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:	Naas General Hospital
Centre ID:	OSV-0001080
Address of healthcare service:	Craddockstown Road Naas County Kildare W91 AE76
Type of Inspection:	Announced
Date of Inspection:	11 and 12 September 2025
Inspection ID:	NS_0161

About the healthcare service

Model of hospital and profile

Naas General Hospital is a model 3* public acute hospital. The hospital is located in the Health Service Executive (HSE) Dublin and Midlands Health Region† and is part of the Dublin South West integrated healthcare area (IHA). Services provided by the hospital include:

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

The following information outlines some additional data on the hospital.

Number of beds	204 inpatient beds 18 day case beds

* A Model 3 hospital typically admits undifferentiated acute medical patients, provides acute surgery, acute medicine, and critical care.

† The Regional Health Area HSE Dublin Midlands HSE Dublin and Midlands provides health and social care services to Dublin South City and West and Dublin South West, Kildare, West Wicklow, Laois, Offaly, Longford and Westmeath.

How we inspect

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

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

During the inspection, inspectors:

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

About the inspection report

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

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
11/09/2025	09:00 – 18:20	Eileen O'Toole	Maeve McGarry Angela Moynihan Kay Carlos
12/09/2025	08:45 – 15:45	Eileen O'Toole	Maeve McGarry Angela Moynihan Kay Carlos

Information about this inspection

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

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

The inspection team visited the following clinical areas:

- Emergency Department, Acute Medical Assessment Unit and Discharge Lounge
- Moate Ward (31-bedded medical ward)
- Curragh Ward (31-bedded medical ward, specialising in the care of older persons)

During this inspection, the inspection team spoke with representatives of the hospital's Senior Management Team, Quality and Risk, Human Resources and clinical staff.

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.

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

The emergency department had two triage rooms and a total approved capacity of 24 trolleys which was divided into the following areas:

- two resuscitation bays (adult and paediatric)

[§] 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.

- eight single cubicles and two treatment rooms for the treatment of patients categorised as majors
- six bays identified as a medical assessment unit for care of older persons
- three isolation rooms with negative pressure but not ensuite
- three bays for the treatment of patients with minor injuries

The department also had a Rapid, Access and Treatment (RAT) area with capacity for three patients, a mental health assessment room and an ambulatory decision unit with a maximum capacity for six patients. In addition the emergency department had a surge capacity of 24 trolleys comprising 14 trolleys in the transit area and trolleys along identified areas on the corridors.

The Acute Medical Assessment Unit (AMAU) had a total of five bays and had a maximum capacity of 18 patients. The Discharge Lounge had a maximum capacity of two beds and six chairs.

Moate and Curragh wards were 31-bedded wards consisting of four six-bedded multi-occupancy rooms, one three bedded multi-occupancy rooms and four single rooms. Both of these wards were two of the four wards that were identified as having surge capacity of a further two trolleys on the corridors, if required. There were no patients cared for on trolleys in the corridor on either of these two wards at the time of inspection.

Inspectors spoke with a number of patients in the clinical areas visited. Patients were complimentary about the care they received across all clinical areas visited as part of this inspection. Patients informed inspectors that they were *"looked after well",* that the staff were *"friendly"* and that they were *"kept up to date with what was happening"*. One patient described difficulty sleeping within the emergency department because of the noise, whilst another patient on a trolley on the corridor reported that they had *"no complaints".* Overall, the patients reported that they were *"happy with the care"* they received.

Some patients said they had not received information about the hospital's complaints process but if they wanted to make a complaint or had concerns about the care they received, that they found staff very approachable and would talk to them. One patient spoke about the information package they had received on admission which contained information on the complaints procedure. One patient in the emergency department described information seen displayed on the walls in relation to making a complaint.

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.

Naas General Hospital was found to be compliant with two national standards 5.2 and 5.8 and substantially compliant with two national standards 5.5 and 6.1 assessed under this dimension. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

The hospital had integrated corporate and clinical governance arrangements in place which were appropriate for the size, scope and complexity of the service delivered.

Since HIQA's last inspection in July 2024, Naas General Hospital is now part of the Dublin and Midlands Health Region. A number of changes had occurred at HSE level to align with the corporate and clinical governance arrangements in the new Health Regions configuration. The hospital's general manager (GM) had defined reporting and accountability arrangements to the integrated healthcare area (IHA) manager of Kildare, West Wicklow and upwards to the regional executive officer (REO) of HSE Dublin and Midlands Health Region. Monthly performance meetings were held with the IHA manager where key performance metrics were reported pertaining to finance, workforce, quality and safety risks, scheduled and unscheduled care access and hospital activity levels. The new reporting arrangements for the governance structures described to the inspectors were consistent with those outlined in the hospital's organisational charts.

The hospital's clinical director (CD) provided clinical oversight and leadership and reported to both the GM and the regional clinical director. The director of nursing (DON) was responsible for the organisation and management of nursing services at the hospital and reported to the GM and to the regional director of nursing and midwifery.

As per previous inspection findings, the Senior Management Team (SMT) was the main governance structure at the hospital with responsibility for ensuring oversight and governance of the quality and safety across the hospital services. The SMT meetings were chaired by the GM, met in line with its terms of reference and specific time-bound actions were assigned to an individual.

The Quality and Patient Safety (QPS) Committee continued to be chaired by the CD, attended by members of the SMT and relevant multidisciplinary team members. The committee's responsibilities included the review and monitoring of the hospital's risk management systems and continuous quality improvement programmes, the review and monitoring of performance metrics and the monitoring of all committees which reported into the QPS committee. The QPS Committee was also designated responsibility to ensure consistency and accountability across all committees. Inspectors saw evidence that reports were generated by committees which demonstrated the status of specific time-bound action items, key performance indicators achieved and detailed action items completed and barriers to progress other actions.

The Emergency Department Governance Multidisciplinary Team Committee had responsibility for reviewing and improving the flow and experience of patients in the emergency department. The committee was chaired by the clinical lead and reported into the unscheduled care group. Terms of reference outlined that the committee met weekly however, minutes of meetings reviewed indicated that the committee was not meeting in line with this frequency. The committee had a set agenda which included review of data and key performance indicators, incidents and complaints, staffing and infrastructure.

The Infection Prevention and Control Committee (IPCC) was chaired by the GM, met in line with their terms of reference and reported into the QPS Committee. The IPCC was accountable for developing and delivering an integrated infection prevention and control programme. Meetings were action oriented and an action log was developed clearly outlining time bound person specific actions. From evidence provided during this inspection, it was clear that the hospital had effective oversight and governance arrangements in place for the hospital's infection prevention and control programme.

The Drugs and Therapeutics Committee was assigned with responsibility for the safe and effective use of medication in the hospital. The committee, chaired by a consultant physician, reported into Clinical Governance Committee annually. Terms of reference outlined that the committee meet three times per year however, minutes of meetings reviewed indicated that the committee was not meeting in line with this frequency. Meetings were action orientated with actions assigned to individuals, however these actions were not always time-bound. Medication safety was a standing agenda item at the Drugs and Therapeutics Committee meetings. The Medication

Safety Committee was a subcommittee of the Drugs and Therapeutics Committee and also reported into the QPS Committee, producing a comprehensive report detailing medication incidents, risks and education.

The Deteriorating Patient Committee (DPC) was responsible for overseeing the implementation, evaluation and monitoring of the Early Warning Systems (EWS)[§§] and sepsis management within the hospital. The committee was chaired by the CD, met in line with their terms of reference and meetings were action orientated with actions assigned to individuals, however these actions were not always time-bound. The committee reported into QPS Committee quarterly and both the Deteriorating Maternity Patient Committee and Sepsis Committee reported into the DPC.

The Deteriorating Maternity Sub-Committee had responsibility to oversee the number of maternity presentations to the emergency department, the number of transfers, number of admissions, audit activity in relation to IMEWS and any issues in relation to the maternity pathways in place within the hospital. The hospital did not have an obstetrics, gynaecological or neonatal service on site. This subcommittee met quarterly, was chaired by the CD and reported into the Deteriorating Patient Committee. The Sepsis Committee met quarterly, was chaired by an emergency department consultant and had oversight of audit activity in relation to sepsis and relevant education.

Inspectors were informed of the oversight of transitions of care which took place across a number of committees in the hospital. There was a weekly operational meeting, which was chaired by an operations manager and attended by members of the SMT where the data for the preceding week was reviewed which included attendances, patient experience times (PETs) and quality improvement projects. This meeting was also a planning meeting for the week ahead with emphasis on the upcoming weekend and surge planning. A monthly patient flow meeting took place which was a nursing forum where data from the operational meeting was discussed which included attendees from outpatient parenteral antimicrobial therapy[***] and Discharge Lounge. A weekly Community Hospital Integration Forum provided an opportunity for both hospital and community based staff to discuss patients with delayed transfers of care from hospital and complex discharges. The hospital held a weekly length of stay meeting where patients that have a hospital stay longer than eight days were discussed with the medical teams and included the patients predicted date of discharge. To plan for the weekend, the hospital held a weekly meeting with the on call medical team and the patient flow department where possible discharges

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

[***] Outpatient Parenteral Antimicrobial Therapy (OPAT) allows suitable patients on intravenous (IV) antibiotics to be discharged early from hospital and treated in their home or community setting by a team of specialist nurses

and patients requiring review were highlighted.

