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:	Letterkenny University Hospital
Centre ID:	OSV- 0001039
Address of healthcare service:	Kilmacreenan Road Ballyboe Glencar Letterkenny Co Donegal F92 AE81
Type of Inspection:	Unannounced
Date of Inspection:	01/07/2025 and 02/07/2025
Inspection ID:	NS_0151

About the healthcare service

Model of hospital and profile

Letterkenny University Hospital is a model 3* HSE public acute hospital. It is a member of and is managed by the HSE West and North West Regional Health Area†. Services provided by the hospital include:

- accident and emergency care
- acute medical in-patient services
- emergency and elective surgery
- surgical post-operative care unit (SPOCU)
- critical care
- oncology and haematology
- coronary care
- renal dialysis and urology services
- maternity and neonatal care
- paediatric services
- diagnostic services
- symptomatic breast centre
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	378 inpatient beds 9 day-case beds

*A model 3 hospital typically admits undifferentiated acute medical patients, provides acute surgery, acute medicine, and critical care. They typically have a category 1 or 2 Intensive Care Unit (ICU) and may have a high dependency unit (HDU).

† The HSE West and North West Regional Health Area provides health and social care to people living in Donegal, Leitrim, Sligo, West Cavan, Mayo, Galway and Roscommon.

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 publicly available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

[‡]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.

Capability and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

- **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.

- **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)
01/07/2025	*09:00 – 18:00hrs*	Robert McConkey	Patricia Hughes Denise Lawler Laura Byrne
02/07/2025	*09:00 – 16:45hrs*	Same as above	Same as above

Information about this inspection

An unannounced inspection against the *National Standards For Safer Better Healthcare* was undertaken at Letterkenny University Hospital on 01 and 02 July 2025. The hospital had previously been inspected against those standards in November 2023 and November 2022.

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

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

The inspection team visited four clinical areas:

- Emergency department (ED) including the acute medical assessment unit (AMAU)
- Medical 6
- Medical 8
- Surgical 2.

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

- Representatives of the Hospital's Management Team (HMT), quality and safety, complaints management, facilities, and HR.

- Representatives from each of the following committees or work streams:
  - Infection Prevention and Control
  - Medication Safety
  - Deteriorating Patient
  - Transitions of Care
- Staff from a range of disciplines in the various clinical areas inspected.

Acknowledgements

§ 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.

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.

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

As part of this inspection, inspectors visited the emergency department, which operates 24 hours a day, 365 days a year and is supported by an acute medical assessment unit (AMAU). The emergency department provided care for undifferentiated adult, maternity and paediatric patients with acute and urgent illness or injuries. Attendees to the emergency department at Letterkenny University Hospital presented by ambulance, were referred directly by their general practitioner (GP), or self-referred.

Inspectors observed staff in the emergency department actively engaging with patients in a respectful and friendly manner. Children and their parents could be cared for in a designated paediatric zone, which was audio-visually separated from the main waiting area. Inspectors observed that patients in corridor care did not always have access to call bells, although they were positioned close to the nurses' station. Inspectors spoke with patients in the emergency department to hear their experience of the care received on the day of inspection. Patients described staff as "*kind*", "*apologetic*", and "*doing their best*". A few patients reported long waiting times after having been triaged. Inspectors found that where this occurred, it was because the person was classified as less-urgent and not in need of a cubicle immediately, whereas other people needed a cubicle more urgently based on their triage classification. Another patient described the waiting area as cold and uncomfortable, and noted that they were not offered refreshments during their wait. This was raised with hospital management who advised that breakfast, lunch and dinner is served to all patients who are admitted to the hospital but awaiting a bed in the hospital. Patients waiting in the emergency waiting room can purchase refreshments in the vending machines or visit the hospital canteen. Some patients commented on the poor cleanliness of toilet facilities. Inspectors observed that the comment boxes had no available feedback cards for use and posters were inconsistently displayed in the emergency department. A patient raised an issue re the variety of uniforms being worn by staff and being unable to know who was who. This was raised with the general manger who acknowledged that there are a lot of different uniforms in place and that while there are posters displaying these, circulation will be increased to assist patients.

Inspectors observed kind and respectful interactions between staff and patients across all clinical areas visited. Patients described staff as "*fantastic*", "*very obliging*", and "*always doing more*". Patients told inspectors that they "*get very good care*" and that "*nurses are powerful*". Staff on the wards were observed assisting patients with mobility, hygiene, and meals, and promoting patient dignity through the use of privacy curtains and appropriate communication.

Patients who spoke with inspectors in the ward areas were not always aware of the formal complaints process in use at the hospital. This is discussed further under National Standard (NS) 1.8.

Overall, there was consistency between what inspectors observed in the emergency department and the clinical ward areas visited, and what patients told inspectors about their experience of receiving care in those areas.

Capacity and Capability Dimension

This section describes the themes and national standards relevant to the dimension of capacity and capability. It outlines the national 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 national standards related to workforce.

Overall, the hospital was deemed to be substantially compliant with one of the four national standards assessed (NS 5.2) and partially compliant with the three remaining national standards (NS 5.5, 5.8 and 6.1). This represents a decrease in compliance in these standards from the 2023 inspection when there was substantial compliance with both NS 5.2 and 5.8 and partial compliance with NS 5.5 and 6.1.

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

At the time of inspection, Letterkenny University Hospital was transitioning to the national (since 2024) HSE Regional Health Area model. A draft organogram outlining the proposed structure and reporting lines was provided to inspectors. The IHA structures were scheduled to become fully operational at the beginning of March 2026. Under this structure, acute hospitals and community care were aligned within an Integrated Healthcare Area (IHA) which is a sub-division of the HSE West North West (WNW) health region.

There were four IHAs within this region and Letterkenny University Hospital was in the IHA for Donegal. The hospital general manager at Letterkenny University Hospital reported to the IHA manager who in turn, reported to the Regional Executive Officer (REO). The REO of HSE WNW reported to the Chief Executive Officer of the Health Service Executive (HSE).

At the time of inspection, interim arrangements were in place, including weekly meetings between the IHA manager and the Letterkenny University Hospital general manager. Inspectors were informed by hospital management that these meetings largely took the form of a 1-1 review of issues between the IHA Manager and the Hospital Manager. In parallel with this process some elements of the former Saolta Governance Structure were retained, for example, performance monitoring of hospitals within the region continued to meet under the chairmanship of the Regional Clinical Director (for the previous Saolta Group, now RHA) Urgent and Emergency Care Governance Meeting, while the previous Saolta Scheduled Care Governance Group Meeting continued to meet under the leadership of a designated IHA Manager. Both the Chief Clinical Director and IHA Manager reported to the Regional Management Team and the REO. At the time of inspection, these meetings were not yet supported by documented terms of reference, defined membership, or formal minutes.

There were clearly defined governance arrangements in place at Letterkenny University Hospital as previously found in 2023. The hospital had a directorate structure in keeping with those found in 2023 but the reporting structures external to the hospital were reported to be transitioning to the recently established regional health area (RHA). The two managed clinical and academic networks (MCANs), women and children's, and cancer and the four directorates, medicine, perioperative, radiology and pathology were reflected in the hospital's governance organogram and each reported to the HMT. The directorates and MCANs were led by associate clinical directors who reported operationally to the hospital manager and clinically to their

respective clinical directors of the directorate or MCANs and who, in turn reported to the regional clinical director of HSE WNW health region.

The hospital had established governance committees with documented terms of reference, defined membership, and scheduled meeting frequencies. These included the Hospital Management Team (HMT), the Quality and Patient Safety Committee (QPSC), the Infection Prevention and Control and Antimicrobial Stewardship Committee, the Drugs and Therapeutics Committee, the Deteriorating Patient Committee, the Unscheduled Care Governance Group, and the Patient and Family Experience Forum. Minutes and agendas were submitted for each committee, with evidence of structured reporting, action tracking, and multidisciplinary attendance.

Hospital Management Team

The terms of reference for the HMT dated May 2024 outlined the committee's purpose, objectives, membership, reporting relationships, and meeting frequency. The committee was responsible for overseeing hospital performance, risk management, and strategic planning. The schedule of meetings was twice per month. It was chaired by the general manager. Membership included clinical, corporate, and operational leads, with representation from each directorate and MCAN. While the terms of reference stated that HMT members were expected to participate in monthly performance review meetings with the Hospital Group Executive Management Team, these meetings were not yet taking place at the time of inspection as the hospital group was still transitioning to the new regional health model.

Minutes from HMT meetings held in May and June 2025 demonstrated satisfactory attendance by the members. There was evidence of structured governance practices, including directorate and MCAN-level reporting, action tracking, and escalation of risks. Risks discussed included staffing deficits in the colposcopy service and an unrelated issue of 24 hour, seven day access to a maternity theatre for obstetric cases and emergencies located in the Delivery Suite. Inspectors sought and received further assurances on both these issues from senior hospital management after the inspection. Inspectors found that access to theatre for maternity cases was via the maternity theatre between 8am to 5pm Monday to Friday and via the main theatre outside of these hours. Discussions had taken place between the hospital management and the HSE WNW region to seek to provide additional staffing to enable 24/7 access to the theatre within the delivery suite, however funding was not available and so access to main theatre out-of-hours was continued.

The HMT minutes reflected engagement with national quality initiatives, including the National Maternity Experience Survey.

Quality and Patient Safety Committee

The Quality and Patient Safety Committee (QPSC) was a key governance forum responsible for overseeing quality improvement, risk management, incident management, complaints and service user feedback. The committee met monthly and was chaired by the general manager. It reported to the HMT. Membership was multidisciplinary and included senior clinical, nursing, midwifery, operational, and the patient advice and liaison (PAL) co-ordinator.

The committee's terms of reference were in date and appropriate to its function. Minutes from meetings held in February, March, and April 2025 demonstrated satisfactory attendance from the membership, continuity across meetings, structured agendas, and appropriate escalation of risks. The committee reviewed departmental reports, action logs, and updates on incidents, complaints, litigation, and service user feedback. Concerns regarding incomplete discharge letters and electronic discharge prescriptions were raised at all three meetings, with the issue explicitly noted as a patient safety concern. Pharmacy and IT were engaged to implement system improvements, and further training was planned.

Training records were a recurring theme, with fragmented systems noted and work underway to consolidate data into a single human resource (HR) managed database. Complaints were consistently referenced, and the committee monitored resolution timelines against HSE targets. Good practice was evident in the committee's oversight of quality improvement plans, risk register updates, and service user engagement through PALS.

Infection Prevention and Control and Antimicrobial Stewardship Committee

The Infection Prevention and Control and Antimicrobial Stewardship Committee met monthly and was chaired by the general manager or the assistant general manager. Membership was multidisciplinary and included medical, nursing, antimicrobial stewardship (AMS) pharmacist, QPS and IPC staff. The committee's terms of reference were in date and outlined its responsibilities for surveillance, outbreak management, AMS, and compliance with national IPC standards.

Minutes from meetings held in March, April, and May 2025 demonstrated structured reporting and follow-up on actions. The committee reviewed hand hygiene compliance, care bundle audits, carbapenemase producing *enterobacterales* (CPE) screening, and environmental hygiene. Quality improvement plans were developed in response to audit findings, and monthly IPC reports were submitted to the QPSC. The committee also monitored training uptake and supported the rollout of the hospital's audit tool.

