Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Mercy University Hospital
Centre ID:	OSV-0001059
Address of healthcare service:	Grenville Place Cork Co Cork T12 WE28
Type of Inspection:	Announced
Date of Inspection:	12/08/2025 and 13/08/2025
Inspection ID:	NS_0156

About the healthcare service

Model of hospital and profile

The Mercy University Hospital was founded in 1857 by the Sisters of Mercy and is a model 3*, general acute hospital. The Mercy University Hospital is a voluntary hospital providing services on behalf of the Health Service Executive (HSE) through a Service Level Agreement under Section 38 of the Health Act 2004. The hospital is governed by a Board of Directors and is a member of the South West Regional Health Area†.

Services provided by the hospital include:

- emergency care
- general medicine
- acute and elective general surgery
- intensive care
- day care
- outpatient care
- oncology services
- radiology and laboratory services

Mercy University Hospital also has governance and management responsibility for St Francis Unit, which is an 18 bedded transitional care unit located on St. Mary's Health Campus on the north side of Cork. The unit cared for patients who had been medically discharged from the acute clinical services and who were in a transitional state between hospital and home, or longer-term care.

The following information outlines some additional data on the hospital.

Number of beds	230 inpatient beds 74 day case beds

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

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

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information since the last inspection.

During the inspection, inspectors:

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

About the inspection report

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

[‡]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.

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
12/08/2025	*08.30 – 18:00*	Rosie O'Neill	Mary Flavin Marguerite Dooley Angela Moynihan Úna Cahill Yvonne Young
13/08/2025	*08:30 – 15:20*	Rosie O'Neill	Mary Flavin Marguerite Dooley Yvonne Young

Information about this inspection

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

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

The inspection team visited four clinical areas:

- Emergency Department and Acute Medical Assessment Unit
- St Francis Transitional Care Unit
- St Joseph's Ward
- St Brigid's Ward.

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

- Infection Prevention Control and Antimicrobial Stewardship Committees
- Drugs and Therapeutics Committee
- Deteriorating Patient Committee
- Bed Management

Inspectors spoke to hospital staff from a variety of disciplines in the clinical areas visited during the inspection.

Acknowledgements

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

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

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

Inspectors visited four clinical areas during this inspection. The combined Emergency Department (ED) and Acute Medical Assessment Unit (AMAU) provided unscheduled and emergency care for patients over 16 years of age. The ED had a capacity of 26 bays, and was comprised of 19 single bays, one, three-bedded area and two, two-bedded dedicated resuscitation areas. Three of the single bays were assigned to the AMAU.

The AMAU was open Monday to Thursday (08.00 am -5.00 pm). Patients were identified for the AMAU pathway based on clinical need following initial assessment in the ED.

St Francis was an 18-bedded transitional care unit located on the grounds of St. Mary's Health Campus. The unit was comprised of nine single rooms and three, three-bedded rooms.

St Josephs was a 29-bedded, general medical ward comprised of four single rooms, three, six-bedded rooms, one four-bedded room and one three-bedded room.

St Bridget's was a 26-bedded, medical, surgical and oncology ward, comprised of 17 single rooms, one two-bedded, one three-bedded and one four-bedded room.

Inspectors observed staff speaking and interacting with patients and their families in a respectful and kind manner. It was evident that staff took time to listen to and talk with patients. On the day of inspection, inspectors spoke with a number of patients and family members.

All were complimentary about the staff and the care they received commenting that,
"*I was kept up to date on my discharge*", "*the staff are powerful*", and "*everything is perfect*". Not all of the patients inspectors spoke with were aware of the hospital's complaints policy, but outlined that they would raise any concerns with the nursing staff.

Capacity and Capability Dimension

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

The Mercy University Hospital was found to be substantially compliant with four national standards (5.2, 5.5, 5.8, 6.1) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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

Mercy University Hospital (MUH) had formalised corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe, and reliable healthcare. An organisational chart demonstrated the hospitals governance, management and committees structures, and included the recently established directorate structures.

Board of Directors

Inspectors reviewed the Board's Code of Governance, Corporate Ethics, and Business Conduct, which stated that the board was collectively responsible for leading and directing the hospital's activities and setting the organisation's strategic aims, in the best service of its mission and values. The 10-member Board was led by a Chairperson, meetings were held monthly with hospital management. The hospitals' chief executive officer (CEO), chief financial officer and the executive clinical director (CD) provided reports to the board. Inspectors reviewed agendas and minutes from meetings, which showed reporting on hospital services, finance, workforce, and clinical matters, and demonstrated that actions arising from meetings were assigned to named individuals, were time-bound, and followed up from meeting to meeting.

Executive Management Board

The hospital's CEO was supported by the Executive Management Board (EMB), which had collective responsibility for overall executive management and provided

strategic and operational leadership for the hospital. In line with the Terms of Reference (ToR), that required updating since June 2025, the EMB was chaired by the CEO and met every two weeks. Membership was multidisciplinary and included the hospital's executive CD, CDs of the two clinical directorates (medicine and laboratory service; surgery and radiology services), director of nursing (DON), operations director, and quality, risk, and patient safety director (QRPS). Minutes of the most recent meetings submitted to HIQA demonstrated that actions arising from meetings were assigned to named individuals, were time-bound, and followed up from meeting to meeting. Up to March 2025, the hospital attended performance meetings with the then South, South West Hospital Group. Scheduled performance meetings had not taken place since the formation of the Regional Health Area South West (RHA SW). Hospital management advised inspectors there were plans to recommence these performance meetings in September 2025 and provided a draft organogram outlining the proposed reporting structures. This should be progressed by management in the RHA South West.

The hospital's executive CD provided clinical governance and oversight to consultant colleagues, non-consultant hospital doctors (NCHDs) and clinical services at the hospital. The executive clinical director reported to the hospital's CEO and had a collaborative working relationship with the regional CD. The CD's of the two clinical directorates provided oversight of clinical services in the directorates and reported to the executive CD. The hospital's DON was responsible for the organisation, management and delivery of nursing services in the hospital and reported to the hospital CEO.

St Francis Transitional Care Unit

St Francis Transitional Care Unit (referred to as SFU) was under the governance of the Mercy University Hospital. The unit cared for patients who had been medically discharged from the acute clinical services and who were in a transitional state between hospital and home, or longer-term care. Medical officer cover was provided by two General Practitioners (GP), with input from the units' multidisciplinary team that included physiotherapists, occupational therapists, social workers, and nursing staff. The GPs were supported by a consultant geriatrician to advise on patients with complex needs. Outside of core hours, GP services were available through the local out–of–hours service. The clinical nurse manager (CNM) for SFU reported to the Assistant Director of Nursing (ADON) in the Mercy University Hospital. The ADON visited the unit each month and was readily available by telephone to address any concerns or issues.

Clinical Quality and Safety Governance Committee

In line with the ToR, the Clinical Quality and Safety Governance Committee (CQSGC) was responsible for assuring that high standards of care were provided in the Mercy University Hospital. The CQSGC was chaired by the hospital's executive CD and met quarterly. Membership was multidisciplinary and included the CEO, clinical directorate CDs, DON, QRPS director and quality improvement leads. Organisational charts show a number of sub-committees reported to, and provided quarterly reports to the CQSGC, including the Infection Prevention and Control Committee (IPCC), the Drugs and Therapeutics Committee (DTC), Care of the Deteriorating Patient (including sepsis) Committee (CDPC), and the Integrated Unscheduled Care Operational Group. The two clinical directorates also provided reports to the CQSGC. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were followed up from meeting to meeting but were not always assigned to named individuals, or time-bound.

Infection Prevention and Control and Antimicrobial Stewardship Committees

In line with the ToR, the infection prevention and control committee (IPCC) was responsible for the programme to prevent and control healthcare-associated infections and to oversee and provide leadership on all IPC activity within the hospital. Hospital management confirmed that the AMS committee was currently not operating since 2024 due to staff deficits. AMS was a standing item at the IPCC, with issues also routinely submitted to and addressed at the Drugs and Therapeutics Committee. The IPCC was chaired by the DON, met quarterly, and reported to the CQSGC quarterly. Membership was multidisciplinary and included the CEO, executive CD, clinical directorate CDs, IPC team, QRPS director, and representatives from pharmacy and laboratory services. The day-to-day management of IPC was assigned to the IPC team. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were followed up from meeting to meeting, but not always time-bound.

Drugs and Therapeutics Committee

In line with the ToR, the Drugs and Therapeutics Committee (DTC) was responsible for the governance of medication management, specifically to ensure medication usage was optimised, safe, and cost-effective. The DTC was chaired by a medical consultant, met every two months, and reported to the CQSGC quarterly. Membership was multidisciplinary and included the executive CD, DON, pharmacy manager, pharmacists, QRPS director, operations director and the nurse practice development unit (NPDU). The medication safety working group reported to, and met with the DTC every two months, and prepared an annual report on its activity, which was submitted to both the DTC and CQSGC. Documents submitted to HIQA showed standard agendas, and minutes demonstrated actions were assigned to named individuals, were time-bound, and followed up from meeting to meeting.

