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:	Cork University Hospital
Address of healthcare service:	Wilton Manor Glasheen Cork Co Cork T12 DFK4
Type of inspection:	Announced
Date(s) of inspection:	25 and 26 July 2023
Healthcare Service ID:	OSV-0001064
Fieldwork ID:	NS_0049

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

Cork University Hospital (CUH) is a Model 4* public acute, tertiary referral centre and university teaching hospital managed by the South/South West Hospital Group (SSWHG)† on behalf of the Health Service Executive (HSE). CUH also forms part of the Cork University Hospitals Group (CUHG), which includes Mallow General Hospital and Bantry General Hospital. CUH provides care for people in the catchment area of the HSE South and supra-regional areas of Limerick, Kerry, Tipperary, Waterford and Kilkenny. The hospital is one of two Level 1 trauma centres‡ in the country, comprising 40 different medical and surgical specialties. CUH is also one of eight cancer centres aligned with the HSE National Cancer Control Programme (NCCP) and one of two cancer centres in the southern region of Ireland.

Clinical services provided in CUH include:

- all major medical specialities
- a range of surgical specialities including cardiothoracic, neurosurgical, gynaecological, plastic and reconstructive, maxillofacial, breast and colorectal
- interventional radiology, interventional pain management and palliative care.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	645 inpatient beds 110 day care beds

* A model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit on site, a Medical Assessment Unit which is open on a continuous basis (24/7) and an Emergency Department, including a Clinical Decision Unit on site.

†The South/South West Hospital Group is made up of ten hospitals — Cork University Hospital; Cork University Maternity Hospital; University Hospital Waterford; University Hospital Kerry; Mercy University Hospital; South Tipperary General Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital and Lourdes Orthopaedic Hospital, Kilcreene. The hospital group's academic partner is University College Cork.

‡ The establishment of the major trauma centres represents the first phase in the development of the acute hospital trauma services as set out in the National Trauma Strategy. The services comprise regional trauma networks each with a major trauma centre, the Mater Misericordiae University Hospital in Dublin and Cork University Hospital, which provide specialist trauma care in the one hospital to the most severely injured patients.

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. HIQA carried out a two-day announced inspection at CUH to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. To prepare for this inspection, the inspectors[§] reviewed information, which included previous inspection findings, information submitted by the provider, unsolicited information[**] and other publically available information.

During the inspection, the inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care in CUH
- spoke with staff and hospital management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in CUH
- observed care being delivered, interactions with people receiving care in CUH 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.

About the inspection report

A summary of the findings and a description of how CUH performed in relation to compliance with the 11 national standards assessed during 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 at a particular point in time — before, during and after the inspection.

1. Capacity and capability of the service

This section describes inspector'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 CUH. It outlines whether there is appropriate oversight and assurance arrangements in place at CUH

[§] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare.*
[**] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

and how people who work in CUH are managed and supported to ensure the safe delivery of high-quality care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare services in CUH 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 11 national standards assessed during this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 July 2023	08:50 – 17:15hrs	Denise Lawler	Lead
		John Tuffy	Support
26 July 2023	09:00 – 16:15hrs	Emma Cooke	Support
		Aoife Healy	Support
		Rosarie Lynch	Observation

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 the following four key areas of known harm:

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

Over the course of the inspection, the inspection team visited the following clinical areas:

- Emergency Department, including the Geriatric Emergency Medicine Service (GEMS)
- 1A Ward (acute medical ward)
- 2A Ward (surgical ward)
- 3A Ward (acute medical ward)
- Acute Medical Assessment Unit Blackwater Suite (AMAU)
- Acute Surgical Assessment Unit (ASAU).

During the inspection, the inspection team spoke with the following staff:

- Representatives of the hospital's Executive Management Board:
  - Chief Executive Officer
  - interim Chief Medical Officer
  - Director of Nursing
  - Operations Manager
  - Quality and Patient Safety Manager
- Business Manager for the Unscheduled Care Directorate, CUH
- Assistant Director of Nursing for the Unscheduled Care Directorate, CUH
- Assistant Director of Nursing for Emergency Department Patient Flow, CUH
- A Non-Consultant Hospital Doctor (NCHD)
- A representative from each of the following hospital committees:
  - Executive Quality and Patient Safety
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Steering Committee Acutely Unwell Adult Patient.

[††] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
[‡‡] 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. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

Acknowledgements

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

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

During this inspection, the inspectors visited six clinical areas — the Acute Floor (which comprised the emergency department, GEMS, Bandon Areas and AMAU Blackwater Suite), 1A Ward, 2A Ward, 3A Ward and ASAU.

CUH's emergency department provided care for adult and paediatric patients presenting with acute and urgent illness or injuries. The department's total planned capacity was 85 treatment areas, which included:

- 12 cubicles for the treatment of patients categorised as major
- four resuscitation spaces
- five isolation spaces. There were no negative pressure rooms[***] in the emergency department
- a Rapid Assessment Streaming Triage Treatment Area (RASTTA) with 47 individual patient pods where ambulatory care[†††] was provided
- a Clinical Decision Unit comprising 12 beds
- six single rooms where older persons attending the emergency department were medically reviewed and treated — the Geriatric Emergency Medicine Service (GEMS)
- a designated paediatric area comprising nine assessment areas (six seated and three trolleys). At the time of inspection, the building of a new children's emergency department at CUH was well advanced, with the building works due to be completed in November 2023.

1A Ward was a large 35-bedded medical ward comprising one four-bedded multi-occupancy room, four six-bedded multi-occupancy rooms, one two-bedded multi-occupancy room and five single rooms (four of these five rooms had en-suite bathroom facilities). The ward had

[***] Negative pressure rooms are rooms where the air pressure inside the room is lower than the air pressure outside the room. This means that when the door is opened, potentially contaminated air or other dangerous particles from inside the room will not flow outside into non-contaminated areas. Some negative pressure rooms require an anteroom, which is an airlock room that provides a safe area for healthcare professionals to change into or out of protective clothing, transfer or prepare equipment and supplies, and can protect other rooms from contamination if pressure is lost within the negative pressure room.

[†††] Ambulatory care refers to medical and healthcare services provided by healthcare professionals on an outpatient basis, without admission to hospital.

adequate communal toilet and bathroom facilities for patient's use. On the first day of inspection, all 35 beds were occupied.

2A Ward was a large 31-bedded surgical ward comprising one four-bedded multi-occupancy room, five four-bedded multi-occupancy rooms, one two-bedded multi-occupancy room and five single rooms with en-suite bathroom facilities. The ward had adequate communal toilet and bathroom facilities for patient's use. On the first day of inspection, all 31 beds were occupied.

3A Ward was a large 33-bedded medical ward comprising two four-bedded multi-occupancy rooms, three six-bedded multi-occupancy rooms, one two-bedded multi-occupancy room and five single rooms (four of these five rooms had en-suite bathroom facilities). The ward had adequate communal toilet and bathroom facilities for patient's use. On the first day of inspection, all 33 beds were occupied.

The AMAU comprised eight single rooms and a waiting area with 10-15 seats. There were 20 patients in AMAU on the first day of inspection. The ASAU comprised five beds and was fully occupied at the time of HIQA's inspection.

Inspectors spoke with patients about the care they received in CUH and observed staff interactions with patients and families over the two days of inspection. Patient feedback about the care received in CUH was mainly positive. Patient's experiences were consistent with CUH's findings from the 2022 National Inpatient Experience Survey,[‡‡‡] where the majority of patients (81%) who completed the survey had a very good (52%) or good experience (29%) in CUH. Patients told inspectors that they were treated with kindness and respect and were happy with the level of care they received at CUH. When asked to describe their experience, patients commented that staff were *'excellent', 'attentive', 'wonderful' 'fabulous'*, *'very caring'*, *'outstanding'*, *'approachable'* and *'helpful'*. All patients who spoke with inspectors were complimentary of the food provided in CUH. Inspectors observed staff communicating effectively with patients and family members in the clinical areas visited. Staff were also observed actively engaging with patients in a respectful and kind way, and taking the time to speak with and listen to patients. Inspectors also observed how staff ensured that a patient's individual needs were responded to promptly and this was confirmed by patients who spoke with inspectors. Patients who spoke with inspectors knew who to speak with if they wished to raise an issue or make a complaint. However,

[‡‡‡] The National Care Experience Programme, was a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey (NIES) is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the NIES are available at: https://yourexperience.ie/inpatient/national-results/.

information about independent advocacy services and the HSE's complaints process *'Your Service, Your Say'*[§§§] could be displayed more clearly across CUH.

Overall, patients who spoke with inspectors over the course of the inspection were very complimentary about the staff they met, the level of staff engagement and interaction and with the care received in all the clinical areas visited. Furthermore, there was consistency in what patients told inspectors and what inspectors observed in the clinical areas visited during inspection.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the two themes of leadership, governance and management and workforce. CUH was found to be partially compliant with three national standards (5.2, 5.8 and 6.1) and substantially complaint with one national standard (5.5) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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

CUH had experienced a significant change of personnel at senior management level over the preceding months before HIQA's inspection. Inspectors found that CUH had formalised corporate and clinical governance arrangements in place for assuring the quality and safety of healthcare services provided in CUH. However, at the time of inspection, these governance arrangements were being restructured to strengthen the oversight of the quality and safety of the healthcare services provided in CUH, and to ensure the recommendations from the independent governance reviews carried out in CUH in 2022 were implemented. The revised and restructured governance arrangements were expected to be fully implemented and operational by quarter 4 of 2023. While transitioning to the restructured governance arrangements, it is imperative that hospital management ensure that the existing and revised governance arrangements are effective in providing the necessary assurance required by them about the safe delivery of high-quality and reliable healthcare services in CUH.

Organisational charts submitted to HIQA reflected the integrated corporate and clinical governance arrangements at CUH, and detailed the reporting arrangements to CUH's executive management team and onwards to the Chief Executive Officer (CEO) of SSWHG

[§§§] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from: https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

and the HSE. These arrangements were consistent with what inspectors found during inspection. Inspectors found that staff they spoke with were clear about their role, areas of responsibility and accountability. The hospital was governed and managed by the CEO of CUHG, who had a defined reporting arrangement to the CEO of SSWHG. Since HIQA's previous inspection of CUH's emergency department in 2022, hospital management had appointed a chief medical director who provided clinical advice about the quality and safety of clinical services provided in CUH. The chief medical director's position was filled on an interim basis at the time of this inspection. The director of nursing (DON) was responsible for the organisation and management of nursing services, and reported to the CEO of CUHG and SSWHG's chief director of nursing and midwifery.