Compared with previous inspection findings, there was an improvement in compliance with this national standard. At the time of inspection, it was clear that there were integrated corporate and clinical governance arrangements at hospital level. Governance committees met and in the main, functioned in line with their agreed terms of reference. The QPS Committee had responsibility to ensure consistency and accountability across all committees and had oversight of actions achieved and outstanding. Committees had oversight of the hospital's performance and there was a formalised upward reporting structure to the IHA manager which was clearly identified in the hospitals organisational charts.

Judgment: Compliant

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

The inspectors found there were management arrangements in place to support the delivery of safe, high-quality healthcare services at Naas General Hospital.

An annual programme was developed by the infection prevention and control team (IPCT) which set out the priorities and subsequent actions required. An annual infection prevention and control report, which detailed the hospital's performance in relation to the monitoring of surveillance and compliance with infection prevention and control practices and standards was submitted to the QPS committee and the SMT. The hospital had no antimicrobial pharmacist in post since May 2024 and the antimicrobial stewardship (AMS) technician post which was AMRIC[†††] funded could not be filled until the AMS pharmacist as in place. However, pharmacy had dedicated 10 hours per week to AMS, which resulted in AMS review of patient's prescriptions one or two times per week with a consultant microbiologist, and a report on antimicrobial consumption to IPCC, which inspectors were informed had a positive impact for patients. There was no AMS committee in place at the hospital and inspectors were informed that this was due to competing demands and lack of resources for AMS. The IPCT developed a hand hygiene improvement strategy, 2025 outlining the goals and objectives which included a self-assessment, actions and person with responsibility.

[†††] AMRIC stands for Antimicrobial Resistance and Infection Control Programme. It is a program run by the Health Service Executive (HSE), Health Protection Surveillance Centre (HPSC), and other Irish health organisations to combat antimicrobial resistance and promote effective infection prevention and control in healthcare settings.

The hospital's pharmacy service was led by the chief pharmacist. A medication safety programme was overseen by the Medication Safety Committee which in turn reported into the Drug and Therapeutics Committee and the QPS Committee. The programme outlined the objectives, focus, monitoring and risk assessments. A medication safety report was reviewed at each Medication Safety Committee meeting detailing progress against priority objectives set for 2025. The report was also reviewed at both the Drugs and Therapeutics Committee and the QPS Committee.

The Deteriorating Patient Committee was responsible for the provision of deteriorating patient services under the clinical leadership of the clinical director. The multidisciplinary committee monitored compliance with national guidelines on the early warning systems and sepsis management across the hospital. The national early warning systems in use at the hospital were the Irish National Early Warning Score (INEWS)[‡‡‡], the Irish Maternity Early Warning System (IMEWS),[§§§] and the emergency medicine early warning system (EMEWS)[****]. The hospital provides services to patients aged 16 and older and does not have maternity services. The deteriorating patient committee considered risks beyond the scope of the hospital's designated patient cohort, specifically considering individuals who may present to the emergency department. These risks included a deteriorating paediatric patient, the lack of an obstetric and gynaecological service and the inability to monitor foetus wellbeing. This will be further discussed in national standard 3.1.

There were established management arrangements in place to monitor hospital activity and address factors impacting healthcare service demand and the safe and effective transitions of care. Hospital activity and capacity, patient acuity and responsiveness to meet service demand was monitored and managed through a number of formalised daily and weekly meetings. Daily bed management meetings were described as a dynamic risk assessment process to ensure safe placement of patients, considerate of the hospital's bed capacity, infrastructural challenges and lack of single rooms. Surge beds were utilised based on assessment of patient numbers, patient acuity and availability of staff. This dynamic process often resulted in

[‡‡‡] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.
[§§§] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.
[****] Emergency Medicine Early Warning System (EMEWS) is an early warning system tool used in emergency departments to identify patients at risk of physiological deterioration. This system provides a structured way to monitor key physiological signs, assign a score, and escalate care to prevent adverse outcomes and ensure timely intervention for patients.

transitions of care of patients from one care area to another during their patient journey.

The hospital had a total of 21 surge beds which were available in the AMAU, the Discharge Lounge, the Day Ward, on trolleys in the emergency department and family rooms on wards. The Discharge Lounge could facilitate up to eight patients and staff reported that patients could be awaiting discharge and also awaiting admission into an inpatient bed from the Discharge Lounge. When the AMAU was used for overnight surge capacity, patients could be moved in the morning to inpatient beds or other surge areas such as the Day Ward, or occasionally the Discharge Lounge, to allow the AMAU to resume its intended function. The systems in place to manage surge optimised patient flow, while being responsive to infrastructural challenges but also led to increased transitions of care for patients which poses a patient safety risk. The hospital's Discharge Lounge standard operating procedure did not support the use of the Discharge Lounge for admitted patients.

Similar to HIQA's previous inspection, the mismatch between demand and availability of inpatient bed capacity continued to impact on the effective management of the emergency department. The hospital reported that on average the occupancy rate was 5% over their capacity in 2024 and 7% over to-date in 2025. On the first day of inspection, there were eight admitted patients boarding in the emergency department. The hospital had an escalation protocol in place with a series of clearly defined incremental steps to address demand for urgent and emergency care. Inspectors also saw evidence of future planning with a comprehensive winter plan in draft format. Staff informed inspectors that the hospital faced several ongoing challenges impacting patient flow and service delivery. These included an increase in emergency department attendances, an increase of patient acuity and an increase in presentations in patients over 75 years of age, limited inpatient bed capacity and a lack of single isolation rooms.

The hospital's emergency department attendance rate in 2024 was 34,577 (94 daily presentations) and was 24,575 (101 daily presentations) in 2025 up to the time of inspection, which demonstrated an 8% increase in attendances. There was a 9% increase in presentations of patients aged 75 years and over in the first eight months in 2025. In the weeks preceding the inspection Naas General Hospital had the third highest average duration of time for patients spent in the emergency department across the HSE. The overall average duration of time a non-admitted patient spent in the hospital's emergency department year-to-date (August 2025) was 6.7 hours which is a decrease from 7.2 hours in 2024.

The hospital had defined lines of responsibility and accountability for medical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine who was supported by non-consultant hospital doctors (NCHDs). A consultant in emergency medicine was the clinical lead for the emergency department. The clinical nurse manager, grade 3 (CNM3) reported to the assistant director of nursing (ADON), who in turn reported to the DON.

Hospital management monitored the delayed transfers of care (DTOC) and the average length of stay (ALOS). The ALOS was within the HSE's targets at the time of inspection. The hospital had access to a range of convalescence, rehabilitation and residential beds in stepdown facilities and hospital management had contracted additional capacity in private facilities, to maximise flow of patients through the hospital.

Inspectors reviewed progress made with the compliance plan submitted by the hospital following on from HIQA's previous inspection in July 2024. It was evident that sustained infrastructural investment was a priority for hospital management in order to increase capacity and enhance patient flow processes. The following changes were implemented since the last inspection to improve patient flow; increased opening hours for the AMAU, a focus on early decision making with an inpatient on call medical consultant evening round, the commencement of the RAT initiative running Monday to Friday, a re-design of medical roster to match demand trends, and the appointment of a clinical lead for the emergency department. However, the opening of a new AMAU facility in the hospital was not operational in accordance with the timelines set out in the compliance plan, but increased staffing was in place which allowed the increase of operational hours within the existing AMAU. Long term plans to provide additional capacity were outlined which included a 15 bed short stay admission ward planned for 2026, re-development of a current mental health ward and re-configuration of beds into acute beds planned for 2030 and a 49 bedded wing planned for 2033.

Overall, inspectors found that hospital management had progressed the majority of short term goals within their compliance plan with the exception of the opening of the AMAU. However despite these actions, there was continued mismatch between demand and inpatient bed capacity with increased emergency department attendances in 2025 and increased bed-occupancy rates over capacity in 2025. There was continued impact on the effective management of the emergency department due to admitted patients being accommodated in the department while waiting for an inpatient bed. The long term plans to increase inpatient bed capacity must be prioritised to address hospital overcrowding and to allow the emergency department to function as intended. The frequency of transition of patients, while risk assessed

and performed to maximise capacity and alleviate overcrowding has the potential to pose safety risks for patients and should be monitored closely.

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.

Systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services across the hospital was in place. Data was collected on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report. Data related to emergency department attendances and patient experience times, bed occupancy rate, average length of stay, delayed transfers of care, patient-safety incidents and workforce were reviewed at meetings of the QPS Committee, SMT and performance meetings between the hospital and the IHA manager.

There was evidence of risk management structures and processes in place to proactively identify, manage and minimise risk, and arrangements to monitor the service's performance. The management of reported risks related to the four areas of known harm – infection prevention and control, medication safety, deteriorating patient and transitions of care is discussed further in national standard 3.1.

Whilst the hospital did not have an annual audit plan, audit activity in relation to the four areas of known harm was overseen by the relevant governance committees and feedback was through the QPS Committee. The hospital would benefit from a centralised mechanism to oversee audit findings, required actions and associated recommendations within the hospital.

