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:	Mallow General Hospital
Centre ID:	OSV-0001025
Address of healthcare service:	Limerick Road Mallow Co Cork P51N288
Type of Inspection:	Unannounced
Date of Inspection:	07/05/2025 and 08/05/2025
Inspection ID:	NS_0142

About the healthcare service

Model of hospital and profile

Mallow General Hospital (MGH) is a model two[1] Health Service Executive (HSE) public hospital. It is a member of and is managed by the Regional Health Area South West[2] (RHA SW), also referred to as the HSE South West Region (SWR). For the purposes of the report the SWR will be used. Services provided by the hospital include:

- medical services
- injuries unit
- medical assessment unit
- in-patient services
- endoscopy
- day case elective surgery
- diagnostic services
- outpatient care

The following information outlines some additional data on the hospital.

Number of beds	71 inpatient beds 14 day case trolleys

[1] A Model 2 hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, and a range of diagnostic services.

[2] 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

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* Version 2 2024 (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information since the last inspection.

During the inspection, inspectors:

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

About the inspection report

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

[‡]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.

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)
07/05/2025	09:30 – 17:30	Marguerite Dooley	Mary Flavin Rosie O' Neill
08/05/2025	08:50 – 13:45	Marguerite Dooley	Mary Flavin Rosie O' Neill

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 the following clinical areas:

- Medical Assessment Unit (MAU)
- Injuries Unit (IU)
- St Joseph's Medical Ward
- Medical 2

During this inspection, the inspection team spoke with staff, representatives of; the hospital's senior management team, infection prevention and control, medication management, transitions of care, quality safety and risk; and the deteriorating patient.

Acknowledgements

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

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

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

During the course of the inspection, the inspectors visited the Medical Assessment Unit (MAU), the Injuries Unit (IU), St Joseph's medical ward and Medical 2. Theatre was visited to discuss the decontamination process in place for reusable invasive medical devices (RIMDs).

The MAU had the following capacity; two isolation rooms (with ante-rooms) both en-suite with wheelchair accessible toilet and shower. There were two single rooms and four trolley bays. At the time of the inspection there were seven patients in the MAU. There were two wheelchair accessible toilets and showers on the corridor, and a separate staff toilet.

The Injuries Unit (IU) had two trolley bays, and one single room with a trolley. There was an Advanced Nurse Practitioner (ANP) room and also a Nurse assessment room where patients could be assessed and treated. While there was not a toilet in the IU, there was a wheelchair accessible toilet for use in the shared MAU-IU waiting room. At the time of the inspection there were three patients in the IU.

St Joseph's in-patient medical ward was staffed as a nine-bedded ward, but was the dedicated area to accommodate an additional four patients during surge activity. Beds used during surge were allocated accordingly within existing rooms. There were eight in-patients at the time of inspection, one of whom required isolation. The ward had three single rooms en-suite with toilet and shower. There were three, three-bedded rooms to include one en-suite with shower and toilet. There was a combined toilet and shower, and an additional toilet on the corridor for patient use, however it was noted that in one, a call bell activation cord required replacing.

Medical 2 was a new 24-bedded medical ward, all single rooms en-suite with toilet and shower. Two of the rooms could accommodate in-patients with bariatric care needs and were equipped accordingly. There were 22 patients at the time of inspection, seven of whom required isolation. There was a visitor's toilet, and a separate staff toilet on the ward.

Inspectors spoke with a number of patients and their relatives to ascertain their experiences of receiving care in the hospital. Responses were very positive, with patients describing staff as 'helpful', 'could not speak highly enough about staff', care is 'unbelievable', 'told to use the call bell if I need anything', 'they are very good to me and come the minute I call'. Patients told inspectors that they 'understood their medications, the doctor explained today', another patient had 'no issues with medications'. One relative whose parent had a number of care experiences with MGH noted that staff are 'very vigilant regarding medications' and stated that MGH had a strong interface with integrated care within the community setting. Inspectors observed staff in the MAU and

IU providing patients with discharge instructions, GP letters and education on the use of crutches.

Patients described the hospital as 'spotless', the 'cleaners are around all the time'.

Patients who spoke with inspectors said they would 'speak to a nurse if they wanted to make a complaint', two patients were familiar with the HSE feedback and complaints process '*Your Service, Your Say*'.

Overall, patients were very complimentary about the staff and the care received in the hospital. This was consistent with what inspectors observed over the course of the inspection and the recent findings of the National In-Patient Experience Survey (NIES – 2024).

Capacity and Capability Dimension

Inspections findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Mallow General Hospital was found to be substantially compliant with three national standards assessed (5.2, 5.5, 5.8) and partially compliant with one national standard assessed (6.1). Key inspections 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.

Through discussions with senior management and staff, inspectors found that Mallow General Hospital had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services.

Organisational charts seen by inspectors, set out the hospitals reporting structures detailing the direct reporting arrangements for hospital management, governance and oversight committees. However the hospital organogram should reflect the hospital manager (HM) as the senior accountable officer (SAO). While regional governance transitioned to the South West Region (SWR) on the 03 March 2025, it was clear through discussions with management that a number of regional committees and associated reporting structures had yet to be fully established.

The hospital manager as the SAO had overall responsibility and accountability for the governance of the hospital, and had a reporting relationship to the Integrated Healthcare

Area (IHA) Manager for Cork North and East SWR. The IHA Manager reported to the Regional Executive Officer for the SWR. Health and Social Care Professionals (HSCPs); the Quality and Risk Manager (QRM); and clerical and administration staff reported directly to the hospital manager. While non-consultant hospital doctors (NCHDs) reported to consultants, they also had a reporting structure to the hospital manager.

The Clinical Lead (CL) for the hospital provided clinical oversight and leadership to consultants and NCHDs. The CL reported to the Clinical Director, SWR who in turn reported to the South West Executive Management Team. The CL also maintained links with the Clinical Director for Medicine in the SWR acute model four site. The Director of Nursing (DON) was responsible for the organisation and management of nursing services within the hospital. The catering and household manager; and portering also reported to the DON. The DON had a professional reporting line to the Regional Director of Nursing and Midwifery, SWR.

The Senior Management Team (SMT), chaired by the hospital manager, met fortnightly in line with the terms of reference (ToR), membership included the CL, DON, QRM, and a representative from the consultant staff. Additional staff members could attend on request, and minutes reflected the IHA manager had attended on March 2025. Minutes reviewed by inspectors demonstrated that meetings were well attended, followed a structured format, actions were followed up from meeting to meeting, assigned to a member for progressing, with timelines recorded. The SMT set the strategic direction for the hospital and had oversight of, and responsibility for the quality and safety of the healthcare services. Agenda items included nursing reports, infection prevention and control (IPC), Quality Safety and Risk (QSR); finance, workforce, and service delivery.

QSR updates included discussion on the review of the hospital risk register, incidents and the re-commencement of sub-committees reporting schedule to the SMT. Inspectors were informed that there had been a gap in furnishing reports from various committees due to the vacancy in the QRM post. Minutes reflected that this practice would recommence in June 2025. Inspectors were provided with a standardised reporting template that would be used, which included key priorities, audit activity, key performance indicators (KPI's) and risks. In line with the HSE performance and accountability framework (2023) the hospital manager had previously attended performance meetings with the hospital group, minutes reflected items discussed were access to care, finance and human resources (HR). However there was no evidence that risks and incidents were discussed with the exception of the QRM vacancy. At the time of inspection there was not a schedule for performance meetings with the SWR for 2025. Management informed inspectors that they had daily contact with the IHA Manager, at which point any issues or concerns could be escalated.