Clinical services at CUH were delivered under the leadership and direction of six clinical directorates — medicine directorate, surgery directorate, diagnostics and therapeutics directorate, cancer services directorate, paediatrics directorate and unscheduled care directorate. These directorates were still evolving and embedding at the time of inspection and some directorates were more developed than others. Inspectors were told that, when fully established, each clinical directorate will be led by a management team comprising a clinical director, general manager, DON, assistant director of nursing (ADON) and other members assigned with responsibility for the oversight of risk management, and the quality and safety of clinical services provided in its remit. Each clinical directorate will have a defined reporting arrangement to the CUH's Executive Quality and Patient Safety Committee (EQPSC), which was a subcommittee of the CUHG's Executive Management Board (EMB).

CUHG's Executive Management Board

During the inspection, the CEO of CUHG discussed the defined plans to strengthen and expand CUH's executive management team and this was supported by documentation submitted to HIQA. CUHG's EMB was the senior executive decision-making team with responsibility for ensuring and assuring the quality and safety of healthcare services provided at CUH. The EMB's terms of reference submitted to HIQA were not up-to-date and referenced structures that preceded the SSWHG structure. Minutes of meetings of the EMB for 2023, reviewed by inspectors confirmed that the EMB met weekly and membership comprised representatives from CUH's corporate and clinical function, including the CEO of CUHG, DON, the interim chief medical officer, clinical leads, operations manager and quality and patient safety manager. The EMB reported on CUH's activity and performance against defined quality and safety key performance indicators (KPIs) to the CEO of SSWHG monthly. Comprehensive minutes of meetings of the EMB and minutes of performance meetings between CUH and SSWHG reviewed by inspectors showed that these meetings were action-orientated and that the implementation of agreed actions were monitored from meeting to meeting.

Consistent with the plans to strengthen the governance structures in CUH, hospital management had established or reconfigured several hospital governance committees as described below. These included those with responsibility for ensuring and assuring

healthcare services for the four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Executive Quality and Patient Safety Committee

Inspectors found that CUH's multidisciplinary EQPSC functioned in line with its terms of reference. The EQPSC was the overarching committee with overall responsibility for providing the EMB with assurances about the quality and safety of healthcare services provided at CUH. Chaired by a clinical director, the EQPSC met monthly. EQPSC's membership comprised senior executives with clinical representation from the different health professions and clinical departments across CUH. The EQPSC delegated parts of its assigned responsibility and function to nine subcommittees. These subcommittees had oversight of the quality and safety of the healthcare services in CUH, including compliance with defined KPIs. All nine subcommittees had a defined and formalised reporting arrangement to the EQPSC monthly. Minutes of meetings of the EQPSC reviewed by inspectors showed that the committee had oversight of the quality and safety of healthcare services, risk management and patient safety incidents, infection prevention and control and medication safety practices and standards in CUH. The EQPSC submitted updates three monthly and an annual report to the EMB. It was also evident from minutes of meetings of the EQPSC that the implementation of agreed actions were progressed from meeting to meeting. When the revised and reconfigured governance arrangements are fully implemented in CUH, oversight of the quality and safety of the healthcare services will be delegated to two core committees — Quality, Patient Safety and Risk Committee and Clinical Effectiveness Committee. Hospital management expect these committees to be fully operational in quarter 4 of 2023.

At operational level, inspectors found there were clear lines of devolved responsibility and accountability for three of the four areas of known harm — infection prevention and control, medication safety and the deteriorating patient. At the time of inspection, the following three committees were in place at CUH and or CUHG level:

- Infection Prevention and Control Committee (IPCC)
- Drugs and Therapeutics Committee (DTC)
- Steering Committee Acutely Unwell Adult Patient (SCAUAP).

All three committees reported and were operationally accountable to CUH's EQPSC**.**

Infection Prevention and Control Committee

Inspectors found CUHG had a well-established multidisciplinary IPCC that functioned effectively and efficiently in line with its terms of reference. Chaired alternatively by the DON and operations manager, the IPCC met monthly and membership comprised representatives from different health professions and clinical departments across CUHG including CUH, Bantry General Hospital and Mallow General Hospital. The IPCC reported three monthly to CUH's EQPSC, providing assurances that the infection prevention and control practices in CUH were in accordance with established standards and guidance. Oversight of specific

infection prevention and control practices was devolved to relevant subgroups and or teams, including the infection prevention and control team, hygiene standards team, decontamination service team, reusable invasive medical devices (RIMD) team, antimicrobial pharmacist and surveillance scientist. Each subgroup and or team reported to the IPCC monthly. Minutes of meetings of the IPCC reviewed by inspectors and meetings with staff during this inspection, confirmed the IPCC had appropriate oversight of CUH's compliance with infection prevention and control KPIs, the management of infection prevention and control risks and patient-safety incidents, audit activity and quality improvement initiatives to improve infection prevention and control practices in CUH. However, it was not clear from these minutes if the implementation of agreed actions to improve infection prevention and control practices in CUH was being monitored from meeting to meeting. Defined time-bound actions, assigned to a named person with responsibility to implement the agreed actions will help ensure that improvements to enhance infection prevention and control practices in CUH are implemented in a timely way. This should be an area of focused improvement following this inspection.

Drugs and Therapeutics Committee

Inspectors found CUHG had a well-established multidisciplinary DTC that functioned effectively and efficiently in line with its terms of reference. Chaired by a consultant physician, the DTC met every two months and membership comprised representatives from different health professions and clinical departments across CUHG including CUH, Bantry General Hospital, Mallow General Hospital and Cork University Maternity Hospital. The DTC reported three times a year to the EQPSC, providing assurances about the medication safety practices across CUHG. Minutes of meetings of the DTC, reviewed by inspectors and meetings with staff during this inspection confirmed that the DTC had appropriate oversight of the implementation of CUH's medication safety strategy and antimicrobial stewardship programme.[****] However, it was not clear from minutes of meetings of the DTC reviewed by inspectors if the implementation of agreed actions to improve medication safety practices in CUH were being monitored from meeting to meeting. This should be an area of focused improvement following this inspection.

Steering Committee for the Acutely Unwell Adult Patient

CUH's SCAUAP had oversight of the effectiveness of CUH's deteriorating patient improvement programme, which included sepsis management. Chaired by a medical consultant, this multidisciplinary committee comprised clinical representatives from across CUH. The committee met monthly and reported twice a year to the EQPSC. The committee had oversight of CUH's compliance with national guidelines on sepsis management and the national early warning systems — Irish National Early Warning System (INEWS) (version

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

2)[††††] and Irish Paediatric Early Warning System (PEWS).[‡‡‡‡] It was clear from minutes of meetings of the SCAUAP, reviewed by inspectors that the implementation of agreed actions was monitored from meeting to meeting. However, the implementation of agreed actions to improve the timely response for patients experiencing clinical deterioration should have clearly defined timelines.

Unscheduled Care Programme Board

CUH did not have a Bed Management and or Discharge Committee that oversaw the safe

transitions of care for patients within and from CUH. However, data on scheduled and unscheduled care activity, inpatient bed capacity and compliance with defined KPIs was discussed at monthly meetings of the Unscheduled Care Programme Board (USCPB) and monthly performance meetings between CUH and SSWHG. Chaired by the clinical director of the unscheduled care directorate, the USCPB met monthly and membership comprised representatives from CUH and community services in Cork Kerry Community Healthcare. Minutes of meetings of the USCPB reviewed by inspectors were action orientated however, actions were not time-bound and there was no person assigned with the responsibility to implement agreed actions. The USCPB reported to the EMB of CUHG and Regional Unscheduled Care Governance Group. The frequency and method of reporting to the EMB and regional governance group should be identified more clearly in the USCPB's terms of reference.

In summary, good governance structures recognise the interdependencies between organisational arrangements and clinical practice, and integrate these to support the delivery of high-quality and safe healthcare. CUH had corporate and clinical governance arrangements, but revised and restructured arrangements were being implemented at the time of inspection, that need time to embed. Management at CUHG and SSWHG should ensure that the restructured governance structures function as intended and that there is robust, effective oversight of the quality and safety of the healthcare services provided in CUH. The monitoring of the implementation of agreed actions, identified to improve the quality and safety of healthcare services provided in CUH, could be improved across a number of governance committees at CUH and CUHG levels.

Judgment: Partially compliant

[††††] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. 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.

[‡‡‡‡] The Irish Paediatric Early Warning System (PEWS) applies to infants and children admitted to paediatric inpatient settings. It does not apply to infants within maternity and neonatal units. This National Clinical Guideline is relevant to all healthcare professionals working in paediatric inpatient settings.

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

Findings relating to the Emergency Department

On the days of inspection, it was evident that CUH had defined lines of responsibility and accountability with good medical and nursing leadership, and devolved autonomy and decision-making for the management of unscheduled and emergency care. Governance and oversight of such care lay with the USCPB and unscheduled care directorate. The unscheduled care directorate met monthly and reported on activity in the acute floor, compliance with unscheduled and emergency care KPIs and quality improvement initiatives to the EMB. A consultant in emergency medicine and a clinical nurse manager grade 3 (CNM 3) had clinical and operational oversight of the day-to-day workings of the emergency department. A consultant in emergency medicine was onsite until 11.00pm and off site, but available and accessible thereafter. The clinical director for the unscheduled care directorate, who was a consultant in emergency medicine, reported directly to the interim chief medical officer. The CNM 3 reported to the ADON for unscheduled care in CUH.

On the first day of inspection, 229 people attended CUH's emergency department, this was higher than the average daily attendance of 189 people reported in 2022. CUH reported 68,612 new attendances to its emergency department in 2022, which represented an increase of 3,637 on 2021 numbers and an average monthly attendance of 5,718. Inspectors observed how the emergency department was functioning relative to its intended capacity and the number of people attending for unscheduled and emergency care. At 11.00am on the first day of inspection, CUH's emergency department had 85 patients registered in the department. Twenty-six (31%) of these 85 patients were admitted and boarding in the emergency department while awaiting an inpatient bed in the main hospital. This number was slightly less than the 35% of patients found boarding in the emergency department during HIQA's previous inspection in 2022. Similar to previous findings, CUH did not have a defined surge capacity. Additional inpatient bed capacity was gained by cancelling elective procedures and or placement of additional trolleys in inpatient clinical areas. CUH was in escalation at Stage 2 (amber) level during this inspection and there was evidence that actions aligned with this level of escalation were being implemented to improve effective patient flow and increase inpatient capacity across CUH and Cork Kerry Community Healthcare. The escalation plan comprised actions to be implemented across CUH and Cork Kerry Community Healthcare services to enable a steady state, where demand and capacity in CUH was managed and there was timely access to unscheduled and emergency care within relevant HSE targets.