Deteriorating Patient Committee

In line with the ToR, the Deteriorating Patient (including sepsis) Committee (DPC), was responsible for the provision of deteriorating patient services within the hospital, including advising on the implementation, evaluation, and monitoring of cardiopulmonary resuscitation events, Early Warning Systems (EWS), and sepsis management throughout the organisation. While the TOR submitted was not dated, management stated that the TOR was updated in October 2024. The DPC was also responsible for advising on training requirements, resources required, and supporting all education programmes. The DPC was chaired by the CD of the medicine and laboratory clinical directorate and met quarterly. The DPC reported quarterly to the medical directorate governance group and the CQSGC. Membership was multidisciplinary and included senior medical and nursing personnel, health and social care professionals who commit to cardiopulmonary resuscitation and resuscitation training, EWS, and sepsis. Documents submitted to HIQA showed meetings were attended by key committee members, there was a standard agenda, and minutes from the previous three meetings demonstrated actions were followed up from meeting to meeting, but were not assigned to named individuals, or time-bound. A lack of a dedicated consultant with responsibility for the deteriorating patient was noted as a risk in minutes reviewed by inspectors.

Discharge Planning Committee

In line with the ToR the role of the Discharge Planning Committee was to provide leadership to support management and staff to improve patient flow, discharge and transfer processes from the acute hospital setting. The committee was chaired by the CNM 11 for patient flow, met every two months, and reported to the CQSGC quarterly. Membership was multidisciplinary and included representatives from clinical areas, multidisciplinary teams, and hospital management. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals and followed up from meeting to meeting, and were time-bound.

Integrated Unscheduled Care Operational Group

In line with the ToR, which required review since March 2025, the objective of the Integrated Unscheduled Care Operational Group was to define and implement key actions, initiatives, and workforce structures focused on improved patient flow through the acute floor, culminating in either admission to the appropriate service or discharge to the community. The group was chaired by the operations director, met monthly, and reported to the EMB. Membership was multidisciplinary and included representatives from clinical areas, multidisciplinary teams, hospital management, external GP representation, the National Ambulance Service (NAS), and the regional

community area. Documents submitted to HIQA showed a standard agenda, and comprehensive minutes demonstrated actions were assigned to named individuals, followed up from meeting to meeting but were not always time-bound.

Transitions of Care Committee

At the time of inspection the hospital were establishing a Transitions of Care Committee (TOCC). In line with the ToR which required dating, the purpose of the TOCC will be to oversee the provision of patient services within the hospital when the location of that care changes. The committee will be chaired by the executive CD with plans to meet quarterly and schedule two meetings in 2025.

In summary the hospital had formalised governance arrangements in place for the delivery of high-quality, safe, and reliable healthcare. Details outlined in organisational charts, terms of reference, agendas, and minutes were articulated in meetings with lead representatives during the inspection. Since the reorganisation, the now Regional Health Area South West (RHA SW), had not scheduled performance meetings with the hospital, with plans to commence these in September 2025.

Areas for improvement include:

- re-establishment of regional performance meetings by management in the RHA South West.
- appoint a dedicated consultant with responsibility for the deteriorating patient.
- ensure ToRs are reviewed, updated, dated and approved.
- ensure all actions arising from meetings are assigned to named individuals and are time bound.

Judgment: Substantially Compliant

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

Inspectors found the hospital had management arrangements in place in relation to the four areas of harm.

Infection Prevention and Control

The IPCC was responsible for the IPC and AMS programme in the hospital. The hospital had an annual work plan that set out objectives to be met in 2025, inspectors also reviewed the 2024 annual report. The plan included compliance with national key performance indicators (KPI's), infection control, ventilator acquired pneumonia, hand hygiene, AMS, and surgical site infection. At the time of

inspection, inspectors were advised that due to limited staff resources, the hospital was not in a position to offer a full AMS programme. It was clear from the review of data and in communications with staff that the IPC team was highly visible, available to staff, and reporting through the hospital's governance structures.

Medication Safety

The hospital operated a clinical pharmacy service[§§] from Monday to Friday (8.00am to 5.00pm). Outside of core hours, the operational ADON was the designated point of contact, and pharmacy staff were available by telephone for advice and support. Inspectors were told that due to limited staff resources, pharmacist-led medication reconciliation was carried out on approximately 70% of inpatients, with prioritisation of newly admitted and patients with complex needs. Clinical pharmacists visited clinical areas twice per week and on request. Pharmacists did not provide a service to SFU, but were available for advice and support by telephone. Antimicrobial medication management was supported with staff access to a dedicated pharmacist, consultant microbiologist, and an on-call microbiology service. Inspectors were told the AMS pharmacy position would be full time in quarter three 2025. The hospital had a 2022-2026 medication safety strategic plan in place and an annual work plan that set out objectives to be met in 2025. These included a focus on medication incident reporting, promoting a safety culture, education, and high-risk medications.

Deteriorating Patient

The DPC had an annual quality improvement plan in place that set out the objectives to be achieved in 2025. The plan included key metrics related to the EWS, review of relevant hospital policies, and the use of vasoactive medications. Inspectors discussed the use of vasoactive medications outside of a critical care setting with hospital management and were informed that there was a plan in place to address this risk. This will be discussed further under 3.1. Inspectors discussed the findings from the critical care programme report 2023 and the internal audit in relation to critical care requirements with hospital management. At the time of inspection there was no dedicated co-ordinator for the EWS as had been previously identified in the 2024 HIQA report.

To support the clinical staff's skills, knowledge, and confidence in managing the acutely deteriorating patient, multidisciplinary training was offered that provided practical case-based scenario sessions and simulation training for the clinical management of the deteriorating patient.

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

The hospital had access to the National Ambulance Service (NAS), Protocol 37 and the Mobile Intensive Care Ambulance Service, which ensures that patients with urgent medical needs outside the scope of the hospital are transported directly to other hospitals to provide specialised clinical care.

Transitions of Care

The hospital had comprehensive arrangements in place to manage the transitions of care of patients across the hospital, to SFU, to the community and other hospitals. Hospital flow was reviewed at daily multidisciplinary safety safety huddle meetings. In the clinical areas, there were also scheduled staff huddles in the mornings and afternoons. The unscheduled care group which included representatives from local community services and the NAS, reviewed the hospital's ED patient experience times, ED activity, ambulance turnaround times, patient flow, and discharges. Inspectors found from discussions with hospital management and review of documentation that there were daily, weekly, and monthly scheduled meetings with local hospitals and community services to access community beds to facilitate patient flow and discharges in the hospital. On the day of inspection, there were 24 patients registered in the ED and there were no patient's on trolleys awaiting in-patient beds, however there were 13 surge beds in use in the hospital. The operational management of patient flow is discussed in more detail under national standard 3.1.

Overall, the hospital had management arrangements to support and promote the delivery of high quality, safe, and reliable healthcare services. Areas for improvement include:

- implementation of a full AMS programme
- continued focus on pharmacist-led medication reconciliation
- dedicated coordinator resource for the deteriorating patient and EWS

Judgment: Substantially Compliant

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

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

Risk management

There were risk management structures in place to proactively identify, manage, and minimise risks, and provide oversight of implementation of recommendations from reviews. The hospital had a risk management strategy and improvement plan 2024-2026 in place, which was updated quarterly and demonstrated a proactive approach to managing risk. The hospital maintained a corporate risk register of identified hospital risks with risks assigned to an executive risk owner. The existing controls in place and the additional controls required to minimise these risks were outlined in the risk register viewed by inspectors. Hospital committees managed risks related to their areas of responsibility. Escalation of risks was to the corporate risk committee. This was a subcommittee of the board that reviewed risks recommended for inclusion on the corporate risk register. The risk register was reviewed at relevant committees, quarterly at the CQSGC, and every two months at the EMB. Inspectors were advised that risk management would be an agenda item at the regional performance meetings once re-established with the RHA South West in the coming months. The hospital risks related to the four areas of harm are outlined further under national standard 3.1.

Monitoring service performance

The hospital did not have a formal hospital-wide quality improvement audit plan or clinical audit committee in place to coordinate audit activity across the hospital. The hospital did not have an audit lead or central repository for audit activity. The IPCC, hygiene committee, DTC, DPC and NPDU had oversight of audits carried out and were responsible for the implementation of quality improvement plans (QIPs) relevant to their areas of responsibility.