The Quality Safety and Risk Committee (QSRC), chaired by the clinical lead had met

twice in 2025. Minutes reflected prior to this, the QSRC meeting had last been convened in January 2023. Management cited this was related to the QRM vacancy from June 2023 to February 2025. The ToR for the committee had been updated and there were quarterly QSRC meetings scheduled for 2025. The QSRC reported to the SMT, providing a level of assurance to the SMT that there were appropriate and effective systems in place to cover all aspects of quality and safety across services provided by the hospital. Membership was multidisciplinary. There was a set agenda which included audits and inspections; patient experience, national standards such as children first, safeguarding, open disclosure and assisted decision making; quality improvements such as the hospital patient safety indicator report (HPSIR) and KPI's; IPC, corporate risk register, risks, incidents and training. Actions were time-bound and were assigned to an owner. It was evident from review of minutes, and in discussion with staff that the review of local and corporate risk registers was being conducted. A 'due diligence' report had been furnished to the regional service in quarter one (2025) providing an overview of any risks or issues in MGH. Inspectors were informed that a hospital group QPS meeting had been convened on a six-weekly basis prior to transition to the regional service, at the time of inspection the hospital management did not have clarity if this meeting would be continued.

While the hospitals' Serious Incident Management Team (SIMT) ToR required updating and review, it outlined the process for convening a SIMT meeting with associated timeframes. Objectives included caring for those harmed, appropriate investigation, review and implementing any recommendations from a review.

The Medication Management Committee (MMC) was established to guide the development, implementation and evaluation of a comprehensive medication management programme in the hospital. As per the ToR, the MCC, chaired by a senior pharmacist (the executive pharmacy manager), met quarterly. Membership included a consultant, DON, hospital manager, clinical development coordinator, CNMs and the QRM. The ToR was not dated. Minutes reflected discussion on policies, nurse prescribing, incidents, audit and safety initiatives. However some members were not in attendance for the three most recent meetings, and data on medication related incidents was not presented. While actions were assigned to individuals, they were not time-bound. The MCC reported to the QSRC, however inspectors were informed that a report had not been furnished in 2024 and this was related to staffing resources. The MCC also linked with the Drugs and Therapeutic Committee in the regional acute model four site every two months.

The Infection Prevention and Control and Hygiene Committee (IPCHC), chaired by the hospital manager, met quarterly in line with the ToR. However the ToR, required review and updating. The IPCHC had oversight of IPC practices within MGH. The IPCHC reported to the SMT. Minutes viewed showed IPC was a standing item on the SMT agenda and

updates were provided on healthcare associated infections (HCAIs), which were reported to the HSE Business Intelligence Unit (BIU) on a monthly basis. Inspectors were informed that the IPC staff attend, and provide a verbal update at the monthly regional IPCC meetings. Membership of the IPCHC was multidisciplinary and meetings were well attended. However inspectors noted that a number of members listed in the ToR were not in attendance for some of the meetings. Meetings followed a standard agenda which included the IPC programme, surveillance and monitoring to include HCAIs, care bundles, audits, Quality Improvement Plans (QIPs), antimicrobial stewardship (AMS); laboratory services, decontamination, infrastructure, risk, education and training. Actions were followed up from meeting to meeting, however actions were not assigned to an individual. QIPs developed as a result on non-compliance were available for staff to view online. Minutes reflected the IPCHC annual report and IPC programme will be available in June 2025.

The aim of the Deteriorating Patient Committee (DPC) was to drive continuous quality improvement (QI) related to the recognition and response to the deteriorating patient, and optimise outcomes. Inspectors were informed that the DPC was chaired by a consultant, however the chair was not identified in the ToR, or in minutes reviewed by inspectors. While the ToR was dated August 2024, it was also recorded as a draft document on a number of pages. The DPC met quarterly, while attendance included a consultant and nursing specialities, it was noted a number of members were not in attendance for the three most recent meetings. Actions were assigned to an individual, were time-bound with a status update. Agenda items included QI, sepsis, Irish National Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS), safety initiatives and training. The DPC reported to the QSRC, and the QRM was a member of the DPC. A member of the DPC represented MGH at the recently established quarterly SWR deteriorating patient steering committee.

The Transitions of Care Committee (TOCC) provided a structure and oversight to TOC within MGH, thereby providing a level of assurance to the QSRC that there were appropriate and effective systems in place. In line with the draft ToR, which was awaiting approval, the TOCC was chaired by the QRM and membership include nursing disciplines and the clinical lead. Inspectors were informed that the TOCC was re- established in March 2025, was scheduled to meet every two months and report to the QSRC on a quarterly basis. Review of the March minutes provided to inspectors showed actions were assigned to an individual and while time-bound, there were twenty actions outstanding from 2023. These actions primarily related to documentation, policy development and review, with associated revised time-frames for completion in quarter two and three, 2025.

Overall MGH had 16 committees within the hospital, the majority of which reported to the

QSRC, through to the SMT. These committees included the four key areas of harm and the following; Document Review and Development Group; Hospital Transfusion; Health and Safety; Endoscopy User Group; Theatre User Group; Staff Health and Wellness; Falls-Frailty Group; End-of-Life; Children's First Implementation; Nutrition and Hydration; Near Patient Testing and Radiation Safety. The TUG linked with the Theatre Executive Group in the regional acute model four site.

In summary inspectors were satisfied that MGH had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services but areas for focussed improvement:

- the hospital organogram should reflect the hospital manager as the senior accountable officer
- progress committees formally furnishing reports to SMT
- ensure terms of reference are reviewed and updated
- ensure key personnel or designate attend meetings in line with ToR
- assign actions arising from meetings to individuals for progressing
- clarity to be provided to MGH on regional committee reporting structures
- regional service to establish a schedule for performance meetings with MGH.

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 were effective management arrangement structures and mechanisms in place to support and promote the delivery of high quality care, safe and reliable healthcare services in Mallow General Hospital.

The MAU operated from Monday to Sunday (8am to 8pm). Daily clinical oversight, to include the management of patients and taking a decision to admit or discharge, was the responsibility of the medical consultant on-call, supported by NCHDs. Nursing oversight was provided by a Clinical Nurse Manager II, (supported by nursing staff) who reported to an Assistant Director of Nursing (ADON). Attendees to the MAU were medical patients, aged 16 years and over, at the time of inspection seven patients were in the MAU. Information about the MAU service and the requirement for referral was available to patients and families online. The hospital recorded 2,984 attendances to the MAU in 2021 and 4,529 in 2024, an increase of 1,545 (51.7%). There were 1,372 attendances in 2025.