Patient flow through CUH emergency department and wider hospital level was supported by the CNM 2 for admitted patients and patient flow ADON for the unscheduled care directorate. During the inspection, because of a number of infection outbreaks, four clinical areas were closed to new admissions. In addition, there were 29 delayed discharges, with the majority of these patients awaiting residential and rehabilitation care in the Cork Kerry Healthcare Community services. Closed inpatient areas, delayed discharges, together with

an admission rate of 24.8% from the CUH's emergency department and a reported higher level of average length of stay (ALOS) for medical and surgical patients[§§§§] impacted on the flow of patients through CUH's emergency department. This resulted in increased patient experience times (PETs) and contributed to the boarding of admitted patients in the emergency department.

At 11.00am on the day of inspection, the waiting time in CUH's emergency department from:

- registration to triage ranged from two mins to 31 minutes. The average waiting time for triage was 7 minutes. This was an improvement on the average triage waiting time of 25 minutes found in HIQA's previous inspection in 2022 and was within the 15 minutes triage wait time proposed by the HSE's Programme for Emergency Medicine. Comparatively, CUH was one of the better performing hospitals for triage times when compared to other Model 4 hospital inspected by HIQA to date. It was also evidence of the impact of projects — non-admitted PET, ambulance turnaround times, virtual navigation hub, SAFER patient flow bundle[*****] — implemented after HIQA's last inspection to manage and achieve efficiencies in PETs, improve patient flow and increase inpatient bed stock in CUH. While this is positive, it is imperative that any gains are sustained and further efficiencies and improvements are achieved to attain a steady state. All patients were triaged and prioritised in line with the Manchester Triage System.[†††††]
- triage to medical review ranged from 2 minutes to 576 minutes (9 hours 40 minutes). The average waiting time for medical review was 156 minutes (2 hour 40 minutes), which was similar to other Model 4 hospitals inspected by HIQA to date. The range in waiting time for medical review was similar to the 20 minutes to 8 hours found in HIQA's previous inspection in 2022.
- decision to admit to actual admission in an inpatient bed ranged from 68 minutes to 956 minutes (16 hours). The average waiting time was 544 minutes (9 hours). This was an improvement on HIQA's previous inspection findings, where the range was found to be two hours to 58 hours 28 minutes.

[§§§§] The reported average length of stay (ALOS) for medical patients was 8 days (slightly above the HSE's target of ≤7.3) and reported ALOS for surgical patients was 8 days (significantly above the HSE's target of ≤5.6).

[*****] The AFER patient flow bundle is a practical tool to reduce delays for patients in adult inpatient wards. S - Senior Review - all patients have a senior review before midday by a clinician able to make management and discharge decisions. A – All patients have an Expected Discharge Date and Clinical Criteria for Discharge. F - Flow of patients commences at the earliest opportunity from assessment units to inpatient wards. E – Early discharge - patients will be discharged from base inpatient wards before midday. R – Review - systematic multidisciplinary team review of patients with extended lengths of stay.

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

Overall, during the inspection, it was evident that CUH had defined management arrangements in place to manage and oversee the delivery of unscheduled and emergency care. There was also evidence that the actions and initiatives implemented after HIQA's inspection in 2022 were beginning to achieve efficiencies and improved compliance with national KPIs and national standards. Notwithstanding this, patient flow and inpatient bed capacity in CUH, as evident by the 26 (31%) admitted patients boarding in the emergency department remained a challenge. Capital development and refurbishment projects planned for CUH will increase inpatient capacity in the long-term, but in the interim any patient safety risk arising from the mismatch of capacity and demand need to be managed appropriately and effectively.

Findings relating to the wider hospital and other clinical areas

CUH had effective management arrangements with defined lines of responsibility and

accountability, and devolved autonomy and decision-making, which supported the effective and efficient management of healthcare services at wider hospital level.

Infection, prevention and control

The hospital's multidisciplinary infection prevention and control team provided specialist knowledge and skills and were responsible for the implementation of CUH's infection prevention and control programme.[‡‡‡‡‡] The team comprised:

- 1 whole-time equivalent (WTE)[§§§§§] consultant microbiologist. Clinical staff in CUH confirmed they had access to a consultant microbiologist 24/7
- 1 WTE ADON. At the time of inspection, this position was unfilled
- 1 WTE CNM 2 in infection prevention and control. At the time of inspection, this position was unfilled
- 10 WTE infection prevention and control nurses
- 1 WTE antimicrobial pharmacist
- 1 WTE surveillance scientist.

Implementation of CUH's infection prevention and control plan was appropriately monitored by the IPCC and the EQPSC. The comprehensive infection prevention and control annual report for 2022, reviewed by inspectors provided information on CUH's infection prevention and control surveillance monitoring activity, antimicrobial stewardship practices, infection prevention and control related audit activity, staff education and training, and quality improvement initiatives implemented to improve infection prevention and control practices in CUH in 2022.

[‡‡‡‡‡] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

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

Medication safety

CUH had a clinical pharmacy service,[******] and a formal medication safety programme, which was led by the CUH's chief pharmacist. NCHD-led medication reconciliation was carried out on all patients on admission to and discharge from CUH. CUH was funded for 45.6 WTE pharmacy staff (4 WTE at chief pharmacist grade, 25.2 WTE at senior pharmacy grade and 16.4 WTE at basic pharmacy grade). CUH was funded for 36.9 WTE pharmacy technicians. At the time of inspection, 77.5 (94%) WTE pharmacy positions (pharmacists and technicians) were filled as follows:

- 42.6 WTE pharmacists, which included chief pharmacists (4 WTE), 22.2 WTE senior grade pharmacists and 16.4 WTE basic grade pharmacists
- 34.9 WTE pharmacy technicians.

Hospital pharmacy services were available onsite during core working hours and outside of these hours nursing administration had access to pharmacy stock.

Deteriorating patient

CUH had a deteriorating patient improvement programme and had implemented the appropriate national early warning systems for the various cohorts of patients — INEWS and PEWS and the Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk ($ISBAR_3$)[††††††] communication tool. Compliance with the early warning systems was audited and quality initiatives were implemented to ensure compliance with relevant national guidance. Clinical skills facilitators provided staff training on the use and escalation protocol for all early warning systems in use in CUH. Since HIQA's last inspection, CUH had received additional funding, which resulted in the recruitment and appointment of an additional four WTE clinical skills facilitators.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. The safe transition of care in CUH was managed via three different structures — bed management, discharge coordinators and scheduled care/bed booking — which were overseen by the head of bed management who reported to CUHG's CEO. CUH was well resourced with 8 WTE discharge coordinators (1 WTE discharge coordinator at CNM 3 level and 7 WTE discharge coordinators at CNM 2 level). Notwithstanding this, hospital management had submitted business cases to implement a 12 hours over seven days model for discharge coordinators to further support continual patient flow in CUH. Hospital management had progressed plans to

[******] 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.

[††††††] Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

increase the bed stock in CUH through the procurement of 161 beds in a number of rehabilitation and community services and there was potential to increase this bed base by a further 50 beds. Despite these arrangements, it was clear that the shortage of community rehabilitation, transitional and step-down beds, and shortfalls in home care services in the community impacted on the timely transfer of patients who were medically fit for discharge from CUH.

In summary, CUH had effective management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm. Notwithstanding this, CUH remains challenged by the limited availability of suitable community rehabilitation, transitional and step-down beds, and shortfalls in home care services in the community, which impacts on the ability to transfer patients from CUH. This resulted in a number of patients experiencing a delay in transfer of care, which together with increased attendances to CUH's emergency department, higher ALOS and limited inpatient surge capacity contributed to the boarding of admitted patients in CUH's emergency department. Plans were progressing to increase the bed stock in CUH, but the mismatch between demand for healthcare services and bed availability did impact on the flow of patients through CUH on days of inspection.

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.

Inspectors found CUH had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. CUH reported on a range of KPIs, in line with the HSE's reporting requirements, but there was scope for improvement in this area. Collated performance data was reviewed at monthly meetings of the EQPSC and monthly performance meetings between the CUH and SSWHG.

Risk management

Inspectors found that CUH had an overarching risk management framework with formalised structures and processes to proactively identify, analyse, manage and minimise risks to patients. Risks were identified and managed at local clinical area level and escalated to the appropriate clinical directorate and EMB, when required. Staff who spoke with inspectors confirmed that CNMs were responsible for identifying and implementing controls to mitigate any potential and actual risks to patient safety. Each clinical directorate had a quality and patient safety lead. At the time of inspection, the quality and patient safety lead position was filled, temporarily or permanently, in three of the six clinical directorates — medical, perioperative and paediatrics directorates. Risks identified at local clinical area level were recorded on local risk registers using CUH's electronic risk management system. The effectiveness of the actions to manage and mitigate identified risks were monitored by the

CNMs, quality and patient safety leads and the CUH's Risk Management Committee. More serious high-rated risks not managed at clinical area and or clinical directorate levels were escalated to the EMB and recorded on CUH's corporate risk register. High-rated risks managed at EMB level were discussed at the monthly performance meetings with the SSWHG.

Audit activity

At the time of inspection, there was no coordinated approach to the management and oversight of clinical auditing at CUH. When fully established, each clinical directorate will assume responsibility for overseeing the conduct of audits and the monitoring of implementation of all quality improvement plans arising from audit findings for the clinical services within their remit. This will strengthen the conduct, coordination and oversight of audit activity in CUH.

Management of serious reportable events and patient-safety incidents

Inspectors found there was effective and efficient oversight of the reporting and management of serious reportable events, serious incidents and patient-safety incidents that occurred in CUH. CUH's Serious Incident Management Team (SIMT) was responsible for ensuring that all serious reportable events, serious incidents and patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT also had oversight of the timeliness of implementation of recommendations from reviews of serious reportable events, serious incidents and patient-safety incidents. Chaired by the operations manager, the SIMT met monthly and membership included appropriate clinical and executive management team representatives from CUH. The SIMT reported and was operationally accountable to the EMB. Learnings from serious reportable events, serious incidents and patient-safety incidents were shared with clinical staff at clinical handover and multidisciplinary safety huddles.

