekly telephone conference calls involving the liaison community support team (LCST), complex case management team (CCMT), community placement coordinators, and the operational lead. In addition, weekly conference calls were held with representatives from liaison community support team, discharge coordinators and CUH. At the time of the inspection, the hospital had a total of 25 delayed discharges. Hospital management attributed these delays primarily to the acuity and complexity of patients requiring care, as well as limited access to step-down beds for patients in need of convalescence, transitional care, or rehabilitation. The hospital had commenced tracking the percentage of weekly discharges occurring at the weekend. In 2024, 14.23% of patients were discharged at the weekend, while year-to-date in 2025, the figure was 15.94%. This was slightly below the national target of 17%. The average length of stay for medical patients was 7.3 days, which was slightly above the HSE's target of ≤7 days, and the average length of stay for surgical patients was 6.9 days, exceeding the HSE's target of ≤6 days. ED avoidance pathway initiatives in place included Pre-Hospital Emergency Medicine, Alternative Pre-Hospital Pathway (APP), Pathfinder, and the Urgent Virtual Care Hub.

On the first day of inspection, inspectors were informed by senior management that 284 patients had attended the ED on 18 March 2025, the day prior to the inspection. This figure was significantly higher than the hospital's reported daily average of 229 ED attendances in 2023. In total, the hospital reported 86,886 ED attendances in 2024, constituting an increase of 9,290 attendances compared to 2023, which represented an overall rise of approximately 12%. Attendances by individuals who did not require inpatient admission but required access to mental health services, particularly Child and Adolescent Mental Health Services (CAMHS), posed a significant challenge for the hospital. In 2024, 523 individuals attended the ED requiring access to mental health services, with a further 180 attendances recorded year-to-date in 2025. The absence of timely access to these services resulted in a significant number of cases experiencing extended lengths of stay in the ED. Inspectors were informed that 105 patients were admitted to the hospital on day one of the inspection exceeding the average daily admission rate of 63 reported year to date in 2025. On the same day 80 patients were

discharged from the hospital. Patients attending the ED were triaged and clinically prioritised in accordance with the Manchester Triage System[‡‡‡‡‡].

On the day of the inspection, the hospital was in red escalation. There were 99 patients registered in the department, 36 of whom were admitted. Hospital data provided to inspectors indicated the conversion rate was 36.3%. However, data reviewed by inspectors from the Urgent and Emergency Care Performance Report showed a year-to-date conversion rate of 29.1%, which represented a slight increase from the 2024 figure of 27.5%. The national target for clinical handover within 20 minutes of arrival by ambulance to ED was 80%. In 2024, the hospital achieved a compliance rate of 77.45%, and for 2025 year-to-date, the compliance rate was 76.75%. This indicates that performance was slightly below national target. On the first day of the inspection there were no ambulances waiting and staff spoke positively of ambulance handover times in CUH. The waiting times for this inspection ranged from:

- registration to triage ranged from 6 minutes to 14 minutes. The mean waiting time was 8.5 minutes, which met the HSE emergency programme target of 15 minutes
- triage to medical assessment ranged from 8 minutes to 3 hours and 46 minutes. The mean wait time for medical assessment was 2 hours and 20 minutes
- decision to admit to admission to an inpatient bed ranged from 3 hours 54 minutes to 59 hours and 6 minutes. Mean wait time was 15 hours and 20 minutes.

Data on the emergency department PETs collected at 11.00am on the first day of the inspection, showed that while the hospital did not align with all of HSE targets for the emergency department, there was an improvement compared to the previous inspection.

- 55% of patients were admitted to a hospital bed or discharged within six hours after registration (HSE target 70%). This was an improvement from the previous HIQA inspection which was 50.7%

- 56% of patients were admitted to a hospital bed or discharged within nine hours after registration (HSE target 85%). This was an improvement from the previous HIQA inspection which was 35%
- 93% of patients were admitted to a hospital bed or discharged within 24 hours after registration, which was almost aligned with the HSE target of 97%
- 19% of patients aged 75 years and over were in the ED for more than six hours following registration. This was not compliant with the HSE target of 95% whereby attendees aged 75 years and over should be discharged or admitted within six hours. However, this was an improvement from the previous HIQA inspection, where 38% of attendees were in the ED greater than six hours

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

- 18% of patients aged 75 years and over were in the ED greater than nine hours of registration. This was not compliant with the HSE target of 99% whereby attendees aged 75 years and over should be discharged or admitted within nine hours. This was an improvement from the previous HIQA inspection, where 41% of attendees were in the ED greater than nine hours
- 3% of patients aged 75 years and over were in the ED greater than 24 hours of registration, which was almost aligned with the HSE target of 99% whereby attendees aged 75 years and over should be discharged or admitted within 24 hours.