Referral to the MAU was through a General Practitioner (GP), however the National Ambulance Service (NAS) could refer Monday to Friday (8am to 6pm). While MGH had a policy which included a set inclusion-exclusion criteria for referrals, inspectors were informed that there were 771 (17%) self-referrals to the MAU in 2024. There were 166 (3.6%) attendances that were deemed outside of the scope of the MAU and 115 (2.5%) attendances who presented out-of-hours in 2024 and 27 (1.9%) in 2025. Inspectors were informed, and on review of the Policies, Procedures, Protocols and Guidelines (PPPGs), all self-presenters, to include out-of-hours presentations to the MAU were assessed by a medical NCHD at registrar grade. The hospital was performing well in relation to the HSE national key performance indicator (KPI) of 75% with overall compliance relating to a decision to admit or discharge within six hours, recorded as 84% in 2024 and 90% in 2025. The overall conversion rate to admission was 30% in 2024 and 31% in 2025. There were 99 (2.1%) patients in 2024 and 25 (1.8%) in 2025 that required protocol 37[§§] transfer to an emergency department in an acute hospital.

The Injuries Unit (IU) operated from Monday to Sunday (8am to 8pm). Clinical oversight was provided by the consultant in emergency medicine in the regional acute model four site, and who also attended quarterly meetings in MGH. The IU had a dedicated NCHD, specialising in emergency medicine, providing day-to-day clinical assessment, management and treatment of patients, supported by the CNM II from the MAU, and nursing staff which included Advanced Nurse Practitioners (ANPs) and candidate ANPs (cANPs). Attendances to the IU self-presented, and patients with minor injuries, aged five years and older were accepted. A patient information leaflet outlining what injuries could and could not be treated in the IU was available for patients online and also at the hospital. The hospital recorded 7,490 attendances to the IU in 2021 and 10,883 in 2024, an increase of 3,393 (45.3%). There were 3,883 attendances in 2025. Documents provided to inspectors indicated there was approximately 250 (2.3%) and 136 (3.5%) 'deferred care' in 2024 and 2025 respectively, related to capacity of the unit to see attendances on the day of presentation. Inspectors were informed that a meeting had taken place to seek an additional NCHD to mitigate this occurrence. Overall figures for 2024 and 2025 indicated 91.2% and 88.3% of patients were assessed and discharged within four hours respectively. There were 10 (0.09%) patients in 2024 and 8 (0.2%) in 2025 that required protocol 37 transfer to an emergency department in an acute hospital.

The IPCC supported and oversaw the implementation of the hospitals infection prevention and control programme.[***] It was clear from documents reviewed by

[§§] The Emergency Inter-Hospital Transfer Policy Protocol 37 had been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

[***] An agreed infection prevention and control programme as outlined in the National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services (2017),

inspectors that the IPCT were meeting audit plan objectives. The hospital did not have a dedicated antimicrobial pharmacist, and while the hospital had access to consultant microbiologist advice 24 hours a day, seven days a week, there was limited consultant microbiologist hours assigned to the hospital. Inspectors were informed that assurance could not be provided in relation to antimicrobial stewardship (AMS), and an AMS programme [†††]was not in place. While endoscopes were decontaminated on-site in MGH endoscopy department, the hospital used the services of an external company to process, decontaminate and sterilise RIMD's used in theatre. A service level agreement was in place and a risk assessment had been completed. A number of PPPGs had been developed, outlining the process and steps taken to assure the hospital management of the quality assurance of the process.

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. MGH had the following Early Warning Systems (EWS) in place to support the recognition, escalation and response to the deteriorating patient; INEWS, PEWS and IMEWS. Inspectors were informed that there was an assigned consultant lead for the deteriorating patient which included sepsis. There was a CNM II for the deteriorating patient, who had a dual role as a resuscitation officer. The CNM II reported to the CNM III clinical development coordinator, who reported to the DON. The hospital had a policy for the Management of the Deteriorating Adult Patient, and an operational policy for the MAU, both of which included detail on emergency inter-hospital transfer of patients requiring a higher level of care.

On-site hospital pharmacy services were available Monday to Friday (9am to 5pm) and the ADON could access the pharmacy out-of-hours if required. A clinical pharmacy[‡‡‡] service was provided to the inpatient wards. Inspectors saw evidence of pharmacy-led medication reconciliation in the inpatient areas visited, which at the time of HIQAs previous inspection was not being conducted consistently within the hospital. Inspectors were informed that medication reconciliation was completed by the NCHD on assessment of patients in the MAU, however evidence of this practice was seen in only one of three Medicines Prescription and Administration Record's (MPAR's) reviewed. Similar to findings in the previous HIQA inspection (2023) there was not a formal medication safety programme for the hospital.

At the time of inspection the TOCC had been re-established and the hospital had a number of PPPGs to support patient flow through the hospital. The hospitals CNM III for patient flow, and CNM II discharge coordinator were responsible for the daily operational

sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

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

[‡‡‡] A clinical pharmacy service is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

management of admissions and discharges (to include complex discharges) respectively. The hospital collated data on admission and discharge activity, and also delayed transfers of care (DTOC). Review of documentation and the HPSIR indicated there were approximately 5,073 inpatient discharges in 2024, and 793 in the first two months of 2025. At the time of inspection the average length of stay for medical patients was 5.8 days in 2024 and 6.1 days in 2025, below the HSE national target of less than seven days. The DTOC threshold was two, and daily numbers of DTOC recorded by the hospital ranged from one to eight. On the first day of inspection there were two DTOC recorded. Weekly meetings were convened with consultants to discuss patient discharges. There was a weekly regional DTOC forum, and an egress meeting convened every six weeks, both of which included attendance by hospital and regional colleagues. The discharge coordinator also communicated with community colleagues on a weekly basis to support hospital discharge.

While inspectors found that there were effective management arrangement structures and mechanisms in place to support and promote the delivery of high quality care, safe and reliable healthcare services, areas for focussed improvement included the:

- development of a medication safety programme
- consistency with medication reconciliation conducted in the MAU
- progression of an antimicrobial stewardship programme.

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.

Mallow General Hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services provided, relevant to the size and scope of the hospital.

Information on a range of clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with HSE reporting requirements. This data provided assurances to the SMT at fortnightly meetings. A HPSIR, signed by the hospital manager as the SAO, ensured oversight of reports and minutes reflected the December HPSIR data was discussed at QSRC. The most recent publically available online HPSIR report was November 2024. There were risk management structures in place to proactively identify, manage and minimise risk. The hospital maintained a hospital corporate risk register where risks identified had existing and additional control measures required to mitigate risk, the register was reviewed on a quarterly basis. The

QRM reported to the hospital manager and was a member of the SMT. Risk management was a standing item on the fortnightly SMT agenda, and the QRM provided updates at each meeting. A number of staff in the clinical areas visited were unaware of the risks on the departmental risk register, or frequency of review. Inspectors were informed that training had not been provided on developing risk assessments, however staff noted, the QRM supported this function and could be readily contacted for advice. QPS dashboards were collated for the hospital, ensuring governance and oversight of risk at both regional and hospital level, and will be discussed further under standard 3.3.

Patient-safety incidents were reported directly on the National Incident Management System[§§§] (NIMS) through an electronic direct point-of-entry (ePOE) which became operational in MGH in October 2024. The benefit of this system included the availability of real-time data on incidents or near misses, and prompts to review and commence risk mitigation processes. Incidents were rated by number, category and severity, were tracked and trended by the QRM and discussed at the fortnightly SMT meetings. Inspectors were informed, and were provided with evidence that the majority of incidents reported were classified as category three, minor-negligible. The SIMT would be convened in response to a category one incident occurrence, in line with the HSE Incident Management Framework (2020).