Feedback from people using the service

CUH had a process in place for patients and their families to provide feedback about the care they received. CUH's findings from National Inpatient Experience Survey were reviewed at meetings of the EQPSC and relevant updates were provided at monthly meetings of the EMB. There was evidence that hospital management was working with the HSE to implement quality improvement initiatives to improve patients' experiences. Areas of focused improvement included nutrition for patients, written or printed information on discharge and communication with patients and families about any worries and or fears they may have. The oversight of the monitoring of implementation of quality improvement plans is an area requiring improvement. Hospital management told inspectors that staff resourcing in the quality and patient department had impacted on the ability to monitor the implementation of quality initiatives. It is imperative that the implementation of quality improvement initiatives is monitored and tracked so that the EMB can be assured that all opportunities are used to continually improve the quality and safety of healthcare services provided in CUH.

Overall, CUH had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. Compliance with KPIs in the four areas of known harm was monitored and there was evidence that information from this process was being used to improve the quality and safety of healthcare services and patients' experiences of receiving care at CUH. However, there is scope for improving auditing activity and the governance and oversight of this activity to ensure that care provided at CUH is in line with best practice standards and guidance, that all areas for improvement are identified and to provide assurances on the quality and safety of clinical services provided at CUH. The implementation of quality improvement initiatives should be monitored and tracked to assure the EMB that all opportunities are used to continually improve the quality and safety of healthcare services provided in CUH.

Judgment: Partially Compliant

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

Inspectors found that CUH had appropriate arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. Notwithstanding this, there were a number of unfilled positions across a number of professions at CUH. Staffing shortfalls and the controls implemented to mitigate the effect of such shortfalls was a medium-rated risk recorded on CUH's corporate risk register. Workforce was discussed at monthly performance meetings between CUH and SSWHG.

Workforce findings relating to the Emergency Department

Staffing levels in the emergency department were maintained to support the delivery of 24/7 emergency care.

Medical workforce in the Emergency Department

CUH's emergency department was funded for 14 WTE consultants in emergency medicine. This included an increase of two WTE consultant in emergency medicine positions since HIQA's previous inspection in 2022. At the time of inspection, 89% (12.5 WTE) of these positions were filled. Consultants in the emergency department were operationally accountable and reported to the hospital's interim chief medical officer. All consultants in emergency medicine in CUH were on the specialist register with the Irish Medical Council. There was a senior clinical decision-maker at consultant level in the emergency department each day from 8.00am to 11.00pm, with availability on a 24/7 basis. CUH was an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. Consultants in emergency medicine were supported by 39 WTE NCHDs at registrar and senior house officer (SHO) grades providing 24/7 medical cover. This number included an increase of four WTE NCHDs since HIQA's previous inspection. At the time of inspection,

37 WTE NCHD positions were filled, with the remaining two WTE positions filled through agency staff.

Nursing workforce in the Emergency Department

CUH's emergency department's funded complement of nurses (including management and other grades) was 171 WTE. This included an increase of 6.5 WTE nurses since HIQA's previous inspection. An ADON had overall nursing responsibility for the emergency department. An ADON and a CNM 3 were rostered on duty during core working hours. A CNM 2 was rostered on each shift (day and night). While the 6.5 WTE uplift of nursing staff, brought the emergency department into alignment with the nursing staff requirements as determined per the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*,[‡‡‡‡‡‡] there was a discrepancy between the department's staffing requirement and actual staffing resources. Inspectors were told that the emergency care staffing framework did not take account of CUH's nursing staff requirement for the Clinical Decision Unit and emergency paediatric department. Therefore, these areas were being staffed from the funded complement of 171 WTE nurses. Hospital management were working with the HSE to revise the nursing staff requirement to take account of the staffing requirement for these areas. At the time of inspection, the emergency department had a shortfall in nursing staff. 6% (10 WTE) of the department's nursing staff positions were unfilled — 8 WTE nursing positions, one WTE CNM 1 position and one WTE advanced nurse practitioners (ANPs) position. The 6% shortfall in nursing staff was a significant improvement on the 34% shortfall found in HIQA's previous inspection. Hospital management were managing the nursing staff shortfall through ongoing recruitment campaigns and using agency nurses. Nursing staff in the emergency department were supported by 11 WTE healthcare assistants (HCAs) and all HCA positions were filled at the time of this inspection.

In summary, since HIQA's last inspection, CUH's emergency department had gained an additional two WTE consultants in emergency medicine, four WTE NCHDs at registrar and SHO grades and the shortfall in nursing staff had improved. This uplift in medical and nursing staff had enabled some operational and clinical efficiencies to be achieved, as evident in some improvements in the PETs. It is imperative that these gains are built on and further efficiencies are gained from any resulting reorganisation of work practices in the emergency department and the increased availability of senior decision-makers at consultant level. Notwithstanding this, the emergency department still had a shortfall in medical consultant and nursing staff.

[‡‡‡‡‡‡] Department of Health. *Framework for Safe Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

Workforce findings relating to the wider hospital

Medical workforce in wider hospital

The hospital was funded for 300 WTE medical consultants across a range of specialties. At the time of this inspection, 91% (274 WTE) medical consultant positions were filled, with 26 WTE consultant positions unfilled. Recruitment of medical consultants was ongoing through continuous recruitment campaigns. Consultant staff across CUH were supported by NCHDs at registrar and SHO grades providing 24/7 medical cover. CUH had an approved funding for a total of 505 WTE NCHDs across the different NCHD grades and specialties. At the time of this inspection, 5% (26 WTE) of these NCHD positions were unfilled.

Health and social care professional workforce in wider hospital

The filling of pharmacist's positions at CUH was challenging for hospital management, but not to the same extent as other Model 4 hospitals inspected by HIQA to date. CUH was funded for 45.6 WTE pharmacy staff. At the time of inspection, 7% (3 WTE) of pharmacist positions and 5% (2 WTE) of pharmacy technician positions were unfilled. This shortfall in pharmacy staff impacted on the delivery of a clinical pharmacy service across CUH.

Nursing workforce in wider hospital

CUH was funded for 1,248 WTE nurses (inclusive of management and other grades). This number was inclusive of the additional nursing staff approved under the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland* and *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.* At the time of inspection, 97.44 WTE (8%) of the funded nursing staff positions were unfilled. Shortfalls between the funded, and actual filled nursing staff positions (including management and other grades) were evident across the inpatient clinical areas visited during this inspection.

Nursing staff were supported by HCAs. CUH was funded for 260 WTE HCAs. At the time of inspection, 8% (20 WTE) of HCA positions were unfilled. Nursing staff were not measuring the proportion of care delayed, unfinished or omitted as a consequence of the staffing shortfall. Therefore, it was difficult to quantify the specific impact that such shortfalls had on care delivered in the inpatient clinical areas visited during this inspection.

CUH's staff absenteeism rate in June 2023 was 4.7% (4.4% non-COVID-19 related and 0.3% COVID-19 related), slightly higher that the HSE's target of ≤4%. Staff who spoke with inspectors were aware of the occupational health service and Employee Assistance Programme available for all staff in CUH.

Staff uptake of essential and mandatory training

CNMs and clinical skills facilitators had oversight of the attendance at and uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection prevention and control, medication

safety and INEWS on the HSE's online learning and training portal (HSELanD). Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system.§§§§§§ Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in CUH.

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice at a minimum every two years. Documentation on training uptake, reviewed by inspectors showed that the uptake of essential and mandatory training in standard and transmission-based precautions, basic life support, the early warning system, hand hygiene and sepsis management was sub-optimal and should be an area of focused improvement following this inspection.

Overall, the uplift in medical and nursing staff in CUH's emergency department had enabled some operational and clinical efficiencies to be achieved, as evident in some improvements in PETs. Notwithstanding this, CUH still had unfilled medical consultant and nursing staff positions in the emergency department. Work to fill different staffing positions in the emergency department and across different departments in CUH was ongoing, but there were shortfalls in staffing numbers compared to agreed complements. Service safety was being maintained through agency staff and there was an added burden of responsibility and workload for pre-existing staff. This was not sustainable and hospital management were working to address the issue, but similar to other Model 4 hospitals, they were challenged in their efforts to recruit staff across the professions. Notwithstanding this, hospital management need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are contingencies in place to ensure that CUH can meet the demand for healthcare services. Hospital management should also ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Judgment: Partially compliant

§§§§§§ The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. CUH was found to be non-compliant with two national standards (1.8 and 2.7), partially complaint with three national standards (1.6, 3.1 and 3.3), substantially compliant with one national standard (2.8) and compliant with one national standard (1.7) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

Staff in CUH were committed to promoting a person-centred approach to care and were observed by inspectors to be respectful, kind, courteous and caring towards patients.

Findings relating to the Emergency Department

Inspectors found the situation in which patients were boarding in the department were similar to the inspection findings of June 2022. During this inspection, the emergency department was busy with 85 registered patients in the department at 11.00am. Privacy and dignity was supported for the patients accommodated in individual cubicles in the emergency department. Maintaining the dignity, privacy and confidentiality of patients accommodated in multi-occupancy areas was a challenge. Privacy curtains were used when administering care to patients in these areas, but these curtains did not protect patient's privacy during patient-clinician conversations. These findings were consistent with CUH's findings from the 2022 National Inpatient Experience Survey, where CUH scored lower than the national scores in questions related to the promotion of respect and dignity and waiting times in the emergency department.

Hospital admission avoidance initiatives, such as the Frailty Intervention Team (FIT),******* Community Intervention Team, Outpatient Parenteral Antimicrobial Therapy and the Integrated Care Programme for Older Persons (ICPOP) were used as alternative or supplementary patient care pathways in CUH. CUH also had an alternative pre-hospital pathway (APP) and had introduced the Pathfinder service in March 2023. A pre hospital advisory group was also established to enable and improve the integration between pre hospital services, the emergency department and acute medicine.

The GEMS provided care for older persons attending CUH's emergency department, with care provided by a designated multidisciplinary team led by a consultant geriatrician who had clinical and operational accountability for the service. GEMS was supported by the FIT

******* Frailty at the Front Door is a designated care pathway for older persons who present for unscheduled care with frailty signs and symptoms.

team and used the ICPOP hubs to link in with primary and secondary care services. GEMS had defined KPIs to monitor the quality of care provided in GEMS and service performance. Compliance with these KPIs was reviewed and any non-compliance actioned every month at meetings of the USCPB.

Overall, staff promoted privacy, dignity and autonomy in CUH's emergency department however, any meaningful impact was negated by the department's physical environment. Inspectors did not observe any significant change to the environment where patients were receiving care since HIQA's last inspection in 2022.