Management of patient-safety incidents

The hospital proactively identified, documented, and monitored patient-safety incidents. Patient-safety incidents were reported to the National Incident Management System[***](NIMS), in line with the HSE's Incident Management Framework 2020. This was through the NIMS electronic point of entry (ePOE), a paperless system that facilitated staff to enter incidents directly onto the NIMS. The benefits of the ePOE system included, elimination of duplication, availability of real-time data on incidents or near misses, and provision of prompts to review and commence risk mitigation processes. All incidents were tracked and trended by the quality, risk, and patient safety department. The hospitals' relevant committees, CQSGC, serious incident management team, EMB, and the board had oversight of the management of all patient-safety incidents.

[***] 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).

Inspectors were satisfied there were processes in place to share learning from patient-safety incidents through communication via the various hospital committees, line management structures, quality boards, learning bulletins, newsletters and local education.

To summarise, the hospital had monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety, and reliability of healthcare services in the four areas of known harm relevant to this inspection. Areas for improvement include:

- hospital-wide approach for the oversight and management of audit in line with best practice guidelines
- currently no centralised coordination for clinical audit.

Judgment: Substantially Compliant

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

The hospital had structures and processes in place that ensured the workforce was planned and managed to ensure the safe delivery of high quality, safe, and reliable healthcare.

The Human Resources (HR) manager reported to the CEO and was a member of the EMB. The hospital also had a dedicated medical manpower manager with responsibility for the medical workforce in conjunction with the HR manager.

Workforce

At the time of inspection, the hospital's whole time equivalent[†††] (WTE) was 1549.76. The vacancy rate was 4.26% and the absenteeism rate was 4.92% which was slightly above the HSE target of less than or equal to 4%. To support the retention of staff, the hospital had introduced a number of initiatives, including flexible working hours, specialist posts, internal promotion, and funded training.

Employees were supported by their line managers and HR, with systems in place for staff to access occupational health services and the employee assistance programmes. In addition, the hospital could initiate a critical incident protocol to support staff in the aftermath of a critical incident occurring in the hospital. The

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

hospital also had a number of monthly and yearly staff recognition and award initiatives.

At the time of inspection, the hospital had a consultant complement of 63.62 WTE with one vacancy unfilled at the time of inspection. All consultants practising in the hospital were on the specialist register of the Irish Medical Council. The non-consultant hospital doctor (NCHD) WTE complement was 154 across all grades with no reported vacancies. There was a delay in nine NCHD's commencing employment due to issues outside of the control of the hospital, with plans that they would commence employment in late quarter three 2025. Inspectors were told the shortfall was being covered by in-house NCHD's or locums.

The ED was funded for six WTE emergency medicine (EM) consultants, 4.5 WTE were in post, with plans to interview for the additional 1.5 posts in late quarter three 2025. EM Consultants were on site Monday to Friday (8.00am to 8.00pm), Saturdays (8.00am to 2.00pm), and Sundays (8.00am to 1.00pm). Outside of these hours, an on-call service was provided by the EM consultants. EM consultants reported to the clinical lead for emergency medicine, who was also the CD for the medical and laboratory directorate, who in turn reported to the executive CD. The consultants were supported by 22 NCHDs to include 15 WTE registrars, six WTE senior house officers and one intern. Senior decision makers[‡‡‡] were on site in the ED twenty four hours, seven days a week. At the time of inspection the ED was not participating in a post graduate training scheme in emergency medicine for NCHDs, and inspectors were advised that applications for inclusion on a training scheme were ongoing.

At the time of inspection, the nursing complement was 594 across all grades with a vacancy rate of 22.61 WTE (3.80%) which were at various stages of recruitment. Staffing levels from the clinical areas visited on the day of inspection were reviewed. At the time of the inspection there were sufficient staffing in the clinical areas visited.

The hospitals' IPC team comprised of 1 WTE ADON, 3 WTE clinical nurse specialists, and 1 WTE clerical officer. The hospital had 1.15 WTE clinical microbiologist consultants and 2 WTE microbiology specialist registrars. An additional specialist registrar was commencing in July 2026. The twenty four hours, seven days a week on-call consultant microbiologist service was provided by the 1.15 MUH clinical microbiology consultants, with support from another hospital in the region during

‡‡‡ 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.

periods of leave. At the time of inspection, there was 1 WTE consultant microbiology vacancy. The hospital had submitted a business case to the RHA South West for two additional consultant microbiologist WTE positions. Neither post was approved at the time. The hospital were currently working with the RHA to identify funding for one WTE position. The deficit in consultant microbiologist posts was recorded on the corporate risk register. Inspectors were also advised that the hospital did not have a decontamination lead.

The hospital's pharmacy service was approved for 15.57 WTE pharmacists and 14.97 WTE pharmacist technicians, with all positions filled. There was a 0.7 WTE antimicrobial pharmacist with plans to increase to a full-time position in late quarter three. This was an improvement from the 24% vacancy rate recorded in the 2024 HIQA inspection report.

Training

The hospital did not have a centralised learning management database to record and monitor staff attendance at mandatory and essential training. Inspectors were told that an electronic platform was approved, but would not be in place until 2026. At the time of inspection, the hospital was introducing electronic staff rostering with some functionality on the platform to record staff training. In the clinical areas visited, training records were managed by the CNM, with oversight from the NPDU. Doctors were responsible for uploading their training certification to the national doctors integrated management system.

Inspectors reviewed records for mandatory and essential training for the hospital. Compliance with staff training varied across specialities, with the following ranges observed: 12.3% to 59%% for IPC standard and transmission based precautions, 41.7% to 70.0% for sepsis management training, 47% to 100% for hand hygiene (HSE target 90%). 100% of nurses were trained in the use of the EWS, there were no training records provided for doctors. 100% of nurses and 8.5% of doctors were trained in the Irish Maternity Early Warning System (IMEWS)[§§§] . 100% of nurses in the ED were trained in the use of the Emergency Medicine Early Warning System (EMEWS) and the Irish Paediatric Early Warning System (IPEWS) and 86% of nurses were trained in the use of the Manchester Triage System.[****]
100% of nurses were trained in the Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool, and medication management.

[****] 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.

60% of doctors and 100% of nurses had undertaken basic life support training. 73% of nurses in ED, 64% of nurses in ICU and 27% of nurses across other wards were trained in advanced cardiac life support (ACLS). 74% of doctors were trained in ACLS.

In addition, 61% of nurses were trained in the management of non-invasive ventilation. 53.6% of doctors and 69.5 % of nurses had undertaken 'Children First'[††††] training. 100% of nursing staff had completed the workplace orientation programme on commencement of employment.

Since the previous inspection, improvements related to staff deficits in the emergency department had been progressed and staff deficits in the pharmacy service had been addressed, and there is a plan in place for a centralised learning management database. Areas for improvement that remain outstanding since the last inspection include:

- deficits in WTE consultant microbiologists
- staff attendance at mandatory and essential training
- absenteeism rate remains above the national HSE KPI.

Judgment: Substantially Compliant

Quality and Safety Dimension

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

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

[††††] Children first is a national policy document which assists people in identifying and reporting child abuse

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

It was evident to inspectors during visits to four clinical areas that staff were aware of the importance of promoting patients' dignity, privacy and confidentiality.

Staff were observed drawing curtains, using screens around patients' or drawing window blinds when delivering care and speaking to patients and families in a respectful manner. Information was communicated in a clear and easily understood way and supported with relevant written information.

Inspectors were informed that private rooms were available to patients and families for conversations relating to their care. At the time of inspection, a room in the ED was being converted to a family room. Access to translation services was available to support communication with patients in their native language. Inspectors observed call bells at each bed, with patients confirming knowledge of activating same.

Patients who spoke with inspectors described that *staff should get a gold medal"*, "*all my medications were explained to me" and "the doctor explained what the plan for me was"*. One patient did comment that "*sometimes I feel rushed, when I said it, they apologised*".

Staff communication whiteboards were in place. Patients' healthcare records were stored appropriately, and information was observed to be protected on the day of the inspection.

In summary, it was evident that hospital management and staff were committed to ensuring that patients' dignity, respect and autonomy was respected and promoted.

Judgment: Compliant

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

Inspectors observed that a culture of kindness consideration and respect was actively promoted by all staff in the clinical areas visited.

Staff were observed actively listening to patients' and responding in a considered and caring manner. This was validated by patients' who expressed their satisfaction with the care and kindness they received. For example patients' stated that "*could not fault the care"* and "*was kept up to date, with the doctors visiting every morning".*

In summary, it was evident that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The hospital had a designated complaints officer reporting to the QRPS director and was assigned responsibility for managing complaints in line with the hospital's 2024 complaint handling policy, which was being updated, and was based on the HSE's complaints management policy 'Your Service Your Say'. The complaints officer provided a quarterly report to the CQSGC and gave an in-person update every six months.