Drugs and Therapeutics Committee

The Drugs and Therapeutics Committee met at monthly intervals with a minimum of every two months. It was chaired by a consultant anaesthetist. Membership included the general manager, pharmacy, nursing, and medical staff. The committee's terms of reference were in date and outlined its responsibilities for formulary management, medication safety, audit oversight, and policy development.

Minutes from meetings held in March, April, and June 2025 demonstrated satisfactory attendance, structured governance practices, including review of medication incidents, audit results, and policy updates. Risks identified included missed meetings due to lack of quorum, under-representation of key staff, and absence of a central medical staff email system. The committee was accountable to the QPSC and was to produce an annual medication safety and antimicrobial stewardship surveillance summary report for the QPSC. Inspectors reviewed minutes from the committee and noted discussion of medication incidents, quality improvement plans and staffing challenges.

Transitions of Care Governance

The Unscheduled Care Governance Group (USCGG) was responsible for overseeing transitions of care, bed management, and discharge planning. The committee was chaired by the general manager or deputy hospital manager. Membership was multidisciplinary and included representatives from acute and community healthcare services. It met monthly, although meetings in May and June 2025 were cancelled due to the quorum not being met. The terms of reference were approved in July 2025, following the inspection.

Minutes from meetings held in February, March, and April 2025 demonstrated satisfactory attendance, structured reporting on patient flow, delayed transfers of care, and escalation protocols. The committee reviewed discharge barriers, utilisation of outpatient parenteral antimicrobial therapy (OPAT), and implementation of the SAFER bundle (a practical tool used to reduce delays and length of stay while improving safety and patient flow). A deep dive report was submitted post-inspection, tracking patients with prolonged stays and identifying actions to support discharge. The committee also monitored implementation of specific quality improvement initiatives and nurse involvement in ward rounds.

Deteriorating Patient Committee

The terms of reference for the Deteriorating Patient Committee were in date. The purpose of the committee was to ensure that the deteriorating patient was identified and correct treatment initiated in a timely manner. A consultant physician chaired the multidisciplinary committee which comprised medical, nursing, and operational staff. It

met monthly. Its remit included responsibility to provide a local governance structure to support the implementation and monitoring of compliance the Irish National Early Warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS), Emergency Medicine Early Warning System (EMEWS) and the National Clinical Guideline on Sepsis Management at Letterkenny University Hospital. The committee reported to the HMT via the director of nursing.

Minutes from meetings held in April, May, and June 2025 demonstrated satisfactory attendance at meetings, structured reporting on incidents, audit findings, and quality improvement plans. The committee reviewed sepsis audit results, escalation compliance, and early warning score documentation. A report on deteriorating patient incidents was submitted, and actions were tracked through the hospital's quality improvement framework.

Patient and Family Experience Forum

The hospital had established a Patient and Family Experience Forum which met monthly. Agendas and minutes for three meetings held in February, April, and May 2025 were submitted post-inspection. The forum was attended by hospital management, quality and safety personnel, and patient and family representatives. Topics discussed included service user feedback, ED experience, patient safety concerns, and the development of patient-centred projects. Inspectors heard from staff that the forum formally adopted a terms of reference during its February meeting. These were shared with the inspection team after the inspection. Although dated 2025, there was no signature, date of approval or date for review of same. It was unclear who chaired the forum. The purpose, aims and objectives, membership and accountability arrangements were set out along with the membership, frequency of meetings (monthly for 10 months in the year), quorum, and reports. Quality improvement plans arising from the forum were presented at the quality and patient safety committee.

In summary, Letterkenny University Hospital had formalised internal governance structures with defined terms of reference, multidisciplinary membership, and structured reporting for most committees. Governance oversight of quality, safety, and patient experience was evident across key committees. External governance arrangements under the regional health area model however, were yet to be formalised, terms of reference for the patient and family experience forums were incomplete, and quorum-related disruptions impacted continuity in some governance forums.

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.

There was an assistant director of nursing (ADON) on-site-duty for the hospital 24 hours per day, seven days per week as well as on-site on-call consultant cover during core working hours, and off-site on-call consultant cover, out-of-hours across all aspects of the hospital.

Inspectors found that the hospital had established management arrangements to support the delivery of services in the emergency department. Senior nursing management with responsibility for ED outlined the governance structure in place, reporting to the assistant director of nursing (ADON) with responsibility for the emergency department, cancer services and acute care who in turn reported to the DON. Weekly governance meetings were held, attended by the consultants, ADON, CNM3, patient flow coordinator and clinical facilitator. Minutes from the meetings were reviewed. These included discussion of patient safety incidents, complaints and compliments, staffing, education, performance metrics and other operational matters. Management and oversight of patient experience times (PETs) and implementation of escalation measures to ensure effective patient flow was discussed at weekly emergency department meetings. The CNM3 attended daily patient flow meetings and participated in safety huddles held four times per day. The CNM3 attended two of these huddles during their shift, with the remaining two held during the night shift and attended by the CNM2 in charge of the ED.

The emergency department had admission avoidance pathways in place to support patient flow such as, the acute medical assessment unit (AMAU), advanced nurse practitioner-led treatment and assessment areas, frailty intervention team (FIT) and the community-based services, 'Pathfinder'.

The hospital reported an improvement in their conversion rate (the percentage of the total number of patients who present to the ED, who are subsequently admitted to hospital) of 29.2% year-to-date for 2025, compared to 31.3% in 2024. Delayed transfers of care (DTOC) continued to impact patient flow, with 33 patients identified as DTOC during this inspection period.

In follow-up to documentation reviewed by inspectors, the hospital's self-assessment of compliance with external recommendations relating to escalation protocols stated that the Letterkenny University Hospital escalation policy was dated November 2024 and remained in draft, pending agreement and sign-off. Senior hospital management confirmed that the policy had not yet been finalised and was undergoing internal review and consultation with clinical leads. Inspectors were informed that the topic

was scheduled for discussion at an upcoming unscheduled care meeting and that finalisation of the policy remained a priority for the hospital's executive team.

Infection prevention and control

Inspectors found that infection prevention and control governance arrangements were in place across the hospital. The consultant microbiologist and the assistant director of nursing for IPC led the IPC and antimicrobial stewardship committees. Inspectors reviewed the IPC service plan, annual report, and outbreak reports.

In clinical areas, inspectors observed appropriate use of isolation signage, availability and use of personal protective equipment (PPE), and adherence to screening protocols. In Medical 6 ward, inspectors noted that all patients were screened for CPE on admission and weekly thereafter.

Medication safety

The drugs and therapeutics committee did not have a formalised strategy or annual plan in place. Committee members explained that they identified short, medium and long-term goals and objectives on a whiteboard within the pharmacy, particularly those related to medication safety. The hospital had a formulary in place. Reporting to the HMT on medication safety was via the reports to the quality and patient safety committee (QPSC). Inspectors viewed the Drugs and Therapeutics 2024 report for the QPSC dated June 2025, where it listed achievements and progress of the committee including, new medications added to the formulary, new and revised medication related policies, an update on new policies, procedures and guidelines approved for use, review of audit results and approval of quality improvement plans (QIPs), mitigation plans for impending medicine shortages, and updates on education provision and grand rounds. The report listed key priorities for the committee which included approval of updates to the terms of reference, expansion of membership of the drugs and therapeutics committee and agreement and implementation of a medication management policy. Risk and barriers to meeting its objectives were also noted on the report to the QPSC including the fact that four of the 12 meetings held in the past year had been cancelled due to being unable to fulfil the quorum. Medication safety is discussed further under national standard 3.1.

Deteriorating patient

Inspectors reviewed meeting minutes and confirmed that the committee monitored compliance with the protocols relating to early warning scores, sepsis management and escalation. In clinical areas, inspectors observed use of the Irish National Early Warning Score (INEWS), the communication tool - Identify, Situation, Background, Assessment and Recommendation (ISBAR) and safety huddles.

Transitions of care

Inspectors reviewed minutes of the unscheduled care governance groups and confirmed that the team used the hospital performance visualisation platform and navigational hub to monitor patient flow.

Hospital management told inspectors that the hospital was in black escalation (HSE escalation guidance) and that all actions for this level had already been taken. At the time of inspection, there were 33 people who had been medically discharged (delayed transfer of care) but who were being cared for in the hospital while they were either waiting on a availability of a home care package, a bed community hospital bed for rehabilitation or on a bed in a nursing home. Hospital management reported that delays in discharge were primarily due to lack of access to community beds, home help packages and rehabilitation services. Inspectors heard how the hospital was actively working with community partners to address these issues.

In summary, inspectors found that the hospital had some established management arrangements in place to support the delivery of healthcare services. The drugs and therapeutics committee however, did not have a formalised strategy or annual plan in place. A draft policy incorporating external recommendations relating to escalation protocols in the emergency department was yet be finalised and approved.

Judgment: Partially Compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas in line with the HSE's risk management framework. Local risk registers were maintained in the emergency department, Surgical 2, Medical 6 and Medical 8, and were reviewed at least twice yearly. Staff in all areas demonstrated awareness that risks not resolved locally were escalated to the hospital's corporate risk register via the risk register committee and shared with the regional clinical director for quality and risk.

Risks relating to the four key areas of harm, namely infection prevention and control, medication safety, the deteriorating patient, and transitions of care, were recorded on both local and corporate risk registers, and are discussed further under national standard 3.1. Examples included risks associated with lack of isolation facilities, lack of clinical pharmacy services, delays in clinical handover, and delayed transfers of care. Corrective actions and controls were documented within the risk registers to mitigate these risks.

The hospital's risk register committee met regularly and was chaired by the general manager. Risks were reviewed with assigned owners and updated accordingly. The QPS manager was a member of the risk register committee and confirmed that risks were actively tracked and reviewed. A member of the QPS committee was responsible for risk management oversight.

Management of patient-safety incidents

Patient-safety incidents were reported directly to the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework.

A positive culture of incident reporting was reflected in the hospital's year end 2024 Hospital Patient Safety Indicator Report (HPSIR), which demonstrated consistent reporting activity across a range of clinical areas and incident categories. Staff in clinical areas confirmed routine use of NIMS for direct reporting of incidents such as falls, medication errors, and issues related to deteriorating patients. Serious incidents were escalated to the Serious Incident Management Team (SIMT), with preliminary assessment reports being completed and reviewed. There was a 98% compliance with the 30-day requirement for submission of notification of incidents to NIMS. This exceeded the HSE target of 75%.

Monitoring service performance

The hospital did not have a formalised overarching quality and safety programme although inspectors noted that there were arrangements in place to monitor performance across key areas of service delivery. Performance data was reviewed internally through established governance forums, including the quality and patient safety committee and the hospital management team. In addition to unscheduled care metrics, the hospital tracked indicators such as activity levels, bed occupancy, average length of stay, rates of infection and outpatient activity. These data informed operational decision-making and supported service planning at hospital level. Monthly submissions were made to the HSE's Hospital Patient Safety Indicator Report (HPSIR), which included data on inpatient discharges, delayed transfers of care, emergency department attendances, wait times for older adults, infection

prevention and control, and incident reporting. The quality and patient safety committee reviewed these reports and escalated concerns where necessary.

Audit Activity

The hospital had monitoring arrangements in place to evaluate aspects of service performance. Monthly audits were also conducted for environmental hygiene, patient equipment, hand hygiene, and early warning score documentation in clinical areas. The hospital had acquired a specific audit tool for this purpose. Hospital staff however, reported login issues and gaps in audit records in some areas. This was raised for attention with hospital management during the inspection.

