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:	Portiuncula University Hospital
Address of healthcare service:	Dunlo Ballinasloe Co. Galway H53 T971
Type of inspection:	Announced
Date(s) of inspection:	9 and 10 May 2023
Healthcare Service ID:	OSV-0001033
Fieldwork ID:	NS_0041

About the healthcare service

Model of Hospital and Profile

Portiuncula University Hospital is a model 3[*] public acute hospital. It is a member of and is managed by the Saolta University Heath Care Group.[†] The hospital provides acute surgery, acute medicine, critical care and emergency services to adults and children and maternity services. The hospital's catchment areas include East Galway, Westmeath, North Tipperary, Roscommon and Offaly.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	157 inpatient beds 17 day care beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the National Standards for Safer Better Healthcare as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

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

[**] A Model 3 hospital is a hospital that admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine, and critical care.

[†] The Saolta University Health Care Group comprises six hospitals. These are University Hospital Galway and Merlin Park University Hospital, Sligo University Hospital, Letterkenny University Hospital, Mayo University Hospital, Portiuncula University Hospital, Roscommon University Hospital. The Hospital Group's Academic Partner is the National University of Ireland Galway (NUI Galway).

[‡] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how the service performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
9 May 2023	09:00hrs.– 17.00hrs	Nora O' Mahony	Lead
		Patricia Hughes	Support
10 May 2023	09:00hrs.– 16.45hrs	Aoife O' Brien	Support

Information about this inspection

An announced inspection of Portiuncula University Hospital was conducted on 9 and 10 May 2023.

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

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

[§] The 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*

The inspection team visited three clinical areas:

- emergency department
- St Joseph's ward
- St Francis's ward

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

- representatives from the Hospital Management Team
  - General Manager (GM)
  - Assistant General Manager (AGM)
  - Director of Nursing (DON)
  - Associate Clinical Director (ACD) Peri-operative
- the Quality and Patient Safety Manager
- representatives for the non-consultant hospital doctors (NCHDs)
- the Human Resource Manager and the Medical Manpower Manager
- representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Deteriorating Patient Improvement Programme
  - Patient Flow Team.

Acknowledgements

HIQA would like to acknowledge the co-operation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of the service.

What people who use the emergency department services told inspectors and what inspectors observed in the department

On the day of inspection, inspectors visited the emergency department (ED) of Portiuncula University Hospital. The ED provided 24/7 access for undifferentiated emergency and urgent presentations for adult and paediatric patients. The ED was divided into two departments- ED1 and ED2. The ED1 was the main emergency department area. ED2 was the respiratory emergency department, in which all patients with respiratory symptoms, particularly suspected or confirmed COVID-19 were cared for.

Primary Care. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

Attendees to the emergency department were referred directly by a general practitioner (GP), were self-referred or arrived by ambulance. The hospital had defined pathways in place for paediatric and obstetric patients.

The emergency department had a total planned capacity of 13 treatment areas in ED1 and five treatment areas in ED2 (respiratory). In ED1 there was also a minor injury room with two treatment areas and a psychiatric assessment room.

ED1 comprised of :

- One triage room and one triage bay
- six single cubicles
- a resuscitation room comprising of two treatment areas
- two single treatment rooms (one designated for gynaecological assessments)
- a negative pressure isolation room[‡‡] comprising of an ante room[§§] and en-suite facilities
- a paediatric room comprising of two treatment areas
- a psychiatric assessment room
- a minor injury room comprising of two treatment areas.

ED2 (respiratory) comprised of:

- a triage area
- a resuscitation area
- two single treatment rooms (no ensuite)
- a two-bay treatment room (no ensuite).

There were five toilets in the emergency department for patients' use. Three toilets were beside the ED waiting area and two toilets with shower facilities were within the ED1 area. There were no patient toilets in the ED2 area.

There were two separate waiting areas for ED1 and ED2. The ED1 waiting area had 16 chairs and the ED2 waiting areas had eight chairs.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available throughout the ED with hand-hygiene signage clearly displayed. Staff were observed wearing appropriate personal protective equipment in line with the public health guidelines at the time of inspection.

On the day of inspection, the ED was observed to be busy, relative to its intended capacity. Inspectors observed that all cubicles and the isolation room were occupied, and

[‡‡] Negative pressure rooms refer to isolation rooms where the air pressure inside the room is lower than the air pressure outside the room. Therefore, when the room door is opened, potentially contaminated air or dangerous and infective particles from inside the room will not flow outside to non-contaminated areas.
[§§] Anteroom, 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.

admitted patients were accommodated on trolleys on the ED1 corridors. A patient requiring isolation was also accommodated in the psychiatric assessment room.

Inspectors observed staff actively engaging with patients in a respectful and kind manner. Staff were respectful and considerate in their interactions with each other.