Findings relating to other clinical areas

Staff in the inpatient clinical areas visited during this inspection promoted a person-centred approach to care and were observed by inspectors to be respectful, kind, caring and being responsive to patient's individual needs. In general, the physical environment in the inpatient clinical areas visited promoted the privacy, dignity and confidentiality of patients. This was consistent with the human rights-based approach to care promoted by HIQA. What inspectors heard and observed in the clinical areas were also consistent with CUH's overall findings from the 2022 National Inpatient Experience Survey, where participants who completed the survey felt they were treated with respect and dignity, and had enough privacy while receiving care in CUH. Patients were accommodated in mixed gender wards, but the patients who spoke with inspectors did not express any concern or discomfort with this arrangement. The accommodation of patients in mixed gender wards was not underpinned by a formalised policy and on the days of inspection there was no evidence risk assessments had being carried out to identify and mitigate any actual and or potential patient safety risk posed by the arrangement. Inspectors requested that that this be done and measures put in place to address any actual and or potential risk to patient safety arising from the practice.

Inspectors observed that patients' information was not protected and stored appropriately in two inpatient areas visited. Patients' healthcare records were observed to be stored in unlocked cabinets on main corridors, therefore these healthcare records could be easily accessed by passers-by. Whiteboards were used to record relevant clinical information and personal identifiable information was recorded on these whiteboards, which was viewable by others. This was a potential breach of general data protection regulations and was brought to the attention of the CNM for immediate remedy.

Judgment: Partially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
Inspectors found that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care in all the clinical areas visited during inspection. Inspectors observed staff to be respectful, kind and caring towards patients. Staff were observed actively listening to and communicating with patients in an open and sensitive manner, in line with the patient's expressed needs and preferences. Staff were also observed responding in a timely manner to patients and were attentive to patient's individual needs. This was confirmed by patients who spoke with inspectors during inspection. Patients were complimentary of the staff and the care provided by them. A culture of kindness, consideration and respect was promoted at CUH through staff wearing name badges saying 'Hello my name is' and a number of quality improvement initiatives, such as 'let your voice be heard'. Inspectors observed specific initiatives for patients with dementia that enhanced communication with patients in a meaningful and person-centred way.
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.
CUH did not have a designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from the review of complaints. The complaints resolution process was not audited. Corporate governance and oversight of CUH's complaints management process including the timeliness of responses to complaints was overseen by the EQPSC. Formal complaints were discussed at meetings of the EMB and at performance meetings between CUH and SSWHG, when required. Complaints received in CUH were managed in line with the HSE's complaints management policy *'Your Service Your Say.'* Staff in the clinical areas visited during inspection were knowledgeable about CUH's complaints management process. Hospital management encouraged and supported point of contact complaint resolution in line with national guidance. Verbal complaints were managed at local clinical area level by CNMs and escalated to the CNM 3 if not resolved. Written complaints were managed by the ADONs for their area of responsibility, with appropriate input from CNMs and other staff. CUH employed one WTE Patient Advocacy and Liaison Services (PALS) manager and one WTE patient experience coordinator to support and advocate for patients attending CUH. Inspectors were informed that hospital management had submitted an investment paper to SSWHG to increase the number of complaint officers by three WTEs. Verbal complaints were not being tracked and trended at CUH at the time of this inspection. This is a missed opportunity for shared learning and quality improvement. The number and type of formal complaints received was formally reported to the HSE annually. Hospital

management received 342 written complaints in 2022 — 129 complaints related to medical care and 99 complaints related to the emergency department. 85% (292) of these complaints were resolved within the HSE's timeframe of 30 working days. Up to the time of inspection, 64% of complaints received in 2023 were resolved within the 30 days' timeframe. Hospital management should continue to monitor the management of complaints and should ensure that CUH comes into full compliance with the HSE's targets. Sharing of learning from the complaints resolution process with clinical and other staff in CUH requires improvement.

Patients who spoke with inspectors had not received information on CUH's complaints process or on how to access independent advocacy services, but all said they would talk to a member staff if they wanted to make a complaint. Information about *'Your Service Your Say'* and independent advocacy services could be better displayed for patients and families across CUH.

Overall, CUH did not have effective and robust systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service within defined HSE targets. CUH's did not have a designated complaints officer. Therefore, there was no principal point of contact for patients and or families who wanted to make a complaint or raise a concern about the care received in CUH. The quality and patient safety department was the department that patients and or families contacted or submitted their feedback to. CUH formally reported on the number and type of formal complaints to the HSE, but sharing of learning from complaints should also be an area of focused improvement. Information on CUH's complaints process and independent advocacy services should be accessible to patients and their families. Hospital management should continue to monitor the management of complaints and ensure that CUH comes into full compliance with the HSE's 30 days' timeframe.

Judgment: Non-compliant

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

Inspectors found the physical environment of all the clinical areas visited during this inspection was generally well maintained and clean. Notwithstanding this, there was some evidence of general wear and tear, which did not facilitate effective cleaning and posed an infection prevention and control risk. This was consistent with findings from the 2022 National Inpatient Experience Survey, where CUH's score for cleanliness aligned with the national average score (9.0). Emergency supplies and equipment were readily available and accessible in all clinical areas visited and this equipment was checked daily and weekly, and serviced as per CUH's policy.

CNMs who spoke with inspectors were satisfied with the level of cleaning resources and maintenance services during and outside core working hours. Cleaning supervisors and

CNMs had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal cleaning[†††††††] was carried out by designated cleaning staff. Cleaning staff who spoke with inspectors were knowledgeable about the process of environmental and equipment hygiene. CNM 2s had oversight of the standard of cleaning of patient equipment. Inspectors observed the use of a green tagging system to guide and identify equipment that was clean in all clinical areas visited. Environmental and patient equipment hygiene was audited frequently. Environmental and patient equipment hygiene audit findings are discussed under national standard 2.8.

Clean and used linen was appropriately segregated. Hazardous material and waste was observed to be stored safely and securely. Supplies and equipment were stored appropriately, but adequate storage space was an issue in all the clinical areas visited during this inspection. This was a safety risk for staff and patients, most especially for patients experiencing mobility difficulties.

Inspectors observed signage regarding hand hygiene clearly displayed in all the clinical areas visited. Hand hygiene facilities were also strategically located and readily available in all clinical areas. Hand hygiene sinks in the clinical areas inspected conformed to requirements.[‡‡‡‡‡‡‡] Wall-mounted alcohol-based hand sanitiser dispensers and personal protective equipment (PPE) were also readily available. However, on the first day of inspection, inspectors found there was no hand sanitiser liquid in some dispensers in a clinical area where there was an active infection outbreak. This was brought to the attention of the CNM for immediate remedy, but when inspectors followed up on the second day of inspection, the hand sanitiser dispensers remained unfilled. This posed an infection risk for patients and was not consistent with expected infection prevention and control standards.

Infection prevention and control signage in relation to transmission-based precautions was observed in all clinical areas visited. Physical distancing was observed to be generally maintained between beds in multi-occupancy rooms in inpatient clinical areas. However, maintaining adequate physical distancing was a challenge in the multi-occupancy areas in the emergency department.

There were processes in place to prioritise and ensure the appropriate placement of patients requiring transmission-based precautions. The process was underpinned by a formalised prioritisation criteria, with oversight by CUH's infection prevention and control team. Inspectors found the number of isolation rooms with adequate en-suite bathroom facilities in CUH was inadequate for a Model 4 hospital. When no isolation facilities were available, patients requiring transmission-based precautions were cohorted in a multi-occupancy room, in line with national guidance. During inspection, inspectors found transmission-based precautions were not being applied in line with effective infection prevention and control

[†††††††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.
[‡‡‡‡‡‡‡] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

practices or standards. This was brought to the attention of CNMs for immediate remedy. Additionally, inspectors noted how the wearing of PPE by staff during the management of an active infection outbreak was not consistent with national standards and guidance. This was discussed at the time of inspection with the CNMs in the clinical areas, members of the infection prevention and control team and hospital management. Inspectors requested that risk assessments be completed and corrective measures be implemented to mitigate the actual and or potential risk to patient safety arising from this practice. After the inspection, HIQA issued a letter to the CUHG's CEO seeking assurance about the infection prevention and control practices in CUH. The actions reported to be implemented at CUH after that correspondence provided some level of assurance that the infection prevention and control practices would be reviewed and changes made to ensure the practices aligned with infection prevention and control national standards and guidance. It is imperative that these changes are implemented and sustained to improve and ensure infection prevention and control practices across CUH align with expected standards.

Inspectors also observed other issues that posed a patient safety risk in the clinical areas visited. This included, sharps not being disposed of in a safe manner and medications not always stored securely. These issues were brought to the attention of CNMs for immediate action and remedy.

In summary, at the time of inspection, the physical environment in CUH did not support the delivery of high-quality, safe care. There was a shortage of isolation rooms and facilities. Standard and transmission-based precautions were not consistent with infection prevention and control guidance and standards. Further assurances about the infection prevention and control practices in CUH was sought from the CEO of CUHG after the inspection of CUH. Collectively, these issues presented a potential risk to patient safety on the day of inspection.

Judgment: Non-compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.
Inspectors found that there were efficient systems and processes in place to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of healthcare services in CUH. Sources included defined quality and safety performance metrics, audit findings, risk assessments, patient-safety incident reviews, complaints and feedback from patients. Information from these sources and collated performance data was used to compare and benchmark the quality of services provided in CUH to other Model 4 hospitals in Ireland.

Infection prevention and control monitoring

Inspectors were provided with evidence that showed the IPCC monitored and had oversight of the infection prevention and control practices at CUH. Hospital management monitored and regularly reviewed compliance with KPIs relating to the prevention and control of healthcare-acquired infection,[§§§§§§§] and in line with HSE reporting requirements, publically reported on rates of:

- *Clostridioides difficile* infection
- *Carbapenemase-producing Enterobacterales* (CPE)
- hospital-acquired *Staphylococcus aureus* blood stream infections
- hospital-acquired COVID-19 and outbreaks.

In 2022, CUH's rate of new cases of:

- hospital-associated *Clostridioides difficile* ranged from 1.60 to 4.90 new cases per month. CUH was above the HSE's target (less than 2 per 10,000 bed days) for eight of the 12 months of 2022.
- hospital-acquired *Staphylococcus aureus* blood stream infection ranged from 0 to 1.70 new cases per month. CUH was above the HSE's target (less than 0.8 per 10,000 bed days) for six of the 12 months of 2022.
- CPE ranged from none to six cases per month, with an average of 2.16 cases per month.