Quality improvement plans were developed in response to audit findings in several areas and were tracked by the quality and patient safety department. Oversight of implementation was provided by clinical nurse managers, and audit outcomes were discussed at ward meetings and safety huddles.

Inspectors found that there was scope to strengthen monitoring and evaluation processes in specific areas of service delivery, particularly in relation to medication safety and transitions of care, where audit activity was limited or not evident during the inspection. These areas had also been identified for improvement in the previous HIQA inspection.

Service user feedback

Findings from the National Inpatient Experience Survey were reviewed at meetings of the quality and patient safety committee. The hospital maintained a quality improvement plan in response to survey findings, and progress was tracked by the quality and patient safety department.

Service user feedback was collected through comment boxes, QR-coded posters directing service users to the '*Your Service Your Say*' portal, and ward-based feedback forms. While feedback mechanisms were in place in most areas, inspectors observed that there was no feedback cards beside some of the comment boxes.

In summary, while the hospital maintained structured systems for monitoring and improving care quality and safety, supported by risk management, incident reporting, and performance tracking, it did not have a formalised overarching quality and patient safety plan in place. Audit activity informed improvements in several areas. Limited evaluation of medication safety and transitions of care however, persisted as a gap. This issue was previously identified in the 2023 inspection.

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.

The hospital's total approved complement of staff was 2,211 whole-time equivalent (WTE) as of May 2025, an increase of seven WTE since December 2023 (when the pay and numbers strategy was implemented). The hospital's reported absenteeism rate was 7%, which was above the HSE's target of four per cent or less. Staff from the human resources department explained that the absence level had reached a high of 8.5% (HSE target is less than 4%) at the beginning of the year and that there was increased emphasis now on one to one back to work interviews with staff.

The hospital had an approved complement of 85 WTE consultants, with all but one post filled at the time of inspection. Twelve consultants were not on the relevant specialist division of the register with the Irish Medical Council, and the hospital had provisions in place to oversee this. All non-consultant hospital doctor posts were filled at the time of inspection.

Staffing in the emergency department

An emergency medicine consultant clinical lead had overall responsibility for the day-to-day clinical functioning of the department and reported to the Associate Clinical Director for Medicine. Six WTE emergency medicine consultants were employed to provide 24/7 cover in the emergency department.

The CNM3 had overall nursing responsibility for the department and reported to the Assistant Director of Nursing for cancer, ambulatory and emergency care. The department had an approved nursing workforce of 85.6 WTE as follows:

- 8.5 WTE CMN2
- 0.9 WTE clinical facilitator
- 8.6 WTE CNM1
- 62 WTE nurses
- plus 5.6 WTE paediatric nurses for the paediatric ED.

At the time of inspection, staff reported that 10 WTE (11.6%) of the complement of nursing staff were on various types of leave. The emergency department also had an approved complement of 11.9 WTE healthcare assistant (HCA) posts, of which 9.9 WTE were available to the roster at the time of inspection. Rosters indicated that between two and three HCAs were rostered during the day and one to two at night, covering both the AMAU and ED. Staff shortages were escalated to the CNM3 to the ADON on site duty and staff complete incident forms in the event of unfilled shifts. Staffing was discussed at clinical governance meetings. The hospital used agency staff to replace staff where possible. Inspectors viewed documentation relating to

the levels of agency used. Redeployment was coordinated by the ADON on duty, in response to acuity and dependency throughout the hospital.

Staff in the emergency department had access to an infection prevention and control nurse, an antimicrobial pharmacist, and a 24/7 access to a consultant microbiologist. A full-time pharmacist and pharmacy technician were in place to support medication safety and stock management in the emergency department. The department also had access to a clinical facilitator working 34 hours per week who supported nursing staff to maintain skills and competence.

Staffing in the ward areas

The approved nursing complement on Surgical 2 was 33.8 WTE plus 7.13 WTE healthcare assistants (HCA). Two HCAs were reported to be on various type of leave at the time of inspection.

The approved nursing complement on Medical 6 was 24 WTE. There was 19.96 WTE in post and 1.96 WTE on leave. The approved HCA complement was six WTE. At the time of inspection, 4.81 WTE HCAs were available for the roster with the remainder on leave.

The approved nursing complement on Medical 8 was 31 WTE plus 7 WTE healthcare assistants (HCA). By the end of June 2025, the HR census reported 26.45 WTE nurses and 7.13 WTE available for the roster.

Infection prevention and control and antimicrobial stewardship

The infection prevention and control team was fully staffed at the time of inspection. It comprised 2.5 WTE consultant microbiologists, one WTE ADON, four WTE clinical nurse specialists, 1.8 WTE AMS pharmacists and one WTE surveillance scientist.

Pharmacy staffing

At the time of inspection, the hospital reported having an approved complement of 45.45 WTE pharmacy staff. This included one WTE pharmacy executive manager, one WTE pharmacy executive manager deputy, 15.98 WTE senior pharmacists and six WTE pharmacists. It also included 4.96 WTE senior pharmacy technicians and 16.51 WTE basic grade pharmacy technicians. At the time of inspection there was 41.38 WTE in post while 4.07 WTE posts were vacant. This impacted the hospital's ability to provide a clinical pharmacy service to ward areas. Inspectors heard that three new hires had been approved and were due to commence in September 2025. A further senior pharmacy technician post had also been advertised.

Transitions of care

The patient flow team included one WTE ADON with responsibility for coordination of the following team, 2.63 WTE discharge coordinators, 3.92 patient flow CNM2s, one WTE CNM2 – community intervention team (CIT), one WTE GP Liaison CNM2 and one WTE nurse (temporary reassignment).

Mandatory training

Inspectors viewed training records for staff. Mandatory training requirements at the hospital included the following;

- hand hygiene
- infection outbreak management
- basic life support for specific clinical staff
- clinical handover for specific clinical staff
- medication safety for specific clinical staff
- incident reporting via NIMS.

Despite these requirements, inspectors found that with the exception of Medical 6, mandatory training records at ward and department level were difficult to obtain and were either inconsistent or not available. Where they were produced for review by inspectors, they showed low levels of compliance with mandatory training across all staff groups. This data represented a deterioration in findings from the 2023 inspection.

Inspectors highlighted these deficits and low compliance rates to the general manager during the hospital management team meeting. In response, the general manager acknowledged the training deficits and confirmed that the hospital was working to consolidate fragmented training systems. Nursing compliance was being recorded on the Health Roster however there was low compliance recorded among the medical and dental staff grouping. Monitoring of compliance was performed twice a year where there was engagement with line managers to ensure training was up to date for staff in their areas of responsibility. Training records were then being collated by HR and shared with the management team for review. Following the inspection, the hospital provided hospital-wide data on the percentage of staff (by grouping) who attended training in the past 24 months. The data provided to HIQA reflected the need for considerable improvement in both the uptake, the recording of attendance and monitoring of compliance with attendance at mandatory training across the hospital.

In summary, while inspectors found that staffing levels were broadly aligned to approved complements, absenteeism levels remained high at 8.5% and data at ward and department level on compliance with mandatory training reflected a deterioration from the levels noted in 2023. Both of these issues were previously highlighted in the 2023 inspection report as requiring attention.

Judgment: Partially Compliant

Quality and Safety Dimension

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

The hospital was deemed to be compliant in one of the seven national standards assessed (NS 1.7), substantially compliant with three national standards (NS. 1.6, 1.8 and 3.3) and partially compliant with the three remaining national standards (NS 2.7, 2.8 and 3.1).

This represents an improvement in national standards 1.8 and 3.3, from partial to substantial compliance and a lower rating for NS 2.7, from substantial to partial compliance under the quality and safety dimension since the 2023 inspection.

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

Respecting and promoting the dignity, privacy and autonomy of people receiving care is a core component of a human rights-based approach to healthcare, as advocated by HIQA. This approach requires that care is delivered in a manner that is kind, respectful and responsive to individual needs, and that people are supported to access the right care at the right time, based on their assessed needs. During this inspection, inspectors observed staff across the hospital engaging with patients in a manner consistent with this approach. Staff were seen to be courteous, attentive and respectful in their interactions with patients, and demonstrated a commitment to promoting privacy and dignity in the delivery of care.

The emergency department included a designated paediatric waiting area and one paediatric resuscitation bay equipped with a paediatric resuscitation trolley. No paediatric patients were receiving care in this area at the time of inspection.

At the time of inspection, patients in the ED were being accommodated in cubicles with privacy curtains. However, inspectors observed that some patients were receiving care in corridor areas, including in wheelchairs, without access to call bells or privacy screens. Inspectors observed staff in the emergency department engaging with patients in a respectful and friendly manner. Staff were seen speaking quietly

and clearly to patients in shared areas and drawing curtains to promote privacy during clinical assessments and treatments. Patients described staff as "*kind*" and "*doing their best*", but also reported long waiting times and discomfort while waiting in shared areas.

The physical environment in the ward areas visited generally supported the promotion of privacy and dignity. Single rooms were available in Surgical 2 and Medical 8, and were used for isolation or end-of-life care where possible. In Medical 6 however, there were no single rooms available, patients were accommodated in multi-occupancy rooms with shared facilities. In Surgical 2, two corridor beds were available for use during periods of escalation. While mobile screens were available, inspectors noted that patients placed in corridor areas may have reduced privacy and dignity.

Inspectors also observed staff in wards including Surgical 2, Medical 6 and Medical 8 interacting with patients in a kind and respectful manner. Staff were seen assisting patients with mobility, hygiene and meals, and explaining care in a clear and helpful way. Patients described staff as "*fantastic*", "*very obliging*", and "*always doing more*". Inspectors were informed that the hospital had implemented the 'John's Campaign', which allows carers who normally provide support at home to remain with patients outside of standard visiting hours. Staff confirmed that family members were encouraged to stay with patients where appropriate if they wished to do so, particularly for those with dementia or those receiving enhanced care.

Inspectors observed that patient information was generally stored securely, although in some areas, such as nurses' stations, whiteboards displaying patient names were visible through glass panels. This was raised with ward managers during the inspection.

Staff confirmed that patients at end-of-life were prioritised for single rooms. End-of-life signage was observed to be in use in one of the inspected wards.

Overall, inspectors found that staff across the hospital were aware of the importance of promoting dignity, privacy and autonomy in the delivery of care. However, the use of corridor beds and visibility of patient identifiers in some areas presented challenges to consistently maintaining privacy and confidentiality.

Judgment: Substantially Compliant

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

Inspectors observed staff across the hospital engaging with patients in a manner that demonstrated kindness, consideration and respect. Staff were observed speaking to patients in a calm and courteous manner, assisting with mobility, hygiene and meals, and responding promptly to requests for help. In the emergency department, patients described staff as kind and apologetic, and inspectors observed staff maintaining a calm and reassuring presence despite the pressures of a busy department and long waiting times.

In Surgical 2, staff were observed assisting patients into wheelchairs and offering reassurance in a gentle tone of voice. Staff were heard using encouraging language, such as "*You look lovely and bright this morning*" and were seen to interact with patients in a warm and respectful manner during routine care activities.

In Medical 6, staff were observed seeking consent before taking vital signs and supporting patients with personal care in a way that upheld their dignity and autonomy. Inspectors noted that staff interactions were consistently respectful and patient-focused, and that patients were addressed politely and with consideration throughout the inspection.