Infection prevention and control surveillance data was submitted monthly to the HSE BIU. The hospital monitored and reported the use of reserve antimicrobial Meropenem to the HSE BIU on a monthly basis and this will be discussed further under standard 2.8. However the hospital could not provide assurance around antimicrobial stewardship and there was no AMS programme in place. Inspectors were provided with the IPC and deteriorating patient audit schedule for 2025 to 2026 however no audits related to medication safety or TOC were listed.

Medication safety audits were conducted at ward level as part of nursing metrics however the pharmacy did not have an annual audit plan developed. Inspectors were informed the TOCC had planned to implement an audit schedule. Audit results were discussed at committee meetings and evidence of associated quality improvement plans were provided to inspectors for areas of non-compliance.

Scheduled care activity was monitored by the hospital, and extracted from the in-patient management system (IPMS) and was publicly available through the national treatment purchase fund (NTPF) website. The hospital did not have a formal process for clinical audit, but inspectors were informed that clinical audits were being conducted. There was evidence that the NIES (2024) results had been discussed with hospital staff.

[§§§] The National incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State's Claims Agency (Section 11 of the National Treasury Management Agency Act 2000 as amended).

Inspectors were satisfied that Mallow General Hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services, areas identified for improvement included the:

- development of an annual audit schedule for transitions of care
- development of an annual audit plan for medication safety.

Judgment: Substantially Compliant

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

Inspectors were provided with a breakdown of the whole-time equivalent[****] (WTE) workforce for the hospital. The hospital had approval for eight WTE medical consultants, seven were in post and there was one short term leave. Minutes reflected that one locum consultant would commence in June 2025. One consultant radiologist and two WTE surgical consultants were approved and in post. A consultant microbiologist was assigned eight hours a week to MGH by the SWR, and advice was available through the regional model four site. MGH had approval for 29 NCHD positions as follows: nine WTE registrars, with seven WTE's in post and the remaining two WTE filled through agency; 11 WTE senior house officer's with 8.75 WTE in post and two WTE filled through agency, leaving a deficit of 0.25 WTE; six WTE interns approved and in post. There were three emergency department registrar WTE posts approved for the injuries unit, with two WTE's in post and the remaining one WTE filled through agency. All MGH Consultants were on the Irish Medical Council (IMC) Specialist Register. Senior management outlined the process in place, which included completing a risk assessment, signed by the clinical lead, in the event that a locum consultant was required who was not on the IMC specialist register.

The nursing WTE to include all grades was 166.37 WTE, 150.8 WTE were in post with a 15.57 WTE deficit. Staff on St Joseph's ward rotated through the high dependency unit, and nursing and HCA staff were rostered between the MAU and IU. There was 42 Healthcare Assistant (HCA) posts approved with 38.41 WTE in post and a deficit of 3.59 WTE. Gaps within the nursing roster were managed at local level.

There were 9.5 WTE HSCPs approved and in post to include a social worker. There was one WTE executive pharmacy manager approved with 0.86 WTE in post, three WTE

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

senior pharmacists approved with 2.42 WTE in post due to short term leave. There was approval for one staff grade pharmacy technician with 0.88 WTE in post.

MGH had 2.5 WTE medical scientists approved with 2.57 WTE in post, and one WTE laboratory assistant post filled trough agency. Due to the current staffing level, the laboratory operated Monday to Friday (9am to 5pm), outside of these hours, support was provided by the regional model four site. Approval for a further two WTE medical scientists had been provided however recruitment was unsuccessful. The ability to recruit and retain staff to meet the needs of MGH healthcare service was recorded as a high rated risk on the hospital corporate risk register and management continued to review this risk on a quarterly basis.

While there was a deficit of 10 WTE approved posts within support staffing, four WTE posts had been filled through agency. Since the previous HIQA inspection (2023) there was one WTE grade VI, human resources (HR) in post, however the hospital manager maintained oversight of HR within the hospital.

Compliance with mandatory and essential training ranged from 75% to 100% in the clinical areas visited. 100% nursing staff in the MAU and IU had completed INEWS, PEWS and IMEWS training. Overall mandatory and essential training records for the hospital, provided to inspectors post inspection showed compliance was an area requiring focussed improvement across specialities. This was also a finding in the previous HIQA inspection report (2023). Standard and transmission based precautions ranged from 52% to 75%. Hand hygiene training was mandatory every two years, and compliance ranged from 54% to 80%. Medication safety ranged from 36% to 50%. INEWS was 56% for nursing to 61% for clinical staff. IPEWS and IMEWS training records were provided for nursing staff only and measured 63% and 75% respectively. Basic life support was recorded as 85% for nursing staff and 65% for HCA's, however no training records were provided for clinical staff. Inspectors noted that the hospital had a staff member who had completed a BLS 'train the trainer' course to facilitate training on-site. Advanced cardiac life support (ACLS) training had been completed by 35% of nursing staff. Focus on ACLS training for nursing was in areas such as the high dependency unit, MAU, IU and nursing management. 54% of clinical staff had completed the ACLS. Clinical handover ranged from 42% for clinical staff to 65% nursing. 63% of nursing staff were trained in the use of non-invasive ventilation (NIV) and 40% in the use of AIRVO. In line with the hospitals PPPG, NIV was commenced by clinicians, who also determined NIV settings in response to changes in the patient's clinical status. However NIV training records for clinical staff was not provided. 100% nursing staff had completed integrated discharge planning.

Staff absenteeism rates were tracked, the rate for MGH from January 2024 to April 2025 ranged from 4.83% to 10.03%, this was above the HSEs target of less than or equal to 4%. Employees were supported by their line managers through back to work interviews, and could seek assistance from the hospital HR resource. Staff could avail of the

employee assistance programme (EAP), and could be referred to occupational health within the regional service, if required.

While inspectors found the workplace arrangement in place in the hospital supported and promoted the delivery of high-quality, safe and reliable healthcare. Areas for focused improvement include:

- address actual or potential risk posed by the reported absenteeism rate
- improvement with overall hospital compliance related to mandatory and essential staff training to include medication safety, BLS, EWS and non-invasive ventilation.

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. Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support and safe care and support. Mallow General Hospital was found to be compliant with four national standards (1.6, 1.7, 2.7,3.3) and substantially compliant with three national standards (1.8, 2.8, 3.1). Key inspections findings informing judgements 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 observed staff interacting and engaging with patients in a respectful, considered and kind way. Staff were observed knocking on patient room doors prior to entering. Patients were assisted with their individual needs, privacy curtains were used while providing care and call bells were available if assistance was required. Patient's healthcare records and personal information was observed to be stored appropriately in the clinical areas visited with the exception of the whiteboard in the MAU where the patient surname was visible. While noting the MAU was not a thoroughfare for unauthorised persons, this was a finding in HIQAs previous inspection (2023). Rooms were available to facilitate private discussion between healthcare staff, patients and families. Information on the HSE complaints and feedback process '*Your Service, Your Say*', independent advocacy services, medication, child safeguarding, sepsis and health related topics appropriate to the profile of patients using the service was also on display. Patients rated their experience of the hospital as 9.4%, higher than the national average result of 8.3%, in the 2024 National In-patient Experience Survey (NIES). In summary, services user' dignity, privacy and autonomy were respected and promoted within the hospital but inspectors recommend review of the whiteboard in the MAU, to ensure the patients surname is not visible.
Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
It was evident to inspectors that a culture of kindness, consideration and respect was actively promoted for people accessing and receiving care at the hospital. Patients with whom inspectors met, were very complimentary of the staff and the care provided to them. Inspectors observed staff to be respectful, kind and caring towards patients in the clinical areas visited. Patients were provided with a selection of food choices. Inspectors observed the 'Nurses Philosophy' on display in some of the clinical areas visited and the hospital had access to translator services to meet specific patient requirements.
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.