As per previous inspection findings, there was a process in place to proactively identify and manage patient-safety incidents. Patient-safety incidents were entered on to the National Incident Management System (NIMS).[††††] The hospital's Serious Incident Management Team (SIMT) were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. In addition to scheduled monthly meetings, the SIMT was convened as required. SIMT developed an annual report and all incident data was

[††††] 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).

discussed at the QPS Committee. The dual process for reporting patient-safety incidents, using both the electronic point of entry system and the national paper based incident report form, remained unchanged since HIQA's last inspection. Learnings from patient-safety incidents were communicated to clinical staff through clinical handover, multidisciplinary safety huddles and issuing of learning notices.

The QPS department was responsible for monitoring and responding to findings from the National Inpatient Experience Survey (NIES) 2024. In response to the survey findings, deficits in communication was identified and three quality improvement initiatives were implemented. The Service User Committee met quarterly and had representation from members of the SMT. Patient complaints and positive feedback were reported into the QPS Committee.

The hospital was found to have robust monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services.

Judgment: Compliant

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

Overall, workplace arrangements were in place to support the delivery of safe and effective care at the hospital. The approved staff complement was 1009 WTE with a total of 15 WTE vacancies. The hospital had a high reliance on agency[‡‡‡‡] staff which accounted for up to one in five staff members at certain times. Inspectors were informed that this was due to a fixed whole-time equivalent ceiling implemented in December 2023, which resulted in a decrease in WTE by 72. The hospital reported that at the time of inspection there were a total of 179 WTEs in process of recruitment which had been approved above the fixed ceiling as part of such initiatives as the *Framework for Safe Nurse Staffing and Skill Mix*[§§§§], agency conversion and the HSE National Service Plan. However, the hospital's risk register included a number of high-rated risks related to staffing due to unfilled positions in the hospital service. Actions were implemented to mitigate any actual and potential risks arising from staffing shortfalls, but hospital management described the management of these risks as challenging in the context of national workforce strategies and delays associated with the recruitment process. There was evidence

[‡‡‡‡] Agency staff in healthcare are temporary workers, such as nurses, employed by recruitment agencies to fill shifts and provide care to various healthcare settings.
[§§§§] Framework for Safe Nurse Staffing and Skill Mix

that performance reports relating to workforce and staffing was discussed regularly at SMT meetings.

The hospital had identified the laboratory and radiology services among the services most affected by unfilled positions. In the clinical areas visited during inspection staff did not report any issues with accessing radiology or laboratory services, with the exception of the emergency department where increased turnaround time for laboratory samples out-of-hours was outlined. Staff described ongoing discussions with laboratory staff to ensure good processes and good communication working within the resource constraints.

The hospital's absenteeism rate in July 2025 was 5.9%, with a reported average of 5.2%, which is above the HSE's target absenteeism rate of ≤4%. Inspectors were informed that back-to-work interviews were conducted by clinical nurse managers at ward level and that exit interviews were completed at time of resignation.

The hospital's approved funded complement for nursing staff in the emergency department including management and other grades, was 62.4 WTE with a vacancy rate of 19.9% (12.4 WTE; 3.4 WTE permanent and 9 WTE temporary vacancies). Inspectors were informed that 5 WTE positions were going through the paybill and recruitment process and were due to be filled by October 2025. Shortfalls in nursing staff were managed by redeploying staff from other clinical areas, overtime and or by using agency staff. Rosters reviewed by inspectors evidenced minimal deficits.

Medical staffing levels in the emergency department were maintained at levels to support the delivery of 24/7 emergency care. The emergency department had 5 WTE consultants in emergency medicine (2.6 WTE consultants were appointed on a permanent basis, one of which was on prolonged leave and 2.4 WTE was appointed on a locum basis) which was an increase of 1.1 WTE since HIQAs last inspection. A senior clinical decision-maker[*****] at consultant level was available 24/7 and was on site in the emergency department during core working hours and off site outside core working hours. Consultants were fulfilling a one in four rota,[†††††] with two part time employees taking the same call as full time employees. This arrangement would benefit from a review of sustainability. Fifteen NCHDs at registrar (12 WTE) and senior house officer (three WTE) grades provided 24/7 medical cover in the emergency department. Inspectors saw evidence of a responsive roster for medical staff, with the roster informed by data analysis of emergency department attendance patterns to ensure staffing levels aligned with patient demand. This demonstrated the

[*****] 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.

[†††††] One in four rota is an on-call scheduling system where one person is on duty or on call for every four individuals in the group to ensure continuous coverage,

utilisation of resources to support patient flow to improve patient outcomes and was part of the compliance plan that was submitted to HIQA following the last inspection.

Hospital management confirmed that the majority of permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Consultants that were not registered on a specialist division of the register with the IMC and were overseen in accordance with the HSE's requirements.

The hospital was funded for a total of 10.6 WTE pharmacists which was a decrease of 1.9 WTE from the time of previous inspection. There was a deficit of 3 WTE pharmacists in the hospital with 1.5 WTE of these posts being filled by agency staff. The unfilled pharmacist positions impacted on the ability to provide a comprehensive clinical pharmacy service[‡‡‡‡‡] to all areas within the hospital and on the AMS programme which is discussed further in national standard 5.5. The hospital was funded for a total of 8.8 WTE pharmacy technicians of which there was a deficit of 2 WTE, of which 1.2 WTE was filled by agency staff. A pharmacy service was also provided to two community hospitals which was estimated as requiring 0.3 WTE clinical pharmacist time and 0.5 WTE of pharmacy technician time to fulfil the duties.

The infection prevention and control team (IPCT) supported staff in implementing effective infection prevention and control practices across the hospital. Staff confirmed they had access to microbiology support 24/7. At the time of inspection, the IPCT had 1.5 WTE consultant microbiologists in place, 1 WTE ADON vacant position which was in the process of recruitment and a total of 1.6 WTE clinical nurse specialists (CNS). The nursing department had identified the number of CNS posts as a risk and inspectors were informed that staff with IPC experience within the hospital were redeployed on occasion to cover leave. Management should review the sustainability of this practice. There was 1 WTE vacant surveillance scientist post.

As per previous inspection findings, there was a centralised system to monitor the uptake of staff attendance at mandatory and essential training with oversight by the human resources department. Across the hospital, training records reviewed by inspectors showed that the uptake of essential and mandatory training for nurses and health care assistants (HCAs) was good (84% to 98%) with one exception where HCAs were 79% compliant with complaints management training. Compliance with mandatory training demonstrated a significant improvement from the time of last inspection across this discipline.

NCHD's attendance at essential and mandatory training was recorded on the National Employment Record (NER) system and monitored by the medical manpower division in the human resource department. There were gaps in the uptake of essential and

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

mandatory training for medical staff which needs improvement. For medical staff, hand hygiene compliance was 82%, donning and doffing of personal protective equipment was 52%, both standard and transmission based precautions was 64%, INEWS 61% and basic life support was 58%. Inspectors were informed of the difficulty encountered by the hospital in firstly capturing the completed mandatory training for medical staff and increasing compliance rates. Senior hospital management provided examples of initiatives that were in place to increase uptake across this discipline.

In the emergency department, evidence provided demonstrated that compliance rates for nurses and HCAs with the uptake of mandatory and essential training was good (89% to 100%) and inspectors were informed that all nurses that were eligible (67%) to undertake training on use of the Manchester Triage System§§§§§ had completed the training. Compliance rates for medical staff required improvement, for example, 31% had completed standard based precautions, 23% had completed donning and doffing of personal protective equipment and 45% had completed EMEWS training. Medical staff in the emergency department had good compliance rates in hand hygiene (92%) and basic life support (85%).

As discussed in national standard 3.1, the hospital identified the risk of a deteriorating paediatric patient presenting to the emergency department. An existing control measure was that nursing staff would undertake Paediatric Life Support****** (PLS) training and emergency department medical staff would undertake Advanced Paediatric Life Support (APLS). Inspectors did not see evidence that this measure was fully in place as medical staff did not have any APLS training recorded and a total of 18 staff members had received PLS training. Staff were accessing training from the Irish Paediatric Acute Transport Service (IPATS) with a total of 14% of nursing staff attended training and staff attended paediatric simulation sessions.

Overall, evidence was provided that hospital management were planning, organising and managing their medical and nursing staff in the emergency department and across the hospital to support the provision of high-quality, safe healthcare. Staffing shortfalls were being managed however, management should continue to assess and implement strategies to reduce the reliance on agency staff to ensuring a more sustainable workforce. There was a further increase in emergency department medical consultants from the last inspection in July 2024 and an improvement in the compliance of mandatory training by nursing staff. There was a continued shortfall in

§§§§§ The Manchester Triage System was designed to assist healthcare professionals to determine the clinical priority of patients attending urgent and emergency care facilities. The Tool consists of a series of charts that, when taken together and used by a trained professional, enable a safe and appropriate decision about clinical priority to be made.

****** The Paediatric Life Support (PLS) course equips healthcare professionals with the essential knowledge and skills to recognise, treat and stabilise children facing life-threatening emergencies.

pharmacy staff impacting on the ability to provide a comprehensive clinical pharmacy service and there were gaps in staff attendance and uptake of mandatory and essential training by medical staff.