In Medical 8, staff were observed encouraging patients to mobilise and supporting those with enhanced care needs. Inspectors noted that the ward environment was calm and that staff maintained a quiet and reassuring presence. Staff referenced the "*Get Up, Get Dressed, Get Moving*" initiative as part of their approach to promoting independence and wellbeing and posters were visible in clinical areas supporting the initiative.

Overall, inspectors found that staff across the hospital demonstrated a culture of kindness, consideration and respect in their interactions with patients, consistent with the expectations of this national standard.

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.

Inspectors met with the Quality and Patient Safety (QPS) manager, who managed the complaints portfolio. The hospital used the HSE's national complaints management policy, '*Your Service, Your Say*'. Inspectors reviewed the hospital's complaints management processes and associated documentation, including patient feedback mechanisms, complaints tracking systems, and quality improvement plans. Staff confirmed that verbal complaints were addressed locally with quality improvement actions discussed at weekly meetings. Complaints were escalated to the QPS department or Patient Advice and Liaison Service (PALS) where appropriate.

A process in line with the national complaints management process was in place for formal written complaints, including screening, investigation, response, and quality improvement follow-up. A template for clinical judgement complaint responses was shown to inspectors, which tracked follow-up, actions, and outcomes. More serious complaints were also escalated to the Local Incident Management Team or the Serious Incident Management Team, depending on the nature of the issue.

In the emergency department, inspectors saw boxes for the return of feedback forms but there were no forms available at these points at the time of inspection. Inspectors saw a poster inviting feedback for the Frailty Intervention Team, but there were no questionnaires there. Leaflets or posters specifically outlining the 'Your Service Your Say' policy were not seen by inspectors in the clinical areas visited. Patients who spoke with inspectors in the ED and ward areas were not always aware of how to make a formal complaint. Some said they would ask a family member to support them if they had a concern, while others said they would speak directly to ward staff. Nursing management described the complaints management process, which included local resolution, escalation to the complaints department and use of a standardised template for documenting complaints, actions and outcomes. Inspectors reviewed an example of a complaint, which included investigation findings and evidence of service improvement actions.

Inspectors found that feedback posters and comment boxes were visible in several clinical areas such as Surgical 2, Medical 6 and Medical 8, and feedback forms were available in some locations. Inspectors were shown the QR codes on notices regarding feedback. The hospital provided inspectors with documentation showing that complaints were tracked and trended. A report from January to June 2025 recorded 59 stage two complaints, with analysis by category and source. The QPS annual report noted that year to date, 60% of complaints were fully investigated within 30 working days of acknowledgement (the HSE target is 75%). While not yet meeting the HSE target, this was an improvement from 44% in 2024, 38% in 2023

and 20% in 2022, and against a subsequent increase in the number of stage two complaints received during 2023 and 2024.

A quality improvement plan (QIP) tracker was provided, detailing actions arising from complaints, the National Inpatient Experience Survey, and other sources of feedback. The tracker which was overseen by the QPS manager included recommendations, assigned owners, due dates, and status updates. Examples of QIPs included improvements to communication processes, patient information, and follow-up procedures. Inspectors were informed that complaints and feedback were discussed at multidisciplinary meetings and that learning was shared across services.

The QPS annual report included analysis of patient feedback. In 2024, over 86% of inpatients reported satisfaction with their experience. However, feedback from the emergency department was notably lower, with 24.66% of respondents dissatisfied and 39.73% extremely dissatisfied, totalling 64.39% negative responses. The hospital has developed a QIP in response to the 2024 National Inpatient Experience Survey results, which is tracked alongside complaints-related actions.

The PALS service reported on ongoing initiatives to improve patient experience, including sensory supports for neuro-divergent children and proposals for community engagement clinics. A patient and family experience forum met seven times in 2024, with additional expressions of interest received to expand membership.

Staff were supported with guidance on how to respond to clinical judgement complaints, and the Employee Assistance Programme was available for staff who were involved in cases of complaint.

Overall, inspectors found that the hospital had systems in place to manage complaints and feedback, with evidence of tracking, escalation, and quality improvement. Inspectors noted however, that awareness of how to make a complaint was inconsistent among patients. Inspectors noted several improvements since the November 2023 inspection in that the PALS post was now filled and compliance with the HSE target of 75% (of complaints to be resolved within 30 days) had increased year on year although it was yet to meet the HSE target.

Judgment: Substantially Compliant

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

Inspectors visited four clinical areas during the inspection: medical 6, medical 8, surgical 2 and the emergency department. The physical environment in each area was assessed through direct observation, interviews with staff, and review of cleaning schedules, maintenance records where indicated, and post-inspection documentation.

The emergency department comprised:

- a waiting area, including a separate paediatric zone
- two triage rooms
- 12 cubicles, including two for paediatrics
- four resuscitation bays, one of which was used for paediatric patients
- two single rooms for isolation (no en-suite toilet facilities)
- two single room used for paediatrics (no en-suite toilet facilities)
- two additional single rooms with toilets available in AMAU
- a minor injuries area with a plaster room and eye assessment area
- a relatives' room and a separate baby feeding and changing room.

Since the 2023 inspection, a room within the emergency department was re-designated for the assessment of patients presenting with mental health complaints.

Surgical 2 ward was a 33-bedded ward consisting of two six-bedded rooms, one three-bedded room, two two-bedded rooms, all of which were en-suite, and 10 single en-suite rooms. The ward had adequate toilet and shower facilities for patients. In addition, there was a four-bedded post-operative surgical unit located within the ward footprint. Surgical 2 was predominantly used for surgical patients. It was also used to accommodate medical patients when there were no beds available on medical wards for patients requiring admission. At the time of inspection, 31 of the 33 beds were occupied. One room was closed for painting.

Medical 6 ward was a 20-bedded general medical ward, including three beds designated for urology patients. The ward comprised a mix of multi-occupancy rooms with shared toilet and shower facilities. There were no single rooms available for isolation. At the time of inspection, all 20 beds were occupied, and three patients were identified as patients with delayed transfers of care (where patients have been medically discharged but were waiting on access to a place in a residential home or other arrangement). The ward was clean and well maintained, although storage space was limited, and some equipment was stored in corridors and under stairwells.

Medical 8 ward was a 28-bedded high-acuity respiratory ward with one escalation bed in use at the time of inspection. The ward included five single en-suite rooms used for isolation or end-of-life care. The remaining beds were located in multi-occupancy rooms, all with en-suite facilities. Inspectors observed that the ward was calm and well organised, with appropriate infection prevention and control measures in place.

Inspectors found that wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available, with hand hygiene signage clearly displayed throughout the clinical areas inspected. Staff were observed wearing appropriate personal protective equipment. However, inspectors observed several environmental hygiene issues within the emergency department. These were escalated to the ward and hospital management during the inspection.

All three wards were found to be generally clean and tidy, with minor wear and tear noted with up to date cleaning schedules noted.

In Medical 6, privacy curtains were changed in accordance with hospital policy. Hand hygiene sinks were Health Building Notes (HBN) compliant. Health Building Notes provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation of existing facilities. Patient equipment was marked using the green tag system following cleaning. Linen and waste segregation met standards. One shower was closed due to presence of environmental CPE, and appropriate signage was in place. Cohorting of patients was used when isolation was required and this was supported and co-ordinated by the IPC team. Storage was identified as an issue requiring attention, with supplies stored on corridor and under the stairs. While there were no safety risks identified relating to this, it was untidy and cluttered in appearance. Staff reported that maintenance issues were addressed promptly and that the ward manager and domestic supervisor provided daily oversight of cleaning activities. Cleaning schedules reviewed by inspectors confirmed this.

In medical 8, isolation room doors were observed to be closed. Patient access to face coverings was facilitated through the Clinical Nurse Manager. Healthcare records were stored securely outside cohort areas, and main charts locked in trolleys at the nurses' station. Privacy curtains were clean and changed in accordance with policy, and general clinical areas were clear of inappropriate items. However, some boxes were noted on the floor in storerooms and this was brought to the attention of ward management. Hand hygiene sinks on medical 8 ward were present in clinical areas, though most were not HBN compliant. Clutter was noted in some areas. In the dirty utility room, the bed washer was available and had a valid service date. There was no sluice hopper or separate sink for cleaning patient equipment, though a non-HBN compliant hand hygiene sink was present. Patient washbowls and

bedpans were stored clean, dry and inverted with drip trays. Commodes were clean. Linen segregation was appropriate. Hazardous cleaning chemicals were managed appropriately. An environmental and equipment audit conducted in medical 8 in March 2025 reported 99.1% and 98.2% compliance respectively. A COVID-19 outbreak close-out report for Medical 8 in May 2025 confirmed that environmental hygiene and isolation protocols were reviewed and strengthened following the outbreak.

In surgical 2, ten single rooms were available and used appropriately for isolation, including for patients with *Clostridioides difficile* infection and those receiving end-of-life care. Appropriate signage was in place, and doors to isolation rooms were observed to be closed during the inspection. Curtain change records were visible and current. The sluice room was clean and equipped with a macerator and bedpan washer, both of which had in-date service tags. Commodes were clean and tagged with "I Am Clean" stickers. However, the sluice room lacked a sluice hopper and a separate sink for cleaning patient equipment, and the hand hygiene sink was not HBN compliant. Some maintenance issues were noted, including chipped paintwork, damaged skirting, and a hole in a window covered with cardboard and tape. These had been escalated to maintenance by ward management and were scheduled for repair. Storage areas were cluttered, with cardboard boxes and drip stands stored on the floor. A risk assessment had been completed, and shelving was installed to mitigate the issue. Hand hygiene sinks were present throughout the ward, though only one was HBN compliant. Senior management confirmed that a hospital-wide programme to replace non-HBN compliant sinks was underway, with works scheduled to begin across multiple wards as part of planned infrastructure improvements. PPE was available, and appropriate waste segregation was observed, with one exception where a black bag was found in a white bin, which was rectified during the inspection.

In the emergency department, inspectors observed multiple environmental concerns, including dirty wheelchairs, cluttered waiting areas, and non-HBN compliant sinks. Cleaning sign-off sheets were out of date in several areas, and some toilets had not been serviced recently. These issues were escalated by inspectors to the CNM3, the cleaning supervisor, and the general manager. The department lacked sufficient isolation facilities, with only four single rooms available, none of which were en-suite. Storage of equipment and supplies was inconsistent, with items such as ECG leads and fluids stored on the floor of the clinical room. The treatment room lacked a door lock. Despite these challenges, the department maintained appropriate signage, PPE availability, and emergency equipment. The resuscitation trolley was checked and sealed, and oxygen and suction apparatus were functional. Curtain changes were carried out in accordance with policy, and the domestic supervisor maintained a curtain change record for the department.

The hospital's IPC and AMS monthly reports for the period of January to June 2025, and the IPC annual report for 2024 confirmed ongoing surveillance of environmental hygiene, hand hygiene, and equipment cleaning. These reports included ward-level audit results and QIPs for areas falling below compliance thresholds. The hospital's decontamination guidelines dated September 2024, and hand hygiene guidance dated March 2025 were in date and referenced national standards. Inspectors however, noted infrequent environmental hygiene auditing practices across all clinical areas inspected. Environmental hygiene audits were conducted in the emergency department in June and October 2024 and in March 2025, and resulted in scores of 88.9%, 87.4% and 97.9% respectively. Quality improvement plans were integrated in the audits where less than 90% was achieved. Environmental hygiene audits conducted in Surgical 2 in September 2024 and May 2025 resulted in scores of over 90%. Only one environmental hygiene audit was available for each of the two remaining inspected areas, Medical 6, dated October 2024 and resulting in a score of 88.89% and medical 8 dated March 2025 with a score of more than 90%.