The hospital manager was the designated complaints officer, responsible for managing complaints and for the implementation of recommendations arising from review of complaints. The hospital used the HSEs 'Your Service Your Say' (YSYS) 'Management of Service User Feedback for Comments, Compliments and Complaints Policy (2017)'. Local resolution of complaints was promoted. Verbal complaints were not tracked, however the hospital through the QSRC planned to improve the process to capture informal, point of contact complaints. Information posters about the HSE YSYS and advocacy services were displayed in the MAU-IU and Medical 2. However YSYS patient information leaflets were not available. Inspectors were informed by management, and observed information online, the process for individuals to provide feedback to the hospital, the link brought individuals to the HSE YSYS information page. Contact details for the complaints officer, and the access officer for the hospital were provided on the website. There were feedback boxes for patients, located at the main hospital entrance and in the out-patient department. Complaints were tracked and trended, and a quarterly update was provided to the SMT. The hospital had managed 12 stage-two written complaints in 2024 and four in year to date 2025.

Complaints were managed under the HSE complaints management pathway. Post on-site documentation received by HIQA noted complaints were responded to in line with the national HSE KPIs, however the percentage for compliance rates was not provided. While not mandatory, the HSELand learning module on complaints was recommended for staff but there was no evidence that staff had undertaken this module in training records provided to HIQA. Feedback on complaints and compliments was provided to staff in the clinical area that were the subject of the complaint or compliment, and there was evidence of learning from complaints demonstrated to inspectors. The hospital had completed and returned to the SWR in February 2025, a 'Learning To Get Better' self-assessment and action plan template. One action identified will be the introduction of twice-yearly audit of the complaints process with responsibility assigned to the QRM.

In summary, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. Areas for focussed improvement included the:

- consideration of the tracking and trending of verbal complaints
- providing service user friendly and readily available patient information on the HSE '*Your Service, Your Say'* complaints and feedback service in line with the national YSYS policy in place at the hospital.

Judgment: Substantially Compliant

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

At the time of inspection, inspectors observed the overall physical environment in the clinical areas visited was bright, spacious, well-maintained and clean. There was security personnel located centrally within the hospital and authorised access was required to access clinical areas. Patient call bells were available which could only be cancelled at the point of activation.

Wall-mounted alcohol hand gel dispensers were strategically located and readily available for patient and staff use, with signage promoting the five moments of hand hygiene clearly displayed in clinical areas. While hand hygiene sinks were available, not all sinks conformed to national requirements. Inspectors observed appropriate spacing between beds and trolleys in the clinical areas visited, and Medical two comprised of all single rooms. Patients requiring isolation for transmission based precautions were accommodated based on the HSE antimicrobial resistant infection control (AMRIC) national prioritisation guidance. The process was overseen by the infection prevention and control team who communicated with clinical areas on a daily basis from Monday to Friday. Access to consultant microbiologist advice was available which included out-of-hours. Inspectors were informed that there were 55 single en-suite rooms in the hospital to include two in the MAU which had ante-rooms. There were no outbreaks of infection at the time of inspection. Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited with a readily available supply of personal protective equipment (PPE) and instruction on its use. Staff were encouraged to conduct a point-of-care risk assessment (POC RA) when caring for patients and information on POC RA was on display. Inspectors were informed about, and viewed a risk assessment for aspergillosis relating to previous building works that had been undertaken in the hospital. As previously outlined there were adequate shower and toilet facilities for patient use.

Hygiene services in the hospital were provided by hospital staff (7am to 7pm), and external contract cleaners (6pm to 10pm), and the hospital had a combined environmental cleaning and equipment decontamination policy in place. Clinical nurse managers (CNMs) and cleaning supervisors had oversight of environmental cleaning which included cleaning of the bed space following patient discharge, and terminal cleaning[††††]. Hygiene services implemented an increased cleaning schedule during

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

periods of outbreaks. Disposable curtains were in use in clinical areas, were dated when changed and inspectors saw evidence of the hospitals curtain changing schedule. Weekly tap flushing was carried in the clinical areas, and water testing for legionella was conducted on a quarterly basis. Results were discussed at the quarterly IPCHC meetings and the hospital manager had oversight of reports, which were viewed by inspectors. There was evidence in clinical areas of cleaning 'sign off' sheets to indicate that cleaning had been carried out, and there were also weekly cleaning schedules. Overall, at the time of inspection, staff felt there was adequate staffing available to maintain environmental hygiene standards.

Cleaning of equipment was primarily the role of healthcare assistants (HCAs) with oversight by the CNM. Equipment was tagged with an 'I am clean' label once it was cleaned and decontaminated, however inspectors observed lack of consistency with this practice. Environmental audits indicated that in a number of areas, service of equipment was overdue and this was actioned by biomedical colleagues. Staff completed an online request to maintenance if equipment required repair and there was a timely response to requests. Inspectors observed compliance with the storage of medical gases and chemicals. There was authorised access to utility rooms and there was evidence of current service history on equipment seen by inspectors. Instructions on the use of equipment was also available. Coloured cloths were used for differentiating cleaning areas and there were instructions on dilution of cleaning agents. Posters were on display providing instruction on how to deal with bloods spillages. Inspectors observed clinical and non-clinical waste bins, and there was appropriate segregation of clean and used linen.

There was appropriate disposal of sharps, and sharps bins were signed, dated and partially closed. There was adequate storage facilities. There was point of care testing in utility areas, inspectors were informed that devices were monitored by the laboratory to ensure results could be validated. There were dedicated medication preparation areas in the clinical areas with evidence of secure and appropriate medication storage. Drug fridges were locked and there were twice daily temperature checks recorded. Inspectors observed posters on high-risk medications, APINCH[‡‡‡‡], Sound-Alike-Look-Alike Drugs (SALADs), instruction on magnesium and an algorithm for the treatment and care management of hypoglycaemia. Medication information was available for staff through the British National Formulary (BNF 2025), medicines complete online resource, a guide on intravenous medications, a guide on adult injectable medicines, and the EOLAS online application. Since HIQAs previous inspection (2023) the hospital had undertaken capital works, which included the de-commissioning of an in-patient clinical area within the old infrastructure and relocating the bed capacity to a new build.

‡‡‡‡ 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.

In summary inspectors were satisfied that Mallow General Hospital provided healthcare services in a physical environment which supported the delivery of high quality, safe and reliable care.

Judgment: Compliant

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 in order to inform continuous improvement of services. National KPIs in line with HSE national reporting requirements, were used by the hospital to measure the quality and safety of the service it provided. This was further supported by information collected from audit activity, risk assessments, patient safety incident reviews and complaints. Inspectors were provided with the annual IPC and Deteriorating Patient audit schedule.