Inspectors spoke with a number of patients in the emergency department about their experience of the care. Overall, patients were complimentary about the staff and the care they had received. When asked what had been good about the care in the ED so far patients commented that *'staff are lovely', 'nurses are nice'.* One patient complimented the cannulation skills of the staff '*getting IV access is often difficult for me'* another commented that *'everything looks clean, including toilets.'* All patients did say that staff were '*run of their feet*' and '*doing their best'.*

When asked if anything could be improved about the service or care provided, patients accommodated in the ED corridor overnight awaiting an inpatient bed did comment about the difficulty sleeping as '*lights were on' 'very noisy' 'trolley uncomfortable,* One patient did refer to their location outside the toilet entrance, commenting that it was '*not pleasant.'*

Inspectors observed staff promoting and protecting patients' privacy and dignity. For example, curtains were pulled to ensure privacy and dignity when patients were being clinically assessed and having treatment administered. Patients' also spoke of how staff attempted to protect and promote their privacy and dignity and outlined how examinations or treatments were undertaken in cubicles or treatments rooms.

Their experience was consistent with the hospital's findings from the 2022 National Inpatient Experience Survey.*** When survey participants were asked if they were given enough privacy when being examined or treated in the emergency department the hospital scored 8.7, higher than the national average of 8.1.

Patients who spoke with inspectors did not know how to make a formal complaint, but informed inspectors that if they did wish to make a complaint they would speak to a member of staff or check on the hospital's website. Information leaflets on how to access the hospital's patient advice and liaison service were available within the department.

Overall, there was consistency with what inspectors observed in the emergency department, what patients told inspectors about their experiences of care in the department and the findings from the 2022 National Inpatient Experience Survey.

*** The National Care Experience Programme, is 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 findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

Capacity and capability dimensions

Findings from national standards 5.2 and 5.5 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital. Inspection findings from the emergency department related to the capacity and capability dimension are presented under national standard 6.1 from the theme of workforce.

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

Inspectors found that that Portiuncula University Hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. The hospital was governed and managed by the General Manager who reported to the Chief Operations Officer of the Saolta University Health Care Group.

The Associate Clinical Directors (ACDs) provided clinical oversight and leadership for the five hospital Directorates- Medical, Peri-operative, Women and Children's, Laboratory, and Radiology. The ACDs reported to the General Manager through the Hospital Management Team but were also accountable to their relevant Saolta University Health Care Group Clinical Director.

The Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital. The DON reported to the General Manager locally and to the Chief DON at Group level.

Hospital Management Team

Portiuncula University Hospital Management Team (HMT) was responsible for providing governance for the management and planning of hospital services. The committee was chaired by the hospital's General Manager and met monthly. There was good attendance at meetings by required members. Meetings followed a structured format, they were action orientated, and progress on implementation of actions was monitored from meeting to meeting. The committee's terms of reference was overdue for review. Members of the HMT were accountable to the Saolta University Health Care Group CEO and Executive Council through the General Manager.

Each Directorate[†††] reported to the HMT through formal structured reports, as did the quality and safety department, human resources, information technology, nursing and

[†††] Medical (including ED), Perioperative, Women & Children, Radiology and Laboratory.

clinical support services and estates. The HMT reported to the Saolta University Health Care Group at alternative monthly performance meetings. The Portiuncula University Hospital Management Team provided effective overall governance for the hospital.

Quality and Safety Governance Group

The Quality and Safety Governance Group was the main committee assigned with overall responsibility to develop, implement and evaluate the quality and safety programme at the hospital. The committee was chaired by the General Manager and met quarterly with good attendance from most required members- with some exceptions. The hospital should review attendance of core members at meetings and support required members to attend.

The Quality and Safety Governance Group provided updates on the hospital's and departmental risk registers, reported on patient-safety incidents, complaints and compliments, provided feedback on the patient experience survey and provided updates on the progress of implementation of national and hospital quality improvement plans. The Quality and Safety Governance Group provided effective oversight for the quality and safety of healthcare services at the hospital.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control Committee provided effective oversight of infection prevention and control and antimicrobial stewardship at the hospital. The committee met quarterly and was chaired by the General Manager. Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA were well attended by required members, meetings followed a set agenda with feedback from relevant subcommittee. Actions were assigned to a responsible person, with progress followed from meeting to meeting.

The Infection Prevention and Control Committee was operationally accountable and submitted quarterly reports to the Quality and Safety Governance Group who in turn reported to the Hospital Management Team. The Infection Prevention and Control Committee at the hospital also reported to the Saolta University Health Care Group Infection Prevention and Control Committee on a quarterly basis. HIQA was satisfied with the governance and oversight of infection prevention and control, antimicrobial stewardship and infection outbreaks at the hospital. The infection prevention and control risk register was reviewed by the IPC committee and the Quality and Safety Governance Group.

Drugs and Therapeutics Committee

The hospital had a Drugs and Therapeutics Committee with responsibility for the governance and oversight of medication safety practices at the hospital. The committee was co-chaired by a consultant anaesthetist and chief pharmacist and met monthly. The committee was operationally accountable and reported to the Hospital Management

Team. The committee was action orientated with actions assigned to a responsible person and progressed from meeting to meeting.