The hospital's infrastructure challenges were acknowledged by senior management, and efforts to secure funding for environmental upgrades were ongoing. This included planned refurbishment works in medical 6 and broader improvements supported by hospital estates planning.

In summary, with the exception of the emergency department, the physical environment in the inspected wards largely supported the delivery of safe care. Quality improvement plans were in place to address audit findings, and a hospital-wide sink replacement programme had commenced. Inspectors however, found evidence of suboptimal standards of cleanliness, and lack of evidence of compliance with cleaning schedules in the emergency department, and with regular environmental hygiene audits across the inspected areas. This is an area for improvement by the hospital.

Judgment: Partially Compliant

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

Infection prevention and control

The hospital's IPC and AMS monthly reports confirmed ongoing surveillance of audit activity, including care bundles, hand hygiene, and environmental hygiene. The IPC annual report for 2024 and the IPC service plan for 2025 outlined audit schedules and quality improvement priorities. These reports were reviewed by the Infection Prevention and Control Committee, which met monthly and reported to the Quality and Patient Safety Committee.

Audit activity in relation to infection prevention and control was evident across all clinical areas inspected. Monthly hand hygiene audits were conducted in medical 6, medical 8, surgical 2 and the emergency department. In medical 8, compliance was consistently high, with 100% recorded in June 2025 and previous monthly audit results ranging from 86.7% to 100%. In surgical 2, compliance was 87% in June and 80% in July 2025, below the hospital's target of 90%. A time-bound quality improvement plan (QIP) was in place to address this. Hand hygiene audit results for emergency department averaged at 89% for the first six months of 2025 (range 80-100%) an action plan was documented when results were at 80% in May 2025.

Environmental hygiene and equipment audits were also carried out. In medical 8, a March 2025 audit reported 99.1% compliance for environment hygiene and 98.2% for equipment cleaning.

The most recent environmental hygiene audit for Medical 6 had been conducted in October 2024 yielding a result of 89%.

The equipment hygiene audit conducted in the emergency department in March 2025 resulted in a score of 98.2%. The environmental hygiene audit scores recorded in June and October 2024 and March 2025 were 87.4%, 88.99% and 97.9%. Quality improvement plans were documented when the score was less than 90%. A sharps management audit conducted in the emergency department on 3 July 2025 reported 60% compliance, below the 85% target. A time-bound QIP was implemented with assigned responsibilities.

In surgical 2, peripheral vascular care (PVC) care bundle audits showed variable compliance, with results ranging from 50% to 100% across 2024 and 2025. A detailed QIP was developed in October 2024 to address low compliance, including education and assigned responsibilities.

In Surgical 2 and Medical 8 inspectors found awareness by staff of appropriate cohorting of patients if required.

Medication safety

Representatives from the Drugs and Therapeutics Committee reported improvements in compliance with time-critical medication administration, development of prescribing aids, and implementation of quality improvement plans. Inspectors were told of a quality improvement plan related to the timely administration of time-critical medication. This was seen on the hospital-wide tracker which was in place to monitor open and closed quality improvement plans, including those arising from audits, incidents and service user feedback.

Inspectors reviewed the hospital's medication safety audits and found that audit activity in relation to medication safety was limited across the clinical areas reviewed. Staff reported that this was due to staffing shortages, and technical issues with the hospital's audit tool. Representatives from the Drugs and Therapeutics Committee acknowledged that medication safety auditing at ward level remained limited, and that access to real-time medication information at the point of care was not consistently in place. These issues were also reflected in ward-level observations, where inspectors noted the absence of sound-alike, look-alike drugs (SALAD) lists, high-risk medication signage, and medication reconciliation in audits in several areas. These issues were raised with both the Drugs and Therapeutics committee representatives and with hospital management during the inspection, and in writing to the general manager after the inspection.

Post-inspection, the hospital submitted a report from the Drugs and Therapeutics Committee to the Quality and Patient Safety Committee dated 6 June 2025. This document referenced audit activity and quality improvement planning but did not include specific audit findings, results, or details of actions taken.

The deteriorating patient

Audits of early warning scores were conducted in Medical 6, Medical 8, Surgical 2 and in the emergency department. In Medical 6, the Irish National Early Warning Score (INEWS) was audited monthly, with results available on the ward's quality board. In Medical 8, staff reported consistent use of INEWS and ISBAR, with audit results discussed at safety huddles and staff meetings. In Surgical 2, audit results were displayed on the ward's quality board, and staff confirmed that findings were used to inform training. The 2024 INEWS audit results had indicated sustained high compliance across most wards, with over half achieving greater than 90% compliance in at least 75% of audited months. A hospital-wide INEWS escalation audit conducted in June 2025 showed variable compliance across wards although there was evidence of continuous improvements in compliance with the INEWS escalation protocol month on month, for most wards.

Compliance with the use of the emergency early warning score (EMEWS) in the emergency department had yet to reach the HSE target of 90% but had increased from 58.9% in August 2024 to 81.2% in December 2024 and 79.9% in March 2025.

Sepsis audits were also conducted. The 2024 National Sepsis Clinical Audit Report for the hospital showed improvements in key treatment indicators (lactate measurement and intravenous fluid resuscitation) but also showed areas for improvement including timely antimicrobial delivery and compliance with the sepsis 6 bundle. A QIP was developed and placed on the Deteriorating Patient Committee agenda, mandating monthly emergency department audits and HSELanD training. However, inspectors did not see evidence of the actions in the QIP being implemented during inspection. Most actions on the QIP had no time-bound targets or accountability metrics.

The emergency department was included in the scope of the hospital's adult sepsis audit, and monthly ED-specific audits were mandated as part of the hospital's quality improvement response.

Transitions of care

Audit activity in relation to transitions of care was limited. Staff referred to the use of the navigational hub for the live monitoring of transitions of care. The navigational hub is a HSE initiative which functions as a bed bureau or case management system used to improve patient flow and reduce unnecessary emergency department visits by connecting patients with specialists or appropriate care services efficiently.

The three most recent interdepartmental handover audits were conducted in September and October 2024. These audits assessed eight standards including timing, location, ISBAR use, governance, and communication. While the audits reported full compliance across the eight headline standards, individual elements within the audit tool were marked as non-compliant. No associated quality improvement plans were submitted to address these deficits.

A summary audit dated December 2024 reviewed clinical handover practices across multiple departments, including the emergency department. A targeted quality improvement plan was developed to address identified gaps, including mandatory ISBAR training, structured templates, and protected handover environments. The plan was time-bound and a re-audit was scheduled, though clarity on assigned implementation responsibilities was lacking. At the time of inspection, the re-audit had not yet taken place.

Patient feedback and experience

Patient feedback mechanisms were in place across all clinical areas. In Medical 6, Medical 8 and Surgical 2, feedback forms and QR code posters were available at ward entrances and bedside areas. Staff reported that feedback was reviewed during ward meetings and safety huddles, and quality improvement plans were developed in response to concerns raised.

In the emergency department, while staff confirmed that feedback mechanisms were in place, inspectors noted that feedback forms were not available at the time of inspection.

The hospital maintained a tracker for complaints and feedback, and the Quality and Patient Safety Committee reviewed service user feedback as part of its monthly governance meetings. Patient satisfaction surveys were conducted, and results were incorporated into quality improvement planning.

In summary, inspectors found evidence of some audit activity in all clinical areas, with quality improvement plans developed in response to some but not all audit findings. Gaps were noted in audits of medication safety and transitions of care in particular. Further improvements are required to ensure consistent implementation and continuing evaluation.

Judgment: Partially Compliant

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

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services. The hospital collected data on a range of quality and safety indicators in line with national HSE reporting requirements. Performance data was reviewed through local governance meetings and at the navigational hub.

The hospital maintained a corporate risk register, with risks reviewed at least twice yearly. Risks related to IPC, medication safety, deteriorating patients, and transitions of care were documented. The QPS Committee monitored risk escalation and mitigation, and local ward-level risk registers were in place in the emergency department, Medical 6, Medical 8, and Surgical 2. High-rated risks were escalated and included in the corporate register when not resolved locally.

Performance data collected on the days of HIQA's inspection showed that at 11am on each day of the inspection, the hospital was compliant with most but not all key performance indicators for the emergency department. On each day of the inspection, 50% of patients aged 75 years and older were discharged or admitted

within nine hours of registration (HSE target for this age group is 99%). All patients in this cohort however, were discharged or admitted within 24 hours.

Inspectors reviewed data on patient experience times (PET), including registration to triage, triage to medical assessment, and interval from 'decision to admit' to placement in an inpatient bed. The time taken to triage a patient following registration was found to be within the HSE target (15 minutes or less) on both days of the inspection. On 1 July 2025, the mean interval from triage to medical assessment was 199 minutes, and the interval from 'decision to admit' to an inpatient bed was 189 minutes. On 2 July 2025, the mean time from triage to medical assessment was 234 minutes. These times reflected the totality of patients including those who following triage were classified as less urgent.

Risk management processes specific to the emergency department were in place and were incorporated into the hospital's broader governance structures. Inspectors were informed that the emergency department maintained a dedicated risk register, which was integrated into the risk register overseen by the assistant director of nursing (ADON) service manager for the area. Risks were assessed locally by the ward management, with risks either retained for local management or escalated as appropriate. The ED risk register was reviewed during the inspection and included long-standing risks with documented existing controls, assigned owners, and due dates for review. Risks identified included infection prevention and control concerns (e.g. COVID-19 and CPE compliance), intravenous infusion pump availability, space constraints, lone working, and incidents of violence and aggression. Emergency Department patient experience times (PET) were also listed on the register. Ward management reviewed ED risks annually, and the risk register was subject to oversight by the hospital's quality and patient safety coordinator.

Inspectors reviewed the clinical governance arrangements for medical staff in the emergency department. The clinical lead described the use of safety huddles three times per day, attended by doctors, CNMs and the consultant-on-call.

Infection prevention and control

IPC systems were in place across the hospital, including daily IPC team presence, access to microbiology services, and routine screening protocols. IPC signage including point of care risk assessments, PPE availability, and isolation protocols were in place. IPC audits were conducted, and QIPs were developed in response to non-compliance. However, some audits had lapsed due to staffing shortages, and not all areas had access to HBN-compliant sinks. A replacement programme was in progress. Staff were familiar with IPC protocols, and inspectors observed appropriate use of PPE and isolation signage across all inspected areas.

Inspectors found that IPC risks were included on the hospital risk register and reviewed by the quality and patient safety coordinator. Risks included COVID-19, CPE, compliance with IPC protocols and intravenous infusion pumps. Inspectors saw evidence of existing controls and actions.

Medication safety

Inspectors found that although the hospital had a medication administration policy in place, there was no comprehensive medication management policy in place.