The infection prevention and control and Hygiene committee (IPCHC) had oversight of infection prevention and control (IPC) practices within MGH. There was one moderate-rated risk on the hospitals corporate risk register in relation to infrastructure. Surveillance data relating to rates of Clostridium Difficile infection (CDI), Carbapenemase-Producing Enterobacterales (CPE), hospital-acquired Staphyloccus Aureus blood stream infections (HA SA BSI) and hospital-acquired COVID-19 was submitted by the hospital to the HSE BIU. The IPCHC provided a monthly report to the SMT and surveillance data for MGH was reviewed at the QSRC. Minutes reflected HCAI rates for 2024: HA SA BSI rate was 0.8 per 10,000 bed days used (BDU), the national KPI target is less than 0.8 per 10,000 BDU; HA CDI rate was less than 1.7 per 10,000 BDU below the national KPI target of less than 2 per 10,000 BDU; HA CPE rate was 0.4 per 10,000 BDU, there is no national target associated with this indicator. There were no reported cases of Methicillin Resistant Staphylococcus Aureus, and there were no HCAIs reported in February or March 2025. Compliance with targeted screening for CPE ranged from 93% to 100%.

Hand hygiene audits were conducted every two months using a standardised tool, audits reviewed by inspectors showed the compliance rates ranging from 85% to 100% across the various clinical areas visited. Overall hand hygiene compliance for MGH was recorded as above the HSE KPI of 90% in 2024. As reflected in minutes from meetings, where hand hygiene audit results showed non-compliance, IPC had provided refresher training and the area was re-audited within one month. Results were available online for each area. Care bundles were also monitored, the results were available and reported to the

IPCHC quarterly. There was evidence that quality improvement plans (QIPs) were in place when results fell below the recommended KPI of 90%. The development of a QIP was the responsibility of the CNM to address non-compliance for areas within their remit with oversight from the IPC team. Equipment and environmental audits were conducted quarterly (with the exception of the high dependency unit, theatre and endoscopy, where audits were conducted monthly) and results ranged from 94% to 100% across the clinical areas visited. Audit results were on display on quality boards in clinical areas visited with associated QIPs.

Inspectors were informed that an annual audit plan had not been developed for medication safety. Staffing had impacted on the ability to conduct audits and this included audit of antibiotic consumption. Inspectors noted medication safety was captured on monthly nursing metrics and audit results for two of the clinical areas visited ranged from 91.5% to 98%. There was no data available at local departmental level relating to medication safety in the MAU-IU. Meropenem restricted antibiotic usage was reported monthly to HSE BIU and there was evidence of a controlled prescribing and dispensing process in place. Usage ranged from 0.79 to 3.07, above the documented usage for a similar sized hospital within the SWR. Inspectors were provided with results from the hospital antimicrobial prudent prescribing indicator (HAPPI) audit 2024, conducted across four clinical areas. Areas for improvement were noted, with a focus for re-audit relating to improving start-stop dates, promote the use of the EOLAS application and accurate documentation of allergy status. An audit of five MPARs relating to the prescribing and administration of insulin was conducted in August 2024 across five clinical areas. Results ranged from 0% to 100%, the audit identified the allergy section was not completed. An associated QIP was developed and documentary evidence provided to inspector's showed actions had been progressed and completed at the time of inspection.

There was strong evidence of audit activity relating to the deteriorating patient including sepsis. An audit of identify, situation, background, assessment and recommendation (ISBAR3) labels ranged from 88% to 93%. INEWS observational chart audits were conducted monthly on five to six charts, and escalation and response audits were conducted quarterly. An associated QIP was developed if results were less than 80%. Inspectors viewed audits conducted in quarter one 2025 across three clinical areas. Overall compliance comparison results with INEWS escalation and response ranged from 73.5% to 96.6%. INEWS observational chart audits ranged from 89.3% to 100%. Compliance with clinical handover for one area was 62.9% to 94.4%. Associated QIPs included education and re-audit. Audits of sepsis forms were conducted at hospital level in 2024 and 2025, associated action plans included training, twice yearly audit and identification of sepsis champions. An audit of 18 patients with suspected or confirmed infection were all escalated for medical review. However, reviewing the patient in a timely manner (66.7%), documenting evidence that a senior doctor was consulted

(73.3%) and that a registrar was consulted if no response to treatment (60%) required improvement. Sepsis forms were commenced (66.6%), INEWS was recorded with the exception of one chart. Of the sepsis forms commenced (12), compliance with documenting: 'time-zero' was (41.6%), the site of infection (91.6%), urine output (69.2%), blood cultures and lactate taken, both (91.6%), antimicrobials administered (83.3%); intra-venous fluids administered (90.9%) and oxygen (88.8%) where required.

The hospital had participated in the national sepsis clinical audit in quarter four, 2024 where compliance with completion of the sepsis six bundle was 57%. There was improvement in the audit since 2022 with the exception of intravenous (IV) antibiotic administration down to 71% from 80% and IV fluid bolus down to 86% from 100%. While an associated action plan was developed, actions were not time-bound. On day two of inspection, inspectors saw evidence of adherence to the sepsis six bundle with two examples provided. Audit results are discussed at the DPC and CNM meetings to ensure learnings are cascaded to relevant nursing and clinical staff. Deteriorating patient audits were only conducted in in-patient ward areas.

Discharge audits using a standardised tool were completed across five clinical areas. Overall compliance ranged from 83.3% to 100% with improvement required in relation to the discharge plan reflecting patient's current condition. Management informed inspectors that they planned to audit predicted dates of discharges, and average length of stay associated with transfers from other acute hospitals. Practice development would commence an audit on clinical nurse handover in May 2025.

It was evident from review of documentation and discussion with senior management and staff, that the results from the NIES (2024) had been discussed with staff through information sessions delivered by the QRM. The hospital had the third highest score nationally and a QIP had been developed relating to discharge and transfer of patients. While there was not centralised coordination for clinical audit, minutes of the QSRC reflected a plan by the hospital to ensure oversight of clinical audit and activity, developing a clinical audit proposal form, similar to other sites within the SWR. Nursing metrics were conducted monthly, using a standardised tool, audits reviewed indicated good compliance. QIPs were developed for areas of non-compliance and updates would be provided to the QSRC. Patient Safety alerts were communicated through the QSRC, and the QRM was responsible for ensuring implementation of required actions. The hospital reported data relating to compliance with the six-hour KPI for the MAU to the acute medicine programme. The hospital participated in the hospital group venous thromboembolism (VTE) audit in quarter four, 2024, where 100% of patients audited were prescribed prophylaxis however a risk assessment was only completed in 9% of cases. VTE was also publically reported on the HPSIR, and the hospital in-patient enquiry (HIPE) system indicated that in one month between November 2024 and February 2025,

MGH was above the national average. VTE rates were discussed at the QSRC and local validation of results was an action arising.

Overall the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information, however areas for continued focus include:

- continuing to drive improvement with EWS
- continuing to drive improvement in compliance with sepsis six
- developing an audit plan for transitions of care
- developing an annual audit plan for medication safety.

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 in place to identify, monitor analyse and respond to information relevant to the provision of safe services related to the four key areas of harm.