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.

Naas General Hospital was found to be compliant with two national standards (1.7 and 3.3), substantially compliant with two national standards (1.8 and 2.8) and partially compliant with three national standards (1.6, 2.7 and 3.1). Key inspection findings leading to these judgments are described in the following sections.

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

Inspectors noted that staff adopted a person-centred approach to care, treating patients with respect while upholding their dignity, privacy, and autonomy. Staff interactions with patients were observed to be kind and respectful. Patients who spoke to inspectors described staff as *"top class"* and *"could not be nicer".*

Patients were made aware of their immediate surroundings and were advised how to get assistance. Inspectors spoke with patients who were accommodated on chairs along a corridor in the emergency department, and there were no reported issues with getting assistance although they did not have access to a call bell. Inspectors spoke with some patients on the ward that had physical bells as the call bell system was not working, and patients reported that they received assistance quickly, with no delays *"never a wait, day or night".*

However, the physical environment did not always ensure that patients' dignity, privacy and autonomy were respected and promoted. Patients were cared for on trolleys on corridors within the emergency department. Physical distancing between beds in multi-occupancy rooms was not always in line with national guidance. At the time of inspection, the family room on a ward was repurposed to accommodate three surge beds. The beds were placed in close proximity to each other with no call bells

and no storage facilities for patient's belongings. Inspectors were informed that the family rooms were used for surge beds when no other space was available in the hospital, and that this option offered greater comfort than placing patients in corridors.

Efforts to maintain dignity and privacy were observed in the emergency department however, it was not possible to maintain privacy and confidentiality when communicating and interacting with patients being cared for on chairs or trolleys outside cubicles. There was a risk that others (patients, visitors and staff) could overhear conversations and personal information exchanged between patients, medical and nursing staff.

Inspectors found that patient's personal information was not always protected. Inspectors observed healthcare records stored openly and not locked on the ward and within the emergency department. This was brought to the attention of nursing management to be addressed. White boards containing patient personal information was on display in both wards visited at time of inspection

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital. Notwithstanding this, the following areas for action were identified:

- the physical environment did not always ensure that patient's dignity, privacy and autonomy were respected and promoted
- patients' personal information was not always protected or stored correctly in the clinical areas visited.

Judgment: Partially Compliant

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

Staff were committed and dedicated to promoting a person-centred approach to care. It was evident that a culture of kindness was actively promoted by staff and management. Staff were observed providing care with kindness, consideration and respect. This was validated by a patient who told inspectors that staff were *"very kind"* and described their experience as being *"looked after well"*.

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

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.

There were effective processes in place at the hospital to respond to feedback and complaints received from patients and or their families. The patient experience manager was the designated person with responsibility for the management of complaints received and was supported in their role by the quality, risk and patient safety manager.

Complaints received at the hospital were managed in accordance with the HSE's *'Your Service Your Say'* management policy. Hospital management supported and encouraged point of contact complaint resolution in line with national guidance. Verbal complaints were managed at local clinical area level where possible, reported on, tracked and escalated up to management.

The Service User Feedback Committee reported into the QPS Committee quarterly on the number and type of complaints, verbal and written, received monthly and on key performance indicators. In 2024, the hospital received 118 verbal and 119 written complaints of which 100% were acknowledged within the five working days' timeframe and 88% were resolved within the HSE's 30 working days' timeframe. Positive feedback was also captured and reported on – the hospital received 2,335 compliments in 2024.

Complaints were tracked and trended to identify emerging themes and categories. Treatment and care, and communication and information were the top themes arising from the tracking and trending of complaints in 2025 year-to-date. The number of patients accessing patient advocacy services was also tracked, as was the number of family meetings and complaint reviews in progress.

There was some evidence that quality improvement initiatives were developed and implemented to improve services and care as a result of complaints received. For example, a patient discharge pack was developed to improve communication at the time of discharge. The pack included patient information leaflets and a leaflet titled

'Leaving Hospital' which included a checklist for the patient to complete to ensure safe discharge.

Information on how to make a complaint was on display on all the clinical areas visited during the inspection and a *'Your Service Your Say'* leaflet was included in the admission pack for patients. Inspectors did not see any information on independent advocacy services on display but there was evidence that patients had access to patient advocacy service as the number of such patients was tracked. Also, inspectors were informed that information was available and provided to patients from the patient experience manager, if required.

Overall, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and/or their families. However, information on how to access independent advocacy services was not clearly displayed in the clinical areas inspected.

Judgment: Substantially Compliant

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

During the inspection, the inspectors observed that the physical environment in the clinical areas visited was clean. There was evidence of some wear and tear such as cracked paint on walls, marked and cracked flooring and rust on pipes and showers. This did not facilitate effective cleaning. Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms in Moate and Curragh wards, but this was not the case with some of the trolleys on the corridor in the emergency department nor in the family room that was utilised for surge capacity in Moate ward at the time of inspection.

The emergency department was clean with some exceptions, however, the additional trolleys accommodated resulted in added patient equipment in the general areas and impacted on the space available to move around. The area used for rapid assessment and treatment was used for storage of large amounts of medical consumables[††††††] and equipment. Security and the risk for decontamination of products was brought to the attention of ward management at the time of inspection. Senior management was aware of the risk and the area had been risk assessed by the IPCT in March 2025 who had made recommendations which had yet to be implemented. The entry doors to the emergency department were found to have closure issues which resulted in an

[††††††] A medical consumable is defined as a product that a healthcare professional uses on a daily basis to improve patient care. Medical consumables tend to be disposable, single use products.

insecure environment and was brought to the attention of ward management for action. Sterile supplies equipment were stored on the ground on the corridors which did not enable effective cleaning of the floor underneath.

The transit area in the emergency department was a temporary area with a total of 14 trolley spaces which comprised of a six-bedded multi-occupancy bay and trolleys accommodated along corridors. Inspectors were informed that patients placed in the transit area were risk assessed to have less acuity but required a trolley and were not suitable for fit to sit.‡‡‡‡‡‡ Emergency equipment was available in this area. Within the transit area, call bells had been installed in the corridors for patient use since the last inspection. There was no hand hygiene sink available for staff within the transit area but wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available. There were two toilets available for patient use but no showering facilities. There were access and egress risks associated with this area which will be further discussed in national standard 3.1. The hospital has plans to upgrade this area with permanent cubicles in 2026.

A significant challenge for the hospital was the aging infrastructure with limited availability of isolation rooms, which was identified as a risk and placed on the hospital's risk register. There was a formalised process with a prioritisation matrix to ensure the appropriate placement of patients requiring transmission-based precautions, with oversight provided by the IPCT. The hospital had a total of 28 single rooms, 16 of which had ensuite toilet facilities and six of those had anterooms. There were five single rooms in the emergency department, none of which were ensuite or had anterooms. Sustained infrastructural investment in order to increase single rooms was a priority for hospital management. As a result of the challenges associated with the infrastructure and limited availability of single rooms the IPCT collected data on the number of patients that had a known IPC risk and who were not isolated as per national guidelines. In quarter 1, 2025 there was an average of 31 patients per day who had a known infection who were not isolated. These patients were cohorted together where possible and placement was based on IPCT advice and out-of-hours this function was undertaken by nursing administration. Personal protective equipment (PPE) was available outside single and multi-occupancy rooms with patients requiring transmission-based precautions. Inspectors found that some PPE was stored on the floor outside some rooms which did not enable effective cleaning of the floor underneath.

One ward visited had an active infection outbreak which was being managed at the time of the inspection. Signage in relation to the correct and appropriate use of

‡‡‡‡‡‡ Fit to sit in an emergency department is an initiative that designates specific, comfortable seating areas for patients who are stable and conscious enough to sit in a chair rather than being on a trolley.

standard and transmission-based precautions were displayed in clinical areas. As per the previous inspection, inspectors observed the door of a room where a patient was requiring transmission-based precautions was open, this was not consistent with national guidance and was raised with CNMs and actioned immediately. Inspectors also observed staff members not adhering to standard and transmission-based precautions which was immediately addressed. These issues were discussed with both the IPCT and SMT and it was highlighted that this was repeated findings from the previous HIQA inspection.

The CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place. Cleaning schedules were updated and monitored by the cleaning supervisor daily. Inspectors were informed of the increased schedule of cleaning undertaken at times of outbreak on the ward. Patient equipment was cleaned by nursing staff and/or health care assistants but as per previous inspection findings there was no system to indicate that the equipment was cleaned. Inspectors observed the storage of cleaned and used/dirty equipment stored side-by-side on one ward and equipment was found to be stored along the corridors on this ward also. Environmental and equipment audits were completed monthly and this will be discussed further in national standard 2.8.

Hazardous waste was observed to be safely and securely stored. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited. While hand hygiene sinks in the emergency department met the required specifications[§§§§§§], not all sinks observed in the other clinical areas visited met the necessary requirements. Not all areas in the emergency department had access to hand hygiene sinks. Inspectors were informed that an ongoing programme of sink replacements was scheduled to complete by the end of 2025. Linen was segregated but inspectors observed overflowing linen bags and storage of full linen bags on the floor in the dirty utility room.

