Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Our Lady's Hospital Navan
Centre ID:	OSV-0001052
Address of healthcare service:	Townparks, Navan, Meath C15RK7Y
Type of Inspections:	Unannounced
Date of Inspections:	19 and 20 November 2025, and 26 and 27 June 2024
Inspection ID:	NS_0174 and NS_0083

About the healthcare service

Model of hospital and profile

Our Lady's Hospital Navan is a model 3* public acute hospital. The hospital is in the HSE Dublin and North East (DNE) health region. Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- intensive care
- diagnostic services
- outpatient care.

The provision of emergency surgery ceased in Our Lady's Hospital Navan in 2010. The hospital provides elective surgery only and does not provide acute surgery. To support this level of service, the HSE has ambulance bypass protocols in place for acutely unwell patients. If patients self-present with a suspected surgical condition the hospital has a process in place to transfer the patient to the appropriate hospital.

A model 3 hospital is a hospital that generally admits undifferentiated† acute medical patients, provides 24/7 acute surgery, acute medicine, and critical care. The Small Hospitals Framework (2013) provides for smaller hospitals (model 2 hospitals) to provide services in collaboration with larger hospitals (models 3 and 4), so they work together to deliver care in an integrated way and through co-operative working across a region.

The following information outlines some additional data on the hospital.

Number of beds (as at 19/11/2025)	138 inpatient beds 10 day case beds

* A model 3 hospital is a hospital that admits undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine, and critical care.

† Undifferenciated patients are patients who come to the health services for the first time seeking care for their current symptoms. They have not been assessed by a healthcare professional (e.g. GP) and may present to the emergency department with a wide variety of medical or surgical conditions.

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. These inspections were 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 these inspections, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During both inspections, 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 these inspections 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 each inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

This report provides a composite of findings relating to two separate inspections. The report has been compiled in this way as following the first inspection, there were a number of matters that required further escalation within the HSE for resolution and clarity for HIQA relating to the ongoing configuration of services. Findings from the first and second inspections have been presented together in the report, demonstrating areas where improvement was achieved between inspection, and also outstanding areas where further progress is required to ensure better levels of compliance against the National Standards.

The inspections were carried out during the following times:

Date	Times of Inspection	Lead Inspector	Support Inspector(s)
26/06/2024 27/06/2024	9:00hrs – 17:00hrs 9.00hrs – 16:15hrs	Bairbre Moynihan	Geraldine Ryan Nora O'Mahony Mary Flavin

Date	Times of Inspection	Lead Inspector	Support Inspector(s)
19/11/2025	09:00 – 17:15hrs	Emma Cooke	Bairbre Moynihan Aedeen Burns Lorenza Cafolla Jennifer Smyth
20/11/2025	09:00 – 15:50hrs	Emma Cooke	Aedeen Burns Lorenza Cafolla Jennifer Smyth

Information about these inspections

HIQA carried out a two-day unannounced inspection at Our Lady's Hospital Navan on 26 and 27 June 2024 to assess compliance with national standards from the *National Standards for Safer Better Healthcare.* This inspection focused on 11 national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm, these being:

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

The findings of this inspection identified non-compliance with two national standards and partial compliance with six national standards. Two standards were found to be substantially compliant and one standard was found to be compliant. Key areas of concern identified on this inspection related to governance and management arrangements, risk management, workforce arrangements, audit activity and the physical infrastructure and environment of some of the clinical areas visited. Risks associated with the presentation of undifferentiated surgical patients existed at the hospital. At the time of the June 2024 inspection, hospital management informed inspectors that Our Lady's Hospital Navan was under consideration for

[§] 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.

transformation from a Model 3 to a Model 2[§§] hospital in line with the provisions of the Small Hospitals Framework (2013).

Following the June 2024 inspection, HIQA engaged with the hospital, Integrated Health Area (IHA) Manager and Regional Executive Officer (REO) of the Dublin North East (DNE) health region to escalate concerns and identified risks. During this engagement process which included correspondence, telephone contact and meetings, hospital management and the IHA Manager committed to addressing the risks identified. The purpose of this engagement was also to provide an update to HIQA on the progress made to implement the planned actions to address the risks identified.

The actions implemented by hospital management and the Dublin North East health region to address the risks identified are included in this report. The hospital were also required to develop a compliance plan which outlined the actions the hospital was required to implement in order to comply with the national standards. As part of HIQA's ongoing engagement with the hospital, HIQA monitored the hospital's progress with implementing their compliance plan and formally sought three updates from the hospital in November 2024, April 2025 and July 2025.

Due to the level of partial and non-compliances found against the national standards and associated risks identified on the June 2024 inspection, and the fact that some issues that were outside of the direct control of the hospital needed to be escalated within the HSE following the inspection for resolution, HIQA determined that a second follow-up inspection of Our Lady's Hospital Navan was necessary. An unannounced inspection was carried out at the hospital on the 19 and 20 of November 2025. The purpose of the follow-up inspection was to determine the progress made in addressing the risks and areas of partial and non-compliance with the relevant national standards identified during the previous inspection. The follow-up inspection in November 2025 identified both evidence of progress with actions set out in the compliance plan, and also a requirement for further work to be progressed in the areas of governance and management, risk management, incident management and workforce if compliance with the national standards is to be achieved. The findings from the follow-up inspection are discussed throughout this report.

At the time of the follow-up inspection in November 2025, hospital management reported that decisions regarding the transformation of the hospital at a national level were still outstanding and the hospital continued to operate as a model three hospital without the provision of acute on-site surgical services. Therefore, HIQA found that the patient-safety risks associated with the hospital not providing acute

[§§] A Model 2S hospital, from a surgical perspective, is an elective hospital which, as with all Model 2 hospitals, receives no unscheduled, undifferentiated surgical patients.

surgical services on-site continues to be a challenge and cannot be fully managed until a decision is made relating to this issue.

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

Table 1 outlines the clinical areas visited by the inspection team during the June 2024 and November 2025 inspection.

Table 1 Clinical areas visited during both inspections

June 2024 Inspection	November 2025 Inspection
Emergency Department (including the medical assessment unit (MAU) and minor injuries unit (MIU))	Emergency Department (including the medical assessment unit (MAU) and minor injuries unit (MIU))
Pius Ward (escalation ward)	Ledwidge ward (formally Pius Ward, escalation ward)
Male Medical (medical ward)	Tara Ward (medical)
Regional Orthopaedic Unit (ROU)	Cirrus Ward (medical and acute rehab)
	Bective Ward (medical)

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to these inspections. 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 outlined in Table 1, the inspection team visited a number of clinical areas during both inspections. During both the June 2024 and November 2025 inspections, patients who spoke with inspectors were very complimentary about the care they

received in the clinical areas inspected. Patients' comments to inspectors included; "very nice staff", "very good here", "being looked after" and "staff come quickly."

During both inspections, inspectors visited the ED, the medical assessment unit (MAU) and the minor injuries unit (MIU). The ED provided undifferentiated care for adults 24/7 presenting with a medical condition. In line with the surgical bypass arrangement in place within the hospital, patients assessed as requiring surgical intervention were transferred to another hospital.

The ED had a total planned capacity of seven bays comprising a triage room, two-bedded resuscitation area for the treatment of patients categorised as major and five other bays. In addition to the seven bays there is also a negative pressure isolation room, a mental health assessment room and a triage room. During both inspections, inspectors observed additional patients boarded on trolleys on the corridor and patients on chairs. Notwithstanding this, the department was functioning well during both inspections.

The MIU was external to the main ED. This consisted of three consulting rooms and a clinical room. All consulting rooms were found to be in a state of disrepair during the June 2024 inspection, however by the time of follow-up inspection in 2025, the MIU had moved to a temporary location with notable improvements in terms of the physical environment. This will be discussed further under national standard 2.7.

The MAU contained an examination room and a six-bedded multi-occupancy room. During both inspections, beds in the MAU were in use as surge beds accommodating patients who were medically admitted and awaiting beds. During the course of the June 2024 inspection, inspectors identified concerns associated with the use of CCTV in the MAU as patients were being monitored by a CCTV camera. These concerns had been addressed by the follow up-inspection in November 2025. This along with other findings will be discussed under national standard 1.6.

Pius ward which was used for times during escalation of the ED had been renamed as Ledwidge ward at the time of the follow-up inspection. The ward contained seven beds, one of which was a single en-suite room. During the inspection of June 2024, inspectors observed multiple physical and environmental issues on this ward which were followed up during the 2025 inspection and will be discussed in further detail under national standard 2.7.

The Male Medical Ward (Tara) (24 beds) and the Regional Orthopedic Unit (ROU) (23 beds) wards were visited in June 2024. The ROU contained one single en-suite room each and was bright, spacious and welcoming for patients. However, at that time Male Medical was in need of refurbishment. There was also a limited number of single en-suite rooms for isolation purposes observed by inspectors in the clinical areas inspected as part of the November 2025 inspection. Tara Ward comprised 24

beds in total inclusive of six single en-suite rooms used for isolation purposes. Cirrus Ward also comprised 26 beds with one single en-suite room available for isolation purposes. Bective Ward comprised 15 beds with one single en-suite isolation room. The physical environment of all the clinical areas inspected during the course of both inspections will be discussed further under national standard 2.7.

Patients spoken with over the course of both inspections reported that while they had not been given any specific information regarding making a complaint, they were confident that they knew how to make a complaint if necessary.

Capacity and Capability Dimension

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

HIQA's June 2024 inspection found the hospital to be partially compliant with all standards (5.2, 5.5, 5.8 and 6.1) relating to capacity and capability.

The follow-up inspection in November 2025 identified notable improvements with features of the national standards relevant to leadership, governance and management. There was evidence of progress with actions set out in the hospital's compliance plan. However, overall compliance remained the same with national standard 5.2, 5.5, 5.8 and 6.1 remaining partially compliant.

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

At the time of the June 2024 inspection, inspectors identified a number of concerns relating to the day-to-day governance and management arrangements in place at Our Lady's Hospital Navan. These related to the governance, management and oversight of:

- Pius Ward (renamed as Ledwidge ward in 2025), which was used as part of the hospital's escalation response
- arrangements for safe transitions of care
- medication safety
- hospital policies, procedures, protocols and guidelines

- the presentation of undifferentiated surgical patients to the emergency department.

HIQA sought assurances from hospital management in relation to the governance, management and oversight of concerns outlined above and these assurances were provided. These will be discussed in further detail throughout the relevant standards in the report.

The follow-up inspection in November 2025 identified both evidence of improved compliance and also a requirement for further work to be progressed. There was evidence that many actions in response to HIQA's findings from the 2024 inspection had been progressed, for example, formalised governance and management arrangements were now in place for the escalation ward (Ledwidge ward) and the hospital had also established a Transition of Care Committee. However, further improvements were required in the areas of governance and management, risk management, incident management and workforce if compliance with the national standards is to be achieved.

While HIQA identified evidence of progress across some of the features of the national standards inspected, concerns around medication safety at the hospital remained. Governance and oversight arrangements in place for medication safety did not support the delivery of high-quality, safe and reliable care as evidenced by similar findings to that of the June 2024 inspection. Following the November 2025 inspection, HIQA formally sought assurances from hospital management in relation to risks identified with medication safety. These assurances were provided and will be discussed further under national standard 5.5. Formalised governance arrangements were in place at local and regional level for assuring the delivery of services at the hospital. The hospital was now under the governance of the Dublin North East (DNE) health region. The hospital manager was the accountable officer and reported to the Integrated Health Area (IHA) Manager of the DNE health region who in turn reported to the Regional Executive Officer (REO). Reporting and accountability arrangements for the hospital executive and relevant oversight committees were clearly outlined in updated organisational charts viewed by inspectors.

Hospital Executive Committee

The Hospital Executive Committee (HEC) was the key corporate governance structure assigned with the responsibility for ensuring the quality and safety of healthcare services at the hospital. The hospital manager was the chair of the committee and a sample of minutes of meetings reviewed by inspectors outlined that this committee was now meeting every two months as outlined in its terms of

reference which was an improvement since the June 2024 inspection. Meetings were action orientated with timelines and persons assigned to tasks.