The medication safety programme in the hospital was further enhanced by the Medication Safety Committee which was chaired by a consultant in emergency medicine and reported to the Drugs and Therapeutics Committee. This committee met quarterly and progressed medication safety issues such as audit and monitoring of medication safety, medication safety incident review and actions to mitigate a reoccurrence, updating of the hospital's medication prescribing and administration record and providing medication safety education and training. The committee provided a comprehensive quarterly report to the Drugs and Therapeutics Committee. Medication safety was an agenda item at the HMT and the Quality and Safety Governance Group meetings and the quarterly reports were provided to these committees.

Deteriorating Patient Improvement Programme (incorporating Sepsis)

The hospital had a deteriorating patient improvement programme.[‡‡‡] The Deteriorating Patient Improvement Programme Governance Group had appropriate oversight of the implementation of early warning systems[§§§]relevant to the hospital[****] and the National Clinical Guidelines –Sepsis Managements for Adults (including maternity) and Management of Septic Shock and Sepsis Associated Organ-dysfunction in Children at the hospital.

The committee provided updates to governance groups such as the Paediatric, Intensive Care and ED Clinical Operational Groups to support the management of the deteriorating patient.

The committee was chaired by a consultant physician with membership including senior management and clinicians. Minutes of meetings reviewed showed that meeting were held quarterly. The quorum of required members was not always achieved, this should be reviewed.

The terms of reference provided to HIQA were in draft with a final review by committee members planned. There was some inconsistency between the terms of reference and minutes reviewed by HIQA and this should be reviewed and finalised following this inspection.

[‡‡‡] The National Deteriorating Patient Improvement Programme (DPIP) is a HSE priority patient safety programme using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.

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

[****] The Irish National Early Warning System (INEWS), the Irish Maternity Early Warning Systems (IMEWS) and the Paediatric Early Warning systems (PEWS) were used in Portiuncula University Hospital to support the recognition and response to a deteriorating patient

Patient flow Team

The hospital's patient flow team held monthly meetings to review patient flow objectives, risks and incidents. These meetings were action orientated with assigned persons responsible for actions. Members of the hospital's patient flow team attended the monthly Saolta University Health Care Group monthly Unscheduled Care Group meetings to review performance, discuss challenges and actions required to support patient flow for example, patients awaiting transfer to a model 2 or model 4 hospital within the group were discussed. Patient flow issues were also discussed at the ED Clinical Operational Group and Directorate meetings

Overall, the hospital had integrated corporate and clinical arrangements in place which were appropriate to the size, scope and complexity of the services provided. These governing arrangements had defined roles, accountability and responsibility for assuring the quality and safety of services provided. Senior management and clinicians at the hospital had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital.

The hospital should review and finalise the terms of reference of the Deteriorating Patient Committee and align the terms of reference with the meeting structure.

Judgment: Substantially compliant

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

Findings relating to the emergency department

HIQA was satisfied that the hospital had effective management arrangements in place to support and promote the delivery of emergency care in the hospital. There was evidence of strong clinical leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the on-site consultant in emergency medicine supported by non-consultant hospital doctors.

The Emergency Department Clinical Operational Group was set up in January 2023 to oversee the governance activity in the ED. The committee's membership was multidisciplinary and included emergency department consultants, non-consultant hospital doctors, nurses, the General Manager, the Quality and Patient Safety Manager and representatives from patient flow, the frailty team, the radiology department, the information technology department and the laboratory. The group met monthly, had a structured agenda which included items such as ED activity, key performance indicators, overcrowding, the risk register, incidents and complaints, staffing, information technology,

diagnostics and housekeeping. Ongoing issues were also discussed such as security, paediatric relocation, and new ED build, psychiatric patient in ED and ICU admissions from ED. The Emergency Department Clinical Operational Group effectively managed the ED.

The emergency department was under the clinical governance and oversight of the Medical Directorate led by the Associate Clinical Director for Medicine. The committee met monthly and was attended by senior management, consultants from the medical directorate including consultants in emergency medicine, the Quality and Patient Safety Manager and the Medical Manpower Manager. Patient flow issues were discussed and actions identified were progressed. The committee provided effective oversight and governance for the ED.

An ED medicine consultant, the Assistant Director of Nursing (ADON) for patient flow and the Quality and Risk Manager met monthly to review and manage ED related incidents. All complaints related to the ED were reviewed and managed by an ED medicine consultant, the Clinical Nurse Manager (CNM) 3, the ADON patient flow and the Complaint's Officer.

On the first day of inspection, management at the hospital stated that it was in escalation,[††††] and the General Manager outlined the additional actions taken to support patient flow in line with hospital policy.

On arrival to the emergency department, all attendees were promptly assessed for signs and symptoms for COVID-19 and streamed to the most appropriate care pathway, in line with national guidance.

At 11am on the first day of inspection, there were 31 patients in the emergency department, 14 of these patients were admitted under the care of specialist consultants and accommodated in the ED while awaiting an inpatient bed. The inpatients were managed by the Inpatient Clinical Nurse Manager 2 and cared for by two ED nurses with an additional ED nurse providing assistance as required. Ten of the admitted patients were in the department over nine hours and two admitted patients were in the department over 24 hours. The average wait time from arrival in the department to decision to admit was 6.7 hours (range 3 to 11 hours), the average wait for an inpatient bed since decision to admit was 14 hours (range 3 to 61 hours).