Inspectors found that the management of infection outbreaks at CUH was in line with national guidance.

It was evident that monthly environmental, equipment and hand hygiene audits were undertaken at CUH using a standard approach underpinned by a formalised policy. Findings from environmental audits carried out in the months preceding HIQA's inspection, showed that all the clinical areas visited during this inspection were not compliant with the HSE's target of 90%, and that CUH continually underperformed in this area. There was evidence that action plans were developed when environmental and equipment hygiene standards fell below expected standards. However, all corrective actions were not time-bound. Responsibility for implementing the action plans lay with the infection prevention control team and CNMs with oversight by the IPCC. The underperformance in achieving the expect standard of environmental hygiene suggest that the timely implementation and effectiveness of action plans should be an area of focused improvement following this inspection.

Hand hygiene audits were conducted regularly in CUH with oversight from the infection prevention and control team. Findings from hand hygiene audits carried out in 2022 showed

[§§§§§§§] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf.

that the majority of inpatient clinical areas visited during the inspection were compliant with the HSE's target of 90%. Where compliance was below the 90%, there was evidence showing that additional staff training on effective hand hygiene practices was provided by the infection prevention and control team.

Patients in CUH were screened for multi-drug resistant organisms (MDROs), including CPE and Methicillin-resistant *Staphylococcus aureus* (MRSA) in line with national guidance and compliance with screening protocols were audited. In the three months prior to HIQA's inspection, CUH's compliance with CPE screening of eligible patients in the clinical areas visited during inspection ranged between 66% and 100%. This identified that some improvement was needed to ensure CPE screening of all eligible patients in CUH reached 100%.

Antimicrobial stewardship monitoring

Inspectors found evidence of monitoring and evaluation of antimicrobial stewardship practices at CUH. CUH's Antimicrobial Stewardship Committee was responsible for developing and implementing CUH's annual antimicrobial stewardship programme. The DTC had oversight of the implementation of this programme and compliance with defined antimicrobial stewardship KPIs. Information on antimicrobial consumption in CUH was submitted monthly to the Health Protection Surveillance Centre (HPSC).There was evidence that quality improvement initiatives, which included increased education and training for staff, were implemented to improve antimicrobial stewardship practices in CUH.

Medication safety monitoring

CUHG's DTC had oversight of the monitoring and evaluation of medication safety practices at CUH. While there was evidence that medication audits were carried out in 2022, this is an area requiring improvement. Initiatives to improve medication practices in CUH were included in the hospital's medication safety programme for 2023. Performance data relating to medication practices was collated monthly in CUH through the HSE's 'Test Your Care' nursing and midwifery metrics.******** Documentation submitted to HIQA showed a high level of compliance with the medication metrics in 'Test your Care' in the months preceding HIQA's inspection. However, there was scope for improvement in relation to some medication practices. For example, improvements were required in relation to recording a patient's weight on the medication record, the legibility of prescriptions and the minimum dose interval specified on the patient's record. There was limited evident from documentation reviewed by inspectors that time-bound action plans were developed when medication practices fell below expected standards. Information on medication alerts and findings from medication audits and patient-safety incidents were shared with staff via a dedicated desktop folder accessible on computers in the clinical areas, medication safety bulletins and staff training and education sessions.

******** Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

Deteriorating patient monitoring

The SCAUAP had oversight of CUH's compliance with national guidance on INEWS, ISBAR$_3$ use and clinical handover. Performance data relating to the escalation protocol for the deteriorating patient was collected monthly through 'Test Your Care' nursing and midwifery metrics. Compliance with national guidance on INEWS and ISBAR$_3$ was audited regularly in CUH and the documentation reviewed by inspectors showed a good level of compliance with guidance in all clinical areas visited in the months preceding HIQA's inspection. Time-bound quality improvement plans were developed when audit findings showed improvements were needed. Audit findings and actions to improve clinical practice for the deteriorating patient were shared with staff at clinical handover and multidisciplinary safety huddles. Inspectors also observed a quality care board on display in one clinical area visited, which displayed information on compliance with 'Test Your Care' nursing and midwifery metrics and audit results.

Transitions of care monitoring

Transitions of care at CUH was supported by the bed management team and discharge coordinators who had oversight of the measures in place to support effective patient flow in and out of CUH. Inspectors found there was no formal audit plan in relation to the transitions of care, but CUH tracked and monitored attendances to CUH's emergency department, TrolleyGar numbers,[††††††††] PETs, the number of persons who leave the emergency department without completion of treatment, ALOS, delayed transfer of care (DTOC) and ambulance turnaround times every month. A number of multidisciplinary meetings were held daily to ensure continual and effective patient flow through CUH. A daily situational report also provided hospital management, bed management and the discharge coordinator teams with an overview of bed status in CUH. A weekly meeting between CUH's bed management team and the community complex discharge team in Cork Kerry Community Healthcare also enabled discussions on and planning for the safe transfer of care for patients with complex needs.

Feedback from patients

Staff in all three clinical areas visited were not aware of the CUH's findings from the National Inpatient Experience Survey and could not provide examples of quality improvement plans or a change in practice introduced to improve the experience for people receiving care in CUH. This should be an area of focused improvement following this inspection.

Overall, there was evidence that CUH used information from monitoring activities to improve practices in relation to the infection prevention and control, medication safety practices and compliance with the early warning system. Auditing of medication practices could be strengthened and improved in CUH. A formal audit plan for all four areas of known

[††††††††] The HSE system known as TrolleyGAR enables daily monitoring of emergency department patients waiting in an inappropriate bed space after a decision to admit as an inpatient has been made and informs the hospitals' response during busy periods.

harm would better support the auditing of clinical practice and services at CUH's. Audit findings would also provide hospital management and people receiving care with assurances on the quality and safety of clinical services provided at CUH. Compliance with environmental hygiene standards should also be an area of focused improvement in CUH following this inspection.

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.

Inspectors found there were systems and processes in place at CUH to identify, evaluate and manage immediate and potential risks to people using the healthcare services in CUH. Each clinical directorate had a designated risk and patient safety advisor, but at the time of inspection, this position was filled (two on a permeant basis and one temporarily) for three of the six clinical directorates in CUH. Inspectors found that the management of identified risks at CUH was in line with the HSE's integrated risk management policy. Staff took responsibility for managing risks in their clinical areas and risks were recorded on local risk registers. CNMs identified, applied and monitored the effectiveness of corrective actions to mitigate any actual or potential risks to patient safety in their areas of responsibility. More serious risks not managed at clinical area level were escalated to the relevant clinical directorate and reported on that directorate's risk register. High-rated risks not managed at clinical directorate level were escalated to hospital management and recorded on CUH's corporate risk register. It was clear that CUH's corporate risk register was reviewed and corrective measures were updated periodically at meetings of the Risk Management Committee and EMB. During the course of the inspection, inspectors observed mitigating measures applied to manage risks recorded on local and corporate risk registers.

At the time of this inspection, 26 moderate and high-rated risks related to the four areas of known harm were recorded on CUH's corporate risk register. These included risks related to:

- staffing resources across all professions
- infrastructure and facilities, ineffective bed capacity to meet service demand
- ineffective patient flow in the unscheduled care pathway and the potential impact on the quality of care delivered, patient experience, potential poor patient outcomes, and non-compliance with PETs due to lengthy wait times, delays in off-loading patients from ambulances and patients boarding in the emergency department
- lack of isolation rooms
- lack of sufficient numbers of critical care beds in CUH
- risk of potential delay in diagnosis and treatment due to inability to provide access to diagnostics in a clinically deemed appropriate timeframe
- COVID-19 — short term disruption to services, outbreaks in CUH due to uncontrolled transmission

- risk of potential harm to patients due to inadequate capacity in the ophthalmology services.

Inspectors discussed the capacity issues in the ophthalmology services with hospital management and were informed that the ophthalmology services in Cork and Kerry were being reconfigured by management at SSWHG over the coming months to support additional capacity in the region. Following this inspection, inspectors have requested regular updates on progress in relation to the reconfiguration plans be provided to HIQA.

Findings related to the Emergency Department

CUH had effective and robust systems and processes in place to identify, evaluate and manage actual and potential risks to people attending the emergency department. Performance data was collected in line with the HSE's reporting requirements on a range of different KPIs related to the emergency department — the number of attendances to and admissions from the department, DTOC, ALOS and ambulance turnaround times. The USCPB had oversight of CUH's performance and compliance with these KPIs.

Data on PETs collected at 11.00am on the first day of inspection, showed that CUH was not compliant with any of the HSE's PET targets. At that time, 85 patients were registered in the department and of them:

- 50.7% were admitted to a hospital bed or discharged within six hours after registration. CUH was not in line with the national target of 70% for this KPI.
- 35% were admitted to a hospital bed or discharged within nine hours after registration. CUH was not in line with the national target of 85% for this KPI.
- 4% were in the department for more than 24 hours after registration, which was almost aligned with the national target of 97%.
- 29 (35%) of the 85 patients registered in the emergency department were aged 75 years and over. Of these:
    - 38% were in the department for more than six hours after registration. CUH was not compliant with the national target of 95% for this KPI
    - 41% were in the department for more than nine hours after registration. CUH was not compliant with the national target of 99% for this KPI
    - 90% were in the department for more than 24 hours after registration. CUH was not compliant with the national target of 99% for this KPI. CUH's compliance with the nine hour PET for patients aged 75 years and over had improved since HIQA's last inspection, but compliance with the 24 hour PET had declined. Inspectors recognised the balance to be gained between meeting defined PETs and caring for this cohort of patients in an environment, such as the one provided by GEMS that is more suitable to their needs.

Infection screening and outbreak management

Patients were screened for MDROs, including CPE at point of entry to CUH as per the national guidance. Inspectors reviewed a sample of patient healthcare records and discharge documentation and noted that the patient's MDRO or other transmissible infection status was recorded. However, information on patient's COVID-19 vaccination status was not recorded on all the healthcare records reviewed. Due to the limited number of isolation rooms at CUH, all patients requiring transmission-based precautions were not isolated within 24 hours of admission or diagnosis as per national guidance. Potential risks were mitigated by the cohorting of patients requiring transmission-based precautions in multi-occupancy rooms. On the days of inspection, inspectors found that the practice of isolating or cohorting patients who require it was not in line with national and or CUH guidance.