Of the 99 patients registered in the ED, 33 were aged 75 years and over. According to the HSE urgent and emergency care (UEC) data up to 30 March 2025, there were 3,138 ED attendances by patients aged over 75. This was a decrease of 8% compared to 2024. The conversion rate for this group was 54.2%, which was slightly higher when compared to similar model four hospitals. In total, admissions for patients over the age of 75 accounted for 28% of all hospital admissions YTD 2025.

The hospital had a range of policies in place that addressed the four key areas of harm: infection prevention and control, medication management, the deteriorating patient, and safe transitions of care. In addition to these, inspectors reviewed a number of other policies, including those related to risk management, complaints management, clinical audit, the hospital's escalation policy, and health records management. Policies, procedures, protocols, and guidelines (PPPGs) were developed at the relevant committees and escalated to the EMT for sign off. All PPPGs were accessible to staff in the clinical area via the hospital's computerised document management system. However, during the inspection, it was noted that in some clinical areas, staff were either unable to access or experienced difficulty accessing policies via the online system. Inspectors also noted a number of policies were identified as being due for review and updating to ensure they reflected current best practice.

Overall, while the hospital had systems in place to identify and manage potential risks of harm associated with the four areas of harm, and patient experience times in the ED had improved since the previous inspection, areas for improvement were identified:

- address the risk posed by the lack of pharmacy-led medication reconciliation and a clinical pharmacy service across all clinical areas
- continued focus on meeting national KPIs related to PETs
- a number of hospital policies, procedures, protocols, and guidelines required review
- support from regional services is required to assist with ED attendances requiring access to mental health services.

Judgment: Partially Compliant

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

The hospital had a patient safety incident management system in place to identify, report, manage, and respond to patient safety incidents, in line with national legislation, policy, and guidelines. Patient safety incidents were reported on the National Incident Management System (NIMS).[§§§§§] Governance and oversight of patient safety incidents was provided by the SIMT, QSRC, and the EMT.

A total of 2,395 clinical incidents were reported to the NIMS for 2024. However, data provided to inspectors by the hospital showed that a total of 2,463 clinical incidents were reported for the same period. Therefore, the total number of incidents reported by the hospital did not match the number reported on NIMS, indicating a discrepancy in the data. For 2025 year-to-date, a total of 322 clinical incidents were reported on NIMS, which was consistent with the data provided to inspectors by the hospital. The number of SREs reported for 2024 on the NIMS and in data supplied by the hospital was 21. For 2025 year-to-date, the number of SREs reported on NIMS was three. However, data provided to inspectors by the hospital indicated that there were seven SREs in 2025. This discrepancy in the reported numbers was noted.

The percentage of incidents reported onto NIMS within 30 days of notification for the hospital was 46.4% in 2024, and 33% for January and February 2025. This performance was below the national target of 70%. Post-onsite documentation submitted to inspectors by the hospital identified that four reviews were commissioned into Serious Incidents in 2024. None of these reviews were completed within the HSE's target timeframe of 125 days.

Staff who spoke with inspectors were knowledgeable about how to report, manage, and respond to patient safety incidents. Staff were also aware of the most common patient safety incidents reported in the hospital, including slips, trips and falls, pressure ulcers, and medication errors. Patient safety incidents occurring in the hospital were tracked and trended in clinical directorates that had a designated QPS lead. However, inspectors were informed by hospital management that there was a 6-12 month gap in the tracking and trending of incidents due to staffing deficits within the QPS department. There was no formal structure in place to provide oversight at committee level for clinical incidents reported in relation to infection prevention and control, the deteriorating patient, or transition of care. These incidents were discussed at the QSRC. In the absence of a QPS lead, responsibility for follow-up was assigned to the CNM. Staff told inspectors that

[§§§§§] 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).

feedback on incidents was provided informally by the CNM in the clinical area and shared through hospital huddles, communication folders, and staff ward meetings.