During the June 2024 inspection, inspectors found that the HEC did not have effective oversight of the governance of unscheduled care at the hospital which included undifferentiated surgical presentations to the hospital. The Unscheduled Care Committee (USCC) had only met three times over a 20 month period despite a frequency of two monthly set out in its terms of reference. Furthermore, the presentation of these patients was not being appropriately monitored and audited, and actions were not being identified in response to concerns raised by medical staff. Following the June 2024 inspection, HIQA formally sought assurances from senior hospital management in relation to the identified concerns. The hospital's response outlined that definitive measures were put in place to ensure appropriate governance and oversight of these patients.

HIQA followed up on these measures as part of the November 2025 inspection and following a review of evidence and through discussion with staff, inspectors found that undifferentiated surgical presentations to the hospital were now being monitored and discussed at meetings of the HEC, USCC and Quality and Patient Safety Committee (QPSC). The USCC was also now meeting in line with its terms of reference. While there was evidence of ongoing monitoring, hospital management provided inspectors with only one audit that had been completed by the hospital of undifferentiated surgical presentations at the time of the follow-up inspection advising a follow-up audit was planned for November 2025. The follow-up audit was received after the inspection. In addition and subsequent to the November 2025 inspection, HIQA was provided with an audit report of the 'Management of Surgical Patients attending the ED of Our Lady's Hospital Navan who Require Inter Hospital Transfer' which had been completed by the Dublin North East Health Region Quality and Patient Safety Directorate. Findings in relation to these audits will be discussed further under national standard 5.8 and 3.1.

Quality and Patient Safety Committee

The multidisciplinary Quality and Patient Safety Committee (QPSC) managed the quality and safety of healthcare services on behalf of the HEC by providing strategic leadership and appropriate direction and decision making on all quality and patient safety committee activities within the hospital. Chaired by the clinical director, the QPSC met every two months, in line with its terms of reference. The committee reported to and was accountable to the HEC. A sample of meeting minutes reviewed outlined there was oversight of risk registers, incident reporting, scheduled care and human resources. Meetings were action orientated with actions assigned to

individuals. It was evident that the implementation of agreed actions were monitored from meeting to meeting.

HIQA's June 2024 inspection identified concerns with the governance, management and oversight of hospital policies, procedures protocols and guidelines (PPPGs). There was a lack of clarity in terms of oversight arrangements and inspectors identified a number of PPPGs that were not approved and were out of date. In response to concerns identified, hospital management provided assurances that the most up-to-date versions of PPPGs were readily available to staff. Furthermore, the hospital had established a Policy, Procedure and Guideline Committee who were formally accountable to the HEC. However, inspectors found that staff in the clinical areas inspected continued to experience difficulty accessing policies, procedures and guidelines. This will be discussed further under national standard 3.1.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control Committee (IPCC) were responsible for the governance and oversight of infection prevention and control. The committee was accountable to the HEC and the hospital manager was the chair of the committee. While findings from the June 2024 inspection found that the committee was not functioning in line with its terms of reference, a sample of minutes of meetings reviewed indicated that the committee were now meeting quarterly and that meetings were action orientated, time bound and assigned to action owners.

A number of sub-committees provided updates on relevant issues to the IPCC including; the hygiene committee, a decontamination committee and an environmental monitoring committee. The Antimicrobial Stewardship (AMS) Committee, Sepsis Committee and newly convened Policy, Procedures and Guideline Committee also provided updates at committee meetings.

Drugs and Therapeutics Committee

The Drugs and Therapeutics Committee (DTC) was accountable for the governance and oversight of medication safety practices at the hospital. Updated organisational charts reviewed by inspectors indicated that the committee was both accountable to and reported to the QPSC and HEC. The committee reported directly to the hospital manager via the HEC but also was a standing item agenda of the QPSC. The committee was chaired by a consultant physician. Terms of reference was updated since the last inspection to reflect that the committee was meeting quarterly instead of every six weeks. However, documentation reviewed outlined that the committee only met three times in 2024. At the time of the follow-up inspection in November 2025, the committee had met three times in 2025. Standing item agendas at the meeting included medication safety and incident reports, policies, procedures and

guidelines and formulary selection. Meetings were action orientated with persons assigned to actions however, actions were not time bound. Furthermore, it was not clear from a sample of minutes of meetings reviewed if actions were being actively progressed from each meeting. The Antimicrobial Stewardship (AMS) committee provided a report to the DTC at each meeting.

During the 2024 inspection, inspectors were informed that medication reconciliation was the DTC's biggest risk but this was not on the corporate risk register. During the follow-up inspection, medication reconciliation was recorded as a risk on the corporate risk register. This will be discussed further under national standard 3.1. A business case was submitted for a pharmacist to ensure medication reconciliation for all patients was complete, however, hospital management reported that this had not been approved at the time of the follow-up inspection in November 2025.

The DTC provided governance and oversight for medication-related policies, procedures and guidelines. However, inspectors noted that staff in the clinical areas inspected had difficulty accessing these policies. This will also be further discussed under national standard 3.1.

The Deteriorating Patient and Sepsis Committee

The Deteriorating Patient and Sepsis Committee (DP&SC) had overall responsibility for all aspects related to the management of the deteriorating patient at the hospital. Terms of reference for the DP&SC (approved in 2025) outlined that the committee reported to the HEC and was chaired by an emergency medicine consultant. However, inspectors found that clinical governance reporting structures for the DP&SC were not reflective of accountability arrangements set out in terms of reference for relevant oversight committees. HIQA's June 2024 inspection identified that while the committee reported to the HEC, minutes reviewed of the HEC indicated that no report was provided by this committee to the HEC. HIQA's follow-up inspection in November 2025 also identified this finding noting that the DP&SC was not listed as a committee having reporting responsibilities in the HEC's terms of reference. Furthermore, updates from the DP&SC was not a standing item agenda at meetings of the HEC. Minutes of HEC meetings from May, July and November 2025 reviewed indicated that no report was provided to the committee. Notwithstanding this, there was evidence that updates in respect of the DP&SC were discussed at the QPSC of which the hospital manager was a member.

The DP&SC met quarterly and minutes of meetings reviewed showed that the committee met three times in 2025 with a further meeting planned. Agenda items discussed included sepsis related incidents, EWS audits, education and training in relation to the deteriorating patient, blood stream infections and blood culture

contamination rates. Meetings were action orientated with time-bound actions assigned to individuals.

Transitions of Care Committee

HIQA's June 2024 inspection found that formalised arrangements were not in place at the hospital for transitions of care. Following this inspection, the hospital established a Transition of Care Committee with the first committee meeting held in August 2024. Terms of reference outlined that the committee was responsible for the ongoing review of transitions of care at the hospital. Chaired by the Director of Nursing, the committee was accountable to the QPSC and met every second month. Standing agenda items included: incidents, audits, risks, training and policies relating to transitions of care. Meetings were action orientated with time-bound actions assigned to individuals. A sample of minutes of meetings reviewed demonstrated evidence of progress from meeting to meeting.

Overall, HIQA found evidence of progress in relation to having formalised governance arrangements in place at Our Lady's Hospital Navan between June 2024 and November 2025. The majority of concerns raised in relation to governance and management of the ED were addressed. Formalised governance arrangements were now in place for the escalation ward and the hospital had established a Transitions of Care Committee. However, the presentation of undifferentiated surgical patients to the ED continues to remain a challenge for the hospital until decisions regarding the transformation of the hospital at a national level are made. Despite progress made, inspectors identified that effective management arrangements were not in place for medication safety. This will be addressed in national standard 5.5. In addition, while actions in respect of findings associated with policies, procedures and guidelines were completed, the November 2025 inspection found that these had not been effectively implemented. This will be addressed further in national standard 3.1.

Table 2 outlines the hospital's level of compliance and relevant key findings associated with national standard 5.2 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings:	**Key Findings:** ▪ clinical governance reporting structures for the DP&SC did not reflect those set out in terms of reference for the committee

▪ the HEC was not providing the necessary governance and oversight of unscheduled care in the hospital, the hospital's emergency department, medical assessment unit, minor injuries unit and Pius Ward (escalation ward) ▪ the HEC did not have effective oversight of some of the committees reporting into it, for example, the Drugs and Therapeutics Committee.	▪ actions arising from meetings of the DTC were not time bound ▪ actions set out in the hospital's compliance plan pertaining to medication safety were not fully and effectively implemented.

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

HIQA's June 2024 inspection found that while some management arrangements were functioning, a number of areas required strengthening in line with findings in relation to governance discussed under national standard 5.2. Areas requiring strengthening included transitions of care, consultant microbiology cover and management arrangements of the escalation ward.

During the follow-up inspection in November 2025, there was evidence of strengthened management arrangements relative to findings specific to the emergency department, the escalation ward and transitions of care. However, similar findings were identified in relation to consultant microbiology cover and medication safety.

Emergency Department

Following the June 2024 inspection, inspectors sought additional information and assurances pertaining to findings in the ED. Specifically inspectors sought additional information in relation to the following:

- dates for the relocation of the Minor Injuries Unit (MIU) to a new temporary premises
- commencement dates for a five day emergency medicine consultant cover for the ED
- consultant out-of-hours arrangements for the ED.

During the follow-up inspection in November 2025, there was evidence of progress in relation to the above findings within the ED from the previous inspection. The MIU had relocated to a new temporary premises on 30 September 2024. The unit was located directly opposite the main entrance of the ED. The allocation and admission of patients to the unit was supported by documented admission and exclusion criteria. The unit operated seven days a week from 8am to 8pm. Patients were initially triaged in the ED and assigned the appropriate pathway based on documented admission criteria. Patients remaining in the MIU at 7pm were transferred back to the main ED. The unit was staffed by one Advanced Nurse Practitioner (ANP) or one registrar each day.

The hospital had defined lines of responsibility and accountability for medical and nursing leadership in the ED and there was evidence of progress in relation to medical staffing concerns identified on the previous inspection. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine of which there were two in place at the time of the November 2025 inspection. Findings from HIQA's June 2024 inspection identified that an emergency medicine consultant was only available onsite for four days a week, however, this had now increased to five days a week. Out of hours, one of the two emergency medicine consultants provided on call cover. While these on call arrangements were reported by medical staff as being satisfactory and proportionate to the level of activity in the ED, such a rota may be a challenge to sustain in the longer term. A locum emergency medicine consultant who was familiar with the hospital provided cover for periods of leave.

Emergency medicine consultants were supported by four non-consultant hospital doctors (NCHDs), all at registrar grade. The shift pattern of these registrars had also changed since the June 2024 inspection with one registrar working 8am to 8pm and a second registrar commencing 12pm to 10pm. Out of hours there was one registrar working 8pm to 8am. The change in this shift pattern was to ensure adequate cover at senior level in the ED during out of hours. Staff who spoke with inspectors reported that this shift was having a positive impact on patient flow within the ED.

The ED provided undifferentiated care for adults 24/7 presenting with a medical condition. A surgical consultant and two NCHDs were on call 24 hours, seven days a week to review patients presenting to the ED with a suspected surgical condition. Similar to HIQA's previous inspection, inspectors were informed that the surgical team had no admission rights in the hospital. As discussed under national standard 5.2, patients presenting with a surgical related complaint who required intervention were transferred to another acute hospital in the region. Hospital management reported that on average 1.5 surgical patients per day were being transferred from the ED with patients waiting an average waiting time of 10.5 hours for transfer. While these patients were being actively cared for and accessing interventions such

as diagnostics prior to being transferred, the presentation of undifferentiated patients continued to remain a challenge for the hospital.

An assistant director of nursing had operational oversight of the ED Monday to Friday. There was a CNM2 on duty each shift and they had overall responsibility for the nursing services in the ED out of hours and at the weekend. Progress relating to nurse management arrangements since the previous inspection included ensuring that the CNM2 was supernumerary as the shift lead. The CNM2 as the shift leader on both days of the November 2025 inspection was supernumerary in line with the Department of Health's safe staffing framework,*** however, nursing management did report that at times the CNM2 would still be allocated patients if the ED was particularly busy but the frequency of this occurring had significantly decreased according to nursing management in the ED. The ED had also received an uplift in nursing staffing since the previous inspection with an additional nurse allocated to the day and night shift, however, the ED continued to have a nurse staffing deficit which will be discussed further national standard 6.1.