Patients admitted to MGH were not universally screened for multi-drug resistant organisms (MDROs).Targeted screening took place in line with specific criteria and based on the result of a risk assessment conducted on admission. All patients admitted to the HDU were screened. Compliance with MDRO screening was audited twice yearly by IPC, compliance ranged from 93% to 100%. The IPMS supported the identification of patients with MDROs by means of an alert symbol. Patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. There were no outbreaks of infection at the time of inspection. Outbreak meetings were convened when required, with Public Health in attendance, The IPC CNS developed the outbreak report, learnings were shared with staff and information was available on the hospital sharefile. The hospital did not have a dedicated AMS pharmacist but pharmacy staff provided advice when required. The hospital had access to consultant microbiologist advice from the regional model four site, and a consultant microbiologist was assigned to the hospital for eight hours a week. The SMT had overall responsibility for decontamination practices in MGH. RIMDs were sent to an external contractor for processing. The endoscopy unit conducted a number of tests on equipment, and water testing was also carried out, both of which provided assurances to the SMT in relation to decontamination.

A clinical pharmacy service was provided at the hospital. There was evidence of pharmacy-led medication reconciliation. Two forms of verification of medications were used, and a tick box on the MPAR indicated when this practice was carried out.

Medication reconciliation was undertaken by the NCHD on assessment of patients in the MAU. Allergy status was recorded on all healthcare records reviewed by inspectors. Posters on high-risk medications, SALADs and APINCH were on display. Controls were in place for prescribing and dispensing restricted antibiotics, which included communication with the medical team and ensuring duration reflected microbiologist advice. In one clinical area, inspectors observed low weight molecular heparin in various strengths stored together, which may have posed a risk, this was brought to the attention of management. The pharmacy manager communicated all Health Products Regulatory Authority alerts to staff through e-mail. The hospital had six nurse prescribers and oversight remained with the DON, supported by practice development. Risk reduction strategies were in place, for example, high-risk medication potassium chloride was not stored at ward level, with the exception of theatre and HDU, where it was stored securely. Alert labels were available for the MPAR to highlight patients on insulin.

Practice development provided refresher training on medication safety, addressing common errors, and pharmacy staff provided education at NCHD induction. Inspectors were informed that clinicians educated patients on medications at the point-of-care regarding side effects, interactions with other medications, rationale for any changes made were provided and documented on the GP letter. Clinical nurse specialists provided advice on medication, specific to the cohort of patient. The QRM was scheduled to meet every two months with the executive pharmacy manager to ensure appropriate oversight of risk in relation to medication safety.

The hospital had a PPPG for the management of the deteriorating patient using the EWS. The PPPG included 'cues for caution' for patients on night time BIPAP or home oxygen, and the emergency response with strong consideration given to transferring a patient to a higher level of care in the absence of a critical care unit or anaesthetic personnel. The MAU had an operational PPPG outlining the procedure to be followed in the event that a patient required transfer to an acute setting which provided a higher level of care.

The PPPG included the emergency inter-hospital transfer (protocol 37) request pro-forma, or request for a mobile intensive care ambulance service (MICAS) transfer which operated Monday to Friday (9am to 5pm) from the regional model four site. Minutes reflected that timely review of acutely unwell patients was discussed by the SMT. Through discussion with management and staff, inspectors were informed that the hospital took a proactive approach to recognising the deteriorating patient, which included review by a senior decision maker, and establishing a ceiling of care in collaboration with patients and their families to ensure patients were not transferred inappropriately. Awareness relating to requirements to transfer was discussed with NCHDs on induction. Staff could escalate any concerns to the hospital manager, consultants or the DON as appropriate, and inspectors were informed the consultant on-call attended on-site to MGH at weekends. The hospital conducted monthly simulation

training. Education sessions were conducted every two weeks and the range topics included heart failure, sepsis, acute stroke, heart rhythm recognition, gastro-intestinal bleed. NCHDs stated they received good support and supervision from consultants and could link with grand rounds in the regional acute model four site. Critical laboratory and radiology results were communicated in a timely manner. Patients for low risk elective day procedures were pre-assessed. Awareness was raised in relation to the rationale to use IMEWS, potential presentations and the importance of history taking. NCHDs acknowledged there was a strong focus on sepsis in MGH and nurse sepsis champions had been identified.

In discussion with staff and on review of minutes, paediatrics aged five years and above were accepted to the injuries unit. In line with the current service provision of the hospital, intervention for the management of a deteriorating child, should it arise, was limited and required transfer to an appropriate healthcare setting. The hospital did not have anaesthetic personnel employed in the hospital and consultant anaesthetic cover was arranged for elective day-case procedures. The hospital cardiac arrest team conducted weekly safety huddles, and convened monthly meetings. Occurrence of, and outcomes following cardiac arrests were monitored by the hospital. Forty in-patients in 2024, and eight in 2025 required transfer to a higher level of care setting. Three patients in total from day-care and endoscopy required transfer in 2024.

Non-invasive ventilation (NIV) was available for use in the hospital and an approved PPPG was in place since May 2025. The policy set out the indications and contra-indications for commencement of NIV and the step-by-step process to use the equipment with photographs to guide the healthcare worker. As referenced in standard 6.1, training records for clinicians in the use of NIV equipment was not provided, and training was not identified as a role or responsibility for clinicians in the PPPG. However the decision to commence NIV was made by clinicians, who determined the appropriate NIV settings, which were adjusted according to the patients clinical condition. Inspectors discussed training with management at the time of inspection and were informed the clinical facilitator provided training on NIV and would support clinical areas where required. Training in the use of NIV requires improvement in a timely manner.

Referral to the MAU from a GP was through a phone call to the unit, once the medical registrar accepted the patient, an appointment time was provided. The NAS contacted the consultant on-call, who accepted the patient if their care needs could be met in MGH. MGH facilitated an information meeting with GPs to raise awareness of inclusion criteria for the MAU. INEWS was used in the MAU, and IMEWS where appropriate. There was an MAU booklet where staff recorded vital signs, medications, INEWS, ISBAR. The booklet included a sepsis screening form with algorithm, and if the discharge plan was discussed with the patient or family. Information on the MAU whiteboard provided a detailed

overview of the patient requirements to include time-critical medications. Three formal safety huddles were conducted daily (11.30am, 2pm, 4pm), with the CNM for patient flow, NCHD, consultant and nursing staff in attendance. Inspectors were informed that the nursing staff conducted two additional informal safety huddles. A quality board in the MAU provided information on topics such as airway management, chronic obstructive pulmonary disease inhaler guide, and audit results with associated QIPs. The hospital had four nurse prescribers for ionising radiation with oversight provided by the consultant radiologist. Point of care testing available in the MAU (D-dimer, C-reactive protein, blood gas analysis) improved turnaround times, and laboratory staff validated point of care devices. Documentation for patients discharged from the MAU included a GP letter, prescription if required, follow up plan for diagnostics or review, and a nursing discharge letter.

The TOCC was re-established with initiatives such as audit of predicted date of discharge planned. An updated letter for transferring patients to another care setting had been implemented. Documentation required for transfers to MGH included a photocopy of the MPAR, a nursing, and a clinical transfer letter, and a letter for any other service required. Risks identified included documentation accompanying transfers to MGH, when this arose, MGH linked directly with the healthcare setting in question. The age profile for MGH was the older adult, and the hospital conducted a clinical frailty assessment. There were twice daily safety huddles conducted at ward level and a daily multi-disciplinary hub using ISBAR, at 12 noon. The hospital had the following patient flow pathways in place; (8am-8pm), patients were streamed through the MAU with exception of some patients from out-patients department or day-care. Admissions were managed by the patient flow CNM or ADON. For admissions between (8pm-8am), there was a discussion with the GP and registrar on-call. Self-presenters were assessed in MAU, and admitted if required, or referred to the most appropriate healthcare setting, or to their GP. The hospital had a selection criteria if surge capacity was used.