Medication patient-safety incidents that occurred in the hospital were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Data submitted to inspectors by the hospital, showed that medication safety incidents for 2024 had decreased compared to 2023. A total of 63 medication incidents had been reported year-to-date for 2025. The most frequently reported incidents related to the prescribing and administration of medication. The DTC provided oversight of all medication safety incidents and reviewed the effectiveness of actions and measures implemented to improve medication safety within the hospital. Inspectors were informed by staff that feedback to the clinical areas on medication safety incidents was provided by the medication safety officer or pharmacist.

Overall, inspectors found that while processes were in place in the hospital to manage patient safety incidents, the following areas required improvement:

- oversight and monitoring of patient safety incidents require strengthening to ensure robust governance and accountability
- address compliance rate for entry of patient safety incidents onto NIMS within 30 days of notification
- address the risk posed by non-compliance with the HSE target for completing reviews of serious incidents within 125 days of notification
- address the risk posed by the inconsistent availability of information on the tracking and trending of patient safety incidents across clinical
- address the risk posed by discrepancies between the number of incidents reported by the hospital and those recorded on NIMS to ensure accurate and aligned data reporting.

Judgment: Partially Compliant

Conclusion

An unannounced two-day inspection of Cork University Hospital was carried out on the 19 and 20 March 2025 to access compliance with 11 national standards. The inspection focused on five of the eight themes of the *National Standards for Safer Better Healthcare*, with particular attention given to four key areas of known harm, these being infection prevention and control, medication safety, the deteriorating patient, and safe transfers of care.

Capacity and Capability

There was evidence of corporate and clinical governance arrangements in place to assure the delivery of high-quality, safe, and reliable healthcare. However, the terms of reference for several committees require revision to accurately reflect the hospital's restructured governance arrangements. Additionally, agreed actions aimed at improving the quality and safety of healthcare services needs to be time-bound across multiple committees to ensure accountability and effective follow-through. The hospital had effective management structures in place to support and promote the delivery of high-quality, safe, and reliable healthcare services. The EMT demonstrated a strong operational understanding of the challenges and issues affecting the quality and delivery of healthcare within the hospital. Several committees had been established by hospital management to oversee and support planned objectives and provide assurances around key areas such as infection prevention and control, medication safety, the deteriorating patient and, safe transitions of care. However, the hospital had not developed a formal annual plan or a defined medication safety programme for 2025. There was evidence the hospital had established effective and systematic arrangements to monitor and evaluate the quality, safety, and reliability of care. There was structured oversight of performance against key indicators, particularly within the four areas of known harm. Evidence reviewed by inspectors, demonstrated that data from these monitoring processes was actively used to inform quality improvement initiatives and enhance both patient safety and the overall care experience. Nevertheless, there remains an opportunity to strengthen the oversight and governance of audit activity to ensure that recommendations arising from audits are implemented in a timely and consistent manner. The implementation of quality improvement initiatives should also be systematically tracked and monitored to provide assurances to the EMT that all opportunities to enhance the quality and safety of healthcare services are being fully acted on. Re-establishing the Clinical Audit Committee would support a more coordinated approach to the governance and oversight of clinical audit activity. Additionally, progressing with the recruitment of approved vacant posts within the quality and patient safety department would further strengthen the hospital's capacity to effectively oversee and manage audit, risk, and patient safety incidents. Workforce arrangements at the hospital were planned, organised, and managed with the objective of ensuring the delivery of high-quality, safe, and reliable care. However, a significant number of key positions across various professional disciplines remained unfilled. This was also a finding from HIQA's previous report in 2023. Recruitment efforts to address staffing gaps in the ED and other areas of the hospital were ongoing. The safety of services was being maintained through the use of agency staff, additional hours, locum staff, and 'bank' staff. While this approach ensured continuity of care, it placed an additional burden of responsibility and workload on existing staff, which was not considered sustainable. Hospital management were actively working to resolve staffing challenges but faced difficulties progressing recruitment across professional groups, primarily due to delays in

the approval process and a need for support from regional services. Staffing for the paediatric ED required review. Unfilled pharmacy positions across the hospital had impacted the ability to provide clinical pharmacy and medication reconciliation services in all clinical areas where these were required. Additionally, deficits in compliance with essential and mandatory training requirements were noted, which was also a finding from the previous HIQA inspection. Furthermore, the hospital's absenteeism rate remained higher that the HSE target of 4%. These should be areas of focused improvement.