Additional progress made in the ED since the previous inspection included the introduction of EMEWS on 14 October 2024. This was also described as a positive and effective change within the department and will be discussed further under national standard 2.8 in terms of its implementation.

As outlined under national standard 5.2, formalised governance and management arrangements were now in place for the escalation ward (Ledwidge ward). A clinical nurse manager 3 and a site nurse manager were assigned responsibility for the governance and management of the unit. On day one of the November 2025 inspection the escalation ward was not operational as the ED was functioning well within its approved capacity. On day two of the November 2025 inspection, the ward had opened to alleviate pressures within the ED. The ward had capacity for seven patients of which there were six at the time of inspection. The ward was staffed by two nurses of which one was always required to be a permanent staff nurse and the other agency staff. Staff who spoke with inspectors were aware of reporting and accountability arrangements for the ward. During hours, staff reported to the clinical nurse manger 3 and out of hours staff reported to the site nurse manager. Staff were familiar with the wards' inclusion and exclusion criteria which was supported by a formally documented standard operating procedure reviewed by inspectors and accessible by staff within the ward.

The majority of patients presenting to the MAU were GP referrals and admissions to this unit was guided by documented inclusion and exclusion criteria. Since HIQA's previous inspection, there had been no progress in securing a consultant to lead the MAU and support increased patient turnover. Minutes of meetings reviewed outlined that this issue was escalated to the Regional Quality and Patient Safety Agenda by

hospital management. The MAU tracked patient activity including those who required escalation and those admitted to hospital.

Overall, there was evidence that actions set out in the hospital's compliance plan relative to the ED and the escalation ward were completed with notable improvements observed by inspectors and reported by staff. Notwithstanding this, it was evident that the presentation of undifferentiated surgical patients still remained a risk for the ED, this will be discussed further under national standard 3.1.

Findings relevant to the wider hospital

The follow-up inspection of November 2025 focused on progress made in response to findings relative to the four areas of known harm that were the focus of both inspections - infection prevention and control, medication safety, the deteriorating patient (including sepsis) and transitions of care. Specifically inspectors looked at progress made in relation to consultant microbiology cover and transitions of care which were identified as areas requiring strengthening in the June 2024 inspection. These are discussed in more detail below.

Infection Prevention and Control

During HIQA's inspection of June 2024, inspectors found that the lack of an onsite presence of a consultant microbiologist restricted the development of the infection prevention and control programme. The hospital's compliance plan outlined that a new on-site consultant would be in place by December 2024. However, the follow-up inspection in November 2025 found that while a new consultant microbiologist had taken up post in June 2025, consultant microbiology arrangements remained the same in so far as this consultant was also primarily based off site. Inspectors were informed that the consultant would attend the hospital twice per month or as requested. During out of hours, the hospital had access to two agency consultant microbiologists who were known to the hospital but also based off site.

The remaining infection prevention and control team comprised one IPC CNS, one CNM 2 and an antimicrobial stewardship pharmacist. Inspectors were informed that the surveillance scientist post was vacant since September 2025, this had been recently filled but a commencement date had yet to be finalised.

The team produced an annual report for 2024 and there was evidence that this was presented and discussed at the hospital's IPCC. An annual plan was also completed for 2025 which set out key objectives of the year with a focus on surveillance, antimicrobial stewardship activities, education, hand hygiene, policies, procedures and guidelines and key performance indicators. An antimicrobial stewardship annual report was also completed and included an annual action plan for 2025. Similar to

[***] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland

HIQA's previous inspection in June 2024, inspectors found that the consultant microbiologist was primarily based off site, which did impact on the IPC team's ability to fully implement the infection prevention and control programme. While the current microbiologist attended the hospital twice per month and additionally if required, inspectors were informed that regular AMS rounds were not taking place. Staff reported that patients would be escalated as required via phone to the consultant microbiologist. In recent years, hospital management have tried to jointly fill this post with other hospitals within the region but have been unsuccessful. At the time of the follow-up inspection in November 2025 efforts were being made to try and secure a joint post with a nearby Model 3 hospital.

Medication Safety

Similar to HIQA's previous inspection, the follow-up inspection in November found that the hospital continued to have a limited clinical pharmacy service.[†††] There was a documented medication safety programme that was led by the Pharmacy Executive Manager. There was evidence that the programme was regularly reviewed and updated to evaluate progress made against key areas of focus which included: medication safety incidents, policies, procedures and guidelines, data, infrastructure and workforce, technology and education.

During the follow-up inspection in November 2025, inspectors found that effective management arrangements for medication safety at the hospital were not in place as evidenced by repeated findings from the June 2024 inspection. The hospital's compliance plan outlined that many of the medication safety actions identified in response to inspection findings were complete, however, inspectors found multiple examples that indicated that these actions were not effectively implemented or sustained. Furthermore, a medication safety action set out in the hospital's compliance plan was not completed despite being reported as completed. Similar to HIQA's previous inspection, inspectors found that the storage and use of intravenous potassium chloride was not in line with hospital policy and that appropriate systems such as audit were not in place to monitor compliance. In addition, staff could not access up-to-date medication policies, procedures and guidelines in a timely manner to guide the safe use of medicines at the point of prescribing, preparation and administration.

Following the November 2025 inspection, HIQA formally wrote to the hospital seeking assurances that pharmacy resources were being effectively and efficiently organised, prioritised and managed in order to provide the necessary assurances for medication safety at the hospital. The hospital response outlined the actions to be taken by

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

hospital management to address these findings including the approval of additional pharmacy resources which will be discussed further under national standard 6.1.

Deteriorating Patient Improvement Programme

The hospital had clinical leadership at consultant level for the implementation of the early warning systems at the hospital. There was a designated lead for all relevant early warning systems for the various cohorts of patients: the Irish National Early Warning System (INEWS),[‡‡‡]the Irish Maternity Early Warning System (IMEWS) and the Emergency Medicine Early Warning System (EMEWS).

Transitions of Care

As outlined in national standard 5.2, formalised systems and processes were now in place to support transitions of care and flow at hospital with the establishment of a Transitions of Care Committee. Transfer policies and defined admission and exclusion criteria were in place to support the safe transfers of patients to and from the hospital.

In summary, HIQA's follow-up inspection in November 2025 found evidence of strengthened management arrangements relative to findings specific to the ED, the escalation ward and transitions of care. However, inspectors found that effective management arrangements for medication safety at the hospital were not in place as evidenced by repeated findings from the June 2024 inspection. Furthermore, consultant microbiology arrangements continued to limit the full implantation of the infection prevention and control programme.

Table 3 outlines the hospital's level of compliance and relevant key findings associated with national standard 5.5 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings: ▪ formal management arrangements to monitor issues that impacted on the effective and safe transitions of	**Key Findings:**

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

care in place in the hospital were not in place ▪ there was no assigned manager of Pius Ward ▪ lack of an onsite presence of consultant microbiologist restricted the development of the infection prevention and control programme.	▪ effective management arrangements for medication safety at the hospital were not in place as evidenced by repeated findings from the previous inspection ▪ the limited onsite presence of a consultant microbiologist was impacting the ability to fully implement aspects of the infection prevention and control programme. For example, AMS rounds.

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.

HIQA's inspection in June 2024 found that risk management structures and processes to identify, manage and minimise clinical risk in the hospital were not sufficiently robust to provide assurance to hospital management of the quality, safety and reliability of the services provided at the hospital. Findings specifically identified the following;

- the hospital corporate risk register was not being regularly updated
- the risk of surgical presentations to the ED was not being continuously evaluated through auditing despite being recommended from a patient-safety review conducted by the hospital
- risks associated with escalation ward had not been appropriately identified or assessed.

During the follow-up inspection of November 2025, inspectors found that formalised risk management structures and processes were still under development at the hospital and had yet to be fully embedded in the hospital's overall clinical governance structures. Inspectors reviewed the hospital corporate risk register in relation to the key areas of harm which were the focus of this inspection. While all risks were clearly described and assessed with existing controls documented to mitigate the risk, only nine risks indicated a date in which they were next due for review. Hospital management reported that risks were regularly reviewed and discussed both informally with hospital management and formally at the HEC and QPSC meetings with the corporate risk register being a standard item agenda at the

QPSC. However, a sample of meeting minutes reviewed from both these committees provided limited evidence that these risks were being formally reviewed and that the focus at this stage still remained on documenting and standardising the process for managing and reviewing the corporate risk register.

At the time of the November 2025 inspection, the highest rated risk recorded on the risk register related to surgical presentations to the ED due to the lack of appropriate surgical facilities and expertise in the hospital resulting in delayed transfers and treatment and poor patient outcomes. Documented controls in place included the assignment of a surgical registrar to the ED at all times, bypass protocols, patient pathways, the use of EMEWS and surgical audit with oversight by a consultant at all times. Inspectors observed evidence of these controls in place as part of the follow-up inspection and discussed the effectiveness of these controls with senior hospital management. While the hospital could not fully prevent the risk, management were satisfied that existing controls were effective in terms of the reducing the risk. Clinical staff who spoke with inspectors in the ED demonstrated a good awareness of controls in place to mitigate against the risk of surgical presentations to the ED, however, this risk was not documented on the ED's risk register which will be discussed further in national standard 3.1.

Following the November 2025 inspection, minutes of meetings reviewed by inspectors outlined that the management of trauma patients within the hospital required review with a specific requirement for a policy and procedure to be clearly communicated on the management of trauma patients attending radiology. This was being actioned by the consultant lead in emergency medicine.

The hospital collected and collated data related to for example, patient-safety incidents, patient experience times, complaints and compliments and workforce. These were reported at meetings of the HEC and the QPSC and at monthly performance meetings between the hospital and at IHA level.

The hospital had systems in place to proactively identify and manage patient-safety incidents. Incidents were entered on to the National Incident Management System (NIMS)[§§§]. There was evidence that quality improvement plans were developed following a review. However, inspectors identified a missed opportunity in terms of formalising the review of an incident at the hospital. This will be discussed further under national standard 3.3.

HIQA's June 2024 inspection found that while audits were a standing item agenda at the QPSC, it was not clear if the recommendations from audits were monitored and

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

overseen by the committee. In the follow-up inspection, a review of minutes from the QPSC identified that while updates in respect of audit activity at departmental level were discussed, there was no overarching system or structure in place to ensure recommendations from audits were being monitored with appropriate oversight from the relevant committee. Inspectors were informed that a clinical audit group was in the process of being developed under the clinical leadership of a consultant physician. A sample of audits reviewed by inspectors identified that quality improvement plans were not always completed following an audit.

As part of the hospital's compliance plan following the June 2024 inspection, the DTC were to complete an audit of discharge medication by December 2024. The audit was documented as complete on the hospital's updated compliance plan provided to HIQA however, there was no evidence that this audit had been completed. Following the November 2025 inspection it was confirmed to inspectors that the audit had not been completed.

Similar to HIQA's previous inspection, quality and safety walk arounds continued to take place by members of senior management. A sample of recent quality and safety walk arounds of clinical areas reviewed by inspectors demonstrated that walk arounds had identified areas for action with assigned action owners.

Overall, similar to HIQA's previous inspection, there was evidence that systematic monitoring arrangements were in place for identifying and acting on opportunities to improve the quality and safety of services at the hospital. However, further action was required to ensure these systems were formalised, consistent and effective. While there was evidence of ongoing monitoring of surgical presentations and transfers of surgical patients by hospital management at HEC, USCC and TOC meetings, a repeat audit had not been completed by the hospital at the time of the follow up inspection in November 2025 despite hospital management informing HIQA that this would commence in September 2024 following the previous inspection.