For verbal complaints, local resolution at the point of care was encouraged in the first instance, with a patient liaison officer available Monday to Friday (08.00am to 4.00pm) to support patients, families and staff. Verbal complaints that could not be resolved locally were escalated to the complaints officer. Written complaints were managed by the complaints officer with input from key stakeholders. In quarters one and two of 2025, 77% of complaints were closed within 30 working days, exceeding the HSE target of 75%. All complaints were recorded on the national complaints management system and were tracked and trended across the HSE categories of complaints.

Inspectors observed posters in areas visited outlining the feedback, compliments and complaints process, with a number of options, including a link to a feedback page via a quick response (QR) code, which could also be accessed on the hospitals website. Inspectors observed information leaflets on how to access independent advocacy services in clinical areas inspected. Inspectors were informed that information on advocacy services was on all correspondences issued from the complaints service.

At the time of inspection the complaints officer and patient liaison officer were piloting an initiative, whereby information on the feedback, compliments and complaints process, and advocacy services was included in all correspondence issued to patients from the out patients department. In addition, inspectors were also told the hospital were currently introducing feedback, compliments and complaints

feedback postal stations which will include access to feedback forms across the hospital.

The hospital had plans to establish a patient engagement forum, which was currently reflected on the hospitals organogram. Inspectors were informed that this would now form part of the new RHA South West regional forum being established.

Patient feedback was shared with staff, individually, through line management structures, departmental staff meetings, quality boards and the twice yearly feedback, compliments and complaints casebook.
Overall, at the time of inspection, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

Inspectors noted the age and physical layout of the hospital presented challenges and risks in protecting the health and welfare of service users. On the days of inspection, the hospital's physical environment was clean and well maintained with some minor exceptions. Inspectors noted some wear and tear on doors and work surfaces that did not facilitate effective cleaning and posed an infection risk.

The 2024 inspection highlighted a number of infrastructural issues that required attention. Inspectors reviewed a detailed infrastructural and refurbishment action plan, which outlined plans, progress and expected timeframes. For example, in the ED there was now a refurbished clean utility room for medication preparation. A number of issues remained outstanding on St Brigid's ward related to storage, narrow doorways and lack of observation windows on room doors.

In the clinical areas visited there was limited access to shower and toilet facilities for patients. Inspectors noted that there was ongoing refurbishment works in clinical areas, which further impacted on the availability of facilities for patients. In one clinical area visited a number of patients requiring single room isolation were required to leave their rooms to access toilets and showers on the corridors. The IPC team visited the clinical areas daily and with ward staff carried out risk assessments to identify patients suitable for these isolation rooms. Hospital management informed inspectors that challenges with the hospital's infrastructure was recorded

as a high-rated risk on the corporate risk register with particular reference to the impact on IPC. These ongoing challenges were constantly being managed, regular quality walkabouts were carried out and ongoing mitigation controls put in place as issues arose. At the time of inspection the hospital had undertaken a feasibility study, to secure capital investment to build a new hospital block that would provide single en-suite bedrooms to current healthcare standards.

Inspectors observed 'yellow' infection control signage on doors in clinical areas that did not outline the types of precautions to be taken. The IPC team informed inspectors that they provided extensive training on the use of signage supported by daily visits to clinical areas. Inspectors noted in one clinical area healthcare staff were not adhering to the IPC guidance and brought this to the attention of staff and the IPCC.

At the time of inspection there was on going refurbishment works in two clinical areas. Inspectors viewed the hospital policy, construction permits and risk assessments signed by the IPC team. These outlined the type of works being undertaken, risk management and IPC measures.

Inspectors reviewed legionella and water testing results for 2024 and 2025 in SFU and measures implemented to address report findings as required. Inspectors were told a water safety working group was established and met quarterly to address issues of water quality following the 2024 inspection. The hospital also had a standard operating procedure for the regular sampling of water in the endoscopy unit, with results followed up with the staff and the IPC team.

In the clinical areas visited physical distancing of greater than one metre was observed between beds in the multi-occupancy rooms. Alcohol hand gel dispensers were strategically located and readily available with hand hygiene signage outlining the World Health Organisation (WHO) 5 moments of hand hygiene clearly displayed throughout the four clinical areas. Inspectors noted hand-hygiene sinks for clinical use in clinical areas visited conformed to national standards. At the time of inspection, the hospital had an ongoing sink replacement programme in place. Personal protective equipment was available in the clinical areas visited.

Inspectors were informed that hygiene services were available twenty four hours a day, seven days per week. Inspectors observed a green tagging system to indicate equipment had been cleaned in the clinical areas and were informed that primarily HCA's carried out equipment cleaning with oversight from the CNM. Terminal cleaning[‡‡‡‡] and environmental cleaning was carried out by the hygiene services staff, with additional cleaning available during outbreaks of infections. Oversight of cleaning was by the hygiene services manager and CNM's. In one clinical area inspectors noted, cleaning was not being carried out in line with the standard

operating procedure (SOP), and brought this to the attention of the staff. Staff completed an online request to maintenance if equipment required repair and there was a timely response to requests.

Inspectors observed appropriate waste management in the clinical areas visited with clinical and non-clinical waste bins. There were dedicated medication preparation areas with evidence of appropriate and secure medication storage. Medication fridges were locked and temperatures monitored daily. Inspectors observed posters on high-risk medications, APINCH[§§§§], sound-alike-look-alike drugs as well as a range of flow charts and medication safety information on medication management. Sharp bins were partially closed, signed and dated. There was appropriate segregation of clean and used linen.

The hospital had systems and processes in place to support the bed allocation of patients and inspectors viewed the guidance for the prioritisation for patients requiring isolation. The IPC team worked closely with bed management and liaised with staff daily to prioritise patients for single-room isolation as required. The hospital had 66 single rooms, including nine in SFU, 42 with en-suite facilities, five had a toilet only and the remaining 19 had no facilities. The hospital also had six negative pressure rooms. Staff were aware that this was not sufficient to meet current demand.

In summary, 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, especially vulnerable patients. The inadequate number of toilet and shower facilities and the lack of single rooms with en-suite facilities posed a risk of transmission of communicable infectious diseases. Hospital management were constantly monitoring challenges with the infrastructure with an ongoing plan of work in place.

Areas for improvement:

- continued focus on infrastructural challenges to include lack of single rooms
- address risk posed by insufficient toilet and shower facilities
- continued focus on staff education relating to IPC signage
- ensure environmental cleaning is in line with PPPGs

Judgment: Partially Compliant

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

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

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

The hospital collated data on a number of national key performance indicators for unscheduled and scheduled care including, ED patient experience times, admissions, discharges, average length of stay and delayed transfers of care. The hospital also collected, collated and reviewed data relating to, infection prevention and control, patient safety incidents, complaints, workforce and risks that had the potential to impact on the quality and safety of services.

Infection prevention and control

The IPCC had oversight of IPC practices in the hospital. Every month, as per the HSE's reporting requirements, surveillance data was submitted relating to hospital-acquired *staphylococcus aureus blood stream infections* (HA SA BSI), *hospital-associated Clostridium difficile* (c-difficile) and *carbapenemase-producing enterobacterales* (CPE). In addition outbreaks of infection were also reported to the Department of Public Health. Inspectors were told a sub-committee was formed to address the rates of HA SA BSI in 2023 and 2024. The most recent hospital patient safety indicator report published for June 2025 showed zero HA SA BSI infections for the four months from March to June.

Inspectors reviewed the hospitals surveillance report for the first six months of 2025, which showed rates of *Meticillin resistant Staphylococcus aureus* (MRSA), CPE, *Vancomycin Resistant Enterococci* (VRE) and other multi drug resistant organisms (MDRO's) were tracked and trended. SFU figures were not included in this surveillance data, with any new healthcare acquired infection in SFU reviewed and recorded separately. CPE rates had decreased from sixteen cases in 2024 to four cases between January and June 2025. C-difficile rates of new cases for the first six months of 2025 ranged from 1.50 to 5.80 (target <2.0 per 10,000 bed days). The ongoing high rates were recorded on the corporate risk register. The hospital carried out MRSA nasal screening on all patients admitted overnight to the hospital. VRE screening was carried out on patients admitted to the critical care unit, St Patricks and St Brigids' wards, with weekly screening of patients thereafter.

In the critical care unit the hospital monitored rates of central venous catheter (CVC) blood stream infection rates and reported three cases in 2024, compared with four cases in 2023. The hospital also monitored rates of ventilator acquired pneumonia reporting two cases in 2024, compared to one case in 2023. There was an improvement in quarter one 2025 with both recorded as zero infections. The hospital reported all notifiable diseases to public health in line with national policy.

The IPC team were also focusing on a quality improvement plan to support key areas identified to prevent surgical site infection and had recently introduced an initiative on the preoperative showering of patients.