The hospital had piloted and was in the process of implementing 'The Productive Ward' project across the hospital. The project aim was to enable good stock management, reduction of stock quantities and utilisation of limited storage space. Inspectors witnessed the completed project on both clinical wards visited at time of inspection. This initiative formed part of the compliance plan following the previous

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

inspection and there was good storage practices observed on the wards inspected but had yet to be implemented in the emergency department.

The hospital's call bell system had reached its end of life and inspectors were informed the system was unsupported for repair or replacement. Inspectors had identified a lack of call bells in the family rooms on wards that were used for surge purposes, one of the wards were using physical bells as call bells and some patients on the corridors in the emergency department did not have access to call bells. This risk was on the risk register with existing controls and actions required which were all overdue.

In summary, investment is required to improve the infrastructure within the hospital and senior management has identified this requirement. In the interim, as found at the previous inspection, the physical environment does not fully support the delivery of high-quality, safe and reliable care:

- limited isolation facilities posed a risk of transmission of communicable disease
- the hospital did not have a national integrated patient management system
- the call bell system was inadequate
- not all hand wash sinks were compliant with required specifications
- not all patient care areas had sufficient sinks for hand hygiene
- spacing between trolleys located on the corridor in the emergency department and spacing between beds in the family rooms was not always adequate.

Notwithstanding the infrastructure deficits, opportunities for improvement which were highlighted to management during the inspection included the following:

- appropriate standard and transmission-based precautions were not in place as per national guidance, doors of isolation rooms were open
- instances of staff members were not adhering to standard and transmission-based precautions
- security and the risk for decontamination of consumables stored in RAT within the emergency department
- there was uncertainty regarding the current system for cleaning of patient equipment
- storage of PPE in the appropriate manner which impeded effective cleaning
- overflowing linen bags.

Judgment: Partially Compliant

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

Compared to previous inspection findings, there was an improvement in compliance with this national standard. At the time of this inspection, there were assurance systems in place to adequately monitor, evaluate and continuously improve the healthcare services provided. Hospital management used information from a number of sources to compare and benchmark their healthcare services to support the continual improvement of healthcare services.

The IPCT reported on rates of Methicillin-Resistant Staphylococcus aureus (MRSA), Clostridioides difficile (C. difficile) infection, Carbapenemase-Producing Enterobacterales (CPE) and Staphylococcus aureus bloodstream infections (SaBSI) healthcare-associated infection acquisition rates monthly. This information was presented to the IPCC quarterly meetings and into the QPS committee. The IPCT produced an annual report of surveillance activity showing year on year activity and if there were any noted trends. Patients were screened for CPE in line with national guidance and compliance was audited, with a level of compliance (ranging from 74% to 93%) reported in the year to date which is an opportunity for improvement. CPE screening compliance was discussed at IPCC meetings and inspectors were informed that feedback was given through the DON for action.

The IPCC had oversight of findings from equipment, environmental, outbreak and hand hygiene audits. Patient care equipment audit was scheduled to occur every two months with a hospital benchmark of 80%. Environmental audits were performed by a contracted cleaning service company monthly. A good rate of compliance with environmental and patient equipment hygiene standards was reported in the three clinical areas visited. Compliance rates ranged from 84% to 96.6% in the emergency department, 90.3% to 96.7% in Curragh ward and 86.2% to 97.1% in Moate ward. Results of audits were sent to both the CNM and the ADON with a post audit action plan for completion as required. An outbreak audit was performed when a ward declares an outbreak. There were 17 outbreak audit tools completed in 2024 with an average result of 86.12% and four completed in quarter one, 2025 with an average result of 85.25% which did not achieve the hospital benchmark of 100%. Inspectors reviewed the outbreak audit performed in Moate ward as a result of the outbreak that was declared at the time of inspection with a result of 91.7%. Inspectors did not see evidence of specific timebound actions following the audit or evidence of re-audit.

In the months preceding this inspection, Curragh ward was compliant with the HSE's hand hygiene standard of 90%. The emergency department and Moate ward were not compliant with the benchmark, both scoring 70% in May 2025. A review of compliance achieved in hospital wide hand hygiene audits in 2024 demonstrated an ongoing issue with compliance (range from 40% to 100%). The average hand

hygiene compliance for quarter one, 2025 was 89.1%. Naas General Hospital had purchased a hand hygiene scanner, a training tool to improve hand hygiene technique. Hand hygiene is an opportunity for improvement and continued focus.

As discussed in national standard 2.7, the IPCT collected data on the number of patients that had a known IPC risk and who were not isolated as per national guidelines. As part of this data collection the IPCT also collated what organism the patients had that was not isolated as per national guidelines. The IPCT also carried out an audit of correct labelling of patient charts to identify if patients admitted with a multidrug resistant organism (MDRO) was clearly identified and that their status was included on clinical and ward handover.

The IPCT monitored compliance with completion of care bundles******* for patients with a peripheral vascular cannula demonstrating good compliance rates in 2024, ranging from 85% to 92% averaging 89%. Actions to improve compliance consisted of education, feedback and re-audit.

Naas General Hospital took part in the annual point prevalence survey of antimicrobial use in 2024. Key findings demonstrated a slight decrease of patients receiving at least one antimicrobial (43.3% in 2024 down from 44.8% in 2023). The overall compliance with antibiotic duration was 75.6% compared to 89.3% nationally. On the day of survey 32% of patients were suitable to switch to oral antibiotics compared to 18.7% nationally. In summary, the results indicated that antimicrobial usage should be improved at Naas General Hospital. The IPCT were constrained by the lack of an AMS pharmacist. The pharmacist that performed 10 hours of AMS rounds weekly and was joined by a consultant microbiologist to enable timely decision making and actions but this work was constrained by aging information technology infrastructure.

Medication safety and medication storage and custody were monitored on a monthly basis as part of the nursing and midwifery quality care metrics. There was good rates of compliance on Curragh ward (90.7% to 100%) and on Moate ward (92.9% to 100%) in the months preceding the inspection. In the emergency department compliance with medication safety required improvement (76.5% to 86.2%). The poor compliance rate was attributed, in the main, to the lack of a patient weighing scales in the department which was on order. Actions for non-compliances were timebound and assigned to an individual but remained open as the issue was not resolved. The audit schedule for medication safety was reported on in the medication safety report which is discussed at the Medication Safety Committee, Drugs and

******* A care bundle is a structured way of improving the processes of care and patient outcomes through the use of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

Therapeutics Committee and into the QPS committee.

The Deteriorating Patient Committee (DPC) monitored the rate of compliance with the early warning system's escalation and response protocol, sepsis and the implementation of relevant quality improvement actions to improve clinical practice. Compliance with INEWS escalation and response protocol was monitored in the ward areas. Moate ward demonstrated good compliance with 95.4% compliance from May to September 2025. In the emergency department compliance with EMEWS was audited and showed good compliance (88.8% to 90.6%). Inspectors did not see any evidence of audit activity in relation to INEWS in Curragh ward.

The Deteriorating Maternity Sub-Committee monitored the compliance of the use of the IMEWS chart for women pregnant or post-partum (42 days) presenting to the emergency department which had a compliance rate of 98% to 100% in 2025 up to time of the inspection. The rate of IMEWS chart completion and the IMEWS escalation and response rate was monitored with areas of non-compliance discussed at the committee with actions identified for named individuals.

In 2024, the national clinical programme for sepsis performed a clinical audit in each acute hospital to assess compliance with the national clinical guideline – 'Sepsis Management for Adults (including maternity)'. This audit measured compliance with key metrics from initial patient presentation to completion of immediate treatment. Naas General Hospital was 68.2% compliant which was the highest score achieved across the Dublin and Midland Health Region. Sepsis audits performed in the hospital in January and February 2025 had a 57% compliance rating. A sepsis audit of 18 patient charts (focusing in the emergency department) between April and September 2025 for patients with a suspicion or confirmed sepsis showed a compliance rate of 80.4%. A maternity sepsis audit was performed in the emergency department with a compliance rate of 91.2% from March to September 2025. The Sepsis Subcommittee provided oversight of audit activity in relation to sepsis and reported into the DPC and QPS. Inspectors saw evidence that the committee was action focused to improve compliance.

Evidence was provided to inspectors of a nursing clinical shift handover annual audit which included audit of the use of ISBAR3 clinical handover tool in Moate ward and in the emergency department. Moate ward demonstrated good compliance at 92% while the emergency department audit did not provide compliance ratings. Inspectors did not see any evidence of audit activity in relation to clinical handover in Curragh ward.

The hospital monitored and tracked metrics relevant to transitions of care including the number of new attendances to the emergency department, patient experience times, the average length of stay of a medical and surgical patient, weekend

discharge rate and the rate of delayed transfer or discharge every month.

Staff in clinical areas visited were aware of the hospital's findings from the National Inpatient Experience Survey taken in May 2024. Hospital management had, with the HSE, developed a quality improvement plan to address the survey findings and staff who spoke with inspectors were aware of the quality improvements measures implemented.

Overall, compared to the previous inspection in 2024, there was improvement in the compliance level for this national standard. Assurance systems were in place to monitor and support the continual improvement of healthcare services. Areas for improvement and focus is to improve compliance in areas where audit results do not meet expected standards, to ensure re-audit occurs and to ensure consistency of audits across all clinical areas.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to identify, evaluate, and manage immediate and potential risks to people using the service.