Table 4 outlines the hospital's level of compliance and relevant key findings associated with national standard 5.8 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings:	**Key Findings:**

▪ the hospital corporate risk register was not being regularly updated ▪ the risk of surgical presentations to the ED was not being continuously evaluated through auditing ▪ risks associated with escalation ward had not been appropriately identified or assessed. ▪ it was not clear if the recommendations from audits were monitored and overseen by the QPSC	▪ the risk register did not indicate that all risks were being formally reviewed and updated by the relevant oversight committee ▪ only one audit of surgical presentations to the ED was completed by the hospital since the previous inspection ▪ there was no overarching system or structure in place to ensure recommendations from audits were being monitored with appropriate oversight from the relevant committee ▪ a medication safety audit was not completed as indicated in the hospital's compliance plan ▪ quality improvement plans were not always completed following an audit.

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

HIQA's June 2024 inspection found that hospital management were planning, organising and managing their nursing, medical and support staff. Notwithstanding this, a number of areas were identified as requiring significant improvement following that inspection. These related to ED workforce resources, high staff absenteeism rates and limited onsite presence of a consultant microbiologist. Poor compliance rates amongst some staff disciplines with mandatory training was also identified as an area requiring improvement.

The follow-up inspection of November 2025 found that while good progress was made in terms of addressing concerns identified with ED workforce arrangements, challenges in relation to nursing staffing in the ED remained. In addition, inspectors found similar findings to that of the 2024 inspection in relation to high staff absenteeism rates, consultant microbiology presence and staff compliance with mandatory training.

Emergency Department Workforce

There was evidence of progress in relation to ED workforce resources since the previous inspection. As outlined in national standard 5.5, a senior clinical decision-maker[****] at consultant level was now on-site in the hospital's ED five days a week. Consultants in emergency medicine were supported by four WTE non-consultant hospital doctors at registrar grade with no vacant posts at the time of inspection.

Staffing in the Minor Injuries Unit (MIU) comprised two registrars, two Advanced Nurse Practitioners (ANPs) and two senior nurses and a clinical nurse manager. At weekends there was only one ANP on duty for Saturday and Sundays. The June 2024 inspection identified that 1.5 WTE advanced nurse practitioner (ANP) posts were vacant in the MIU. The follow-up inspection identified that the post had been filled on a 0.5 WTE basis leaving one WTE ED ANP post available.

The ED had received an uplift in nursing staff since the previous inspection. The uplift in nursing staff resulted in an additional nurse being placed on day and night duty. The ED was now approved for 29 WTE nurses (inclusive of managerial and staff nurse grades). Despite the uplift, the ED was experiencing a shortfall of 3.8 WTE nurses at the time of the November 2025 inspection. This shortfall resulted in the use of regular agency staff which were familiar with the ED to fill any gaps in rosters. However, on the day of inspection the ED had its full complement of nursing staff. A review of ED nursing staff roster for October and November 2025 showed that agency staff was consistently required on days and nights to fill roster gaps. The continued use of agency staff to fill nursing roster gaps is not sustainable in the long term and requires ongoing review by senior hospital management.

Workforce findings related to the wider hospital

At the time of the November 2025 inspection, the hospital's approved complement of staff (all staff) was 681.7 WTEs with 26 WTE vacancies. Similar to the previous inspection, the majority of these vacancies (six) were amongst the nursing discipline (three staff nurse, two clinical nurse specialist and one ANP ED).

The hospital were approved for 18.8 WTE consultant posts of which there were 17.9 WTE in place at the time (variance of 0.8 WTE) of the November 2025 inspection. Notwithstanding this the hospital was seeking approval for a further two WTE consultant posts in cardiology and microbiology which had received approval previously as shared consultant posts with other hospitals. During both HIQA inspections the hospital was staffed appropriately with NCHDs with the hospital

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

having 82 WTE NCHDs at the time of the November 2025 inspection with no reported deficits.

While a new onsite consultant microbiologist had taken up post in June 2025, consultant microbiology arrangements remained the same as the previous inspection in so far as this consultant was employed on an agency contract and was based in another country, and therefore primarily based off site. Inspectors were informed that the consultant would attend the hospital twice per month or as requested. Minutes of meetings of the infection prevention and control team and outbreak meetings confirmed that the consultant was in attendance. During out of hours and periods of consultant leave, the hospital had access to two agency consultant microbiologists who were known to the hospital but also based off site.

During both the June 2024 and November 2025 inspection there were no vacancies in the pharmacy department. The hospital were approved for six WTE pharmacists and four pharmacy technicians. A business case was submitted to the regional employment control committee for an additional two WTE pharmacist posts (one WTE for medication reconciliation and one WTE to lead the medication safety programme). At the time of the November 2025 inspection, these posts had not been approved. However, correspondence received from the hospital on 10 December 2025 in response to risks identified with medication safety at the hospital outlined that these posts had now been approved.

Training

The human resource department had oversight of mandatory training at the hospital. During both HIQA inspections, inspectors identified that improvements in the uptake of mandatory training amongst some staff disciplines was required.

HIQA's June 2024 inspection found that the uptake of mandatory training from consultants and non-consultant hospital doctors was an area which required significant improvement. Minutes of relevant oversight committees and training records submitted post the November 2025 inspection identified that this remained an ongoing issue for hospital management. Training records received following the November 2025 inspection found very poor compliance amongst doctors with mandatory training requirements. For example, training records provided indicated low compliance rates amongst doctors with medication safety training. Inspectors escalated these concerns to hospital management and formally sought assurances in relation to the actions being taken to improve compliance rates amongst doctors with this training. The hospital's response outlined that the newly approved medication safety pharmacist will undertake an in-depth training programme targeted at all appropriate clinical grades but as an interim measure the hospital will engage an external medication safety expert to provide training and strengthen medication

safety for all NCHD's. Hospital management also reported that while doctors did receive medication safety on induction, training records required improvement as it did not accurately capture the uptake of this training.

While there was evidence that training compliance rates were discussed at HEC and regional performance meetings very little progress had been made since the previous inspection in relation to medical staff compliance with INEWS (63%). Hospital management outlined that an email was recently circulated to staff in relation to implementing the hospital's disciplinary policy if staff continue to not commit to fulfilling their mandatory training. Hospital management outlined that the records provided in respect of doctors may not be an accurate reflection of the uptake of mandatory training due to certificates of completion not being provided to the human resources department.

HIQA's June 2024 inspection found poor compliance rates of mandatory training amongst all staff in complaints managements. The uptake of this training had improved by the November 2025 inspection with 78% of nurses and 76% of doctors having completed same.

Poor compliance amongst healthcare assistants was also noted with mandatory training in standard and transmission based precautions and hand hygiene. Inspectors found that further action was required to ensure that all clinical staff attend mandatory and essential training at the required frequency appropriate to their scope of practice, and that attendance and uptake of training is recorded for all staff, including medical staff.

The human resource department tracked and reported on staff absenteeism rates and reported to the QPSC. HIQA's previous inspection on June 2024 reported absenteeism rates above the national KPI target of 4.5% (5.84% in May 2024). By September 2025, the absenteeism rate had risen to 8.21%, above the 2025 target of less than or equals to 4.0%. Inspectors were informed that in order to improve these rates, back to work interviews were being conducted. Staff were also being reminded about the availability of occupational health and employee assistance schemes.

Overall, the November 2025 inspection found evidence of progress since the last inspection which demonstrated that hospital management were planning, organising and managing the workforce to support the provision of high-quality, safe healthcare. However, the majority of this progress was associated with ED workforce arrangements. Notwithstanding this, the ED continued to operate with a nursing deficit and was reliant on the use of regular agency staff to fill nursing shifts. Furthermore, inspectors found repeated findings from the 2024 inspection in relation to poor compliance amongst doctors with mandatory training and high absenteeism rates.

Table 5 outlines the hospital's level of compliance and relevant key findings associated with national standard 6.1 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings: ▪ the CNM2 as the shift leader in the emergency department was not 100% supervisory in line with safe staffing frameworks ▪ the hospital did not have the required number of staff nurses to implement the EMEWS ▪ 1.5 WTE advanced nurse practitioner post was vacant in the minor injuries unit ▪ poor compliance rates in complaints management training across all disciplines of staff ▪ poor compliance rates with mandatory training for healthcare assistants and medical personnel were identified ▪ there was limited onsite presence of consultant microbiologist due to an ongoing vacant permanent post ▪ staff absenteeism rates were above the national KPI.	**Key Findings:** ▪ nurse staffing levels in the ED were reliant on the use of agency staff to fill the current shortfall (3.8WTE) in nursing staff ▪ staff absenteeism rates were above the national KPI ▪ there was limited onsite presence of consultant microbiologist ▪ poor compliance rates with mandatory training for medical personnel was identified ▪ records pertaining to the attendance at and uptake of mandatory training required improvement for some disciplines.

Quality and Safety Dimension

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

HIQA's inspection in June 2024 found the hospital to be complaint with standard 1.7, substantially compliant with standards 1.8 and 3.3, partially compliant with standards 1.6 and 2.8 and non-complaint with standard 3.1.

The follow-up inspection in November 2025 found some improvements with features of the standards related to quality and safety. There were some improvements with the level of compliance with national standard 2.7 found to be partially compliant. National standard 1.7 was also found to be compliant again. However there was no change in the level of compliance with national standards 1.6 and 2.8 which were both found to be partially compliant again and national standard 3.1 which was found to be non-compliant. Furthermore, there was a deterioration in compliance with national standard 3.3 found to be partially compliant on this inspection.

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

Inspection findings from the June 2024 inspection found that patients' right to dignity and privacy was not maintained as inspectors observed a wall mounted CCTV screen across from the nurses' station in the MAU where patients could be observed sitting in or at their bedside. At the time of this inspection, this practice was not supported by the hospital policy and HIQA sought assurances that this practice would be addressed.

HIQA followed up on the assurances received by hospital management as part of the November 2025 inspection and found that the CCTV was removed and an updated policy was in place.

Over the course of both inspections staff demonstrated an awareness of the requirement to respect and promote the dignity, privacy and autonomy of the people using the service. In general, staff in the clinical areas inspected were observed to be kind and caring towards patients and responsive to their individual needs. Patients were familiar with their immediate surroundings and understood how to use their call

bell to request assistance. Curtains were used to promote and protect the dignity and privacy of patients when clinical care was provided.

However, the physical environment did not always ensure that patients' dignity, privacy and autonomy were respected and promoted, particularly in the ED. It was not possible to maintain privacy and confidentiality when communicating and interacting with patients being cared for on chairs or trolleys outside cubicles. There was a risk that others (patients, visitors and staff) could overhear patient-clinician conversations and personal information exchanged between patients, medical and nursing staff.

Inspectors found examples on both inspections where patients' personal information was not always protected. For example in the June 2024 inspection, inspectors observed that patient bed spaces in the ROU contained personal information relating to the patient including their name, dietary requirements and if they had swallowing difficulties. This was brought to management's attention at the time to be addressed. During the November 2025 inspection, inspectors observed healthcare records stored openly and not locked in the ED. This was also brought to the attention of nursing management and was resolved.

Overall, during the course of both inspections, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care. The follow-up inspection in November 2025 confirmed that the use of CCTV in the MAU had stopped in line with assurances provided following the June 2024 inspection. Notwithstanding this, similar findings were identified in relation to the ED environment impacting patients' dignity and privacy. Furthermore, the protection of patients' personal information was identified as an opportunity for improvement on both inspections.

Table 6 outlines the hospital's level of compliance and relevant key findings associated with national standard 1.6 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings: ▪ CCTV cameras were in place in patient bay areas in the MAU. Management were unaware of this and the hospital policy did not support this practice	**Key Findings:** ▪ the physical environment in the ED did not always ensure that patients' dignity, privacy and autonomy were respected and promoted ▪ patients' personal information was not always protected in the ED.

▪ an inspector observed poor communication skills by a staff member with a patient in the emergency department.	

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

During both inspections, inspectors observed staff attending to patients and being kind and caring in the clinical areas inspected. Clinical staff actively promoted a culture of kindness, consideration and respect though their communication, interactions and recognising the individuality of the patients.

Patients who spoke with inspectors stated that staff were 'very nice staff', 'very good here' and 'I get help when I need it'. Patients reported that they were supported with their care needs and described the care as 'excellent', and 'very happy with the care'.

Information leaflets on a range of health topics were readily available and accessible for patients. Overall, hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital and this was confirmed by the patients who spoke with the inspectors.