The remaining 17 emergency department patients were all in the department under six hours. The average time waiting from registration or triage was 10 minutes, in line with the 15 minutes triage time recommended by the HSE's emergency medicine programme. The majority of these ED patients (70%) had been reviewed by an ED doctor. The average wait time from referral to review by a specialist team was from 20 minutes to 3 hours.

At 11am on the day of inspection the ED was managing the ED patients well, however the lack of hospital capacity resulted in the accommodation of 14 admitted patients in the ED with eight patients accommodated on corridors which was a thoroughfare for all emergency department traffic.

[††††] A hospital's escalation policy, sets out (within the parameters of the national framework) the key stages of steady state, escalation, full capacity protocol, de-escalation and review

The lack of information technology facilities in the ED was identified as a risk in the ED risk register. Patient's status and location in the department was tracked manually by staff on the ED's whiteboard. All ED patients' status was denoted by different colour stickers - yellow for adult patients, green for paediatrics patients and red for admitted adult patients. The progress of each patient's journey was updated on the whiteboard, such as medical review completed or referred for specialist review.

In 2022, the overall attendance rate at the hospital's emergency department was 29,788, which equated to an average attendance rate of 2,482 per month or an average of 80 attendances every day. There had been a 12% increase in ED attendance since 2019 when there was 26,594 attendances (pre pandemic). The daily attendance rate to the ED was steadily increasing and on the days of inspection there had been between 104 and 116 daily attendees to the ED. The number of attendances at the ED was lower than other model 3 hospitals, but the hospital inpatient bed capacity was also lower than most model 3 hospitals.

In 2022, an average of 22.6% of people who presented to the ED were admitted to the hospital (conversion rate), this percentage compared well to other model 3 hospitals inspected by HIQA. On the day of inspection, inspectors were informed that the conversion rate year to date was 28%.

The average length of stay (ALOS) for patients in 2022 was compliant with national targets. Medical patients ALOS was 6.1 (national target ≤7.0) and surgical patients ALOS patients was 3.5 (national target 2022 ≤5.6). On the day of inspection the ALOS for medical patients was 15 days, which was higher than the national target and the ALOS for surgical patients of 6, higher than 2023 national target of less than or equal to 5.0. Hospital management attributed the higher lengths of stay for medical patients to the increase in the number of patients aged 75 years and over requiring admission with complex medical needs and delays in transfer to alternate levels of cares (model 2 or 4 hospitals) due to lack of available inpatient beds in those hospitals.

At the time of inspection, there were five patients in the hospital who had completed their acute episode of care and were experiencing a delay in the transfers of care (DTOC)[‡‡‡‡] to the community, this number compared well to other model 3 hospitals. A bed utilisation study carried out in March 2023 by Saolta University Health Care Group commended the hospital, as on the day of the study there was no delays to patient flow.

The hospital had systems and processes in place to support continuous patient flow through the emergency department, the hospital and onto the community which are outlined below:

- A review of the hospital's status was held daily Monday to Friday at 9am and 12.30pm. The 9am review was attended by senior managers, patient flow team, Clinical Nurse Manager (CNMs) (ward and ED) and the Patient Advice and Liaison

[‡‡‡‡] Delayed transfers in care: A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred.

Service (PALS) Coordinator to identify any actions to supports patient flow. At 12.30pm scheduled care requirements for the following day were reviewed and risk assessed against the demand for inpatient beds, the available beds and the ED activity. All available resources (staff and clinical areas) were reviewed and utilised to facilitate ongoing scheduled care. When demand exceeded capacity, non-urgent cases were postponed in consultation with the primary consultant, to facilitate the use of St Clare's day ward area to accommodate admitted patients until a ward bed was available.

- Daily structured whiteboard[§§§§] rounds were held on inpatient wards with the ward CNM's, the Discharge Coordinator and Health and Social Care Professionals (HSCPs) to support any actions to progress each patient's journey in accordance with the SAFER[*****] patient flow bundle.
- A discharge lounge was operational four days per week and accommodated four patients to free up beds for new admissions. Inspectors were informed that the discharge lounge operated very effectively.
- The inpatient coordinator tracked the number of patients awaiting alternative care in model 2 or 4 hospitals and liaised with these hospitals.
- The hospital held weekly integrated discharge meetings with integrated discharge colleagues from the community.
- The hospital held weekly meetings to discuss patients who had delayed transfers of care with the ADON for patient flow and the Discharge Coordinator.
- The hospital reviewed in-patients with length of stay over 14 days with participating consultants HSCP's, ward CNMs, AGM or GM and the Discharge Coordinator to identify and action any supports to progress the patient's journey.

The following was in place to support patient flow through the ED:

- ED consultant led review of all ED patients at 8am, 11am and 3pm to discuss the plan of care and progress outstanding diagnostics or results to support a decision to discharge and admit.
- Pathways of care such as 'deep vein thrombosis pathway' were in place to support admission avoidance.

[§§§§] A whiteboard which staff update the patients detail such as name, consultant, predicted date of discharge.