In June 2025 a hand hygiene audit was carried out across clinical areas which showed overall compliance at 77.7%. In the three months prior to inspection in the four clinical areas visited, compliance with hand hygiene ranged from 57% to 93% (national target 90%), with evidence of quality improvement plans (QIPs) in place to address non-compliance. Documentation reviewed by inspectors showed hand hygiene was an ongoing focus of the IPC team, with identification of ward based auditors, regular auditing of practice, and ongoing education.

The hygiene services committee monitored cleaning practices across the hospital. Inspectors reviewed documentation for environmental hygiene, and equipment sign off sheets and audits. The compliance rates for the four clinical areas visited ranged from 92.2% to 100%, with QIPs in place to address non-compliance.

Antimicrobial Stewardship

Due to limited staff resources the AMS team were not in a position to offer a full AMS service, and there was currently no AMS committee as outlined in standard 5.2. The team monitored the use of restricted antibiotics, and the clinical pharmacists highlighted patients on prolonged courses of restricted antibiotics for review by the clinical microbiology team. Inspectors were informed that the overall prevalence of antibiotic use across the hospital was 52% compared to 42.9% nationally.

Inspectors were informed that there were no local antimicrobial guidelines for the hospital, due to limited staffing resources to develop guidelines. In the absence of local guidelines staff were directed to use guidelines in use in another hospital in the region. AMS ward rounds were carried out in ICU only.

The hospital had not reported into the 2024 national antimicrobial point prevalence report and at the time of inspection the hospital were currently not reporting 2025 data due to limited staff resources. The limited staffing to support a full AMS programme was recorded on the corporate risk register.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. The hospital reviewed the number of medication incidents per bed days with a rate of eight to nine compared to the national KPI of three per 1,000 bed days, with a steady increase in reporting since 2020. A higher reporting rate is reflective of a positive patient safety culture. In January 2025 an audit was carried out on the appropriate use of one type of restricted antibiotic with a score of 41%, following a targeted QIP, in April compliance had risen to 86.6%. Inspectors were

informed pharmacy students were asked to conduct audits in areas such as medication reconciliation.

The NPDU oversaw medication safety audits carried out in clinical areas as part of nursing quality care metrics. In the three months prior to inspection audits demonstrated overall compliance with medication safety, custody and storage ranged from 93% to 100%. In the clinical areas visited staff told inspectors, feedback on results of audits was to the CNM and staff at departmental meetings and safety huddles. In July 2025 the NPDU carried out a post medication administration audit in four clinical areas. Compliance ranged from 65% to 100%, QIPs were put in place, with a plan to re-audit in quarter three 2025. At the time of inspection there was an ongoing audit on the use of topical medication patches, and it was outlined to inspectors how findings and any required actions would be disseminated.

Inspectors reviewed the 2025 medication safety quality improvement work plan with updates for quarter one and two 2025. The focus was on increasing reporting of medication incidents and promoting a safety culture, ongoing analysis of incidents to identify areas for targeted improvements, face-to-face education, management of high risk medications, the implementation of national guidance on chemotherapy use, and the use of a risk assessment tool for the recognition and management of venous thromboembolism (VTE, blood clots) associated with hospitalisation. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

<u>Deteriorating patient monitoring</u>

The hospital monitored compliance with the EWS escalation and response protocol in clinical areas as part of the nursing quality care metrics. In quarter four 2024, a hospital audit was undertaken of the EWS escalation and response with an overall compliance rate of 37.7%. In quarter one 2025 audits were carried out in five clinical areas, compliance with the EWS escalation and response was 41.4%, and compliance with completion of the documentation was 71.5%. Inspectors found no evidence of documented QIP's to address these results. Audits were carried out in two months of quarter two on compliance with the EMEWS in the ED. Inspectors were informed that resources were deployed in piloting the new electronic EMEWS, which will enable automatic measurement of compliance. Inspectors did not find any evidence of regular monitoring of compliance with the national guideline $ISBAR_3$ communication tool.

Inspectors found limited evidence of regular auditing of compliance with sepsis management in the hospital. In March 2025, an audit was undertaken of the patient

journey through the ED. In patients where sepsis was suspected, compliance with commencing a sepsis form stood at 47.4%, of these 66.6% were fully completed. For patients that required antibiotics, if the sepsis form was used the median time for administration of antibiotics was 24 minutes, within the national KPI of 60 minutes. For patients where the sepsis form was not used the median time for administration of antibiotics was 150 minutes. Inspectors were informed that the hospital had recently established an ED sepsis management working group, with a QIP focusing on early recognition and administration of antibiotics within one hour per national guidelines, with a plan to re-audit in quarter three 2025.

Transition of care

The hospital tracked national KPI's, these included new attendances at the ED, ED patient experience times, average length of stay of medical and surgical patients and delayed transfers of care. Predicted date of discharge was tracked by the hospital with compliance at 83%.

At the time of inspection, the ED were participating in an ongoing patient flow improvement programme, with a number of QIPs introduced to enhance patient flow across the ED. Initial results saw ambulance turnaround times increase to 60% compliance with the national KPI of 20 minutes.

While the hospital systematically monitored and evaluated healthcare services. Areas for improvement include:

- continued focus on the prevention of healthcare acquired infections
- ensure a comprehensive AMS service
- an ongoing focus on compliance with hand hygiene
- focus on compliance with the deteriorating patient escalation and response protocol
- focus on compliance with the national guidance on sepsis management to include audit
- continued focus on compliance with the national guideline ISBAR$_3$ communication tool
- ensure quality improvements plans are developed when areas for improvement are identified.

Judgment: Partially Compliant

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

Risk management in the hospital was supported by the HSE risk management policy 2023. The quality, risk and patient safety director was responsible for the

management for the corporate risk register, which was reviewed every two months by the corporate risk subcommittee of the board, and at the CQSGC and EMB. The highest rated risks related to hospital acquired infections due to a lack of isolation rooms and shared facilities, hospital infrastructure, consultant microbiologist staff shortages and overcrowding in the ED. The ED risks were discussed at the monthly clinical risk meeting. In the clinical areas visited, CNMs escalated risks through line management structures, with oversight from the DON. There were no ward risk registers, but there were a number of risk assessments related to risks such as placement of trolleys on the wards and mixed gender multi-occupancy rooms. At the time of inspection there were no mixed gender rooms in the clinical areas visited. Inspectors discussed the corporate risk register with hospital management, and access to radiology services and the out-of-hours external radiology reporting services. To further support patients, there were nine nursing staff approved to refer patients for ionising radiation with oversight provided from the hospitals nurse prescribers clinical consultant lead.

Infection, Prevention and Control

The IPCC reviewed the IPC risk register and incidents and reported to the CQSGC quarterly. The hospital carried out universal screening of MRSA and CPE. Risk assessments for other multi drug resistant organisms (MDRO's) were carried out and further screening initiated, with patients isolated as required in line with national guidance. In addition, in three identified high risk areas, patients were screened for VRE on admission. The hospital's information patient management system (iPMS) supported the identification and appropriate management of patients with MDROs by alerting staff to patients who were previously inpatients in the hospital with MDROs. Staff were also encouraged to conduct point of care risk assessments. In SFU, inspectors found
the nursing assessments completed for MDRO's in the health care records did not correlate with what was recorded on the iPMS. This was brought to the attention of staff at the time. In MUH, reusable invasive medical devices were sent to an external provider for decontamination and a service level agreement was in place.

It was evident from talking to management and staff that IPC and the associated limitations of the infrastructure was a daily and ongoing focus in the hospital. In 2024 the hospital recorded 27 outbreaks of infection. In quarter one and two 2025 there were nine outbreaks recorded, to include five covid-19, two norovirus, and one influenza A. This was an improvement on the 15 outbreaks recorded in the same period in 2024. Inspectors reviewed outbreak reports, which showed outbreak control meetings were convened with relevant stakeholders to oversee the management of the outbreaks. The reports outlined meetings, issues identified, corrective actions and outcomes. Learning was shared with staff through email communication, IPC safety bulletins, departmental meetings and safety huddles.

Members of the IPC team carried out site visits to SFU and were available for advice to staff via telephone.

Medication Safety

The DTC reviewed the medication safety risk register, medication incidents and reported to the CQSGC quarterly. The highest rated risks related to the lack of electronic access to medicines information in all clean utility rooms, and use of vasoactive medications outside of the critical care environment. Since the inspection in 2024, the hospital had developed a list of high-risk medications stored separately from the main ward stock, with prescription records and pharmacy requisition books updated. Inspectors noted in one clinical area different concentrations of the same drug stored beside each other, but in separate compartments. In SFU inspectors noted a number of boxes of a similar types of sedative type drugs stored together. As a potential patient safety risk these issues were brought to the attention of management. There was also a list of sound-alike-look-alike drugs, available in the clean utility rooms. Inspectors were told that high risk medications and sound alike look alike drugs were not always stored separately from the general ward stock. Additional safety controls were in place, depending on the medication, such as additional labelling, separate storage and additional checks in supply, prescribing and administration. Inspectors noted and were informed that the variance in the patient prescription charts identified in the 2024 HIQA inspection report had been addressed.