Table 7 outlines the hospital's level of compliance and relevant key findings associated with national standard 1.7 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Compliant	Compliant

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

The hospital had a complaints procedure in place and continues to promote the HSE's complaints management policy '*Your Service, Your Say*'. The complaints coordinator was the designated person with responsibility for the management of complaints received with the hospital manager assigned with overall accountability. The complaints coordinator was supported by ten designated complaints officers. Complaints was an agenda item at QSEC and HEC committees.

The hospital promoted resolution of Stage 1 complaints at the point of contact in line with national guidance. This was supported by information provided to inspectors in the clinical areas visited. Where point of contact resolution was not possible, the CNMs escalated to the complaints coordinator.

The complaints coordinator was responsible for tracking and trending of Stage 2 complaints which was shared at local designated complaints officer meetings, QSEC and HEC. Inspectors reviewed documentation and meeting minutes which identified a 75 complaints year-to-date yielding a 58% increase in Stage 2 complaints compared to 2024 figures for the same period. Safe and effective care, dignity and respect and access to care were the top three themes. There was good compliance with the complaints resolution against the national target. Documentation received on inspection indicated a breach in national target on one occasion which inspectors were advised may have been attributed to resourcing challenges during a period of leave.

Information regarding how to make a complaint, including *'Your Service, Your Say,'* leaflets, was not on display in the clinical areas. An example of these leaflets was provided to inspectors, it included information pertaining to the local complaints process including escalation to the regional health area or the Ombudsman in the event a service user was dissatisfied with the local response. The leaflet incorporated information regarding the Patient Advocacy Service. The majority of patients who spoke with inspectors were not familiar with the hospital's complaint process, however, they advised they would raise concerns with a member of staff if required.

Performance with complaints management was reviewed at monthly performance meetings with the hospital. Records reviewed showed that percentage of complaints responded to within 30 day timeframe ranged between 70-100%

Unidentified red boxes were observed in the clinical areas which inspectors were informed were intended for patient feedback. No comment cards or stationary were available at these boxes. Stickers identifying these boxes and comment cards were made available upon conclusion of the inspection.

Inspectors were informed the hospital's quarterly patient engagement newsletter for staff was collated and disseminated to staff. However, these newsletters were not observed in the clinical areas inspected. Feedback in the clinical areas on complaints was shared via clinical handover and safety huddles.

Completion of HSELand†††† training on communication was mandatory for staff and the newsletter indicated that compliance was low amongst staff. This was discussed under national standard 6.1.

Overall, the hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people who use their services. Notwithstanding this, opportunities for improvement were identified during both inspections.

Table 8 outlines the hospital's level of compliance and relevant key findings associated with national standard 1.8 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Substantially compliant	Substantially compliant
Key Findings: ▪ *'Your Service, Your Say'* leaflets were not readily available to patients in every clinical area ▪ feedback following complaints resolution was not routinely fed back to the local areas.	**Key Findings:** ▪ Information regarding how to make a complaint, including *'Your Service, Your Say'* leaflets, was not on display in the clinical areas.

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.

Findings from HIQA's June 2024 inspections identified that the physical environment in the hospital was generally well maintained with the exception of the minor injuries unit (MIU) and Pius Ward (escalation ward).

The follow-up inspection found that the maintenance of the physical environment varied across the clinical areas inspected with the physical environment noted to be good overall, however improvements were required within the ED. Some progress was made in relation to the escalation ward and MIU, however, the lack of appropriate isolation facilities and inadequate storage in the clinical areas inspected continued to impact on the delivery of quality, safe and reliable care.

†††† HSeLanD is the Health Service Executive's (HSE) national online learning and development portal.

Emergency Department

Similar to HIQA's previous inspection, inspectors found that the design and layout of the ED did not facilitate an environment that promoted effective infection prevention and control practices and safe medication practices.

The ED was clean with few exceptions, however, the additional trolleys within the various sections resulted in added patient equipment and supplies in the general areas and impacted on the space available to move around.

Inspectors observed that a room within the ED was being used as both a staff room and a storage room. The room contained sterile dressings, respiratory equipment and other supplies which may be a risk for contamination. This was brought to the attention of the clinical nurse manager to be addressed immediately and a formal risk assessment was requested by inspectors. All sterile supplies were removed from the room as an immediate action and the purpose and function of the room was under review by hospital management.

The hospital had two negative pressure rooms[‡‡‡‡] in the ED and Intensive Care Unit (ICU). Inspectors observed that the negative pressure dial in a room used for isolation in the ED was not working on the day of inspection. This was also a finding of the June 2024 inspection and as part of the hospital's compliance plan, hospital management had committed to addressing this and confirmed that it had been fixed at this time. On the day of the November 2025 inspection, staff were unaware if this had been escalated to maintenance and the room was occupied at the time with standard and droplet precautions required. On day two of the follow-up inspection in November 2025 the negative pressure dial was still not working. Inspectors were informed that it had been escalated to maintenance to be fixed and the room was no longer occupied by patients requiring infection prevention and control precautions. This reduced the capacity in the ED to accommodate patients requiring IPC precautions.

Storage presses on the main corridor in the ED containing intravenous fluids were unlocked and easily accessible. This was brought to the attention of nurse management to be addressed immediately and inspectors observed that the presses were locked upon review.

The Controlled Drug (MDA) press in the ED for medication requiring strict precautions was located directly beside a patient trolley in the resuscitation bay. This

[‡‡‡‡] Negative pressure rooms, also called isolation rooms, are a type of hospital room that keeps patients with infectious illnesses, or patients who are susceptible to infections from others, away from other patients, visitors, and healthcare staff.

resulted in medications for all patients being accessible and prepared directly at a patient bedside.

The June 2024 inspection found that the design and layout of Pius (escalation ward) did not facilitate an environment that promoted effective infection prevention and control practices in line with national and international best practice. Patient rooms contained shared bathroom facilities. None of the rooms contained a window and no mechanical ventilation was installed as an alternative. Three patients had confirmed COVID-19 and staff were unable to maximise natural ventilation. Inspectors requested a formal risk assessment be completed to mitigate identified risks. This finding also formed part of the hospital's compliance plan where the hospital were looking at installing mechanical ventilation ward for this room, however, this was identified as a non-viable option by maintenance and estates. Controls put in place to mitigate the risk in this clinical area included having defined inclusion and exclusion criteria for the ward which was set out in a standing operating procedure reviewed by inspectors in the clinical area. The procedure also outlined the requirement to notify IPC when the ward was being open for escalation purposes.

Findings relative to the wider hospital.

Inspectors found over the course of both inspections in the clinical areas that not all hand hygiene sinks observed in the clinical areas visited met the met the required specifications,[§§§§] necessary requirements. This was not identified as a risk on the IPC risk register or corporate risk register. Wall-mounted alcohol-based hand sanitiser dispensers were readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited.

Cleaners were employed by the hospital and cleaning supervisors and clinical nurse managers had oversight of cleaning in their respective areas. Clinical nurse managers who spoke with inspectors were satisfied with the level of cleaning resources in place. Patient equipment was observed to be generally clean in all clinical areas visited. Cleaning of patient equipment was assigned to nursing staff and healthcare assistants and there was a system in place to identify cleaned equipment. During the November 2025 inspection, inspectors observed that cleaning supplies and chemicals were not consistently stored appropriately enabling easy access in one of the clinical areas inspected which was brought to the attention of nursing management and addressed. Environmental and patient equipment audits were carried out and these are discussed further under national standard 2.8.

There was a lack of appropriate isolation rooms across the hospital which was identified as a risk and placed on the hospital's risk register. The ROU and Male Medical Ward had multiple multi-occupancy rooms. The infection prevention and control nurses liaised with staff in the wards and visited on a daily basis to support

appropriate placement of patients who required isolation for infection control purposes. There was a lack of appropriate storage facilities observed in the clinical areas inspected during both inspections which resulted in equipment being stored on corridors.

Overall, similar to findings of the June 2024 inspection, inspectors found that the physical environment did not fully support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care. While progress was made in relation to the MIU and infection control risks identified with the escalation ward were being risk assessed, inspectors found similar findings to that of the previous inspection.

Table 9 outlines the hospital's level of compliance and relevant key findings associated with national standard 2.7 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Non-compliant	Partially compliant
Key Findings: ▪ the Minor Injuries Unit was in a state of disrepair ▪ multiple findings were identified in Pius Ward which created an overall risk to patients ▪ not all hand wash sinks were compliant with the required specifications ▪ limited isolation facilities posed a risk of transmission of communicable disease ▪ the negative pressure system in a patient single room in the ED was not operational ▪ the outlets in a number of hand hygiene sinks were unclean.	**Key Findings:** ▪ storage presses in the main ED corridor storing intravenous fluids were open and easily accessible to staff ▪ designated storage rooms in the ED with sterile supplies and equipment were being used as staff break rooms ▪ the negative pressure system in a patient single room in the ED was not operational ▪ limited isolation facilities posed a risk of transmission of communicable disease ▪ not all hand wash sinks were compliant with the required specifications

§§§§ Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

	▪ the location of the controlled medication press resulted in medications being accessible and medications being prepared directly beside patients.

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

HIQA's June 2024 inspection found that while the hospital had some assurance systems in place these were not robust enough for the hospital to be assured of the quality and safety of care. Areas for action included the requirement for audits in relation to transitions of care and undifferentiated surgical patients to the ED. Furthermore inspectors found that quality improvement plans were not also developed in response to findings from audits.

Hospital management used information from a variety of sources (including KPIs, findings from audit activity, risk assessments, patient-safety incident reviews and complaints) to compare and benchmark the quality of their healthcare services with other similar hospitals within the IHA region, and to support the continual improvement of healthcare services.

The IPC Committee continued to actively monitor and evaluate infection prevention practices in the hospital. Inspectors reviewed the hospital's annual report for 2024 which detailed the IPC activities. IPC activity now included practices in Ledwidge ward (escalation ward). The IPCT had developed an infection and prevention and control plan for 2025 which included an AMS plan. The plan set out the key areas of focus for IPC activities including risk assessments, PPPGs, surveillance and education. While there was evidence of progress achieved with set targets in the plan, IPC resources and lack of a consultant microbiologist based on-site continued to impact the ability to fully implement the IPC programme at the hospital with the IPCT having to prioritise workload due to competing demands.

Hospital management reported on rates of *Clostridioides difficile* infection, Carbapenemase-Producing *Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections, hospital-acquired COVID-19 and infection outbreaks through weekly surveillance that was reviewed and discussed at IPCT meetings. This information was presented monthly on the IPC surveillance dashboard and reported at meetings of the IPCC, QPSC and at monthly performance meetings with the region.

The hospital took part in the National Hand Hygiene audits in 2024 and achieved 93% compliance which was above the national target of 90%. While overall compliance with hand hygiene audits was good, a sample of hand hygiene compliance audits from clinical areas inspection required improvements. For example, hand hygiene observation compliance for the ED in Q2 2025 was noted at 69%. A supporting QIP was not in place to address poor compliance, however a re-audit in Q3 2025 demonstrated improved compliance of 93%.

The hospital was auditing staff adherence to completion of the INEWS observation chart monthly and escalation and response protocol quarterly. Compliance rates in relation to the escalation and response protocol required improvement across a number of parameters measured. Inspectors reviewed time-bound action plans with persons responsible for implementing actions in response to audit parameters where results fell below 80% from Q1 to Q3 2025.

National guidelines on clinical handover recommend that compliance with national guidance should be audited regularly to ensure continuous quality improvements. HIQA's June 2024 inspection did not find any evidence of monitoring of compliance with the national guidance on clinical handover and the use of Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool.[*****] The follow-up inspection of November 2025 found that compliance with this guideline was now being monitored and a sample of audits reviewed from the clinical areas inspected identified that good compliance overall with the majority of criteria associated with nursing clinical handover achieving 100%, however compliance with the use of ISBAR for interdepartmental handover and safety huddles required further action. A time-bound quality improvement plan was developed in response to audit findings.