[*****] The SAFER patient flow bundle is a practical tool comprising five elements to reduce delays for patients in adult inpatient wards (excluding maternity). S - Senior Review - all patients have a senior review by a consultant or by a registrar enabled to make management and discharge decisions. A - All patients have a predicted discharge date. F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. E - Early discharge - patients discharged from inpatient wards early in the day. R – Review - a systematic multidisciplinary team review of patients with extended lengths of stay.

- Consultants in emergency medicine held daily review clinics for approximately 5-8 patients.
- The frailty at the front door services reviewed and assessed patients over 75 years (or over 65 years if suitable) to support admission avoidance or early discharge. The team liaised closely with the Integrated Care Programme for Older Persons[†††††] and Community Intervention Team,[‡‡‡‡‡] public health nurses and services such as Alone and Age Action to provide community supports and services for this older population. The Frailty team reported to the ED Clinical Operational Group. The team was multidisciplinary and included a: clinical nurse specialist, physiotherapist, occupational therapist, healthcare assistant and clerical support. A 0.5 whole-time equivalent[§§§§§] (WTE) registrar and consultant had recently joined the team.
- A minor injury unit was staffed by advanced nurse practitioners[******] (ANP) 7/7.
- Two radiographers were on call to facilitate access to emergency diagnostics in a timely manner.
- There was a Hospital Ambulance Liaison Person on site in ED part time (employed by National Ambulance Service (NAS) and meetings were held between the NAS link for PUH, the ADON for patient flow, the hospital's General Manager and the Assistant General Manager to discuss improvement measures.

The hospital had some short, medium and long-term plans in place to address the challenges with the ED infrastructure, the inpatient capacity and the lack of isolation facilities within the hospital. The implementation of these plans should support patient flow through the ED and included:

- a 12 -bedded ward, with 8 single en-suite rooms, expected to be operational in quarter three 2023
- a 50-bedded replacement block with additional isolation facilities currently under construction, expected to be operational quarter 4 2024
- a new ED modular build specification with additional capacity sent to national estates for capital funding approval.

[†††††] Health Service Executive. Integrated Care Programme for Older Persons. Dublin, Health Service Executive. 2022. Available online from: https: https://www.hse.ie/eng/about/who/cspd/icp/older-persons/

[‡‡‡‡‡] Community Intervention Team (CIT) is a specialist, health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services/acute intervention for a defined short period of time at home, in a residential setting or in the community, thereby avoiding acute hospital attendance or admission, or facilitating early discharge

[§§§§§] Whole-time equivalent - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

[******] Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

The hospital had 13 single rooms, many without en-suite facilities, and the demand for isolation facilities largely outweighed the hospitals isolation capacity. This impacted on the wait time for admitted patients to be transferred from the ED to an inpatient bed. For example, on the day of inspection one patient was accommodated on a trolley in the isolation room in the ED for over 60 hours due to lack of appropriate inpatient isolation facilities. The lack of isolation facilities was recorded in the hospital's risk register and escalated to group and HSE levels. In response, at the time of inspection, the hospital was well advanced with plans to open a 12 -bedded ward with 8 en-suite single rooms in quarter three of 2023.

Findings relating to the wider hospital and other clinical areas

The hospital had management arrangements in place in relation to the four areas of known harm: infection prevention and control, medication safety, the deteriorating patient and transitions of care which were the focus of this inspection and are discussed in more detail below.

Infection, prevention and control

The hospital had an overarching infection prevention and control (IPC) programme as per national standards.[††††††] The hospital's antimicrobial stewardship (AMS) team were responsible for implementing the hospital's antimicrobial stewardship programme.[‡‡‡‡‡‡] The IPC and AMS teams worked closely, held joint meetings and developed a joint annual report.

The IPC team comprised of 0.5 WTE antimicrobial stewardship pharmacist, 0.6 WTE consultant microbiologist, 1 WTE surveillance scientist, an infection prevention and control clinical nurses specialist and an IPC Clinical Nurse Manager 2. At the time of inspection, due to planned leave there was only 0.3 WTE consultant microbiologist cover. The consultant microbiologist was only on site three days per month at the time of inspection. Inspectors were informed that microbiology advice was available from Galway University Hospital 24/7.

The joint annual infection prevention and control and antimicrobial stewardship report outlined the achievements and workload undertaken in the previous year which included– surveillance and screening undertaken, national metrics monitored, antimicrobial stewardship activity, management of outbreaks, consultation on building works, education provided, policies, procedures and guidelines reviewed and audits completed. The infection prevention and control team had developed an infection prevention and control

[††††††] National Clinical Effectiveness Committee. National Clinical Guidelines. Draft Guidance on Infection Prevention and Control. 2022. Available on line from: ncec-ipc-guideline-2022-for-consultation.pdf (hse.ie)

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

plan that set out objectives to be achieved in relation to infection prevention and control in 2023.

Medication safety

The hospital's pharmacy service was led by the hospital's chief pharmacist. At the time of inspection the hospital had 13 WTE pharmacists in post, with five new approved WTE posts vacant. There was ongoing recruitment to fill the vacant posts but the hospital highlighted a current difficulty recruiting pharmacists with no applicants applying for current vacancies. The hospital should continue recruitment to fill vacant pharmacist posts to support medication safety.