Quality and Safety

Inspectors noted that staff demonstrated a person-centred approach to care, treating patients with respect while upholding their dignity, privacy and autonomy. Interactions between staff and patients were observed to be kind, respectful, and compassionate. While there was clear evidence that hospital management and staff recognised the importance of respecting and promoting the dignity and privacy of patients receiving care, the practice of accommodating patients on trolleys in the ED corridor required review. In addition, the use of whiteboards in clinical areas should be reviewed to ensure that patient confidentiality is maintained at all times. Inspectors observed staff actively listening and communicating effectively with patients in a kind and sensitive manner, taking into account each patient's individual needs, preferences, and expressed concerns. The hospital had systems and processes in place to respond openly and appropriately to complaints and concerns raised by people using the service. However, vacant posts within the quality, patient safety department (including the position of a designated complaints officer) had an impact on the hospital not meeting the national KPI target for resolving complaints, and data reports on complaints were not being completed. Inspectors also noted that 'Your Service Your Say' leaflets and information about the patient advocacy service should be more readily accessible to patients throughout the hospital. The physical environment in the clinical areas visited was generally secure, well maintained, and clean. The environment supported the delivery of high-quality, safe, and reliable care, contributing to the protection of patients' health and welfare. However, inspectors noted that the recommended one metre physical distancing was not consistently maintained between trolleys in the ED due to overcrowding. Additionally, storage issues were identified in some of the clinical areas visited. There was systems in place at the hospital to monitor, evaluate, and continuously improve the healthcare services and care provided. Nonetheless, there was a need to improve compliance with CPE screening protocols and to address rates of healthcare-associated infections that remained above national target. Furthermore, the hospital should strengthen compliance in areas where audit results fall below expected standards and ensure the frequency of audits is consistent across all clinical areas. The hospital had systems and processes in place to identify, evaluate, and manage immediate and potential risks to people using the service. However, HSE targets for ED performance times were not being achieved,

and a number of hospital policies, procedures, protocols, and guidelines required review. There was a patient safety management system in place to identify, report, manage, and respond to patient safety incidents in line with national legislation, policy, and guidelines. Despite this, the national targets for the timely reporting of patient safety incidents and the completion of serious incident reviews were not being met. Oversight and monitoring of patient safety incidents requires strengthening to ensure robust governance and accountability.

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

Compliance Classifications

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

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present

moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance Plan for Cork University Hospital

Inspection ID: NS_0119

Date of inspection: 19 and 20 March 2025

Compliance Plan Provider's Response

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

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

- **Improvements are required to strengthen the oversight and governance of audit activity to ensure compliance with the implementation of audit recommendations.**

I. Directorates to develop an audit schedule to include monitoring audit findings and track recommendations. This will be overseen by the QPS lead where in post. CUH will seek to install QPS leads in the remaining 3 directorates. (See Theme 6.1).

II. It is the hospital's ambition to reconvene the Audit Committee subject to the recruitment of key staff to support the QPS function. (See Theme 6.1).

Medium Term

- **The implementation of quality improvement initiatives should be systematically monitored and tracked to provide assurance to the EMT that all opportunities to enhance the quality and safety of healthcare services are being fully acted upon.**

I. Quality & Patient Safety leads to provide oversight of quality improvement initiatives within their directorate. *

II. Establish a quality improvement initiatives recommendation tracker accessible to all relevant stakeholders on a shared folder. *

III. Feedback provided on quality improvement initiatives by QPS leads at Directorate meetings. *

(*See no. 1 above & Theme 6.1).

IV. Updates on quality improvement initiatives to the QSR Committee which reports to the EMT.

Medium term

- **Improvements are required to progress the recruitment of approved vacant posts.**

I. See Theme 6.1

Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

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

- **Address the vacancies within the QPS Dept**

1. Submit portfolio of posts; vacant & required to post prioritisation process.

Immediate

- **Address the vacancies across the various professional and administrative disciplines**

1. Ongoing recruitment for unfilled professional and administrative disciplines

Ongoing

- **Review approved staffing levels within the paediatric ED, separate from the staff allocation of the adult ED**

1. Recruitment for unfilled professional posts in CUH currently underway following approval of the paediatric ED business case.

Ongoing

- **Address vacant pharmacy positions within the hospital**

I. Posts approved at Regional Level including pharmacy posts and development posts associated with ED, paediatric ED and the Acute Floor. These are being progressed through HR and recruitment processes.

Ongoing

- **Address deficits in essential and mandatory training compliance**

I. It is the hospital's ambition to ensure mandatory training needs assessment will be completed for all CUH staff.
II. Training schedules to be revised and agreed to address training needs identified.
III. Implement centralised electronic system (QPulse) to capture and monitor mandatory training.