Staff in the clinical areas visited had access to medicine information on posters, desktop computer applications and phone applications. Up-to-date prescribing guidelines, antimicrobial guidelines, medicines formularies and other medication information were available at the point of preparation. Inspectors were told of an ongoing QIP which will ensure the availability of all electronically available medicines information at all points of preparation across the hospital. In addition, there were eighteen nurse prescribers for medicinal products in a number of clinical specialities with oversight from the DON and the NPDU. In one clinical area inspectors observed nursing staff wearing red aprons, indicating not to be disturbed while administrating medication.

Deteriorating Patient

At the time of inspection, there was no deteriorating patient risk register in the hospital. The 2025 work plan outlined the three areas of immediate focus, these were the EWS, policies, procedures, protocols and guidelines (PPPG's) and the use of vasoactive medications outside of the critical care environment. Patient safety incidents were reviewed by the quality, risk management department and disseminated to relevant stakeholders.

The hospital used the INEWS, EMEWS, IMEWS, PEWS, ISBAR$_3$ communication tool and sepsis clinical decision support tool for the management of the deteriorating patient.

EWS was not used in SFU, inspectors were told patients that deteriorated were transferred back to the hospital in line with the units' policy. In the 2024 inspection inspectors noted different versions of the INEWS is use, which has since been addressed.

Staff who spoke with inspectors were clear on the escalation process for deteriorating patients. It was noted that the ISBAR$_3$ sticker was not consistently used in patient healthcare records as part of this process. Staff used the ISBAR$_3$ communication tool for shift handover and for internal and external patient transfers.

While the paediatric service had transferred to the regional model four site, on occasions paediatrics continued to present to the ED. The hospital had a policy in place which outlined the process for children (up to the age of 16 years) presenting to the ED to include assessment, and transfer to an appropriate level of care if required. The hospital also had a transfer PPPG and an assessment risk matrix to determine the personnel and equipment that was required on transfers.

The hospital had eighteen observation beds across a number of wards in the hospital, with a higher staff to patient ratio, ranging from 1:4 to 2:5. In these areas staff were provided with informal training on the management of specific medical devices used to support patients, such as non-invasive ventilation. At the time of inspection the hospital informed inspectors that there was a plan to introduce four specific telemetry beds in September 2025.

Inspectors raised concerns with the DPC in relation to a legacy practice where vasoactive medications were administered to patients in the observation areas outside of a critical care setting. A review of patient data carried out in July 2025 highlighted that eight patients remained in the observation units, while vasoactive medications were administered, during periods ranging from three hours to six days. The hospital did not have a supporting PPPG or inclusion, exclusion criteria in place to support the practice, but did have an infusion monograph to support drug administration. The DPC had reflected this practice as a risk related to current intensive care and high dependency capacity, in minutes seen by inspectors. Inspectors were told that this practice would be discontinued in September 2025, with this patient cohort being cared for in the critical care unit.

Hospital management informed inspectors that a dedicated staff resource with responsibility for the deteriorating patient programme would be appointed in quarter three 2025, this would support staff in the management of the deteriorating patient.

Transitions of Care

At the time of inspection, there was no transitions of care risk register. Patient safety incidents were reviewed by the quality, risk management department and disseminated to relevant stakeholders. The hospital had guidelines in place to support the transfer of patients from the ED, patients being transferred from critical care to other hospitals and the transfer of paediatric patients who present at the hospital requiring transfer to other hospitals.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services. The hospital had a number of transfer and discharge policies, and templates to facilitate safe transitions of care.

The hospital had a guidance document in place to support patients in SFU, which included an inclusion and exclusion criteria in place, and patients consent was required to transfer to SFU. Patients had a discharge plan in place prior to transfer, an average length stay was seven to fourteen days with a maximum of thirty days in exceptional or complex cases.

On the day of inspection, the ED and AMAU where functioning well. At 11.00am there were 24 patients registered in the ED with no patients on trolleys awaiting an inpatient bed. 21% of patients were GP referrals, 58% were self-referrals and 8% were ambulance referrals. All patients were triaged and prioritised in line with the Manchester Triage System. There were 33,075 attendances to the ED in 2024 and 15,770 from January to June 2025. The re-admission rate within 30 days was recorded at 13.1% which was above the HSE target of less than or equal to 11.1%. Compliance with ambulance handover within 20 minutes was 50% below the national target of 80%.

- the average waiting time from registration to triage was 17 minutes, the HSE target is 15 minutes.
- the average time from triage to medical assessment was 70 minutes which had disimproved from HIQA's previous inspection in 2024 (43.5 minutes). Inspectors noted that there was a delay of 76 minutes in triage for one patient, and inspectors discussed this with staff.
- the average time from medical assessment to decision to admit was four hours and 32 minutes, which was an improvement since HIQA's inspection in 2024.

- the average time from decision to admit to admission to an inpatient bed in the hospital was two hours and 15 minutes, which was an improvement on HIQA's inspection in 2024.

Data on the hospital's ED patient experience times collected at 11.00am on the first day of inspection, showed that the hospital was compliant with all HSE targets.

- there were three patients (12.5%) in ED greater than six hours (target 70%)
- there were two patients (8.0%) in ED greater than nine hours (target 85%)
- there were no patients in ED greater than 24 hours (target 97%)
- there was one patient 75 years of over (4%) in the ED greater than six hours (target 97%)
- there were no patients 75 years of over in the ED greater than nine hours (target 99%)
- there were no patients 75 years of over in the ED greater than 24 hours (target 99%)

This was an improvement on the last inspection when the hospital was compliant with two targets. In quarter one and two of 2025, patients aged 75 years and older accounted for 18% of all ED attendances. Hospital management described a prioritised approach in admitting this patient cohort to beds, through the hospital's journey to zero initiative. In addition, since the last inspection an additional patient flow co-ordinator was in position to support the flow of patients through the ED.

The ED conversion rate for all patients was 24% year to date, inspectors were informed the conversion rate for patients 75 years and older was 50%.

6.3% of patients left the ED before completion of treatment between January and June 2025, which is above the national average of less than 5%. Inspectors were told that these patients were followed up at the time, with their GP the following day and with social support services where required.

At the time of the inspection the hospital was engaged in a pilot programme which enhanced security. In addition staff within the ED had access to 'man down' emergency alarms.

On the day of inspection, there were sixteen delayed transfers of care (DTOC), and inspectors were informed this had reduced to thirteen in the afternoon. DTOC ranged between eleven to twenty-five year to date 2025, and hospital management told inspectors challenges to egress included limited availability of rehabilitation and specialist long-term beds in the region.

The average length of stay for medical patients was 7.2 days, above the HSE's national target of seven days. The national target for elective surgical admissions

was 4.5 days and six days for emergency surgical admissions, the hospital was recording 5.4 days.

To support patient flow, the hospital had an additional sixteen surge beds and a number of admission avoidance pathways in place, which included:

- trauma bypass protocol pathway.
- minor injuries pathway to the Local Injury Unit located off site in St Mary's campus.
- AMAU pathway in the ED.
- Frailty Intervention Therapy Team pathway.
- pathway for the management of deep vein thrombosis
- Integrated Care Programme for Older People
- Mercy Home Care.
- ambulatory care pathway.
- private insurance care service.
- transfer pathway for emergency surgical patients.
- out-patient pathway review and follow up.

Policies, Procedures, Protocols and Guidelines (PPPGs)

The hospital had a PPPG approvals committee in place, with responsibility for the final signoff of all PPPG's in use in the hospital. The hospital had a suite of up-to-date infection prevention and control PPPGs adopted from the HSE national guidelines which included policies on standard and transmission based precautions, outbreak management, managements of patients in isolation and equipment decontamination. Policies for the management of reusable invasive medical devices and the track and trace system in theatre where out of date. The hospital had a number of medication safety PPPGs which required updating. Prescribing guidelines could be accessed by staff at the point of care through desktop computers. To support the deteriorating patient a number of policies required review and updating, to ensure alignment with national policy. While the hospital did not have a document management system in place for PPPGs, all PPPGs were accessible to staff on the hospitals intranet.

The hospital had a range of patient information leaflets which were given to patients during and prior to discharge. Examples included patient discharge information leaflets.

Mercy Home Care was a service introduced with the support of a CNM and three healthcare assistants to provide support to patients who were discharged home and waiting for a home care package. This was supported with an inclusion and exclusion criteria to identify patients suitable for the service. Since commencement of the service in January 2024 there were 180 referrals, 165 (91%) were accepted for the home care support, with 146 (88%) discharged from the service and 18

(12%) requiring hospital readmission. There was a total of 2,521 bed days saved since January 2024.