Risks were discussed at committee meetings and escalated to the hospital manager if the risk could not be managed at local or committee level. The hospital corporate risk register was reviewed quarterly, corporate and clinical risks were escalated, where required, to the regional service. Oversight of risk was the responsibility of the hospital manager as the SAO. Due to staffing, the laboratory service within MGH operated from Monday to Friday (9am to 5pm). The hospital had a contingency in place with the regional model four site in relation to out-of-hours blood sample analysis, and cross-match of blood for day-case procedures where required. A service level agreement was in place but required review since December 2024. In the event of an emergency arising within the hospital, universal donor blood was available. At the time of inspection patients requiring a blood transfusion for medical reasons, attended the regional model four site and returned to MGH following the transfusion. SMT minutes reflected that measures

to provide a blood transfusion service for inpatients in MGH was being addressed.

The NTPF was used to access scheduled care in other hospitals to positively impact on the hospital waiting list. In discussion with management and reflected in minutes, the paediatric out-patient Ear Nose and Throat (ENT) waiting list was a challenge. There was sessional visiting to MGH and the availability of ENT services within the region was having an impact on MGH.

The hospital had a number of PPPG's, some of which required review and updating. National PPPPGs relating to IPC, risk, incident management and YSYS were in use. Theatre and endoscopy PPPGs outlined the referral process, determination of suitability to have the procedure conducted in MGH, triage process and pre-assessment. The laboratory had a PPPG relating to accessing blood, outlining the alerts in place should the product exceed timeframes. A discharge policy was in draft format. While there had been no reported incidents related to safeguarding or absconsion, the hospital did not have an absconsion policy in place. PPPGs were available on the hospital Q-Pulse document management system, when developed were discussed at relevant committees, following stakeholder feedback, were reviewed by the QRM and SMT before final approval.

In summary inspectors were satisfied that the hospital had systems in place to identify, monitor analyse and respond to information relevant to the provision of safe services Areas for focussed improvement included the;

- review and update of PPPGs
- provision of training in the use of non-invasive ventilation for clinical and nursing staff
- continued review of any risks associated with current operational hours of the laboratory service.

Judgment: Substantially Compliant

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

Mallow General Hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines.

The hospital had introduced the electronic point of entry NIMS system and there were 682 reported incidents in 2024, and 186 in the first four months of 2025. Compliance with the HSE national KPI of 70%, where incidents are reported onto NIMS within 30

days stood at 52% in 2024, improving to 100% in 2025. Incidents included three serious reportable events (SREs) in 2024 and one in 2025. At the time of inspection, inspectors were informed there were no open SREs and no serious incidents (SI's) had been reported. There were three incidents requiring further follow up related to the four key areas of harm. Incidents were tracked and trended and the hospital received QPS dashboard reports from the SWR providing detail on the number and type of incidents, risks and complaints. However inspectors noted some variance in the number of incidents in the QPS dashboard and post on-site documentation submitted to HIQA.

Medication incidents were assigned a National Coordinating Council Medication Error Reporting and Prevention (NCC MERP) classification. Entry onto NIMS included 88 medication incidents in 2024 and 79 in 2025, however not all incidents had been assigned a MERP classification. Three were classified as 'E' and one assigned as 'F'. The hospital reported the rate of healthcare-associated infections on a monthly basis to the HSE BIU. The hospitals SIMT provided oversight and management of SREs and SIs in line with the HSE Incident Management Framework (2020). Staff who spoke with inspectors were knowledgeable about the incident reporting process, and staff were aware of the most common patient-safety incidents. However a number of staff did not have experience reporting an incident onto NIMS. Minutes of meetings reviewed indicated that reporting of incidents in 2025 had decreased comparative to quarter one, 2024. Learning from incidents was shared with staff at departmental level, the QRM provided monthly reports to departments. Incidents were a standing agenda item for committees meetings to include the SMT, however minutes reflected that incidents had not been discussed at the three most recent medication management committee meetings.

Inspectors were satisfied that the hospital had patient-safety incident management systems in place, but recommend that the hospital raise awareness amongst staff to ensure all incidents and near misses are reported and ensure all medication errors are assigned NCC-MERP classifications.

Judgment: Compliant

Conclusion

Capacity and capability

While inspectors were assured that there were formalised clinical and corporate governance structures in place in Mallow General Hospital, clarity was required on the regional reporting structures and a schedule for regional performance meetings was outstanding. Terms of reference required review and updating for a number of

committees. Activity within the hospital was well managed. Both the Injuries Unit and Medical Assessment Unit had seen significant increases in attendances since 2021, both departments were operating effectively. The hospital had effective workforce management arrangements in place. Similar to HIQAs previous inspection findings in 2023, mandatory and essential staff training was an area that required focussed improvement in particular, training related to the use of non-invasive ventilation and basic life support. Due to staffing the laboratory operated during core hours Monday to Friday, contingency measures had been put in place and management were monitoring the service provision.

Quality and Safety

It was evident to inspectors that there was a strong collaboration between the senior management team, clinical and hospital staff, with a focus on the quality and safety of the healthcare provided. Inspectors were informed that there was an emphasis on recognising the deteriorating patient, to ensure escalation of care to an appropriate hospital setting. Paediatrics aged five years and above were accepted to the injuries unit, in line with the current service provision of the hospital, intervention for the management of a deteriorating child, should it arise, was limited and required transfer to an appropriate healthcare setting. The hospital did not have anaesthetic personnel employed in the hospital and consultant anaesthetic cover was arranged for elective day-case procedures. Incidents were reported and managed in line with national guidelines. Local resolution of complaints was promoted, however verbal complaints were not tracked. The HSE complaints and feedback process '*Your Service, Your Say'* (YSYS) was on display in some of the clinical areas visited, but the hospital should make available YSYS patient information leaflets. The hospital did not have an antimicrobial stewardship programme. There was evidence of audits related to the four key areas of harm and associated QIPs developed and on display in clinical areas visited, however an annual medication audit plan should be developed. Patients and families with whom inspectors spoke with were very complimentary of the care they received and this was consistent with what inspectors observed on the day and in line with the 2024 NIES findings.

Following the inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress of the hospital in implementing the short, medium and long term actions being employed to bring the hospital to full compliance with the national standards assessed during inspection.

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality,	Compliant

safe, reliable care and protects the health and welfare of service users.	
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.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for Mallow General Hospital.

Inspection ID: NS_0142

Date of inspection: 07 and 08 May 2025

Compliance plan provider's response:

Standard	Judgment
6.1. Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Partially Compliant
1. The hospital will continue to closely monitor absenteeism rates. 2. Actively manage absenteeism via the managing attendance policy within the HSE. 3. Support will continue to be provided to staff via line management, occupational health and the employee assistance programme to maximise staff attendance at work. 4. Risk assess services that experience staff absenteeism and adjust service provision accordingly. 5. Prioritise mandatory and essential staff training to focus on medication safety, BLS, EWS and non-invasive ventilation.	
Timescale: Immediate and ongoing	