In 2022, the hospital had a number of infection outbreaks — CPE, *Clostridioides difficile*, and COVID-19. Inspectors found that the management of these infection outbreaks was in keeping with national guidance and the process was underpinned by a formalised up-to-date policy. It was evident that multidisciplinary outbreak teams were convened to advise and oversee the management of infection outbreaks in CUH. Summary reports from infection outbreaks, reviewed by inspectors were comprehensive and outlined control measures to mitigate the actual and potential risk to patient safety in the short-term, potential contributing factors and recommendations to reduce reoccurrence of the infection outbreak. The uptake of flu vaccination for nurses and HCAs was below the HSE's target of 75% and should be an area of focused improvement following the inspection.

Medication safety

CUH had a comprehensive clinical pharmacy service. NCHD-led medication reconciliation was carried out on admission and discharge and was reviewed by a pharmacist post admission. Pharmacy technicians replaced medication stock in all clinical areas every week. Inspectors observed CUH's high-risk medications list, which aligned with the acronym 'A PINCH'‡‡‡‡‡‡‡‡ and sound-alike look-alike medications (SALADs) list. Staff were observed using risk-reduction strategies to support the safe use of for high-risk medicines. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of prescribing.

Deteriorating patient

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose clinical condition deteriorates. Staff in the clinical areas visited were knowledgeable about the INEWS escalation process. Staff reported that there was no difficulty accessing medical staff to review a patient experiencing acute clinical deterioration. The $ISBAR_3$ communication tool was used when requesting a medical

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

review of a patient. At the time of this inspection, hospital management were in the process of establishing an outreach multidisciplinary critical care team to review patients discharged from the hospital's Intensive Care Unit and patients with a triggering early warning system. This team will further support the timely review of patients experiencing acute clinical deterioration. Inspectors reviewed a sample of healthcare records and found that the grade of NCHD who reviewed patients with a triggering early warning score was in line with the national escalation protocol.

Safe transitions of care

Inspectors found there were systems in place to support the safe discharge and transfer of patients within and from CUH. The ISBAR structure was used for clinical handover. Daily safety huddles took place where any issues that may impact on patient safety were discussed. Nursing documentation reviewed by inspectors contained a very comprehensive discharge planning section, which included requirements for complex discharge and there was collaborative and integration with community services in Cork Kerry Community Healthcare.

Policies, procedures and guidelines

CUH had a ranged of infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, managements of patients in isolation and equipment decontamination. CUH also had a range of medication policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff via CUH's computerised document management system, but a number of the procedures, protocols and guidelines needed review as they were outside the three year review timeframe recommended by the HSE.

Overall, inspectors found that the short and medium-term measures implemented to improve emergency department PETs were beginning to impact positively. While there was evidence of some improvement, PETs at time of this inspection continues to expose patients to a higher level of risk and harm. Given the associated increase in morbidity and mortality with long PETs, this remained a concern for inspectors. There are long-term plans to address inpatient capacity and further improve patient flow in CUH, but while these are being progressed hospital management need to continue to ensure effective measures are implemented to protect patients attending CUH's emergency department from any potential and actual risk of harm. While CUH had systems and processes in place to proactively identify and manage the potential risks associated with the four areas of known harm, there was scope for improvement in the following areas:

- A number of hospital policies, procedures, protocols and guidelines required review.
- Patient's COVID-19 or COVID-19 vaccination status was not recorded on all patient healthcare records or discharge documentation.

- Staff uptake of flu vaccination for nurses and HCAs was below the HSE's target of 75% and should be an area of focus for management following the inspection.

Judgment: Partially compliant

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

There were systems in place at CUH to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Patient-safety incidents were reported on the National Incident Management System (NIMS).§§§§§§§§ CUH's SIMT, EQPSC and EMB had oversight of the management of patient-safety incidents that occurred in CUH.

CUH reported a total of 1,117 clinical incidents********* and nine serious reportable events to the HSE in the first quarter of 2023. CUH's rate of reporting of clinical incidents to NIMS for 2022 ranged from 9.30 to 16.20 per month (average 11.5 clinical incidents per month), which is lower than the incidents reported by other Model 4†††††††††† hospitals that year. All clinical incidents reported in CUH in 2022 were uploaded to NIMS within the required 30 days' timeframe from date of notification.

Staff who spoke with HIQA were knowledgeable about what and how to report, manage and respond to a patient-safety incident. Staff were also aware of the most common patient-safety incidents reported at CUH — slips and trips or falls. Patient-safety incidents that occurred in CUH were tracked and trended by the quality and patient safety department. Staff who spoke with inspectors did not receive feedback on patient-safety incidents. This is a missed opportunity for sharing the learning from patient-safety incidents. Inspectors found that the oversight and monitoring of the implementation of recommendations arising from reviews of patient-safety incidents could be improved. Hospital management told inspectors that this was due to the shortfall in the staffing resource in CUH's quality and safety department. Inspectors were told that the reconfigured governance arrangements will result in each clinical directorate having oversight of the implementation of recommendations arising from the review of patient-safety incidents. Each clinical directorate will report on the progress of implementation of the recommendations to the EQPSC, who in turn will provide assurances to the EMB. 71% of the commissioned reviews into serious reportable events in CUH were completed within the HSE's 125 days' timeframe.

§§§§§§§§ 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).
********* A clinical incident is a subset of patient-safety incidents, it's an event or circumstance which could have, or did lead to unintended and or unnecessary harm.
†††††††††† Compared with St James' Hospital; University Hospital Galway; Mater Misericordiae University Hospital; St Vincent's University Hospital and University Hospital Limerick.

Infection prevention and control patient-safety incidents

CUHs infection prevention and control team reviewed all infection prevention and control related patient-safety incidents that occurred in CUH and made recommendations to improve infection prevention and control practices. CUHG's IPCC had oversight of all infection prevention and control patient-safety incidents and the effectiveness of corrective actions.

Medication patient-safety incidents

Medication patient-safety incidents that occurred in CUH were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. CUHG's DTC had oversight of all medication patient-safety incidents and the effectiveness of any actions and measures implemented to improve medication safety practices in CUH. Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not recorded in CUH.

Overall, inspectors found there was a system in place in CUH to identify, report, manage and respond to patient-safety incidents. Nonetheless, the oversight and monitoring of the implementation of recommendations from the review of patient-safety incidents and sharing of learning from this process is an area requiring improvement.

Judgment: Partially compliant

Conclusion

HIQA carried out an announced inspection of CUH to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, CUH was judged to be:

- compliant with one national standard assessed (1.7)
- substantially compliant with two national standards assessed (5.5 and 2.8)
- partially compliant with six national standards assessed (5.2, 5.8, 6.1, 1.6, 3.1 and 3.3)
- non-compliant with two national standards assessed (1.8 and 2.7).

Capacity and Capability

After the onsite inspection in CUH, further assurances about the infection prevention and control practices in CUH was sought from the CEO of CUHG. In subsequent correspondence, the CEO reported that actions had been implemented to improve infection prevention and control practices in CUH and to align with national standards and guidance.

Findings from this inspection provided evidence of the commitment of hospital management and staff to improve care for patients using the unscheduled and emergency care pathway, and improve CUH's compliance with the *National Standards for Safer Better Health*. The revised processes and measures introduced at CUH since HIQA's last inspection have resulted in some operational and clinical efficiencies in the emergency department and this is recognised through an improvement in level of compliance with national standard 5.5. However, the findings of this inspection identified how risks to patient safety remain in CUH and more improvement is needed for CUH to come into full compliance with the national standards.

CUH had corporate and clinical governance structures and arrangements, but these were being revised and reconfigured, and the revised structures being implemented at the time of inspection will need time to embed. Management at CUHG and SSWHG should ensure that the restructured governance structures function as intended to ensure there is sufficient and effective oversight of the quality and safety of the healthcare services provided in CUH. The implementation and effectiveness of agreed actions, identified to improve the quality and safety of healthcare services in CUH, need to be monitored by a number of governance committees at CUH and CUHG levels.

CUH had effective management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm. Notwithstanding this, limited availability of suitable beds in the community, impacted on the ability to transfer patients from CUH, which resulted in a number of patients experiencing a delay in their transfer of care. This, together with increased attendances to CUH's emergency department, higher ALOS and limited inpatient surge capacity impacted on

patient flow and contributed to the boarding of admitted patients in CUH's emergency department.

CUH had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. Information from this process was being used to improve the quality and safety of healthcare services and patients' experiences of receiving care at CUH. However, there is scope for improving the governance and oversight of the auditing activity occurring in CUH so as to assure hospital management and patients about the quality and safety of clinical services provided at CUH.

This inspection identified there were shortfalls in staffing numbers when compared to agreed complements across key healthcare professionals. Since HIQA's last inspection, CUH's emergency department had gained an additional two WTE consultants in emergency medicine and four WTE NCHDs at registrar and SHO grades. While there was also an uplift of nursing staff in the department, shortfalls in medical and nursing staff persisted. Improved staffing enabled some operational and clinical efficiencies to be achieved in the emergency department. It is imperative that these gains are built on and further efficiencies are gained from any resulting reorganisation of work practices in the emergency department.

Staff shortfalls was also found at wider hospital level. Service safety was being maintained through agency staff and there was added burden of responsibility and workload for pre-existing staff. This is a far from an ideal situation that hospital management were aware of and were working to address. Notwithstanding this, hospital management need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are contingencies in place to ensure that CUH can meet the demand for healthcare services. It is also essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

Staff in CUH promoted a person-centred approach to care and were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. Inspectors observed staff being kind and caring towards people using the service. In the main, patients who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff. Patients' personal information was not stored appropriately at all times. Hospital management needs to ensure that there are effective systems and processes in place to ensure compliance with relevant data protection legislation.

CUH did not have effective and robust systems and processes in place to respond to complaints and concerns raised by people using the healthcare service. Hospital management should appoint a designated complaints officer to be the point of contact for patients and or families who want to make a complaint or raise a concern about the care

received in CUH. Information on CUH's complaints process and on how to access independent advocacy services should be accessible to patients and their families.

The physical environment in CUH did not fully support the delivery of high-quality, safe care. There was a shortage of isolation facilities in CUH. Transmission-based precautions were not being applied in line with current best practice infection prevention and control guidance and standards. This was the subject of further assurances sought from the CUHG's CEO after inspection. Inadequate storage facilities for equipment was an issue in all clinical areas visited. Collectively, these issues presented a potential risk to patient safety during the inspection.