The hospital was using the current pharmacist resources to provide a clinical pharmacy service[§§§§§§] to the paediatrics and maternity units, intensive care and chemotherapy services. A clinical pharmacy service was also provided to each of the four inpatient wards, although not full time on all wards:

- St Joseph's ward – 9am to 2pm Monday to Friday
- St Francis's ward – 9am to 5pm Monday to Friday
- St Johns ward – 9am to 5pm four days a week
- St Clare's ward – 9am to 5pm three days a week

The clinical pharmacy service included a clinical review of all prescribed medicine and medicines reconciliation on admission and on discharge when possible.

Deteriorating patient

The hospital's had a designated consultant lead for each of the early warning systems[*******] in use in the hospital, supported by the hospital's INEWS, PEWS and Sepsis Nurse Lead. A group level ADON for sepsis and the deteriorating patient supported the hospital's implementation and ongoing monitoring of sepsis and the deteriorating patient. The hospital had implemented INEWS version 2 and $ISBAR_3$[†††††††] in line with national guidance.

Transitions of care

HIQA was satisfied that the hospital had arrangements in place to monitor issues that impacted safe transitions of care. The hospital's Inpatient Coordinator, Discharge Co-

[§§§§§§] 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.
[*******]Early warning scores are used in acute hospitals settings to support the recognition and response to a deteriorating patient: Irish National Early Warning System (INEWS) (adults), Irish Maternity Early Warning Systems (IMEWS) for use on all women who are currently pregnant or who have given birth or had a miscarriage within the previous 42 days and the Paediatric Early Warning systems (PEWS) (children).
[†††††††]ISBAR: Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.
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ordinator and the ADON for patient flow had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital. Inpatient bed capacity, patient discharge and transfers into and out of the hospital were discussed at daily reviews held in the hospital at 9am and 12.30 and at 3pm when the hospital was in escalation.

To support patient flow the hospital held a weekly multidisciplinary team meeting to review and progress the plan of care for each patient and a weekly review of all patients with a length of stay exceeding 14 days. Inspectors were informed that these review meetings were proactive and beneficial in progressing the patient journey. However, not all hospital consultants participated in these patient reviews. To support patient flow through the hospital and on into the community, HIQA recommends a review of the feasibility and benefits of expanding these review meetings for all hospital consultants.

Hospital activity and compliance with metrics was reviewed at HMT and at Saolta University Health Care Group level during monthly Unscheduled Care Group meetings and bi-monthly performance meetings.

In summary, the hospital had effective management arrangements to support the delivery of emergency care at the hospital. There was evidence that hospital management implemented a range of measures on a daily basis to improve the patient flow through the ED, and to increase surge capacity in the day-care area with as minimal an impact on scheduled care as possible.

On the days of inspection, the hospital was challenged with capacity issues and lack of isolation facilities resulting in poor patient flow from the ED. The mismatch between the demand for inpatient beds, especially isolation facilities, and the hospital's overall capacity resulted in admitted patients being accommodated in the ED awaiting an inpatient bed. This had already been identified by management, and capacity issues should be improved by the addition of the 12 -bedded ward in quarter three 2023, the completion of a replacement block with additional isolation facilities expected to be operational quarter 4 2024 and proposed new ED modular build.

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services for infection prevention and control, medication safety, the deteriorating patient and transitions of care in the wider hospital and clinical areas visited by inspectors on the day of inspection.

Judgment: Substantially compliant

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

Findings relating to the emergency department

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. The emergency department had three whole-time equivalent (WTE) consultants in emergency medicine who were responsible for the day-to-day functioning of the department. The emergency medicine consultants were operationally accountable and reported to the General Manager. The consultants also reported to the Associate Clinical Director for medicine as the ED was under the clinical governance of the Medical Directorate. The emergency medicine consultants also reported to the Group Clinical Director, who inspectors were informed visited the department regularly.

A senior clinical decision-maker‡‡‡‡‡‡‡ at consultant or registrar level was on-site in the hospital's emergency department 24/7. The consultants worked 9am to 5pm with the on-call consultant on site in the department until 7pm. The on-call consultant was onsite at weekends 9am to 5pm. This level of cover was achieved by additional overtime shifts and locum cover which might not be sustainable long term. Medical oversight of the emergency department was provided by the on-call consultant in emergency medicine outside these core working hours.

Inspectors were informed that recruitment was underway for a joint emergency medicine consultant post shared between Portiuncula University Hospital (0.8 WTE) and University Hospital Galway (0.2 WTE) however, this post excludes on-call commitment for PUH. Considering the current 1:3 on-call requirement for the emergency medicine consultant in the department, further planning is required to ensure the sustainability of the on-call roster.

The consultants in emergency medicine at Portiuncula University Hospital were supported by sixteen WTE non-consultant hospital doctors at senior house officer (9 WTE) and registrar grade (7 WTE). On the day of inspection all of these positions were filled. The hospital was not an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine.