There were quarterly hospital risk register review meetings within the hospital and risks that were rated high or where the necessary controls fell outside the risk owner's direct control were escalated to the IHA manager for their review. Risks were discussed at the monthly performance meeting between the hospital and the IHA manager and at the hospital QPS Committee meetings. The hospital utilised a tiered escalation process at ward level where the CNM managed and outlined operational risks, maintained a local risk register at ward level and escalated risks to the ADON.

The ageing infrastructure posed a significant risk to infection prevention and control practices. This risk was escalated to the IHA manager. Hospital management had existing controls in place which included requests for significant capital investment for improvements to existing infrastructure, including new infrastructure as detailed in national standard 5.5. The IPCT monitored and reported on the incidence of specific infections and pathogens within the hospital, monitored trends, comparing year-on-year data, benchmarking against national targets for healthcare-associated infections and had oversight of outbreak management. The IPCT had identified that Naas General Hospital was above the national target for *C. difficile* healthcare-associated infections in the first four months in 2025. There was also a notable increase in new patient CPE infections detected in the same time period. Contributing factors were

identified which included the infrastructure, patient cohort, missed screening opportunities, antibiotic use and patient movement.

As per previous inspection findings, because of inadequate numbers of single isolation rooms, patients requiring transmission-based precautions were not always isolated in line with national guidance but based on IPCT advice. At the time of this inspection, there was an active outbreak of CPE on a ward which was being well managed. There were a total of 17 outbreaks in 2024 and five in quarter one, 2025. Multidisciplinary outbreak teams were convened to identify areas of possible transmission, to determine actions to prevent onward transmission of infection and to ensure that the learnings and recommendations from these infection outbreaks were shared with clinical staff.

Patients were screened for MDROs on admission to the hospital. The hospital did not have a national integrated patient management system. This resulted in the inability to place IPC alerts to a patient hospital number, manual information gathering, manual cross referencing with the laboratory information system and time consuming contact tracing in outbreak situations. This risk was placed on the hospitals risk register and escalated to the IHA manager.

The Medication Safety Committee compiled and maintained the risk assessments and registers in respect of medication safety within the hospital, escalating to the hospital's corporate risk register as appropriate. A comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation[†††††††] was not undertaken for all patients. Medication reconciliation was carried out on prioritised patients, in accordance with a defined inclusion criteria. The hospital had a list of high-risk medications and there was a list of sound alike look alike drugs (SALADs). Inspectors observed the use of risk reduction strategies to support the safe use of insulin, opioids and potassium. Prescribing guidelines, including antimicrobial guidelines and other medication information were available and accessible to staff at the point of care in hard copy format and through an application for smartphones. Inspectors observed that a number of medication monographs[‡‡‡‡‡‡‡] had not been updated in a considerable timeframe. The pharmacy department had provided an automated dispensing cabinet for out-of-hour's access of medication.

[†††††††] Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
[‡‡‡‡‡‡‡] A medication monograph is a factual, scientific document on a drug product that describes the properties, claims, indications, and conditions of use of the drug and contains any other information that may be required for optimal, safe and effective use of the drug.

The relevant version of the national early warning systems — INEWS and IMEWS was used. As per the hospital's compliance plan, the EMEWS was implemented within their emergency department but had yet to be rolled out to the waiting room which was planned for October 2025. The EMEWS chart was utilised on all patients (admitted and patients registered in the department) within the emergency department which was a decision taken by the DPC Committee. 'Sepsis 6' care bundle and the use of Identify, Situation, Background, Assessment and Recommendation tool (ISBAR)§§§§§§§ tool communication tool were used. Staff were knowledgeable about the INEWS escalation and response protocol, and there were efficient processes in place to ensure the timely management of patients with a triggering early warning score.

Inspectors reviewed and discussed access to the intensive care unit (ICU). The DPC identified that the lack of a high dependency unit, ICU capacity and the lack of a critical care outreach team impacted on access to ICU beds. The DPC also reported that some patients received a higher level of care within the hospital's coronary care unit whilst awaiting an ICU bed or transfer to another facility. At the time of inspection, these risks were not identified on the hospitals risk register and inspectors were informed that these will be included for discussion at the next risk register meeting.

The DPC had identified the risk of the deteriorating paediatric patient presenting to the emergency department as the hospital did not admit paediatric patients and did not have a paediatric service onsite. There were existing control measures in place and a pathway for the paediatric patient which placed all paediatric patients into category 2******** (Manchester Triage System), a review in triage by a senior clinical decision maker and the emergency department consultant was informed of all paediatric presentations. Staff had access to Children's Health Ireland formulary via an application†††††††† and had appropriate sized emergency equipment. The DPC tracked the number of paediatric presentations to the emergency department. There were 195 paediatric presentations in 2024.

The DPC had also identified the risk to the pregnant or post-partum woman presenting to the emergency department as there was no obstetric or gynaecology or neonatal service at the hospital. There were existing control measures in place, all pregnant women that presented were monitored using an IMEWS chart and patients were transferred, with referral pathways in place, unless the patient was too unstable

§§§§§§§ ISBAR: Identify, Situation, Background, Assessment and Recommendation tool is used to support communication in relation to the deteriorating patient.

******** Category 2 within the Manchester Triage System corresponds to very urgent indicating that a patient needs evaluation within 10 minutes.

†††††††† An application is a software program that's designed to perform a specific function directly for the user or, in some cases, for another software program.

to travel. The hospital had a Deteriorating Maternity Sub Committee which reported on data in relation to the number of presentations, transfers, and admissions. It also oversaw audit activities relating to IMEWS, including monitoring compliance, chart completion, escalation and response audit.

There were systems and processes in place to support the efficient flow of patients and transfer of patients within and from the hospital. These included the 'Red to Green' days approach[‡‡‡‡‡‡‡‡] and as discussed in national standard 5.2 there were a number of weekly and monthly meetings to review and manage issues impacting on the efficient flow of patients within and from the hospital which included liaising with community partners. Hospital management had access to 18 funded egress beds for patients requiring convalescence and or transitional care and had arrangements with four private hospitals to access beds and or services. Hospital admission avoidance initiatives were also used. These included:

- Community Intervention Team (CIT)
- Frailty Intervention Team (FIT)
- Outpatient Parenteral Antibiotic Therapy (OPAT)
- angina pathway.

Inspectors were informed that further developing clinical pathways was a priority for the emergency department and to extend the model of same day emergency care at Naas General Hospital.

On the first day of inspection, the hospital's Acute Medical Assessment Unit (AMAU) was functioning well as an alternate pathway for patients who met the unit's inclusion criteria. There was a total of 15 patients in the AMAU, 12 referred from the emergency department and three referred for review from General Practitioners. The AMAU had a capacity of 18 patients with five bays, was open Monday to Friday and had recently extended working hours for 12 hours per day. The new AMAU, which as per the hospital's compliance was due to be open by quarter two 2025, was not yet operational and inspectors were informed that it would open in early October 2025. The AMAU was used for overnight surge capacity and staff described the issues encountered when moving patients in the morning so that the AMAU could be utilised as intended.

The emergency department team had identified a number of risks with harm to both patients and staff due to overcrowding. There were also a number of risks identified in relation to infrastructure – lack of clinical space and lack of call bells in patient care areas. In relation to the area identified as the transit area risks included; lack of

[‡‡‡‡‡‡‡‡] The 'Red to Green' approach aims to reduce a patient's length of stay and avoidable delays where a patient may be waiting for things, such as test, investigation and or referrals to happen to progress their care.

privacy for patients, risk of security breach and risk due to lack of support and supervision for staff. The transit area was situated beside the fracture clinic and the outpatient department and so had access and egress points which was not enclosed within the emergency department. The area had been risk assessed and inspectors were informed that patient placement to this area was for a specific cohort of patients. Risks were reviewed annually at a minimum with the clinical lead, and escalated through the hospital channels.

Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. On the first day of this inspection, at 11.00am, there were a total of 30 patients registered in the emergency department. Eight (26.7%) of these patients were admitted and lodging in the department while awaiting an inpatient bed in the main hospital. The average waiting time from:

- Triage to medical assessment ranged from 2 minutes to 100 minutes with an average of 30 minutes, which was a significant improvement on the average of 1 hour, 51 minutes at the time of the previous inspection.
- Decision to admit to actual admission in an inpatient bed ranged from 13 hours 35 minutes to 42 hours, which was a significant deterioration from previous inspection which ranged from 5 hours 20 minutes to 26 hours and 51 minutes.

The hospital continued to have some non-compliances with the HSE's PETs at 11.00am on the first day of inspection but there was also some improvements noted from the previous inspection. Of the 30 patients registered in the emergency department:

- 3.3% of patients present in the emergency department were in the department for more than six hours after registration — this is in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration and a significant decrease on the 35% found in 2024.
- 30% of patients present in the emergency department were in the department for more than nine hours after registration — this is not in line with the national target of 85% of attendees admitted to a hospital bed or discharged within nine hours of registration but showing an improvement in the findings (40%) of 2024.
- 6.7% of patients present in the emergency department was in the department for more than 24 hours after registration — this is not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration but a slight improvement on findings (7%) of 2024.