Inspectors found that medication reconciliation was not consistently performed across wards. A dedicated clinical pharmacy service was available in 13 wards or departments, while 13 others, including surgical, maternity, and several medical wards had no assigned pharmacist. Coverage was further affected by leave arrangements, and cross-cover was described as limited and ad hoc. Inspectors were informed by hospital management that pharmacist allocation was historically driven by ward-level funding and service-specific applications, with priority given to medical wards and high-risk areas such as ICU, emergency department, stroke, paediatrics, and haematology-oncology. Perioperative services remained unsupported despite repeated applications at regional level. In Medical 6, reconciliation was completed by NCHDs, where there was no assigned clinical pharmacy service. In Medical 8, similar arrangements were in place, although staff reported delays in discharge letters due to lack of pharmacy input.

The emergency department had an established clinical pharmacy service. A pharmacist was present during the inspection and provided support to medical and nursing staff, including induction training and access to medication guidance resources. Staff confirmed that the pharmacist contributed to medication safety initiatives and was available for consultation.

Inspectors reviewed access to medication safety information at the point of care in the emergency department. Staff sought to demonstrate access to online resources including IV drug guides and high-risk medication lists but experienced log-in issues at the time. These were rechecked later and were found to be working on this occasion. Laminated posters were displayed on a notice board relating to guidance on paracetamol dosing, the 'Ten Rights of Medication Administration', and antimicrobial displacement values. Posters on opioid overdose recognition and management were also on display.

The hospital had a list of high-risk medications and 'sound alike, look alike drugs' (SALADs), but these were dated in 2019. There were no high-risk medication lists or SALAD lists available in any of the inspected areas. Inspectors observed variation in access to medication information. In Medical 6 and Medical 8, staff relied on outdated British National Formulary books (BNFs) and lacked access to electronic resources at the point of preparation. In Surgical 2, staff used an electronic system to access IV drug guides, but this was not available in the treatment room where IV drugs were prepared. Staff reported limited access to medication information in clinical rooms at ward level where medication preparation occurs. Inspectors observed inconsistencies in medication storage and labelling.

The Drugs and Therapeutics Committee had developed quality improvement plans to address time-critical medication administration and had introduced a medication history-taking policy for pharmacy technicians in June 2025. However, inspectors noted that access to real-time medication guidance at the point of care remained limited due to IT and security restrictions.

The hospital reported 568 medication incidents in the previous year and staff described a strong reporting culture. Incidents were classified using the NCC-MERP (US National Coordinating Council for Medication Error Reporting and prevention) system, but the hospital was unable to confirm how many were categorised as serious. Further detail on the hospital's medication management policy is outlined in the following subsection on Policies, Procedures, Protocols and Guidelines (PPPGs).

The deficits in medication safety were escalated to hospital management during the inspection and in writing following the inspection and the general manager responded with a time-bound action plan to address the deficits.

Deteriorating patient

Processes to identify and respond to deteriorating patients in the emergency department were in place. Staff used multiple early warning score systems, including the Emergency Medicine Early Warning Score (EMEWS), Irish National Early Warning Score (INEWS), the Paediatric Early Warning Score (PEWS), and the Irish Maternity Early Warning Score (IMEWS). While staff demonstrated familiarity with these systems, they reported that differences in the manner of quantification of scores and escalation parameters in the various EWS records could lead to confusion. Inspectors examined use of the early warning scores in a random sample of charts in use in the emergency department and there were no untoward findings. Auditing of the use of early warning scores was in place. The clinical skills facilitator in the emergency department confirmed that audits of the EMEWS were now being conducted using the new national electronic audit tool, and that the last local audit had been conducted in April 2025. ISBAR methodology was used in emergency

department handover documentation. Inspectors reviewed the emergency department card and associated triage sticker system, which included EMEWS scoring for applicable patients. The EMEWS was not used for patients who presented with mental health issues alone.

INEWS and ISBAR were implemented across the inspected hospital wards, with staff familiar with escalation protocols. Audits showed generally high compliance, though some wards demonstrated variable performance. Sepsis audits revealed improvements in some indicators but highlighted inconsistent documentation and bundle completion. Inspectors reviewed healthcare records and confirmed that escalation protocols were followed in most cases, though documentation was not always complete. In three of the clinical areas inspected, staff described timely escalation to medical teams and use of critical care outreach for responsiveness. However, in one clinical area staff reported some delays in response to bleeps and difficulty contacting NCHDs, particularly out of hours. The issue had been escalated to the CNM2, clinical director and assistant director of nursing, and was raised at the hospital management team meeting by inspectors. While no adverse incidents were reported, staff stated that they would escalate to the consultant if an urgent review was required, and confirmed that medical input was ultimately received when needed. Inspectors reviewed healthcare records and found that early warning scores were documented and calculated correctly. However, ISBAR stickers were not consistently used, and documentation of escalation was variable.

Emergency call procedures were clearly displayed, and resuscitation equipment was available and checked. Sepsis management and escalation practices were audited and reviewed at hospital level, with findings and associated quality improvement plans in place as outlined under NS 2.8 and 5.8.

Transitions of care

Transitions of care were supported by integrated discharge rounds. Transitions of care from the emergency department were supported by the use of the ISBAR communication tool for internal and external transfers. Inspectors reviewed audit documentation confirming the use of ISBAR methodology in emergency department handover processes.

Patient flow was managed by the navigational hub (which met twice daily). Predicted date of discharge was inconsistently documented. A deep dive report was used to track individual patients experiencing delays. Despite these arrangements, inspectors identified barriers to timely discharge, including limited access to community beds, home support services, and rehabilitation facilities. Discharge letters and electronic prescriptions were sometimes incomplete or delayed, and these issues were raised as patient safety concerns at governance meetings.

Healthcare record reviews showed that infection status assessments were not consistently documented on admission, and medication reconciliation was frequently absent. ISBAR documentation was used inconsistently, and sepsis forms were not always completed.

In clinical areas, inspectors found that predicted dates of discharge were not consistently documented on whiteboards or in healthcare records. While discharge planning processes were in place and supported by multidisciplinary input, the absence of routinely recorded discharge targets limited visibility at the point of care. In Medical 6, ward management described use of the "*drumbeat*" schedule, a structured daily timetable used to coordinate ward activities including safety pauses, handovers, patient reviews and discharge planning. In Surgical 2 and Medical 8, similar discharge planning arrangements were in place, but inspectors noted that predicted discharge dates were often missing or not updated.

Delayed transfers of care continued to impact patient flow and bed availability. On the day of inspection, the hospital reported 33 delayed discharges. Hospital management attributed these delays to a combination of complex discharge needs and limited availability of community-based beds and carers. Delayed transfers of care were recorded on the hospital's risk register and reviewed through governance structures.

Policies, Procedures, Protocols and Guidelines (PPPGs)

Inspectors reviewed the hospital's PPPGs. National policies were in place for risk management, incident management, early warning systems and complaints.

Inspectors found that IPC policies were in place, including standard and transmission-based precautions, outbreak management, and prioritisation of patients for single-room isolation. These policies were based on national guidance and were available on the hospital's document management system.

The hospital did not have a comprehensive medication management policy. The policy available to inspectors primarily addressed medication administration and did not encompass prescribing, storage, reconciliation, or access to medication information at the point of care. Staff acknowledged that the policy was incomplete and under review, with plans to update it in collaboration with the nurse practice development department by Quarter 4, 2025. It was to include general principles of medication management, medication administration, prescribing practices, and controlled drugs. The absence of a comprehensive policy was escalated to the hospital manager at the time of inspection and in writing following the inspection. A medication history-taking policy for pharmacy technicians was introduced in June 2025.

The IPC PPPGs were based on national guidance and were generally up to date. However, inspectors noted that some policies were not accessible at the point of care, and staff relied on intranet systems that were not consistently available.

In summary, inspectors found that the hospital had many established systems to protect service users from harm associated with the design and delivery of healthcare services. However, significant risks were identified in the emergency department, particularly in relation to overcrowding, environmental hygiene, and medication safety. Across the hospital, gaps in clinical pharmacy services, lack of a comprehensive medication management policy, and delays in discharge processes presented risks to patient safety.

Judgment: Partially Compliant

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

Letterkenny University 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.

Reports of incidents were reviewed by the QPS department and entered on the National Incident Management System NIMS in line with the HSE's incident management framework.

Staff who spoke with inspectors across all clinical areas visited were knowledgeable about how to report a patient-safety incident and were aware of the most common types of incidents reported, including falls, medication errors, and issues related to deteriorating patients. In the emergency department, inspectors were informed that a NIMS incident is submitted in relation to staffing deficits if they were concerned that this could impact on their ability to provide care.

Feedback on incidents was provided to clinical nurse managers (CNMs) through daily incident summaries and quarterly updates from the assistant director of nursing. Incident trends were monitored by the quality and patient safety team, and learning from incidents was shared at ward-level safety huddles and governance meetings.

Feedback was shared with other staff through ward meetings and governance structures. Inspectors confirmed that incident trends were monitored and that QIPs were developed in response to identified issues. For example, in Surgical 2, ward management described daily incident statistics being circulated to staff and quarterly reviews conducted by the assistant director of nursing. How incidents were tracked and discussed at regular ward meetings was also described, although trend data was

not routinely shared with frontline staff. In Medical 6, incidents were reviewed locally and escalated to the hospital's corporate risk register where appropriate. The clinical lead in the emergency department described weekly multidisciplinary team meetings where incident forms were reviewed with the CNM3, assistant director of nursing, general manager or senior NCHDs.

Medication-related incidents were reviewed by the medication safety pharmacist and discussed at the Drugs and Therapeutics Committee. Inspectors were informed that learning from medication incidents was shared through ward-level education and posters, although access to medication safety information at the point of care was inconsistent.

Serious incidents

Serious incidents were managed through the hospital's local incident management team (LIMT) and escalated to the serious incident management team (SIMT) where appropriate. Post-onsite documentation showed that incident reviews were being tracked through the quality and patient safety department. Recommendations arising from serious incidents were tracked and managed by the quality and patient safety department, with oversight by the QPS Committee. Inspectors reviewed documentation showing that serious incidents were discussed at committee level and that quality improvement plans were developed in response to identified risks. This aligned with what inspectors were told during meetings with hospital management. The emergency department was the most frequent location for reported incidents in both 2024 and 2025, with 'no injury' being the most commonly reported category, followed by 'care management'.

Training records reviewed during the inspection showed that 86.2% of nursing staff in one of the clinical areas inspected had completed incident management training. However, in the emergency department, no nurses or healthcare assistants were recorded as having completed training in incident management at the time of inspection. The general manager acknowledged this gap and committed to reviewing training oversight systems.

Overall, inspectors found that the hospital had systems in place to identify, report, manage and respond to patient-safety incidents. There was evidence that relevant governance committees had oversight of incident management, and that learning was shared at ward level. Inspectors noted that there is scope for improvement in the training of staff in the emergency department in relation to incident management.

Judgment: Substantially Compliant

Conclusion

HIQA conducted a two-day unannounced inspection at Letterkenny University Hospital on 1 and 2 July 2025. The inspection was used to assess the hospital against 11 of the 45 national standards drawn from five of the eight themes under the dimensions of capacity and capability, and quality and safety, as set out in the National Standards for Safer Better Healthcare. HIQA assessed the standards through the lens of the four areas of known harm, infection prevention and control, medication safety, the deteriorating patient and, transitions of care.

While some improvements were noted during this inspection compared to the inspection in 2023, there was also continuing or new gaps in compliance found on this inspection. Further work is needed to bring the hospital into compliance with the National Standards for Safer Better Health Care.