The hospital experienced 13 outbreaks in 2024, all of which had been closed out by the end of 2024. Year to date (November 2025) the hospital reported nine outbreaks. The majority of these outbreaks were linked to COVID-19, Vancomycin – Resistant *Enterococci* (VRE), Influenza and Norovirus. A sample of outbreak committee meetings reviewed by inspectors demonstrated good attendance by relevant staff members including the consultant microbiologist and meetings were action orientated with time-bound actions identified and persons responsible. Outbreak reports reviewed included learning points from the outbreak.

Over the course of both inspections, inspectors reviewed samples of environmental and equipment hygiene audits from the clinical areas inspected. Audit results demonstrated good compliance overall with environmental audit results ranging

[*****] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

from 84%-100% in the clinical areas inspected. Good compliance levels were identified in equipment audits also with results also ranging from 90% to 100%. However, as identified in HIQA's June 2024 inspection, while inspectors found evidence of some time-bound action plans with named persons responsible, not all audits had these in place when results fell below the required standard to be met. Notwithstanding this, inspectors observed evidence of quality improvement plans in place for nursing quality care metrics.

The hospital monitored compliance with EMEWS and monthly results submitted following the inspection highlighted poor compliance overall for the year 2025. While compliance with the observation chart was noted to be relatively good at 86%, all other areas including patient monitoring plan and response to escalation were less than 50%. A comprehensive quality improvement plan was ongoing at the time to address poor compliance with EMEWS. The QIP reviewed by inspectors identified actions required, persons responsible and timeframes with a number of actions ongoing at the time of inspection.

Sepsis recognition and management in the ED was monitored on a monthly basis with compliance levels noted at greater than 95% on a sample of monthly audits reviewed from August to September 2025.

The hospital monitored and tracked metrics relevant to transitions of care including the number of new attendances to the emergency department, patient experience times, the average length of stay of a medical and surgical patient and the rate of delayed transfer or discharge every month. The ED was monitoring the number and types of transfers out on a monthly basis. The number of patients requiring transfers out to another hospital ranged from 30 to 60 patients per month with surgical patients accounting for the biggest number of patients who required transfer out.

Table 10 outlines the hospital's level of compliance and relevant key findings associated with national standard 2.8 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Partially compliant	Partially compliant
Key Findings: ▪ no audits had taken place in relation to transitions of care. Inspectors requested the number of surgical patients that presented to the hospital in 2024 and this was	**Key Findings:** ▪ poor compliance with patient monitoring and response to escalation as part of EMEWS persisted in the ED

not readily available and was collated while inspectors were onsite. ▪ when practices fell below expected standards, quality improvement plans were not always developed to improve healthcare services and care provided at the hospital ▪ none of the environmental audits requiring an action plan were time bound and no action owner assigned ▪ auditing of compliance with clinical handover and ISBAR$_3$ use was not in line with national guidance ▪ no INEWS or IPC audits were completed in Pius Ward.	▪ environmental and hand hygiene audits did not consistently have QIPs in place when practices fell below expected standards.

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

Inspectors found that the totality of risks identified during the June 2024 inspection culminated in a risk to patient safety. These risks specifically related to findings associated with medication safety, the management of undifferentiated surgical patients to the ED and the accommodation of admitted patients in the MAU which was impacting on the effective running of the ED.

As previously outlined, Our Lady's Hospital Navan continues to operate as a model three hospital but does not provide acute surgical services on-site. Consequently, the presentation of undifferentiated acute surgical patients at the hospital still persists. As part of HIQA's ongoing engagement since the June 2024 inspection with the hospital and senior management from the Dublin North East health region, HIQA was informed that recommendations from a specially convened taskforce aimed at determining the most appropriate way to address this risk issue were under consideration from senior management within the HSE. At the time of the follow-up inspection in November 2025, the recommendations were awaited for implementation. Therefore, HIQA found that the risk associated with the hospital not providing acute surgical services on-site remains and continues to be a challenge.

Following the June 2024 inspection, hospital management committed to formally auditing surgical presentations at the ED and that an audit process would commence

in September 2024. During the follow-up inspection, hospital management provided inspectors with an audit of surgical patients presenting to the ED from 01 January to 29 February 2024. The audit was noted to be the same audit provided to HIQA after the June 2024 inspection. The audit identified that the average waiting time for transfer out to a more suitable hospital during this time period was 10.5 hours. During this wait period, hospital management reported that patients were being appropriately reviewed in the ED and receiving treatment and accessing necessary interventions such as diagnostics following consultation with the relevant team at the receiving hospital.

There was no quality improvement plan or actions identified arising from the audit findings and no follow-up audit or additional audit was completed by the hospital since the audit time period. Noting that the hospital had committed to formally auditing this following the June 2024 inspection, this was discussed further with senior hospital management and inspectors were informed that the plan was to re-audit surgical presentations at the ED in November 2025 based on data that was being collected and monitored in the ED. Data reviewed in the ED reviewed demonstrated that 2914 surgical patients were seen in the ED from January 2025 up to 05 November 2025 with 258 of these surgical patients requiring transfer out equating to approximately 1.5 surgical patients per day. While hospital management were satisfied that the presentation of surgical patients at the hospital was being closely monitored, actions set out in the hospital's compliance plan associated with formally auditing the presentation of undifferentiated surgical patients to the ED was not fully implemented.

Subsequent to HIQA's November 2025 inspection, HIQA were provided with a follow-up audit that covered a time period from 01 November 2025 to 30 November 2025. No recommendations or action plan was identified with this audit also. A further audit was submitted to HIQA subsequent to the November 2025 inspection which was completed at regional level. The audit looked at the management of surgical patients attending the hospital who require inter hospital transfer and found that effective systems were in place. A quality improvement plan was developed in response to opportunities identified for improvement.

HIQA's June 2024 inspection reviewed incidents that occurred at the hospital associated with the presentation of undifferentiated surgical patients and progress with these reviews were followed up on as part of the November 2025 inspection, these will be discussed under national standard 3.3. Hospital management also reported that generally there were no issues with hospitals accepting patients but this was equally dependent on capacity and resources within the receiving hospital.

The follow-up inspection identified progress in relation to risks associated with the ED, however, as outlined in national standard 5.5, that risks identified with medication safety at the hospital had been fully addressed since the previous inspection. This resulted in HIQA seeking assurances from the hospital again in response to medication safety findings during the follow-up inspection.

At the time of both HIQA inspections, there were risks recorded on the hospital's corporate risk register that were relevant to the four key areas of harm that were the focus of these inspections. As outlined in national standard 5.8, the risk register was a standing item agenda at QPSC, however, the process of formally reviewing and updating the register required further development.

Emergency Department

Inspectors' reviewed the ED risk register within the department. The risk register did not include the risk of undifferentiated surgical patients presenting to the ED. Notwithstanding this, this risk was documented on the hospital's corporate risk register. Documented controls in place included the assignment of a surgical registrar to the ED at all times, bypass protocols, patient pathways, the use of EMEWS and surgical audit with oversight by a consultant at all times. Inspectors observed evidence some of these controls in place, with the exception of audit, as part of the follow-up inspection in November 2025 and discussed the effectiveness of these controls with senior hospital management. While the hospital could not fully prevent the risk, management were satisfied that existing controls were effective in managing the overall risk. Clinical staff who spoke with inspectors in the ED demonstrated a good awareness of controls in place to mitigate against the risk of undifferentiated surgical presentations to the ED and there was evidence of ongoing monitoring of numbers of surgical patients in the ED, however, no follow up audit had taken place since the previous inspection.

Additional risks relating to the ED on the corporate risk register included the ED not having 24/7 ED consultant onsite cover. Controls in place included ED registrars and on call consultant cover out of hours by phone.

The ED was also monitoring the number of paediatric presentations to the ED of which there were a total of 101 up until October 2025. This was due to an increasing trend in paediatric presentations despite the ED not accepting paediatric patients. Due to these increasing numbers, hospital management were training ED staff in the Paediatric Emergency Assessment, Recognition and Stabilization (PEARS) course for management paediatric emergencies should they keep presenting with the view of stabilising and transferring out these patients. Two members of ED staff had completed a PEARS course at the time of the November 2025 inspection. However, inspectors observed that the checklist for paediatric emergency equipment in the ED

had not been maintained and records reviewed demonstrated that paediatric emergency equipment had not been checked for five months.

Similar to HIQA's June 2024 inspection, the ED was functioning well during the follow-up inspection of November 2025. The ED continued to experience an increase in total attendances from 27,553 total attendance in 2024 to 23,688 up until October of 2025. Patients were triaged and prioritised in line with the Manchester Triage System.[†††††] The waiting time from registration to triage for January 2025 to October 2025 was within the 15 minute triage time recommended by the HSE's emergency medicine programme. Patient waiting times from triage to medical review and medical assessment to decision to admit to an inpatient bed were not recorded by hospital management which was also a finding in the June 2024 inspection.

Data on the ED PETs collected at 12pm on day two of the November 2025 inspection, showed that 34 patients were registered within the ED.

- No attendees to the emergency department were in the department for more than 24 hours after registration which was compliant with the HSE target of 97%.
- 1/34 (97%) attendees in the emergency department were in the department for more than six hours after registration. (HSE target 70%)
- 3/34 (91%) attendees to the emergency department were in the department for less than nine hours after registration. (HSE target 85%)
- Two attendees aged 75 years and over who were in the emergency department exceeded the target of either being admitted or discharged within nine hours of registration.
- All attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration in the department.

Continuous and effective flow of patients within the hospital is essential for optimal service delivery in the ED. The average length of stay (ALOS) reported by the hospital for medical patients year to date 2025 was 4.6 days (national target ≤7.0) and for surgical elective inpatient was 2.5 (national target ≤5.0). At the time of the November 2025 inspection, the hospital had two patients with a delayed discharge of care (DTOC). However, similar to HIQA's previous inspection, admitted patients were accommodated in the MAU which impacted on the effective running of the unit. Hospital management reported that this was the subject of ongoing review but could not be entirely prevented as the MAU formed part of the hospital's escalation policy and was used to prevent overcrowding in the emergency department.

Findings related to the wider hospital

There were documented risks on the corporate risk register relating to the four areas of harm which were the focus of this inspection.

Risks related to infection prevention and control of healthcare associated infection were identified, monitored and reviewed by the infection and prevention and control team with oversight by the QPSC. Risks were on the IPC register included infrastructural issues such as lack of isolation rooms and nightingale wards. However, the IPC risk register was incomplete as IPC risks identified had not been appropriately assessed in terms of impact and likelihood. Two of the risks were noted to be overdue. One of these risks related to the lack of surgical site surveillance for orthopaedic patients. Actions required included the need to set up a steering committee to raise compliance levels, however, this was due for review in August 2025 and had not been reviewed at the time of the follow-up inspection.

As previously outlined in national standard 5.5, the November 2025 follow-up inspection identified similar findings in relation to medication safety at the hospital. A clinical pharmacy service was not in place for all wards, five days a week. Medication reconciliation was not routinely carried out on all patients but staff stated that they could request it if required. Since HIQA's previous inspection, the hospital engaged an agency pharmacist in June 2025 to undertake medication reconciliation. Inspectors were informed that complex patients or patients on multiple medications would be prioritised for medication reconciliation.

Inspectors found that actions set out in the hospital's compliance plan relative to medication safety were not effectively implemented or sustained. For example, intravenous concentrated potassium chloride was not managed in line with hospital policy. The totality of medication safety findings, which were similar to that of the previous inspection, culminated in a risk to patient safety which resulted in HIQA formally seeking sought assurances from senior hospital management in relation this risk and was discussed in national standard 5.5.

Patients were screened on admission to the hospital for multi-drug resistant organisms (MDROs) in line with national guidelines. Patients were screened for CPE in line with national guidance and compliance with guidance was audited with overall compliance reported for the month of October 2025 to be 96%.

Risks relating to the deteriorating patient were recorded on the corporate risk register. These included difficulty accessing ICU beds in a level 4 hospital. Controls in place to mitigate this risk included early identification and communication with a level 4 ICU at another hospital, monthly monitoring at regional performance

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

meetings and urgent transfers to other hospitals. Inspectors discussed the effectiveness of these controls in place with senior hospital management who reported timely referrals for patients requiring transfer out and no incidents associated with delays in transferring patients out.