Areas for improvement include:

- continued focus on prevention of HCAI's
- documentation of MDRO's in SFU nursing assessments
- review of the appropriateness and risk associated with the practice of administration of vasoactive medications outside of a critical care area
- review medication management practices relating to storage of medications in SFU
- continued focus on triage to medical assessment time and compliance with HSE national NAS turnaround times target
- continued focus on the management of the deteriorating patient
- ensure consistent use of the ISBAR$_3$ labels in healthcare records
- review and update PPPGs to ensure alignment with national policy
- develop a deteriorating patient risk register
- develop transitions of care risk register

Judgment: Partially Compliant

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

The management of patient-safety incidents in the hospital was supported by the national HSE incident management framework 2020. The hospital had systems in place to identify, report, manage and respond to patient safety incidents in line with legislation and guidelines. Staff who spoke with inspectors were knowledgeable about escalation, management and reporting systems in place for patient safety incidents. Regular reports were provided to each clinical area via the NIMs electronic incident management system.
In the ED there was a monthly clinical review meeting that reviewed incidents, patient experience times, presentations to the ED, service provision and workforce.

All patient safety incidents were reviewed and categorised according to policy. Inspectors viewed quarter one and two 2025 incident management reports, which provided details on the number of reported incidents, categorised by incident, location and outcomes. Medication safety incidents were further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention medication error categorisation.

A serious incident management team (SIMT) meeting, chaired by the CEO, was convened as required to manage category one incidents and other patient safety issues, and had met three times in the two months prior to the inspection.

All patient safety incidents were tracked and trended by the quality, risk and patient safety department, reviewed at relevant committees, the CQSGC, serious incident management team, EMB, and the board.

Overall, the hospital had a system in place to identify, report, manage and respond to patient safety incidents, in particular, in relation to the four key areas of harm.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Mercy University Hospital to assess compliance with 11 national standards from the National Standards for Safer Better Healthcare. The inspection focused on four areas of known harm, infection prevention and control, medication safety, deteriorating patient and transitions of care.
Overall, the hospital was judged to be compliant with four national standards (1.6, 1.7, 1.8, 3.3), substantially compliant with four national standards (5.2, 5.5, 5.8, 6.1) and partially compliant with three national standards (2.7, 2.8, 3.1).

Capacity and Capability
The Mercy University Hospital had formalised governance and management arrangements in place to support and support the delivery of high-quality, safe, and reliable healthcare. The RHA's South West formal engagement with the hospital remains outstanding, with plans to commence regional performance meetings in September 2025.

The hospital had arrangements in place to identify and act on opportunities to continually improve the quality, safety, and reliability of the healthcare services provided, relevant to the size and scope of the hospital. The hospital would benefit from a centralised approach for the oversight and management of audit in line with best practice guidelines.

Since the previous inspection, improvements related to staff deficits in the emergency department had been progressed and staff deficits in the pharmacy service had been addressed, and there is a plan in place for a centralised learning

management database. Outstanding issues include shortfalls in WTE consultant microbiologists and staff attendance at mandatory and essential training.

Quality and Safety

The inspection at Mercy University Hospital demonstrated a commitment by all staff in respecting and promoting the dignity, privacy, and autonomy of patients. Hospital management and staff were dedicated to fostering a culture of kindness, consideration, and respect. This correlated with feedback from the 2024 National Inpatient Experience Survey, where the hospital scored above the national average. The hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service, with a number of initiatives in place to highlight and promote the feedback process to patients.

Overall, the hospital's physical environment was clean and well maintained. The 2024 inspection highlighted a number of infrastructural issues in the hospital. The hospital had a detailed infrastructural and refurbishment action plan in place with the areas for improvement highlighted in 2024, though a number of issues remained outstanding. In the clinical areas visited, there was limited access for patients to shower and toilet facilities. Inspectors noted that there were ongoing refurbishment works, which further impacted the availability of facilities for patients. A number of patients requiring single room isolation were required to leave their rooms to access facilities on the corridors.

Risk assessments were carried out to identify patients suitable for these isolation rooms. Hospital management informed inspectors that challenges with the hospitals infrastructure was recorded as a high-rated risk on the corporate risk register with particular reference to the impact on IPC. These ongoing challenges were constantly being managed, regular quality walkabouts were carried out and ongoing mitigation controls put in place as issues arose. At the time of inspection the hospital had undertaken a feasibility study, to secure capital investment to build a new hospital block that would provide single en-suite bedrooms to current healthcare standards.

Inspectors found limited evidence of regular monitoring of compliance with the national guidance on sepsis management and ISBAR$_3$. Hospital management informed inspectors that a dedicated staff resource with responsibility for the deteriorating patient programme would be appointed in quarter three 2025, this would support staff in the management of the deteriorating patient.

On the day of inspection, the ED was not in escalation. The ED and AMAU were functioning well. The time from registration to triage, and triage to medical assessment had improved since the previous inspection. The ED was in compliance with all patient experience times, which was an improvement from the last inspection, where the hospital were in compliance with two of the five targets. Hospital management described a prioritised approach in admitting patients 75 years and older to beds, through the hospital's journey to zero initiative.

Inspectors raised concerns in relation to a legacy practice where vasoactive medications were administered to patients outside of a critical care setting. Inspectors were told this practice would be discontinued in September 2025, with these patients being cared for in the critical care unit. A number of policies, procedures, protocols and guidelines required review and updating to ensure alignment with relevant national policy. The hospital did not have a deteriorating patient or transitions of care risk register.

The hospital had a system in place to identify, report, manage and respond to patient safety incidents, in particular, in relation to the four key areas of harm. All patient safety incidents were tracked and trended by the quality, risk and patient safety department, reviewed at relevant committees, the CQSGC, serious incident management team, EMB, and the board.

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

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially Compliant

quality, safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for Mercy University Hospital

Inspection ID: NS_0156

Date of inspection: 12/08/2025 and 13/08/2025.

Compliance plan provider's response:

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

Areas for improvement:

1. Continued focus on infrastructural challenges to include lack of single rooms
2. Address risk posed by insufficient toilet and shower facilities
3. Continued focus on staff education relating to IPC signage
4. Ensure environmental cleaning is in line with PPPGs

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1. **Continued focus on infrastructural challenges to include lack of single rooms**
2. **Address risk posed by insufficient toilet and shower facilities**

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

Action Plan

- Immediate repairs or replacement of damaged work.
- Regional Support required to progress the new 72 ensuite single bedroom ward block project, as included in the Acute bed capacity expansion plan 2024-2031,with HSE Estates.
  Continue phased refurbishment of wards rooms under AMRIC and minor capital funding, prioritising St Brigid's Ward (storage, doorway widening, observation panels).
  Include high risk infrastructural issues in corporate risk register, updated quarterly.

- Prioritise inclusion of adequate toilet/shower facilities in future refurbishment/new build plans.
- Continue sink and tap replacement programme to ensure all sinks meet the required standards.

Timescale

Ongoing – short-term (within 6 months) for Minor capital works; medium-term (1–2 years) for refurbishment works and long-term (3–5 years) for new build

3. Continued focus on staff education relating to IPC signage

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

Action Plan

- Develop Standard Operational Procedure (SOP) on the use of current isolation signage to support transmission-based precautions in MUH until AMRIC issue updated transmission-based precautions signage.
- Disseminate SOP on the use of isolation signage in MUH to all key stakeholders and audit compliance.
- On daily IPC nursing ward visits continue to guide and support staff with information on patient alerts and transmission-based precautions to support patient care.
- Continue to highlight transmission-based precautions required to support patient care on IPC bed list email daily.
- Continued focus on staff education relating to IPC signage.

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

- Once AMRIC transmission-based precaution signage is available review SOP for isolation signage and update to support the implementation of new signage.
- Develop IPC safety bulletin to support new AMRIC transmission-based precaution signage.
- Provide training to support change of isolation signage- use of stand at link bridge, ward education, induction education etc.
- Review IPC and Technical Services list of areas in the physical environment such as upgrade of bathrooms, toilets and shower rooms, clean utilities, dirty utilities etc and submit application for AMRIC funding to support required changes. Areas for submission based on IPC risk assessment.

Timescale

End of Quarter 2 2026

4. Ensure environmental cleaning is in line with PPPGs

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

Action Plan

- The Hospital will liaise ensure that contract environmental cleaning service is carried out in line with PPPGs.
- Training requested - site wide re-training on all basic infection control principles with a timeframe of one week for completion as per the complaints monitoring portion of the current compliant service level agreement.

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

- Training matrix and percentage of completion from cleaning contractor form part of monthly Key Performance Indicator meeting between MUH management and senior cleaning contractor management for ongoing monitoring and assurance with environmental cleaning PPPG's.