The emergency department had an approved complement of 51.83 Nursing staff (including CNM grades), 13.7 WTE Healthcare assistants (HCA) and 4.96 Advanced Nurse Practitioner. There were 5 WTE vacant nursing posts on the day of inspection. Hospital management were actively recruiting to fill nursing vacancies. The daily nursing complement rostered to the ED was 11 nurses and three HCAs on day shift and nine nurses and three HCAs on night shift. On the day of inspection the department was short two nurses and one HCA from the day shift, the night shift had its full complement. Inspectors were informed that agency cover was provided when possible to cover vacancies.

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

A clinical nurse manager grade 3 (CNM3), had overall responsibility for the nursing service within the ED and was rostered on duty Monday to Friday during core working hours. The CNM3 reported to the Assistant Director of Nursing (ADON) for patient flow. Issues such as staffing shortages were escalated to the operational ADON. A CNM2 was on duty each shift and had responsibility for nursing services out-of-hours and at weekends. The CNM2 escalated issues to the operational ADON outside core working hours. A CNM2, additional to the complement of nurse staffing for the ED, was responsible for admitted patients in the department during core working hours.

Staff in the emergency department had access to an infection prevention and control nurse who visited the department daily. Staff had access to a 0.5 WTE antimicrobial pharmacist and a consultant microbiologist on site three days per month. Telephone guidance was available from the microbiology team in Galway University Hospital 24/7. At the time of inspection a clinical pharmacist was not assigned to the ED, so clinical pharmacy reviews or medicine reconciliation was not undertaken for admitted patients while accommodated in the ED. Inspectors were informed that the ED staff had access to pharmacy staff for advice. A pharmacy technician visited the department daily to top up the medicine stock.

Security staff were on duty in the emergency department 8pm to 8am, this was a recent development as a result of a risk escalated to group level, this will be discussed further under standard 3.1.

Uptake of mandatory and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The emergency department had a system in place to monitor and record staff attendance at mandatory and essential training, and this was overseen by the clinical nurse manager 3.

HIQA found that staff attendance and uptake at mandatory and essential training could be improved for nursing staff and healthcare assistant staff, especially training on hand hygiene (50% compliance) and training in infection prevention and control (45-52% compliance) and training for nurses in the early warning score systems§§§§§§§ (45% compliance). Records of attendance at and uptake of mandatory and essential training by medical staff in the ED was not submitted to HIQA.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. Attendance at mandatory and essential training for nursing staff in the emergency department could be improved in most areas.

§§§§§§§ Irish National Early Warning System, Irish Maternity Early Warning Systems and the Paediatric Early Warning systems, used in acute hospitals settings to support the recognition and response to a deteriorating patient.

Considering the current 1:3 on-call requirement for the emergency medicine consultant in the department further planning is required to ensure the sustainability of the on-call roster.

There was a variance between the number of approved ED WTEs nurses and in the number in post. ED nurses were also allocated to care for the additional inpatients accommodated in the ED. Although shortages were often covered by agency staff, there was a shortfall in the rostered complement of nurses and HCAs on the day of inspection. Although no impact on patient care was identified at the time of inspection, the shortfall in rostered nurses had the potential to impact on patient care especially as attendance numbers rose throughout the day. The hospital should progress with recruitment efforts to fill the current vacant positions.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings from the emergency department related to the quality and safety dimension are presented under national standards 1.6 and 3.1 from the themes of person-centred care and safe care respectively.

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

Findings relating to the emergency department

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.******** Patient's privacy and dignity in the emergency department was supported for patients in individual cubicles and treatments rooms, however this was not possible for the patients accommodated on trolleys in the narrow ED corridors which were a thoroughfare for the busy ED department. Patient's trolleys were placed near and outside the toilets which impacted on patient dignity and privacy. Patients accommodated in the ED overnight informed inspectors that the department was continuously noisy, bright and busy with people passing nearby their

******** Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

trolleys, which impacted on their dignity and privacy and on their ability to rest and sleep at night.

There were no patient toilets, ensuite or shower facilities in the ED2, so patients in isolation in this area had to use commodes or urinals which further impacted on patient dignity. Patients who were not in isolation, could if able, use the toilets near the waiting areas in the adjacent corridor. The number of toilets in ED1 was not adequate to meet the needs of the number of patients in the department at the time of inspection.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to communicate with patients in a respectful and dignified manner. Patients who spoke with inspectors were familiar with their surrounding and were informed about their plan of care. Staff provided assistance and information to patients in a respectful and dignified manner.

These findings were consistent with the hospital's findings from the 2022 National Inpatient Experience Survey. In this survey, participants were asked if overall, they felt they were treated with respect and dignity while in the emergency department, the hospital scored 9.3 which was higher than the national average of 8.7. Survey participants were asked if a doctor or nurse explained their condition in a way they could understand, the hospital scored 7.7, which was higher the national average of 7.2.

Patients were brought to treatment rooms for examinations and personal care to provide an environment that ensured the patient's dignity and privacy. This was validated by patients who spoke with inspectors and was consistent with the hospital's findings from the 2022 National Inpatient Experience Survey.