Since the June 2024 inspection, a Policy and Procedure and Guideline Committee was established. However, similar to HIQA's previous inspection, staff could not easily access policies at the point of care. Inspectors found that the storage and management of hospital policies procedures and guidelines, particularly medication safety polices requires improvement, with some remaining out of date.

Overall, HIQA found that while the hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services on a day to day basis, these systems were not fully effective to provide assurances to hospital management on the quality and safety of care. HIQA found that the patient safety risks associated with the hospital not providing acute surgical services on-site continues to be a challenge and cannot be fully managed until a decision is made on this matter.

Table 11 outlines the hospital's level of compliance and relevant key findings associated with national standard 3.1 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Non-compliant	Non-compliant
Key Findings: ▪ a number of medication policies and posters were either out of date or in draft format ▪ there was no medication reconciliation policy available for staff ▪ concentrated potassium was not returned to pharmacy ▪ the treatment room, medication trolley and medications were unsecured in Pius Ward ▪ the medication fridge in the MIU was inappropriately stored in the staff room	**Key Findings:** ▪ the service as currently designed continues to carry the risk associated with undifferentiated surgical patients presenting to the emergency department ▪ staff could not easily access PPPG's at the point of care ▪ the IPC risk register was incomplete with identified risks overdue for review ▪ admitted patients were accommodated in MAU which impacted on the effective running of the unit

▪ admitted patients were accommodated in MAU which impacted on the effective running of the unit ▪ the service as currently designed continues to carry the risk associated with undifferentiated surgical patients presenting to the emergency department.	▪ concentrated potassium was not returned to pharmacy in line with hospital policy ▪ paediatric emergency checklists were not maintained in the ED.

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

Similar to findings from HIQA's 2024 inspection, the follow-up inspection found that the hospital had systems to ensure patient-safety incidents were identified, reported and managed but areas for improvement were identified.

HIQA's June 2024 inspection found that incidents in relation to transfers and handovers were not tracked and trended. Since the establishment of the Transitions of Care Committee, incidents relating to transitions of care was now a standing agenda item at committee meetings. Through discussion with staff and following a review of meeting minutes there was evidence that incidents were being followed up with transferring hospitals with learning opportunities being identified.

The hospital used the HSE Incident Management Framework to guide and support the management of patient-safety incidents and Serious Reportable Events (SREs). Patient-safety incidents were reported on the National Incident Management System (NIMS).* Hospital management reported the number of clinical incidents per 1,000 bed days used (BDU) to NIMS monthly.

Records reviewed identified that the number of incidents reported monthly at the hospital was decreasing comparing to the previous year. A total of 1313 incidents were reported in 2024. From January to September, 2025 780 incidents were reported representing a decreasing trend in incident reporting at the hospital. Patient-safety incidents were tracked and trended and all incidents were categorised by hazard type, severity and area of speciality. Analysis of incidents were provided in monthly quality and patient safety reports and discussed at performance meetings at IHA level.

The hospital's Serious Incident Management Team (SIMT) had oversight of patient-safety incidents at the hospital. The QPSC had oversight of the monitoring of implementation of recommendations and quality improvement plans from patient-safety incident reviews. Patient-safety incidents were monitored monthly in terms of progress and also reviewed quarterly at regional performance meetings. Patient-safety-incidents associated with the presentation of undifferentiated surgical patients reviewed as part of HIQA's June 2024 inspection were discussed and reviewed during the follow-up inspection. The majority of these reviews had been closed out with the exception of one which was still outstanding following the November 2025 inspection but was actively being progressed at regional SIMF.

As part of the November 2025 inspection, inspectors reviewed a sample of reviews completed in response to falls. Inspectors found that preliminary assessment forms to assist review decision making had not been fully completed. Inspectors also found an example whereby an incident that occurred in the ED had not been completed in line with the Incident Management Framework. Senior hospital management were satisfied that the incident had been appropriately reviewed, however, the review had not been formally documented and no records were available that a review had taken place.

During HIQA's follow-up inspection, inspectors found that the level of medication safety incident reporting had decreased at the hospital. Reports reviewed outlined a decreasing trend in the numbers of medication safety incidents at the hospital. This was discussed with representatives for medication safety at the hospital who attributed this to a lack of medication safety officer at the hospital. A trend analysis of medication safety incidents identified that most incidents were occurring at the prescribing stage. Inspectors were informed that the analysis was being used to support a business case for an additional pharmacist to provide medicines reconciliation for all patients after admission. Medication related patient-safety incidents were now being further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation which was progress since the June 2024 inspection.

Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported. However, similar to findings from the June 2024 inspection, inspectors found that learning from incidents was not always shared with staff in the clinical areas inspected.

Overall, there were systems in place to effectively identify, manage and report patient-safety incidents. While there was evidence of progress from the previous inspection in June 2024 in terms of using the MERP categorisation and trending incidents associated with transitions of care, inspectors identified a decreasing trend in the culture of reporting patient-safety incidents, particularly medication safety incidents. Furthermore, patient safety-reviews were not always being completed in line with the incident management framework.

Table 12 outlines the hospital's level of compliance and relevant key findings associated with national standard 3.3 monitored during both inspections.

Judgment June 2024	Judgment November 2025
Substantially compliant	Partially compliant
Key Findings: ▪ incidents in relation to transfers and handovers were not tracked and trended ▪ tracking and trending of incidents occurring in the clinical areas were not completed and learning shared with staff.	**Key Findings:** ▪ records reviewed indicated a decreasing trend in the reporting of patient-safety incidents at the hospital, particularly medication safety incidents ▪ learning from incidents was not always shared with staff in the clinical areas inspected. ▪ a review of an incident in the ED was not completed in line with the Incident Management Framework ▪ a sample of preliminary reviews completed into falls were not fully completed.

Conclusion

During the June 2024 inspection at Our Lady's Hospital Navan, HIQA identified a number of risks in relation to the quality and safety of services at the hospital. These risks related to governance and management arrangements, risk management, workforce arrangements, audit activity and the physical infrastructure and environment of some of the clinical areas visited. Inspectors also identified risks associated with the presentation of undifferentiated surgical patients to the hospital. These risks were formally communicated by HIQA to the IHA Manager and Regional Executive Officer of the Dublin North East health region

and ongoing communication with the hospital continued to monitor the hospital's progress in relation to identified risks.

HIQA's follow-up inspection in November 2025 found evidence of progress with the majority of actions set out in the hospital's compliance plan with the exception of those related to medication safety. However, at the time the November 2025 inspection, the recommendations from a dedicated taskforce around the hospital operating as a model three hospital were awaited for implementation. Therefore, HIQA found that the patient safety risks associated with the hospital not providing acute surgical services on-site continues to be a challenge and cannot be fully managed until a decision is made on this matter.

Capacity and Capability

HIQA's inspection in June 2024 found the hospital to be partially compliant with all standards (5.2, 5.5, 5.8 and 6.1) relating to capacity and capability. The follow-up inspection in November 2025 found some improvements in aspects of the national standards relevant to leadership, governance and management with national However, overall compliance remained the same with national standard 5.2, 5.5., 5.8 and 6.1 remaining partially compliant.

HIQA found evidence of progress in relation to having formalised governance arrangements in place at Our Lady's Hospital Navan between June 2024 and November 2025. The majority of concerns raised in relation to governance and management of the ED were addressed. Formalised governance arrangements were now in place for the escalation ward and the hospital had established a Transitions of Care Committee. The presentation of undifferentiated surgical patients to the ED was being monitored with oversight from relevant committees. Notwithstanding this, inspectors found that effective management arrangements for medication safety at the hospital were not in place as evidenced by repeated findings from the June 2024 inspection. This resulted in HIQA formally writing to the hospital following the inspection seeking assurances around medication safety at the hospital. Furthermore, the limited presence of a consultant microbiologist continued to limit the full implementation of the infection prevention and control programme.

There was evidence that hospital management were planning, organising and managing the workforce to support the provision of high-quality, safe healthcare made since the previous inspection in relation to workforce findings. However, the majority of this progress was associated with ED workforce arrangements. Notwithstanding this, the ED continued to operate with a nursing deficit and was reliant on the use of agency staff to fill nursing shifts. Furthermore, inspectors

found repeated findings from the 2024 inspection in relation to poor compliance with mandatory training and high absenteeism rates.

Quality and Safety

HIQA's inspection in June 2024 found the hospital to be compliant with standard 1.7, substantially compliant with standards 1.8 and 3.3, partially compliant with standards 1.6 and 2.8 and non-compliant with standard 3.1. The follow-up inspection in November 2025 found some improvements with aspects of the standards related to quality and safety with national standards 2.7 found to be partially compliant. National standard 1.7 was also found to compliant again. However there was no change in the level of compliance with national standards 1.6 and 2.8 which remained partially compliant and national standard 3.1 which remained non-compliant. Furthermore, there was a deterioration in compliance with national standard 3.3 found to be partially compliant on this inspection.

HIQA found that while the hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services on a day to day basis, these systems were not fully effective to provide assurances to hospital management on the quality and safety of care. During the follow-up inspection of November 2025, inspectors found that formalised risk management structures and processes were still under development at the hospital and had yet to be fully embedded in the hospital's overall clinical governance structures. This was impacted by vacant positions which resulted in the Quality and Safety Department operating at a 50% deficit for seven months. While there was evidence of some progress in relations to concerns raised on the last inspection, repeated findings indicated that not all risks identified in the previous inspection were fully addressed and sustained.

The hospital had systems in place to effectively identify, manage and report patient-safety incidents. However, inspectors identified a decreasing trend in the culture of reporting patient-safety incidents, particularly medication safety incidents. Furthermore, patient safety-reviews were not always being completed in line with the incident management framework.

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

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

Compliance Classifications

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

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

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

Dimension: Capacity and Capability		
Theme 5: Leadership, Governance and Management		
Standard	**Judgments**	
	June 2024	**November 2025**
Theme 5: Leadership, Governance and Management		
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially Compliant	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially Compliant	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	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	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.	Partially Compliant	Partially Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant	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	Substantially Compliant
Theme 2: Effective Care and Support		
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Non-Compliant	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant	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.	Non-compliant	Non-compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant	Partially Compliant

Compliance Plan for Our Lady's Hospital Navan

Inspection ID: NS 0174

Date of inspection: 19 and 20 November 2025

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

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

Key Findings:

- clinical governance reporting structures for the DP&SC did not reflect those set out in terms of reference for the committee

a) The Deteriorating Patient and Sepsis Committee (DP&SC) is now an agenda item at the Quality and Patient Safety Committee (QPSC). The terms of reference for QPSC are amended to include an update from the DP&SC committee. The QPSC reports to the Hospital Executive Committee (HEC).

- actions arising from meetings of the DTC were not time bound

b) The Chair and Co-Chair of the Drugs and Therapeutics committee (DTC) have reviewed the recording template for the DTC minutes to reflect that all actions are timebound with a person assigned to each action.

- actions set out in the hospital's compliance plan pertaining to medication safety were not fully and effectively implemented.

c) There is now a Medication Safety Committee that meets bimonthly. The inaugural meeting was held on 22nd December 2025 followed by a second meeting on 24th February 2026. This meeting is chaired by a Rheumatology Consultant and co-chaired by the newly appointed Quality and Patient Safety Manager. The committee reports directly to the QPSC. The QPSC ultimately reports to the HEC.

The hospital is in the process of recruiting 2 permanent WTE pharmacists – one for mediation safety and the second for medication reconciliation. The pharmacist for medication safety will take the lead for this standard.

d) Staff from OLHN have been successful in obtaining a place on the RCPI SAFE programme. The programme is designed to strengthen safety culture. The team have chosen to focus on medication safety for their topic.

e) The Hospital Executive requested that the Regional Senior Walk Around includes a focus on medication safety. This was completed in one area on 18th December 2025 and a second is planned for 13th March 2026. There is an associated QIP following the December walk around.