Under the capacity and capability dimension, the hospital was deemed to be substantially compliant with one of the four national standards assessed (NS 5.2) and partially compliant with the three remaining national standards (NS 5.5, 5.8 and 6.1). This represents a decrease in compliance in these standards from the 2023 inspection when there was substantial compliance with both NS 5.2 and 5.8 and partial compliance with NS 5.5 and 6.1.

Letterkenny University Hospital had formalised internal governance structures with defined terms of reference, multidisciplinary membership, and structured reporting for most committees. Governance oversight of quality, safety, and patient experience was evident across key committees. External governance arrangements under the regional health area model however, were yet to be formalised, terms of reference for the patient and family experience forums were incomplete, and quorum-related disruptions impacted continuity in some governance forums.

Inspectors found that the hospital had some established management arrangements in place to support the delivery of healthcare services. The drugs and therapeutics committee however, did not have a formalised strategy or annual plan in place. A draft policy incorporating external recommendations relating to escalation protocols in the emergency department was yet be finalised and approved.

While the hospital maintained structured systems for monitoring and improving care quality and safety, supported by risk management, incident reporting, and performance tracking, it did not have a formalised overarching quality and patient safety plan in place. Audit activity informed improvements in several areas. There was limited evaluation of medication safety and transitions of care however, and as

previously identified in the 2023 inspection. Strengthening oversight in these areas remains a key opportunity for improvement.

Inspectors found that while staffing levels were broadly aligned with the approved complements during the inspection, absenteeism levels remained high at 8.5% and data on compliance with mandatory training reflected a deterioration from the levels noted in 2023. Both of these issues were previously highlighted in the 2023 inspection report as requiring attention.

Under the quality and safety dimension, the hospital was deemed to be compliant in one of the seven national standards assessed (NS 1.7), substantially compliant with three national standards (NS. 1.6, 1.8 and 3.3) and partially compliant with the three remaining national standards (NS 2.7, 2.8 and 3.1). This represents an improvement in national standards 1.8 and 3.3 from partial to substantial compliance and a deterioration in national standard 2.7 from substantially compliant to partially compliant under the quality and safety dimension.

During this inspection, inspectors observed staff to be courteous, attentive and respectful in their interactions with patients. They were aware of, and they demonstrated a commitment to promoting privacy, dignity and autonomy in the delivery of care. However, the use of corridor beds and visibility of patient identifiers in some areas presented challenges to consistently maintaining privacy and confidentiality.

Staff across the hospital demonstrated a culture of kindness, consideration and respect in their interactions with patients. Inspectors observed staff across the hospital engaging with patients in a manner that demonstrated kindness, consideration and respect. Staff were observed speaking to patients in a calm and courteous manner, assisting with mobility, hygiene and meals, and responding promptly to requests for help. In the emergency department, patients described staff as kind and apologetic, and inspectors observed staff maintaining a calm and reassuring presence despite the pressures of a busy department and long waiting times.

Overall, inspectors found that the hospital had systems in place to manage complaints and feedback, with evidence of tracking, escalation, and quality improvement. Inspectors noted however, that awareness of the complaints processes was inconsistent among patients. Inspectors noted several improvements since the November 2023 inspection in that the PALS post was now filled and compliance with the HSE target of 75% (of complaints to be resolved within 30 days) had increased year on year although it is yet to meet the HSE target.

With the exception of the emergency department, the physical environment in the inspected areas largely supported the delivery of safe care. Inspectors identified risks in relation to environmental hygiene, storage, and infrastructure in the emergency department. Although quality improvement plans were in place to address audit findings, and a hospital-wide sink replacement programme had commenced, inspectors found evidence of suboptimal standards of cleanliness and lack of evidence of compliance with cleaning schedules in the emergency department, and with regular environmental hygiene audits across the inspected areas.

Inspectors found evidence of some audit activity in all clinical areas, with quality improvement plans developed in response to some but not all audit findings. Gaps were noted in audits of medication safety and transitions of care in particular. Further improvements are required to ensure consistent implementation and ongoing evaluation.

Inspectors found that the hospital had many established systems to protect service users from harm associated with the design and delivery of healthcare services. However, risks were identified in the emergency department, particularly in relation to overcrowding, environmental hygiene, and medication safety. Across the hospital, gaps in clinical pharmacy services, lack of a comprehensive medication management policy, and delays in discharge processes presented latent risks to patient safety. While governance structures were in place to monitor and respond to these risks, further improvements are required to ensure consistent implementation of policies to support safe practice and effective transitions of care.

Overall, inspectors found that the hospital had systems in place to identify, report, manage and respond to patient-safety incidents. There was evidence that relevant governance committees had oversight of incident management, and that learning was shared at ward level. However, there is scope for improvement in the training of staff in the emergency department in relation to incident management.

HIQA will, through the compliance plan submitted by hospital management continue to monitor the progress in implementing the actions identified to bring the hospital into full compliance with these national standards.

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.	Partially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
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.	Substantially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially Compliant

quality, 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.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for Letterkenny University Hospital.

Inspection ID: NS_0151

Date of inspection: 01 and 02 July 2025

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

Issue: LUH escalation plan remained in draft form at time of inspection.

This LUH escalation plan was discussed and reviewed at the LUH Unscheduled Care meeting on the 11th November 2025. Significant work has been undertaken to address identified issues and finalise this document.

This will be submitted for approval at the next HMT scheduled for the 15th December 2025.

Timeline: 1 month

Issue: Lack of a medication safety strategy or plan

The previous LUH Medication Safety Strategy 2018-2023 was updated in October 2025 to further reinforce the hospital-wide commitment to medication safety and to reflect best practice as per the Irish Medication Safety Network's document entitled 'Building a Medication Safety Programme in Acute Care in Ireland: Fundamental Steps Version 2, March 2023'. This updated document was presented and accepted at D&T in October 2025.

This update maintained the vision as outlined in the previous strategy i.e. 'To promote best practice in medication safety for patients by optimising safe use of medications through a culture of learning, collaboration and sharing of knowledge whilst implementing quality initiatives to eliminate avoidable harm from medicines'.

Timeline: COMPLETE

Overall timescale: 1 month

National Standard 5.8	Judgment
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

Issue: "Inspectors found that there was scope to strengthen monitoring and evaluation processes in specific areas of service delivery, particularly in relation to medication safety and transitions of care, where audit activity was limited or not evident during the inspection. These areas had also been identified for improvement in the previous HIQA inspection."

Measure: LUH acknowledges the need for audit and inspection in regard to medication safety and transitions of care. While we endeavour to undertake targeted audits where possible, current resource capacity do not allow for clinical pharmacy input to all in-patients.

Action: We are conscious that providing this direct patient care must remain our priority, and we strive to improve and expand this care on an ongoing basis. With this in mind, we liaise closely with our colleagues in other hospitals within our hospital group, as well as with national organisations such as IMSN and the State Claims Agency, to identify common themes of medication issues and quality improvement initiatives that can be shared across similar sites.

We undertake trend analysis of all medication-related incidents or near misses reported within LUH and actively encourage reporting of same. This allows us to target our quality improvement initiatives to these areas of concern and use real-world examples to provide feedback and advice to medical and nursing staff. Alongside this approach, we horizon scan for potential issues arising both nationally and internationally in an effort to prevent these errors before they occur.

Timeline: Ongoing

Issue: The hospital did not have a formalised overarching quality and safety programme. Regional QPS Strategy document.

Action: A framework for Quality & Patient Safety was developed regionally in 2024. LUH is working on developing a Quality Initiative Forum that aligns with this framework. Proposal to be submitted by the QPS Manager at the next Hospital Management Team meeting on the 15th December 2025.

Timeline: Quarter 1 2026

Issue: Hospital Management reported that group performance meetings with the Integrated Hospital Area (IHA) manager for the HSE West and Northwest Health Region occurred weekly. These meetings were informal in nature and did not constitute structured oversight at group level as previously discussed under NS 5.2.

Measure: In this region, the IHA structures are scheduled to become fully operational at the beginning of March 2026. At the time of the HIQA inspection the Hospital Management were meeting weekly with the IHA Manager for Donegal and as noted these meetings largely took the form of a 1-1 review of issues between the IHA Manager and the Hospital Manager. In parallel with this process some elements of the former Saolta Governance Structure were retained, for performance monitoring all hospitals within the region continued to meet under the chairmanship of the Regional Clinical Director (for the previous Saolta Group, now RHA) Urgent and Emergency Care Governance Meeting, whilst the previous Saolta Scheduled Care Governance Group Meeting continued to meet under the leadership of a designated IHA Manager. Both the Chief Clinical Director and IHA Manager reported to the Regional Management Team and the REO.

Action: In the interim Performance Meetings have commenced with the Regional Management Team since the 8th Of October 2025, The weekly meetings with the IHA Manager for Donegal also continue and as the new IHA Structure becomes formalised so too will the governance meetings within it.

Timeline: Quarter 1 2026

Issue: Inspectors found there was scope to strengthen monitoring and evaluation processes.

Action: The LUH Nursing Quality Care Metrics Governance Committee will:

Provide strategic leadership, governance and supportive oversight for the implementation, co-ordination and continuous improvement of nursing Quality Care Metrics across LUH using the MEG digital platform.

Use the HSE MEG QCM to collate and analyse nursing key performance indicators to ensure the delivery of safe and effective nursing care.

Oversee the standardised implementation of Quality Care Metrics at LUH.

Oversee local administration and updates of the MEG platform.

Ensure QCM MEG Users have completed relevant training (e.g. HSELanD). The meetings are now established and the schedule circulated.

Share learnings and monitor effectiveness of Quality Improvement Plans (QIPs) to encourage standardisation and improvement in care Delivery.

Timeline: Complete

Issue: Comment boxes not containing feedback forms.

Action: Feedback forms are available from stationary stores. We have spoken to the CNM2's in the wards, Departmental Managers to ensure there is ownership over keeping the boxes in their area stocked.

CNM3 in the Emergency Department has been asked to nominate a person to ensure the Feedback Form boxed remain stocked and that they are emptied once per month and sent to QPS for analysis.

Measurement: QPS/ PALS will continue to collate the feedback on a monthly basis and provide a report.

Timeline: Complete

Overall timescale: Complete

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

Issue: Absenteeism is 7% which is higher than the HSE target of 4%.

Measurement: It is recognised that LUH has a high absenteeism rate however, whilst it is above the national average of 4%, LUH is on a par with other sites in the West North West Region. Inclusive of the 7% absence rates for LUH are a number of employees on long term absence. Extension of the HSE Sick Pay Scheme in September 2023 also allows for longer periods of paid absence of staff. LUH also has a higher overall compliment of payroll staff compared to other sites who have higher agency and outsourced staff that are not included in absence levels.

Action: We will continue to monitor absenteeism and the rates of return to work interviews.

Timeframe: Ongoing

Issue: Twelve Consultants not on the relevant specialist register of the IMC.

Action: Ongoing monitoring of Consultants not listed on the Specialist Division of the Irish Medical Council register continues, with regular reviews showing positive progress.

Measurement: All consultants appointed to permanent positions at LUH must be, and indeed are, registered with the relevant Specialist Register of the Irish Medical Council. There are occasions when vacancies arise from our services being expanded or retirements/resignations and the hospital cannot source a consultant on the relevant Special Register for a fixed term contract or locum basis.