Long Term

- **Review actions to address the hospital's absenteeism rate to align with the HSE's target of 4%**

I. Return the overall HR department to full compliment
II. Re-inforce the absenteeism policy with all line managers
III. HR to seek plans from line managers where the relevant department exceeds the HSE target.

Long Term

Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

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

- **The hospital did not have a designated complaints officer in place.**

I. Develop Business Case for designated complaints officers.

Medium term

- **Ensure Your Service Your Say leaflets and patient advocacy service information are readily available to patients in clinical areas.**

I. Provide leaflets and posters to all clinical areas for patients to be able to feedback in a timely manner
II. Procure posters from the independent Patient Advocacy Service and SAGE Advocacy Service to display in all clinical areas.

Immediate

- **Regional services to consider approval for QPS leads for a number of clinical directorates**

I. See Theme 6.1 in relation to QPS staffing.

Medium term

- **Address non-compliance in meeting national KPI target of 75% for resolving complaints within 30 working days**

I. Recruitment of vacant QPS leads coupled with Complains Officers for the hospital (See Theme 6.1 in relation to QPS staffing)

Medium term

- **Address the risk posed due to inability of QPS department to furnish data reports relating to complaints to clinical directorates.**

1. Recruitment of vacant QPS leads post to enable the Patient Experience Coordinator fulfil the roles and responsibilities of the post. (See Theme 6.1).

Medium term

Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

3.1 Service providers protect service users form the risk of harm associated with the design and delivery of healthcare services	Partially compliant

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

- **Address the risk posed by the lack of pharmacy-led medication reconciliation and a clinical pharmacy service across all clinical areas**

See Theme 6.1

Medium term

- **Continued focus on meeting national KPIs related to PETs**

I. Monitoring PET in the Emergency Department through tracking and trending at the Unscheduled Care Programme Board.
II. Continue QI programmes across the acute floor.
III. Reporting nationally.
IV. Daily calls with the IHA Managers.

Ongoing

1. Expand the bed capacity through infrastructural developments to decompress the ED and reduce PET for all patients.

Long Term

- **A number of hospital policies procedures protocols and guidelines required review**

The electronic Document Control & Management system (Q-Pulse) is now upgraded providing greater oversight and ownership of all PPPG's and associated documents.

I. Ongoing training to staff on the 'new' version of Q-Pulse.
II. QPS dept to provide the Chairs of the respective Committees with details of the status of PPG's. Plan required for those requiring review.
III. Overview to be submitted to the QSR Committee.

Medium term

- **Support from regional services is required to assist with ED attendances requiring access to mental health services.**

- Refer to the IHA.

Medium term

Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

3.3 Service providers effectively identify, manage, respond to and report on patient safety incidents.	Partially compliant

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

- **Oversight and monitoring of patient safety incidents require strengthening to ensure robust governance and accountability**

I. Going forward data from NIMS and CMS will be extracted by one user for both the Quality Safety & Risk Committee and the Executive Management Team meetings.
II. QPS leads where in post to provide reports to clinical areas within their directorates to demonstrate tracking and trending of patient safety incidents.
III. See Theme 6.1 in relation to QPS staffing.

Medium term

- **Address compliance rate for entry of patient safety incidents onto NIMS within 30 working days of notification**

I. Identify relevant staff to approve incidents within various departments to expedite the approval process.

Short Term

- **Address the risk posed by non-compliance with the HSE target for completing reviews of serious incidents within 125 days of notification**

The 125 days is dependent on sourcing relevant experts from the Post Graduate Forum. The experience is this can take some considerable time.

I. Train additional staff to undertake systems analysis reviews.

II. See Theme 6.1 in relation to QPS staffing.

Medium – Long term

- **Address the risk posed by the inconsistent availability of information on the tracking and trending of patient safety incidents across clinical**

I. Going forward data from NIMS and CMS will be extracted by one user for both the Quality Safety & Risk Committee and the Executive Management Team meetings.

II. QPS leads where in post to provide reports to clinical areas within their directorates on tracks and trends in patient safety incidents.

III. See Theme 6.1 in relation to QPS staffing.

Medium term

- **Address the risk posed by discrepancies between the number of incidents reported by the hospital and those recorded on NIMS to ensure accurate and aligned data reporting**

I. Identify relevant staff to approve incidents within various departments to expedite the approval process.

II. See Theme 6.1 to also enable QA in relation to QPS staffing.

Medium term

Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years