Timescale

Ongoing

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

Areas for improvement:

1. Continued focus on the prevention of healthcare acquired infections
2. Ensure a comprehensive AMS service
3. An ongoing focus on compliance with hand hygiene
4. Focus on compliance with the deteriorating patient escalation and response protocol
5. focus on compliance with the national guidance on sepsis management to include audit
6. Continued focus on compliance with the national guideline ISBAR$_3$ communication tool
7. Ensure quality improvements plans are developed when areas for improvement are identified.

1) **Continued focus on the prevention of healthcare acquired infections**
2) **Ensure a comprehensive AMS service**
3) **An ongoing focus on compliance with hand hygiene**

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

Action Plan

- Continued focus on the prevention of healthcare acquired infections through the ongoing implementation of the IPC annual plan, quarterly Infection Prevention and Control Committee, review of IPC risks for corporate risk register and IPC local risk register and advising on mitigating controls, education and audit to minimising the transmission of healthcare-associated infections.
- Develop IPC annual plan for 2026 based on IPC related risk factors and National Key Performance Indications.
- Continued implementation of HSE review tool for *Staphylococcus aureus* blood stream infections (where they meet the definition). Where areas for improvement related to reviews are identified disseminate learning to all key stakeholders and where required develop Quality Improvement Plans (QIP) to support.
- Continued review of IPC related polices and updates as required e.g. management of Covid 19 and seasonal influenza, prioritisation for isolation table etc.
- Continued implementation of IPC QIP for hand hygiene to support compliance with hand hygiene- in the form of infrastructure to support hand hygiene, signage and reminders in the workplace, education, audit and feedback in line with the World Health Organisation (WHO) multimodal strategy for hand hygiene.
- AMS is a standing item on the IPCC.
- AMS pharmacist sends emails to clinical microbiology team highlighting patients on reserved or broad-spectrum antimicrobials, with subsequent phone call follow-up with clinical teams
- No local antimicrobial prescribing guidelines due to consultant microbiologist staffing deficits. In the absence of local guidelines, we direct staff to use the antimicrobial guidelines of another hospital in the region

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

- Develop and implement an IPC link person programme to further support local ward and departmental knowledge and understanding of the application of IPC.

- The antimicrobial stewardship (AMS) service is limited due to consultant microbiologist staffing deficits-this risk has been escalated to the corporate risk register and a business case has been submitted for an additional consultant microbiologist who would be lead for AMS.

Timescale
End of Quarter 3 2026

4. Focus on compliance with the deteriorating patient escalation and response protocol

5. Focus on compliance with the national guidance on sepsis management to include audit

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

Action Plan

- CNMII Care of the Deteriorating Patient and Sepsis commences post 03/11/2025
- Audit Schedule determined for Q4 2025 and 2026 based on QIP INEWS audits: Protocols and documentation HCR 18/06/2025. QIP to be developed to address results going forward
- Audit Schedule to include INEWS, ENEWS, IMEWS, and Sepsis
- Care of the deteriorating meetings increase to monthly with actions assigned to named individuals and timebound. Co-Chair Director of Nursing appointed
- Policies identified in QIP 18.06.205 near completion. National guidelines being adopted. Final Policies for approval at PPPG committee
- New National Clinical Guideline No 26 (Sepsis) form to be introduced. Education in progress. HSEland compliance with National Guideline No 26 in Progress

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

- Seek regional approval and funding for additional consultant post to include responsibility for the deteriorating patient.

Timescale
Ongoing

6. Continued focus on compliance with the national guideline ISBAR$_3$ communication tool

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

Action Plan

- ISBAR³ communication tool is audited monthly in Acute Care Services Quality Care Metrics: Patient monitoring and surveillance. QIPs are created to address these results.
- Hospital has established a transitions of care committee, the remit of the Committee is to address all aspects of transitions of care including communication.
- The National Clinical guideline No. 11 will be adopted and local policy developed
- Audit of ISBAR tool use to be completed which includes an audit of ISBAR labels in the healthcare record

Timescale

Q2 2026

7. Ensure quality improvements plans are developed when areas for improvement are identified.

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

Action Plan

- MUH plan to establish a Clinical Audit Office in 2026 which will promote and guide quality improvement plans. Ongoing communication to all Committees and services

Timescale

Ongoing

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

Areas for improvement:

1. Continued focus on prevention of HCAI's, documentation of MDRO's in SFU nursing assessments
2. Review of the appropriateness and risk associated with the practice of administration of vasoactive medications outside of a critical care area
3. Review medication management practices relating to storage of medications in SFU
4. Continued focus on triage to medical assessment time and compliance with HSE national NAS turnaround times target
5. Continued focus on the management of the deteriorating patient
6. Ensure consistent use of the ISBAR3 labels in healthcare records

7. Review and update PPPGs to ensure alignment with national policy
8. Develop a deteriorating patient risk register
9. Develop transitions of care risk register

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1. Continued focus on prevention of HCAI's, Documentation of MDRO's in SFU nursing assessments

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

Action Plan

- Continued focus on the prevention of healthcare acquired infections through the ongoing implementation of the IPC annual plan, quarterly Infection Prevention and Control Committee, review of IPC risks for corporate risk register and IPC local risk register and advising on mitigating controls, education and audit to minimising the transmission of healthcare associated infections.
- Develop IPC annual plan for 2026 based on IPC related risk factors and National Key Performance Indications.
- Continued implementation of HSE review tool for *Staphylococcus aureus* blood stream infections.
- Continued review of IPC related polices and updates as required e.g. management of Covid 19 and seasonal influenza, prioritisation for isolation table etc.
- Develop in conjunction with Nurse Practice Development Unit intrahospital hospital checklist identifying IPC related risk factors including where required a MDRO alert for transfer to SFU.
- Education update regarding compliance with St Francis Unit Nurse Transfer Checklist (SFU V1 April2025)
- IPMS alerts to be update on the patient record.

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

- Develop and implement an IPC link person programme to further support local ward and departmental knowledge and understanding of the application of IPC.

Timescale

End of Quarter 3 2026

2. Review of the appropriateness and risk associated with the practice of administration of vasoactive medications outside of a critical care area

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

Action Plan

- A phased development plan for four High Dependency Unit (HDU) beds to ensure that patients requiring vasoactive support are appropriately managed within a high-acuity environment, thereby preventing the administration of vasoactive medications in general ward settings
- Administration of vasoactive medications on general wards due to constrained critical care bed capacity to be logged on the corporate risk register under inadequate resourcing of critical care beds.
- Pharmacy monographs for phenylephrine for use in ICU and CCU are in the process of being finalised and will be released by 12th November 2025.

Timescale

- Two HDU beds before End of 2025
- Two HDU Beds by end of quarter 1 2026

3. Review medication management practices relating to storage of medications in SFU

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

Action Plan

- An order schedule has been devised with pre agreed stock levels based on usage.
- A maximum ordering schedule has been put in place for sedative type medication.
- CNM2 or designate will review stock levels on Tuesday and Friday of each week.
- Security including swipe access will be reviewed.
- A safe storage of medication audit is schedule.
- Updated and revised controlled drugs register, including schedule two drugs. Appropriate training provided.

Timescale

End of Quarter 1 2026

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

- Weekly visits by Pharmacist /Technician to ensure stock levels are appropriate. A plan is to utilise dedicated hours/WTE for this purpose proposed.

Timescale

End of Quarter 2 2026

4. Continued focus on triage to medical assessment time and compliance with HSE national NAS turnaround times target

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

Action Plan

- The Emergency department in MUH is currently working with the Regional Director of Nursing on a quality improvement project, to improve triage times.
- The implementation of the ED Safer staffing and skill mix framework will assist with an overall improvement in triage times and ambulance turnaround times. Currently, our median time to triage is 17 minutes.
- Clerical processes will be modified to improve the overall triage time.
- Staff will receive additional training to become more proficient with digital EMEWs which will contribute to improving triage times and Patient safety.
- MUH will augment triage training capacity with the addition of a second member of staff as a trainer for the Manchester Triage System, this will allow more focus on the national KPI for triage and assist with the audit and monitoring of triage times. Currently there are 85% of staff trained in Manchester Triage within the Emergency Department.

Timescale

6 months

5. **Continued focus on the management of the deteriorating patient**

   See Standard 2.8

6. **Ensure consistent use of the ISBAR$_3$ labels in healthcare records**

   See Standard 2.8

7. **Review and update PPPGs to ensure alignment with national policy**

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

Action Plan

- Ongoing focus on ensuring PPPG's are updated as per MUH Policy – Policy Document for the Development, Review and Implementation of PPPG's.

Timescale

Ongoing

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

- Introduction of a Document Management System

Timescale

End of 2026

8. **Develop a deteriorating patient risk register**

- Completed - In place

9. Develop transitions of care risk register • Completed – In place