Eight (26.6%) patients in the emergency department were aged 75 years and over.

- There were no patients aged 75 years and over in the emergency department greater than 6 hours after registration. This was compliant with the HSE's target of 97% for this KPI and it was an improvement on the previous inspection findings.
- There were 25% (2) of patients aged 75 years and over in the emergency department greater than 9 hours of registration. This was not compliant with the HSE's target of 99% for this KPI.
- All patients aged 75 years and over were discharged or admitted to an inpatient bed within 24 hours (national target 99%), an improvement on 2024 findings.

Hospital data provided to inspectors indicated the conversion rate of patients admitted to an inpatient bed from the emergency department was 35.72% in 2024 and decreased to 32.17% year-to-date (August 2025) which is the third highest in the HSE. Inspectors were informed that the lack of clinical pathways was the main causative factor and the department needed to develop services to support same day emergency care. Inspectors were informed that other contributing factors to the high conversion rate included the aging population cohort and the fact that AMAU patients were admitted to that service and therefore included in the conversion data.

Data reported at the monthly performance meetings held with the IHA manager in relation to the performance of the emergency department was discussed with staff at the time of inspection. Overall, there were some improvements in 2025 data to-date, such as the time from triage to medical assessment had decreased by 21% from 2024 data and the time for referral to speciality had decreased by 16%.

At the time of the inspection, the hospital had a total of nine delayed discharges. The hospital had commenced tracking the percentage of weekly discharges occurring at the weekend which was below the national target of 17% in 2024 and 2025 year-to date. The average length of stay for medical patients was 6.4 days, which was below the HSE's target of ≤7 days, and the average length of stay for surgical patients was 5.2 days, again below the HSE's target of ≤6 days.

Staff had access to a range of policies, procedures, protocols and guidelines through the hospital's intranet. Hospital policies reviewed on the day of inspection relevant to the four key areas of harm were, in the main, up-to-date and an improvement from the previous inspection.

In summary, while systems and processes were in place to identify, evaluate and manage immediate and potential risks to people using the service, some inspection findings had the potential to affect patient safety. Specifically:

- a comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation was not provided for all patients
- the hospital was non-compliant with some PETs
- the EMEWS was not implemented in the emergency department waiting room
- identified risks in relation to lack of a high dependency unit or lack of critical care outreach team were not on the hospitals risk register
- one clinical pathway in place with a need to expand the model of same day emergency care and to decrease the conversion rate
- the opening of the new AMAU to improve efficient patient flow, set out in the compliance plan was not implemented.

Judgment: Partially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. The hospital used the HSE Incident Management Framework to guide and support the management of patient-safety incidents and Serious Reportable Events (SREs). Patient-safety incidents were reported on the national incident management system (NIMS). Governance and oversight of patient-safety incidents was provided by the QPS Committee. At the time of inspection, there was a dual reporting system within the hospital, manual on paper and through the electronic point of entry.

A total of 645 incidents were reported in quarter four, 2024 and a total of 591 incidents in quarter one, 2025. Systems were in place for the tracking and trending of patient-safety incidents. Analysis of incidents were provided in quarterly QPS Committee reports. The most common type of patient-safety incident reported was slips, trips and falls. Staff who spoke with inspectors were knowledgeable about how to report, manage and respond to patient-safety incidents. Staff were also aware of the most common patient safety-incidents reported in their area. Inspectors reviewed a report which provided an overview and analysis of patient-safety incidents that occurred over a period of time on a ward showing trending of incidents and key learnings from review undertaken.

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious patient-safety incidents and SREs and generated an annual report detailing compliance with national and local key performance indicators. In 2024, the hospital was compliant with the national target for the reporting of patient safety incidents to NIMS and had no category one incidents. There were a total of eight reviews carried out by the SIMT in 2024 and the SIMT had oversight of

recommendations and learning opportunities from reviews. Learning notices were developed and disseminated across the hospital following reviews and inspectors observed good examples of these notices.

Medication related incident reports were reported through NIMS and were reviewed, collated and reported into the Medication Safety Committee, into the Drugs and Therapeutics Committee and also into the QPS Committee. The number of medication incidents reported in 2024 was 308, demonstrating an increase of 30% from 2023. There were a total of 135 medication incidents in the first six months in 2025. Analysis in the local medication safety report categorised incidents as serious, moderate, minor or negligible with no serious incidents in 2024. Analysis of medication incidents as reported to the IHA manager was according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation.

Overall, there were systems in place to effectively identify, manage and report patient-safety incidents. The hospital should continue to implement all incident reporting through one system.

Judgment: Compliant

Conclusion

The hospital had integrated corporate and clinical governance arrangements in place which were appropriate for the size, scope and complexity of the service delivered. Hospital management had progressed the majority of short term goals within their compliance plan but there was a continued mismatch between demand and available inpatient bed capacity. This impacted on the effective management of the emergency department which resulted in admitted patients being accommodated in the department while waiting for an inpatient bed.

Hospital management were planning, organising and managing their workforce across the hospital to support the provision of high-quality, safe healthcare. There were challenges in mitigating the risks associated with staffing shortfalls and management should continue to address the high reliance on agency staff to ensure workforce sustainability.

Staff were observed providing care with kindness, consideration and respect. Staff made efforts to maintain dignity and privacy however, it was not possible when communicating and interacting with patients being cared for on corridors or in some repurposed areas where beds were placed in close proximity to each other.

Investment is required to improve the infrastructure which senior management has identified and has applied for funding to complete. In the interim, as found at the previous inspection, the physical environment does not fully support the delivery of high-quality, safe and reliable care. An opportunity for improvement and action was identified for hospital management when staff members were observed not adhering to standard and transmission-based precautions.

Systems and processes were in place to identify, evaluate and manage immediate and potential risks to people using the service but some inspection findings had the potential to impact patient safety. Systems were in place to support patient flow, adapt to infrastructural challenges and alleviate overcrowding. However, they also contributed to an increase in transitions of care, which may pose a risk to patient safety. A comprehensive clinical pharmacy service was not provided to all clinical areas. Whilst there was some improvement noted in the emergency department, the hospital was non-compliant with some PETs and continues to have high conversion rates, a long average duration of time for patients spent in the emergency department and had one clinical pathway in place.

There were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families and there were systems in place to effectively identify, manage and report patient-safety incidents.

Systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services across the hospital was in place. Hospital management used information from a number of sources to compare and benchmark their healthcare services to support the continual improvement of healthcare services.

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	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.	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.	Partially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for Naas General Hospital.

Inspection ID: NS_0161.

Date of inspection: 11 and 12 September 2025.

Standard	**Judgment**
1.6	Partially Compliant

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

Physical Environment

The necessity for significant and substantial infrastructural investment into NGH continues to be a strategic and operational key priority for NGH Senior Management Team (SMT). Additional and modern infrastructure will enhance both capacity and patient flow processes onsite. The recent opening of the 11 bedded AMAU which aims to increase the effective use of resources within ED by the broadening of the current admission criteria to AMAU. To support/enhance the dignity & privacy of patients who avail of our services.

NGH has a plan in place to improve the physical environment in each of the ward areas within NGH, these works will commence on Moate ward with a completion date set for the end of Q4 2025. These works will include the upgrading of oxygen points at each bed location, with a wall protector at each bedhead and upgrading of patient call bells. NGH is actively working with HSE Estates for this region with a plan to role out similar upgrading to all wards in NGH.

The use of surge beds within the organisation has been identified by NGH as the least preferred measure to be employed when balancing the competing demands for service users who require admission, and as such the use of surge beds is part of the NGH escalation plan. Family rooms are utilised to manage surge at NGH, any patients considered for placement in the family room undergo a dynamic risk assessment to ensure suitability. Equipment has been ordered for theses rooms so that each bed space will have a bed, overbed table, bedside locker and curtain, with the upgrading works outlined above, each location will also have oxygen and emergency call bell. This work is expected to be completed by Q 2 2026. Additional staffing is also being sought as part of the plan to increase overall staffing numbers.

Patients Personal Information not protected or stored correctly

To support staff and ensure clarity regarding their obligations in ensuring that patient's personal information is protected at all times. A review of the existing NGH 510 *Healthcare Record Management for Non Clinical Staff* will be completed to ensure that the requirements for the safe storage of HCR currently used for patients in clinical areas. This policy will be audited for effectiveness in line with the stated implementation plan.

The NGH QRPS will also Completion of hospital wide dissemination of the newly revised HSE Data Protection Notice to be displayed in clinical areas to be completed November 2025 by the Quality, Risk and Patient Safety Department. A wider NGH communication strategy will be disseminated by NGH Senior Management Team regarding staff's obligations and roles when dealing with patients' personal information.

Storage of charts: The NGH Health Care Records Committee has identified the inappropriate storage of patient charts as a risk. This has been identified as requiring a hospital wide quality initiative to include a number of stakeholders including AHP's, medical staff amongst others. This project will be completed by Q1 2026.