Timescale:

a) Complete
b) Complete
c) Ongoing- await appointment of Pharmacist for Medication Safety
d) Completion in Q4 2026
e) Ongoing

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

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

Key Findings:

- effective management arrangements for medication safety at the hospital were not in place as evidenced by repeated findings from the previous inspection

a) The Pharmacy Executive Manager is now in attendance at the quality and safety walk arounds by the senior management team. The audit tool includes medication safety checks for example; - compliance with the return of potassium chloride to pharmacy after use in line with hospital policy, staff training and access to pharmacy/medication policies etc.

The wards have a new daily ward checklist for completion by staff with final sign off by the CNM/nurse in charge. This daily audit includes checks that all staff can obtain a policy, SALAD notifications are up to date and first dose medicine constitutions are available. The Quality and Safety Department will collate all checklists and trend findings. The checklist will be daily until the standards are consistently achieved and will form the basis for a monthly audit and related QIPs into the future.

Additional signage has been placed on Concentrated Potassium to remind staff to return remaining stock to the pharmacy once it is no longer required and the Concentrated Potassium Guidelines have been updated to emphasise the requirement to return unused vials to the pharmacy, and staff have been re-educated on this process.

- the lack of an onsite presence of consultant microbiologist continued to restrict the development of the infection prevention and control programme.

b) The Hospital Manager and Clinical Director have escalated the lack of an onsite presence of a Consultant Microbiologist to the Dublin North East Region (DNE). The IHA Manager will support the Hospital to progress a joint post permanently with Our Lady of Lourdes Drogheda.
c) The current incumbent has agreed to partake in ward AMS / IPC rounds and ICU AMS rounds virtually.

Timescale:

a) Complete and audits are on-going
b) Ongoing - await update from DNE
c) Ongoing - Quarter 2 2026

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

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

Key Findings:

- the risk register did not indicate that all risks were being formally reviewed and updated by the relevant oversight committee.

(a) The oversight committee relative to each risk is now identified and documented on the corporate risk register. In this regard matters of risk will be forwarded by the Risk Manager to the relevant committee chair for oversight and review at committee meetings. The QPS and Risk Managers meets quarterly with the Hospital Manager to review the corporate risk register. The corporate risk register is an agenda item at the HEC whereby, the senior executive team is updated of any changes to the register following the quarterly meeting.

- only one audit of surgical presentations to the ED was completed since the previous inspection.

(b) A second audit of surgical presentations to the ED was underway at the time of inspection and is now completed.

(c) The hospital will again make an application for funding to the DNE to recruit an audit co-ordinator for the hospital.

- there was no overarching system or structure in place to ensure recommendations from audits were being monitored with appropriate oversight from the relevant committee

(d) A Consultant Physician at OLHN has agreed to chair a clinical audit group in Q2 2026. The Hospital Manager and Clinical Director have escalated the need for an audit co-ordinator at OLHN to the DNE region for approval.

(e) A review of all committee TOR and relative agendas will be completed to include the oversight of audits, management of corresponding QIP's and close out of same. This will also ensure that there is reporting pathway for each audit category (i.e. clinical vs non clinical audits) to either the QPSC or the HEC.

- a medication safety audit was not completed as indicated in the hospital's compliance plan

(f) A discharge medication reconciliation audit was completed on 5th March 2026. QIP's relating to this audit will be constructed and improvement plans will be managed by the pharmacy staff for tracking and closure. Audits and QIP's in this regard will be discussed at the Medication Safety Committee and tabled for education at the NCHD Grand Rounds.

- quality improvement plans were not always completed following an audit.

(g) The Hospital Manager has written to Department Heads at OLHN requesting that QIP's are to be completed with action owners and timebound outcomes for all audits conducted within their area of remit. Also see point (e) in standard 5.8.

Timescale:

a) Complete and on-going
b) Complete
c) Ongoing – await feedback from DNE
d) Quarter 2 2026
e) Quarter 2 2026
f) Complete and on-going
g) Complete and Q 2 2026

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

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

- nurse staffing levels in the ED were reliant on the use of agency staff to fill the current shortfall (3.8WTE) in nursing staff.

a) DNE is aware of the need for agency conversion of nursing staff in ED under Phase II of the safe staffing framework. The Director of Nursing has re-escalated this to the Regional Director of Nursing. To note: 3.8 WTE regular agency staff are working in the ED in order to ensure safe staffing levels are maintained in the area.

- staff absenteeism rates were above the national KPI

b) The hospital will continue to monitor and manage absenteeism via the appropriate HR policies and procedures. Departmental absenteeism is now a standing agenda item at all 1:1 department head meetings with the Hospital Manager.
c) In addition, the Hospital manager will engage with all department heads at a group workshop educational session that focuses on the management of absenteeism.

- there was limited onsite presence of consultant microbiologist

d) The Hospital Manager and Clinical Director have escalated the lack of an onsite presence of a Consultant Microbiologist to the Dublin North East Region (DNE). The IHA Manager will support the Hospital to progress a joint Consultant Microbiologist post permanently with Our Lady of Lourdes Drogheda.

- poor compliance rates with mandatory training for medical personnel was identified.

e) The Hospital Manager chaired a workshop with Heads of Departments on Friday 13th February 2026. The theme of the workshop centered on finding new ways of working so as to impact improvement compliance with mandatory training. Working with the Human Resources Department, line managers are to complete a training matrix for disciplines under their remit. This matrix takes account of all mandatory, non-mandatory, desirable and professional development training relative to their team's roles. The training policy for the hospital is under review and will include;

- Emphasis on adherence to mandatory training as a term and condition of all HSE contracts and failure to complete cited as a breach of these terms and conditions resulting in possible disciplinary action.
- The induction period for new staff members will be designed as a mandatory timeline for completion of mandatory training, programme sign off of systems training through a buddy/mentorship programme and PPPG sign off. This will ensure that new staff have the opportunity to complete these tasks in their initial tenure and prior to commencing normal duty.

f) OLHN are actively working on 100% compliance with HCAs completing the ADL module.

Timescale:

a) Ongoing – await approval from DNE
b) Complete and Ongoing
c) End of Q2 2026
d) Ongoing – await a response from DNE
e) End of Q2 2026
f) Ongoing

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

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

- the physical environment in the emergency department did not always ensure that patient's dignity, privacy and autonomy were respected and promoted

a) Attendances to the Emergency Department in OLHN have increased significantly since the current space was occupied. 28,363 attended in 2025 vs in 21,479 in 2019 an increase of 6,884. Over 50% of all inpatients in OLHN are over the age of 75 years. As with other emergency departments in Ireland, in times of surge, patients are not boarded in cubicle spaces. To mitigate this, the ADON for ED and the Consultant lead regularly remind staff of their obligation to maintain patient's privacy and dignity and provide space where possible to talk to patients for intimate and bad news conversations.

- patients' personal information was not always protected in the ED.

b) The ED ADON and ED Consultant regularly address this issue with nursing and medical staff. Daily huddles will include personal information breaches.
c) A hospital-wide policy will be developed to address issues effecting patients' privacy, dignity and autonomy.

Timescale:

a) Ongoing
b) Ongoing
c) Quarter 2 2026 – for policy

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

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

Key Findings:

- storage presses in the main ED corridor storing intravenous fluids were open and easily accessible to staff

a) Storage presses in ED are locked. The Pharmacy Executive Manager is investigating the possibility of procuring swipe access locks for intravenous fluid presses hospital wide with the maintenance department.

- designated storage rooms in the ED with sterile supplies and equipment were being used as staff break rooms.

b) All sterile supplies and equipment were removed at the end of day one of the inspection.

- the negative pressure system in a patient single room in the ED was not operational.

c) This has now been fixed. The negative pressure system is checked daily by the ED staff and any anomalies escalated accordingly.

- Limited isolation facilities posed a risk of transmission of communicable disease.

d) All patients are prioritised for isolation by the patient flow team with the assistance of the infection control team or on call microbiologist out of hours.

- not all hand wash sinks were compliant with the required specifications.

e) The Infection Prevention & Control Team and maintenance teams have conducted an audit of all hand wash sinks and identified non-compliant units. This was discussed at the Project Team Meeting on 5th March 2026 and a schedule of works is being commissioned.

- the location of the controlled medication press resulted in medications being accessible and medications being prepared directly beside patients.

f) Timely access to medications is necessary in resus situations. The MDA press in resus will be reduced to accommodate first line emergency controlled drugs. A second MDA press was installed in the ED treatment room. A risk assessment has been completed to identify and mitigate this risk.

Timescale:

a) Ongoing
b) Complete
c) Complete - with ongoing checks
d) Ongoing
e) Quarter 3 2026
f) Complete

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

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

Key Findings:

- poor compliance with patient monitoring and response to escalation as part of EMEWS persisted in the ED.

a) As indicated in the report, a QIP is ongoing in relation to this finding. The ongoing QIP will be presented to the DP&SC on a quarterly basis. The DP&SC report to the QPSC and feed into HEC.

- environmental and hand hygiene audits did not consistently have QIPs in place when practices fell below expected standards.

b) The Hygiene Committee Chair has reviewed the committee agenda to include QIPs associated with environmental and hand hygiene audits where practice has fallen below expected standards. The Hygiene Committee reports to QPSC.
c) The IPC team have invoked a change in the hand hygiene auditing routine that accounts for a QIP to be completed when practices fall below expected standards and are closed off when results improve.
d) All QIP's relative to hand hygiene will be discussed at the IPC and forwarded to the QPS for oversight.

Timescale:

a) Ongoing (rolling QIP)
b) Complete
c) Complete and on-going

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

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

Key Findings:

- the service as currently designed continues to carry the risk associated with undifferentiated surgical patients presenting to the emergency department.

  a) The Hospital awaits a national decision re: compliance with the smaller hospital framework report (2013) to implement phase 2 of the Reconfiguration of OLHN.

- staff could not easily access PPPG's at the point of care.

  b) The wards have a new daily ward audit for completion by staff with final sign off by the CNM/nurse in charge. This audit includes checks that all staff can obtain a policy. This action will be audited by the Quality and Risk Department. This check is further included on the senior management walk around.

- the IPC risk register was incomplete with identified risks overdue for review

  c) The IPC risk register has been reviewed and updated.

- admitted patients were accommodated in MAU which impacted on the effective running of the unit.

  d) Please refer to Feedback Document, P. 14.

- concentrated potassium was not returned to pharmacy in line with hospital policy.

  e) The concentrate potassium was disposed of on the day. This is audited on the daily check and senior management walk around to ensure compliance.

- paediatric emergency checklists were not maintained in the ED.

  f) This now forms part of the weekly audit checks by the nurse in charge of the Emergency Department.

Timescale:

a) Ongoing
b) Complete – Audit May 2026 by the QPS team
c) Complete
d) Ongoing
e) Complete

f) Complete

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

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

Key Findings:

- records reviewed indicated a decreasing trend in the reporting of patient-safety incidents at the hospital, particularly medication safety incidents.

a) The new medication safety pharmacist will take the lead on adherence to reporting of medication incidents. The Quality and Risk Department will monitor the trend of reporting and report for discussion to the Medication Safety Committee.

- learning from incidents was not always shared with staff in the clinical areas inspected.

b) The risk manager attends CNM meetings with the Director of Nursing to present incident reporting trends, findings and outcomes. This meeting is minuted and CNMs cascade this information to their own teams. ADONs and all heads of departments are directed by the Hospital Manager to ensure compliance with this standard by monitoring local meeting content and ensuring staff are kept informed of updates. The Quality and Safety Department is committed to compiling clear, concise summaries of key learning points arising from incidents and sharing these with staff in all clinical areas. These learning summaries will be presented at the monthly CNM meetings, ensuring that clinical nurse managers receive timely, relevant information to support safe practice. Following each meeting, CNMs will cascade this information to their teams.

- a review of an incident in the ED was not completed in line with the Incident Management Framework.

c) This event has been discussed with the Auditor involved, to ensure that future auditing relating to patient safety is documented appropriately. Please refer to related factual inaccuracy on page 16

- a sample of preliminary reviews completed into falls were not fully completed.

d) These issues have been addressed with the Risk Manager in order to ensure no reoccurrence and that completion and sign off on the reviews are correctly finalised into the future.
Timescale: **a) Ongoing and awaiting appointment of new pharmacist/Q2 2026 for QIP** **b) Q2 2026** **c) Complete** **d) Q2 2026**