In such circumstances a Risk Assessment is undertaken as to the candidate's clinical expertise and experience; support arrangements are then put in place with the relevant Associate Clinical Director. Often these consultants will have Irish or UK experience at consultant level but will not have undergone the Standard Specialist Training Programme or alternatively they will have undertaken their clinical training abroad.

In many cases, these consultants have applications for Specialist Registration in progress, and indeed we have had several such consultants who subsequently had their Specialist Registration confirmed by the IMC and went on to take up permanent posts. At the time of the inspection there were 12 of the 85 consultants in LUH not on the Specialist Registrar of the IMC. As part of our ongoing recruitment of permanent posts at the hospital this number has now reduced to 5 consultants not on the specialist registrar at the time of writing with a further one of those due to leave us at the end of the year.

Timeframe: ongoing, subject to successful recruitment

Issue: Nurse staffing levels

Action: LUH currently utilises SafeCare (module within the Nurse Rostering System) to monitor staffing trends against patient dependency and allow staff allocations be based on patient need. LUH will implement Trendcare (a new system being rolled out Nationally) by the end of 2026.

Timeframe : December 2026

Action: LUH DON will implement a nursing oversight committee within the next 6 months to monitor and manage the recruitment and retention of the nursing workforce to deliver high quality safe and reliable healthcare.

Timeframe : June 2026

Issue: Training around mandatory records availability and consistency.

Actions: Compliance rates on mandatory training will be measured every 6 months, with reporting compliance update presented at Hospital Management Team on a quarterly basis as part of the HR Report.

The HR Manager, Director of Nursing, Director of Midwifery and Hospital Manager will continue to monitor compliance for Nursing & Midwifery on the Health Roster and associated links with the HR master training recording template.

Measurement: HR continue to audit compliance with mandatory training

Timeframe: Ongoing

Overall timescale: 6 /12 months

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

Issue: Storage of supplies in corridors and under stairs & ED storage of equipment.

Action: LUH has significant challenges in respect of space and accommodation/facilities. We are working with HSE Capital & Estates to ensure that all LUH developments including the Ministers recent announcement for the development of a Surgical Hub: new Haematology and Oncology unit and 72 additional inpatient beds are designed with adequate storage to support delivery of care. The lack of storage continues to be problematic on our wards and departments.

Timeline: Ongoing

Issue: Hand hygiene sinks on Medical 8 not HBN compliant & Surgical 2 sluice room lacked a sluice hopper and a separate sink for cleaning patient equipment. Hand hygiene sink not HBN compliant.

Action: A project is underway to replace all non-compliant sinks. It is envisaged that this will be completed in the first quarter of 2026

Measurement: Sinks will meet compliance standards

Timeframe. Quarter 1 2026

Issue: Environmental concerns in ED

Action: A full review of the Environmental Hygiene Audit Frequencies is currently underway across the entire West North West region, involving all hospitals including LUH, Sligo, Mayo, Galway, Roscommon, and Portiuncula.

We are also in the process of rewriting both the Environmental Hygiene Audit Policy and the Senior Management Environmental Audit Policy.

The MEG electronic auditing system is now live in all hospitals in the West North West region since the 1st of October. The system supports real-time reporting, consistent auditing and automatic Quality Improvement Plans. It also supports closing out of Quality Improvement Plans by giving all stakeholders clear visibility of required actions

and prompting staff to close out actions. MEG provides action tracking and trend analysis, ensuring faster follow-up and improved compliance across all LUH.

ED, Medical 6 and Medical 8 have a structured audit plan in place for 2026, which includes three Environmental Hygiene Audits and one Senior Management Environmental Audit. This means each area will be audited four times next year,

For 2026, there is a planned schedule of 145 Local Hygiene Audits and 36 Senior Management Audits across the hospital to ensure significantly increased monitoring of standards.

Timeline : Quarter 2 2026

Issue : "In the emergency department, inspectors observed multiple environmental concerns, including dirty wheelchairs, cluttered waiting areas, and non-HBN compliant sinks"

There are currently 17 wheelchairs within the Emergency Department. They are cleaned every morning using a structured cleaning checklist, and this checklist is maintained and stored within the Portering Department office.

Timeline : Complete

Issue: Cleaning sign off sheets in ED were out of date and toilets had not recently been serviced.

Measure: Due to unusually high levels of sick leave the Domestic Supervisors Office, the level of daily cleaning checks being completed were not at the required standard in some departments. The cleaning checks in the public toilets in ED suffered due to this lack of supervisory resources.

Action: These resource deficiencies have now been addressed and the daily cleaning checks has returned to normal frequencies.

The environmental cleaning issues that were highlighted on the day of the inspection were addressed immediately and continue to be monitored closely a number of times every day.

The cleaning checking in Medical 6 and Medical 8 were inspected on the day and were found to be compliant.

We have a robust maintenance request system which is operated through a call centre and we are constantly striving to ensure that all requests for repairs are completed in a timely and efficient manner.

We have a sink replacement program in place which will bring all WHBs up to current standards and will be completed in early 2026.

Timeline : Quarter 4 2025

Overall timescale: Quarter 4 2025

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

Issue: Audit on clinical handover practices lacked clarity on assigned implementation responsibilities and re-audit had not taken place at the time of inspection.

Action: The Associate Clinical Director for Medicine Directorate is providing the clinical leadership and support, in conjunction with her ACD colleagues, for the implementation and monitoring of the Clinical Handover Policy throughout the hospital. Whilst there have been clear improvements in the quality of clinical handover over the last 12 months, it is accepted that there continues to be room for improvement. Consequently, a re-audit of the Clinical Handover Policy is currently being scheduled for December 2025/January 2026 and based on the findings decided a QIP will be developed to target key areas for improvement.

In addition, guidance has been issued to all clinical staff around designated specialty responsibilities for patient presenting conditions to support effective and efficient transitions of care.

Timescale: Q1 2026

Overall timescale: Quarter 1 2026

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

Issue: Lack of a comprehensive medication management policy

Action: A collaborative project is currently underway between the Pharmacy Department and Nursing Practice Development to develop a comprehensive suite of medication management policies.

The policy suite will comprise four individual documents, governing:

- General principles of medication management
- Medication administration
- Prescribing practices
- Controlled drugs

To complement the policy guidance, instructional videos are in development by Pharmacy and the LUH Centre for Nurse and Midwifery Education focusing on the safe reconstitution and administration of intravenous (IV) medications. These will accentuate the in-person education that is already currently provided.

Existing policies on medication administration and controlled drugs, along with safe prescribing guidance currently delivered by Pharmacy to doctors at induction, will be updated and incorporated into the draft policy suite.

A joint meeting between Pharmacy and Nursing Practice Development held on 9th June confirmed a target completion date for the policy suite in Q4 2025.

The policy development plan and timeline were discussed at D&T June 2025. As work has progressed on this, new issues have been uncovered around administration best practice that need to be resolved to progress this project, extending the timeline slightly.

Timescale: Quarter 1 2026

Issue: Inadequate access to up-to-date medication information for staff at the point of medication preparation in Medical 6, Medical 8 and Surgical 2 wards

The Pharmacy Department at LUH provides medication information through a dedicated folder on the 'LUH Linkopolis' desktop icon available on all hospital PCs. This includes key prescribing and administration resources such as up to date BNF access,

LUH clinical guidelines, LUH Antimicrobial Guidelines and the Saolta IV monographs and Medusa Injectable Medicines Guide, both of which have been approved by the LUH D&T Committee for IV medication preparation.

Clinical staff have previously highlighted difficulty accessing medication information when preparing drugs as ward PCs are typically located outside medication rooms and are often occupied by medical or administrative staff.

Pharmacy had previously started a project to roll out tablets/all-in-one touchscreen PCs to all wards. Mobile devices were initially identified as an ideal solution to facilitate timely access to online medication information which is regularly reviewed and updated to ensure accuracy of information. These were, however, unable to access local file shares where much of our medicines information documentation is hosted, so these were deemed unsuitable.

A review of a number of wards took place in August 2025 by Pharmacy and IT staff, demonstrating different facilities and practices on wards. A bespoke solution for each ward will be required. The Emergency Department has been identified as a pilot site for rolling out a dedicated PC for this purpose. Other wards will require significant investment in upgrading electrical and data cabling to facilitate PCs being installed in areas for medication preparation. An external contractor has been requested to perform an initial scoping exercise in order to assess likely cost.

Timescale: Q2 2026

Issue: Delayed transfers of care impacting patient flow and bed availability

Measure: Delayed Transfers of Carer continues to prove a major challenge to Patient Flow at LUH, particularly in respect of Urgent and Emergency Care. The consequent impact on bed availability also has results in significant delays to elective admissions and surgeries.

Action: LUH fully acknowledges the impact of Delayed Transfers of Care whereby patients in the hospital are clinically fit for discharge either home or to a non-acute residential facility but remain in the hospital because there is not an appropriate facility to accept them or a homecare package available to support them in their own home. The number of delayed transfers of cares have increased steadily over the last 2 years with a daily average of 34 patients in beds at LUH on any given day (12% of the hospitals adult acute beds) and that number regularly reaching 40 (14% of the hospital's acute adult beds). These numbers reflect the profile of patients presenting to LUH (significant elderly, deprived, and acutely/ chronically ill population). It also reflects the fact that the Donegal healthcare system is by far predominantly direct HSE provision of services both in respect of homecare teams and also short and long term

residential facilities. The Homecare Team recruitment has been impacted by the constraints of the Pay and Number Strategy within the HSE whilst 85 beds are closed due to a mixture of recruitment challenges and to facilitate upgrading of the facilities to meet HIQA standards.

There is ongoing recruitment on the part of the community hospitals and community nursing units to recruit additional staff to open close beds and also to appoint additional home carers. These initiatives are projected to see enhanced capacity to accept patients from LUH in Quarters 4 2025 and Quarters 1-2 2026. Work is also ongoing to provide support and rehabilitation care for patients in the community with initiatives such as the Virtual Care Ward which forms part of the Enhanced Community Care Programme supporting patients in their home and avoiding the need for their re hospitalisation.

A new community hospital in Letterkenny is currently under construction and is due to be completed in Quarter 4 2026. This new facility will provide 110 beds including both long term, transitional care, and dementia bed capacity. Also, as noted below, there is ongoing work to develop the facilities available within LUH including a planned 72 additional inpatient beds anticipated to be delivered within the next 5 years.

Timeline: Ongoing

Issue: ED overcrowding

Measure: A Health Planning consultants will assess and identify both the immediate and future clinical requirements, determining the scope of priority projects. They will contribute to the overall DCP, ensuring it provides a strategic framework for the optimal development of the LUH Campus in alignment with its long-term goals and operational needs of the population served.

The Health Planning and Design Teams will work together over the next few months to develop a comprehensive masterplan/ DCP for the campus.

Action: LUH has prioritised four key major infrastructural projects. Each of these projects can proceed independently of each other on the campus of each site but form part of an agreed overall integrated DCP. The delivery of each, either individually, or in parallel, will result in significant improvements in the capacity of the hospital to meet the needs of the population into the future.

Timeline: Ongoing

Issue: Environmental Hygiene in the Emergency Department. **Action:** The environmental cleaning issues that were highlighted on the day of the inspection were addressed immediately and continue to be monitored closely a number of times every day. **Timeline:** Complete
Overall timescale: Quarter 2026

END