White boards: The use of the white boards in the clinical areas functions as a supportive tool to enhance communication between the multidisciplinary team. As part of the wider information technology upgrade for NGH there is a plan to replace the existing whiteboards with electronic boards and funding is currently being sought for same. In the interim a review of the existing white boards will be undertaken and any boards assessed as requiring replacement placement will be prioritised. To support this at local level NGH Assistant Directors of Nursing will support and empower clinical nurse

managers when partaking in their daily Point of Contact rounds in ensuring compliance at ward level.

Timescale:

Q3 2026

2.7	Partially Compliant

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

Physical Environment

The necessity for significant and substantial infrastructural investment into NGH continues to be a strategic and operational key priority for NGH Senior Management Team (SMT). Additional and modern infrastructure will enhance both capacity and patient flow processes onsite. The addition of single occupancy rooms will be of significance in relation to supporting Infection Control Practices in line with national guidance. NGH is actively working with HSE Estates regarding the ongoing infrastructural development of NGH. Significant progress has been made in relation to the following development projects for the organisation:

Short Stay Unit to support patient flow between ED/AMAU is expected to commence Q3 2026

Development of a new story that will include an additional 49 beds, physical medicine, oncology and endoscopy

ICU upgrade due for commencement Q1 2026

The introduction of a second CT scanner

The development of a new endoscopic unit on site to include day beds The provision of additional car parking spaces with the introduction of a multi story car park

The development of a purpose built mortuary to replace the existing prefabricated structure

An expansion of catering to meet the growing needs of the service

An increase in the number of critical care beds with the establishment of a HDU

Ongoing campus wide fire upgrading works commenced in Q3 2025 and is ongoing

Significant progress has been made in relation to the following development projects for the organisation:

Since our inspection a number of projects have been brought to completion in 2025 and a number are due for completion by Q4 2025.

The AMAU is now operational

New main reception

New patient accounts office

New Diabetic day service

Upgrading of the day ward to include new flooring, ceilings, wall protectors, new pantry and improvements to the existing toilet and storage facilities. These works are due for final completion Q4 2025

Upgrade of the public toilet facilities due for completion Q4 2025

Ongoing review of reconfiguration of non clinical staff to relocate to off site premises to increase on site clinical capacity

Productive Ward:

The roll out of the Productive Ward project will assist the organisation with ensuring that good stock management practices are standardised to support IPC practices regarding the storage of supplies both sterile and non sterile. This project will be incrementally rolled out to the remaining areas of the organisation and will include the Emergency Department. In the interim a new storage room has been opened in the ED whilst awaiting the full implementation of this project.

Replacement of sinks -ongoing programme

NGH is committed to ensuring compliance with hand hygiene to support this a replacement programme of existing sinks is underway. All wards have been upgraded, there are 47 sinks left to be replaced, this included ICU which is due to upgrade in Q1 2026, Day Ward will be completed in Q4 2025, OPD Level 2 (which is due for refurbishment / redevelopment to facilitate the Short Stay Unit (Q2 2026), OPD Level 3 and other areas will be completed by Q1 2026

Emergency Department

Regarding the identified security and risk of decontamination of consumables stored in the RAT. Roller doors have been ordered for the Kanban units based in the current RAT room. A Purchase order has been issued to the company to the manufacture and install and this will be end of Q1 January 2026

All doors within the ED have been reviewed to ensure that they met fire compliance and are working effectively. The entry double doors are closing properly. Funding has been applied for the instillation of electronic doors.

ED Transit Area

Hand gels have been placed at the end of all trollies in this area and additional hand gel dispensers have been erected within this area and includes a free standing hand gel dispenser. A review of this area is currently underway in conjunction with NGH IPC and maintenance to install a hand hygiene sick in this area. In addition, this area is due for upgrading as part of the Short Stay Unit to support the emergency department and AMAU patient flow.

Infection Prevention & Control

All staff are trained on an ongoing basis by the IPC team and supported by PPG which clearly sets out the roles and responsibilities of the cleaning of equipment and the environment. The work of the IPC department is supported by the Household services. All staff receive induction to their local clinical area and the process that supports the cleansing of patient equipment. This is supported by environmental and equipment audits. Senior Nurse Management team rounding and coordination with local CNM's which includes feedback from the IPC Updated cleaning schedules for all clinical areas. These are completed daily and signed, monitored by the CNM2 of the ward. Cleaning schedules are audited during the equipment audits. All equipment used is cleaned before and after use with Medipal disinfectant wipes. All equipment is cleaned daily with Trisal (Chlorine based agent).

Storage of PPE in the appropriate manner which impeded effective cleaning. The IPC audit this area in the outbreak audit tool. Any areas of non compliance is discussed with the nurse in charge and is followed up with an e mail to the CNM2 and ADON of the ward. PPG regarding PPE is available to all staff. Lack of storage space on the wards is on the IPC register.

Appropriate standard and transmission based precautions were not in place as per national guidance, doors of isolation rooms were open. IPCN do a clinical round of all the inpatient wards daily. Education sessions are regularly provided to staff on the importance of keeping doors to single rooms and bays with transmission based precautions closed. Staff are required to complete AMRIC HSE Land standard and transmission based precautions every two years. This is also audited in the outbreak tool.

Any areas of non compliance is discussed with the nurse in charge and is followed up with an e mail to the CNM2/ADON of the ward.

Overflowing linen bags. Linen PPG available to all staff. Staff should be aware to regularly change the linen bags. The IPCT audit this area in the outbreak audit tool. Any areas of non compliance is discussed with the nurse in charge and is followed up with an e mail to the CNM2 and ADON of the ward

Instances of staff members not adhering to standard & transmission-based precautions.IPC do a clinical round of all the inpatient wards daily. Education is regularly given regarding the importance of keeping doors to a single/bay with transmission based precautions closed. Staff are required to complete the HSE AMRIC standard and transmission based precautions every two years. This is also audited in the outbreak audit tool. Any areas of non compliance is discussed with the nurse in charge and is followed up with an e mail to the CNM2 and ADON of the ward.

To strengthen NGH IPC practices clinical areas will develop localised QIPs following feedback from the IPC team which will include the relevant stakeholders for that clinical areas. These local QIPs will be supported by the relevant ADON assigned to the clinical area. Ongoing monitoring of compliance with training is undertaken and identified deficits will be addressed through the local line manager.

Timescale: Q1 2026

3.1	Partially Compliant

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

<u>Infection Prevention & Control</u>

NGH recognises the constraints placed by the limited isolation facilities available to meet the growing demand for access to services and the requirement for adherence to national and local IPC policy remains an ongoing challenge. All patients requiring isolation undergo a dynamic risk assessment to support the appropriate placement in the clinical areas. NGH Senior Management Team follow the established escalation process to the IHA. Additional single rooms are required on site and this will be achieved with approval of the 49 beds for NGH. At present NGH awaits the implementation of the National Integrated Patient Management System and funding has been applied to expediate this project. The National Team have identified NGH as requiring this system and it is anticipated that the implementation of IPMS will assist the organisation in the tracking and tracing with regard to IPC alerts thereby enhancing IPC safeguards.

PET Times

To minimise PET times NGH have instituted hospital avoidance pathways. This is supported by RAT and the use of EPIC which identifies the senior clinical decision maker on every shift. PET times are monitored closely by Patient Flow and steps taken to escalate where necessary.

AMAU & efficient patient flow

The AMAU service commenced operation from Monday to Friday 8-8pm in October 2025 and it has extended its opening hours to include Saturday's. This service is supported by staffing that includes senior clinical leadership. From January 2026 this service will be opened on Sunday which will further assist with hospital avoidance pathways.

ED & implementation of the EMEWS

The implementation of the EMEWS to ED remains a priority for both NGH Senior Management Team and Lead Clinicians of the ED. A business case has been submitted for funding and posts approval from the REO. Patients continue to be monitored and observed in line with national and local policy's. Patients continue to be monitored using the INEWS system.

NGH has completed a risk assessment with regard to the lack of a high dependency unit and lack of critical care outreach teams. There are a number of Advanced Nurse Practitioner leads within the organisation that support the review of patients who present with respiratory or chest pain. The post of Critical Care ANP has been included in the estimates for 2026. To support the management of patients and decrease the rate of conversion there are a number of clinical pathways in existence which include COPD, Asthma, Bronchiestasis, chronic cough, angina and radiology. NGH is currently in the process of developing four new additional clinical pathways with the relevant stakeholders that will support care for patients with stable Atrial Fibrillation, rheumatology, abnormal chest x ray follow up and surge assist.

Medication Monographs

NGH pharmacy track the medication monographs and advise staff in relation to the prescribing of medication. This is supported by the prioritisation of new monographs. This is supported by the prescribing guidelines that are available on the wards and the app. In addition, Sharepoint can be accessed on all PC's in the clinical areas.

With regard to the finding of a comprehensive clinical pharmacy service was not provided to all clinical areas and pharmacy-led medication reconciliation was not provided for all patients. There are a number of important posts that including AMC pharmacy, medication reconciliation that was lost to the organisation in the Pay and Numbers Strategy. Whilst low acuity, short stay wards are not currently covered. The pharmacy department has a process in place to address the existing gaps and a bleep referral system is in place for clinical pharmacy reviews. This process is now established and remains under continued review.
Timescale: Q1 2026