CUH used information from monitoring and auditing activities to improve practices in relation to the infection prevention and control, medication safety and compliance with early warning systems. However, auditing of medication practices could be strengthened and improved in CUH. Environmental hygiene standards in all clinical areas visited during this inspection were not compliant with the HSE's targets and this seems to be an area of continual underperformance, which requires focused improvement following this inspection.

CUH had systems and processes in place to identify and manage the potential risks associated with the four areas of known harm. However, there was scope for improvement in this area. There was evidence of some improvement in PETs since HIQA's last inspection, but the PETs in the emergency department at time of this inspection continues to expose patients in the department to a higher level of risk and harm.

CUH had a system in place to identify, report, manage and respond to patient-safety incidents. Nonetheless, the oversight and monitoring of the implementation of recommendations from the review of patient-safety incidents and sharing of learning is an area requiring improvement.

While there was evidence of progress and commitment by the hospital management to achieve efficiencies and improvement in the emergency department, substantive improvements to ensure compliance with the national standards is needed in CUH. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring CUH into full compliance with the *National Standards for Safer Better Healthcare*.

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 11 national standards assessed during this inspection of CUH 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 standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital 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 hospital's 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.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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.	Partially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
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.	Non-compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Non-compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant

Quality and Safety Dimension	
Theme 3: Safe Care and Support	
National Standard	**Judgment**
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.	Partially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for Cork University Hospital

Compliance Plan Service Provider's Response

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:
(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

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

Medium Term

1. Hospital Management will continue to implement and embed the agreed governance restructuring that is currently ongoing in CUH. Monthly updates with be provided to the CUHG Executive Management Board on progress to ensure implementation. ***(In-Progress)***

2. All Clinical Governance committees to develop Quality & Patient Safety dashboards to be monitored at their monthly/bi-monthly meetings ***(In-Progress)***

Short Term

1. The minutes of all CUH committee's meetings (which includes the Infection Prevention & Control committee, the Drugs & Therapeutics Committee, the Steering Committee for the Acutely Unwell Adult Patient, the Unscheduled Care Programme Board) will be recorded in the agreed CUH minutes template that includes an Action /QIP tracker log that ensures actions:

(a) are monitored from meeting to meeting until implemented/completed
(b) are time bound /have clearly defined timelines
(c) have persons assigned with the responsibility to implement the actions /QIP
(In-Progress)

2. CUH to establish a Transitions of Care Committee with responsibility to oversee the safe transitions of care for patients within and from CUH ***(In-Progress)***

3. The terms of reference of the Unscheduled Care Programme Board to be revised to clearly identify the frequency and method of reporting to the EMB and regional governance group.

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Short to Medium Term

1. Audit activity

(a) CUH's newly established multi-disciplinary Clinical Audit Committee in conjunction with CUH Quality Manager have responsibility for the coordination, management and oversight of clinical auditing at CUH. Clinical Audit Committee Terms of Reference to be agreed. ***(In-progress)***

(b) Audit activity to be a standing agenda item on all clinical governance committees monthly/bimonthly meetings. ***(In-progress)***

(c) CUH's current Clinical Audit PPG to be reviewed, updated and circulated to staff ***(In-progress)***

2. Quality Improvement Initiatives/Plans - Standardised system and process to track and monitor the implementation of all hospital quality improvement plans currently in development to be completed and rolled out hospital-wide. ***(In-progress)***

3. Progress the recruitment of vacant approved posts in the Quality & Patient Safety department

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Long Term

1. Further development of CUHG's Human Resource department to support recruitment and workforce development. ***(In-progress)***

2. Documented staffing contingency plans to be developed and implemented to ensure that the CUH can meet the demand for healthcare services

Short to Medium Term

1. Ongoing recruitment for unfilled professional posts in CUH ***(In-progress)***

2. Mandatory training needs assessment to be completed for all CUH staff. Training schedules to be revised and agreed to address training needs identified.

3. Implement centralised electronic system (QPulse) to capture and monitor mandatory training ***(In-progress)***

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:
(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

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

Long Term

1. Capital restructuring of Cork University Hospital as per Archus report. **(10-year plan)**

2. Further development of the Patient Advocacy Liaison Service (PALS), including the recruitment of additional PALS coordinators to maintain awareness of the primacy of the patient throughout the Hospital in relation to all hospital activities. Investment paper submitted to SSWHG and National HSE

Medium Term

1. Non admitted PETs (patient experience times) improvement project currently supported by EMB. This project involves:

(a) Infrastructure review of Emergency Department Rapid Assessment Streaming Triage Treatment Area (RASTTA) A/B to improve Service users' dignity, privacy and autonomy

(b) Initiative that 5 ED POD's are committed to being available to the ED medical teams to deliver individual patient care and communication

(In-progress)

2. CUH Volunteer programme to be progressed. **(In-progress)**

3. Reconfiguration of the Acute Medical Assessment Blackwater Suite to increase ambulatory assessment and treatment capacity from 8 – 12 spaces. **(In-progress)**

Short Term

1. CUH Patient Experience & Engagement committee being established. Terms of Reference to be agreed **(In-progress)**

2. Policy to be developed, approved and implemented regarding the accommodation of patient in mixed gender wards. Policy to include the requirement for the completion of risk assessments.

3. Mandatory training schedules to include the requirement of all staff to complete GDPR - The Fundamentals module on HSEland

4. Review of Whiteboard's privacy gaps currently being undertaken and corrective measure being implemented **(In-progress)** **5.** Children's Emergency Department development (to facilitate the delivery of emergency care to children) **(due completion Dec'23)** **6.** Second family/interview room for Acute Floor being built as part of the Children's Emergency Department upgrade. **(due completion Dec'23)** **7.** The Bandon Suite (Medical/Infection control) is currently being upgraded to enhance and support the delivery of care to patients by increasing treatment capacity from 8 - 10 spaces. **(In-progress)**
Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Medium Term

1. Recruitment of Complaint officers. Investment paper submitted to SSWHG and National HSE

2. Standardised system and process to track and monitor the implementation of complaints feedback / recommendations and sharing of learning currently in development to be completed and rolled out hospital-wide. ***(In-progress)***

3. System to be developed to capture verbal complaints at point of contact so as to ensure trending, learning and quality improvement opportunities

Short Term

1. CUH Quality, Safety & Risk committee and Patient Experience & Engagement committee terms of reference to include responsibility for CUH's compliance with HSE targets relating to complaints management **(In-progress)**

2. Audit of CUH's complaints resolution process to be conducted

3. Quality Assurance checklist to be developed for all written complaint responses **(In-progress)**

4. Information campaign to be rolled out to patient and families on CUH's complaints process and how to access independent advocacy services. CUH website will be continuously updated to ensure that patients have the most relevant information on how to make a complaint.

5. Additional Information for patients and families to be displayed in all patient and family areas

6. QPS lead for 3 of the 6 clinical directorates to be in post to assist with CUH's Complaints process **(In-progress)**

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

National Standard	Judgment

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Long Term

1. Capital restructuring of Cork University Hospital as per Archus report. **(10-year plan)**

2. Hospital Management to ensure any further capital development work includes additional isolation rooms /facilities

Medium Term

1. Risk assessments to be completed in all clinical areas in relation to storage facilities

2. Risk assessments to be completed in all clinical areas where adequate physical distancing in line with National Clinical Guidelines cannot be maintained

3. Facility improvement works being undertaken in ED which includes additional patient/family room, additional storage, sluice room and additional patient treatment areas. **(In-progress)**

Short Term

1. Continue CUH Environmental auditing programme, that includes:

(a) identification of areas or items that do not facilitate effective cleaning and posed an infection prevention and control risk,

(b) immediate actioning of non-compliances

(c) Oversight and monitoring of QIP's at CUH's Infection Prevention & Control committee

(In-Progress)

2. Written risk assessment are required to be completed where patients who require transmission based precautions cannot be accommodated in an isolation room. Cumulative reports are to be presented to the IPCC **(In-Progress)**

3. Gap analysis currently being completed against the National Clinical Guideline No. 30. QIP's identified:

(a) are monitored from meeting to meeting until implemented/completed

(b) are time bound /clearly defined timelines

(c) have persons assigned with the responsibility to implement the action/QIP ***(In-Progress)***

4. Formal auditing of PPE adherence is now being undertaken in COVID19 outbreak wards **(In-Progress)**

5. The Bandon Suite (Medical/Infection control) is currently being upgraded to enhance and support the delivery of care to patients by increasing treatment capacity from 8 - 10 spaces. **(In-progress)**
Timescale: Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Short to Medium Term

1. Continue to monitor and improve CUH's PETs in the Emergency Department through their tracking and trending at Unscheduled Care Programme Board and the Unscheduled Care Morbidity & Mortality group.

2. CUH's Morbidity & Mortality Committee being established. Terms of Reference to be agreed **(In-Progress)**

3. CUH Quality & Patient Safety department and currently upgrading the electronic Document Control & Management system (Q-Pulse), resulting in greater oversight and ownership of all PPPG's and associated documents. The project involves:

(a) a full review of CUH PPPG's and associated documents to ensure the correct ownership and authors have been assigned

(b) The project will also result in line manager's /department heads and clinical governance committees receiving reports on document activity for their area's and allow them to focus on areas that need attention.

(c) An user friendly new Q-Pulse platform will also be rolled out to allow all staff easier and quicker access to all hospital documents and PPPG's.

(d) Training will be provided to all staff on the 'new' version of Q-Pulse.

(This project is due to be completed by year end and will be fully rolled out by March 2024)

4. Ongoing availability of flu vaccine and promotion campaign for all CUH staff **(In-Progress)**

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

Long Term

1. Bring reporting rates for incidents in line with national rates for similar sized hospitals.

2. Implementation of Electronic Point of Entry (EPoE) reporting of incidents.

Medium Term

1. Review of non-compliance with National Incident Management System (NIMS) KPI's to be undertaken, actions identified and implemented, and oversight provided on QPS dashboard report at individual Clinical Governance Committees and Quality, Safety & Risk Committee.

2. Standardised system and process to track and monitor the implementation of recommendations and learning from SREs and Serious Incidents currently being developed to be completed and rolled out hospital-wide. **(In-progress)**

Short Term

1. Incidents relating to deteriorating patient and transitions of care will be tracked and trended by the Quality, Risk & Patient Safety Department

2. Further roll out of hospital-wide training for incident reporting and completion of NIRF forms.

Timescale:

Short term – within 3 months | Medium term – within 6 to 12 months | Long term – within 3 years