Patient information leaflets about the patient advice and liaison service (PALS) were available within the department, and inspectors were informed that the PALS coordinator proactively visited the department to speak with patients to familiarise them with the service.

The department also had patient comfort packs which were provided for patients- although none of the patients who spoke with the inspectors on the day of admission reported receiving a comfort pack. Inspectors were informed that the hospital planned to install a mobile phone charging station in the department to support patients to maintain contact with family and friends.

The hospital had recently reviewed their staff name badges to support better identification of staff for patients. Inspectors were informed that patients and families had been involved in the design of these new badges. Staff in the ED were observed wearing the badges.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. However, despite staff efforts to maintain patients dignity and respect, the practice of accommodating inpatients in the ED and placing patients on trolleys

on the ED corridor impacted on any meaningful promotion of the patient's dignity, privacy and autonomy and was not consistent with the human rights-based approach to care supported and promoted by HIQA. The lack of adequate toilets in the ED areas, and patient accommodated outside toilet entrances further compounded the issues. Both the physical facilities and the processes of patient flow need to be further reviewed and addressed by hospital management.

Judgment: Partially compliant

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

Findings relating to the emergency department

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the emergency department. This data, and the compliance with key performance indicators was reviewed at the ED Clinical Operational Group. Issues were escalated to the Medical Directorate meetings and the Hospital Management Team and reviewed at bi-monthly[††††††††] performance meetings with the Saolta University Health Care Group

At 11am on the first day of inspection there were 31 patients in the department - 14 of these patients were admitted patients accommodated in the ED while awaiting an inpatient bed. The other 17 ED patients were in the department under 6 hours, indicating that the ED was functioning well. However, admitted patients accommodated within the ED was symptomatic of ineffective patient flow from the department and impacted the ED Patients Experience Time (PETs)[††††††] measured from time of registration to ED departure time.

At 11am on the day of inspection, there were 31 patients in the emergency department. Of these patients, it was found that:

- 12 patients (39%) were in the emergency department for more than six hours after registration — not compliant with the HSE's target PET that 70% of all attendees at ED are discharged or admitted[‡‡‡‡‡‡‡‡] within six hours of registration.
- 12 patients (39%) were in the emergency department for more than nine hours after registration — not compliant with the national target that 85% of all attendees at ED are discharged or admitted within nine hours of registration.

[††††††††] Bi-monthly – every two months or six times per year.
[‡‡‡‡‡‡‡‡] Total Emergency Department Time (TEDT) is measured from registration time to ED Departure Time.

- One patient (3%) was in the emergency department for more than 24 hours after registration - compliant with the national target that 97% of all attendees at ED are discharged or admitted within 24 hours of registration.
- Two patients (6%) in the emergency department were aged 75 years and over were not discharged or admitted within nine hours — not compliant with the national target that 99% of all attendee aged 75 years at ED are discharged or admitted within nine hours of registration.
- No patient aged 75 years or over was in the ED over 24 hours — compliant with the national target that 99% of all attendees aged 75 years and over at ED are discharged or admitted within 24 hours of registration.

Most recent published performance data§§§§§§§§ for the year to date September 2022 showed that 68.6% of patients who attended the department between January and September 2022 were discharged or admitted within 6 hours (target 70%), 88.3% within 9 hours (target 85%) and 99.8% within 24 hours (target 99%). In Portiuncula University Hospital, admitted patients accommodated in the ED were transferred to an 'ED virtual ward' on decision to admit, so although physically accommodated in the ED, the patients were no longer registered on the hospital's electronic system as being in the ED.

Management at the hospital informed HIQA that admitted patients accommodated in the ED who were registered on the 'ED virtual ward' were not included in the patient experience time performance data reported monthly to the HSE. Total Emergency Department Time (TEDT) is measured from registration time to ED departure time. As the admitted patients accommodated in the ED had not physically left the ED, they should be included in this metric. This should be reviewed by the hospital as a priority following this inspection to ensure the accuracy of the hospital's reporting of PETs and the HSE Performance Assurance reports.

It is to be noted that findings from the 2022 National Inpatient Experience Survey for ED waiting times, as reported by patients, showed that Portiuncula University Hospital compared well to the national average for the 'less than 6 hours' and '12 to 24 hour' PETs:

- The national average for people waiting less than 6 hours in the emergency department before being admitted to an inpatient bed was 28.9%. The rate for the emergency department at Portiuncula University Hospital was higher at 34.3%.
- The national average for people waiting 6 to12 hours in the emergency department before being admitted to an inpatient bed was 32.9%. The rate for the emergency department at Portiuncula University Hospital was 44.3%.

§§§§§§§§ Most recent published HSE Management data. September 2022. Available on line From: https://www.hse.ie/eng/services/publications/performancereports/2022-performance-reports.html

- The national average for people waiting 12 to 24 hours in the emergency department before being admitted to an inpatient bed was 23.9%. The rate for the emergency department at Portiuncula University Hospital was 17.9%.

According to published data, the percentage of ED patients who left the department before completion of treatment from January to September 2022 was 4.4%, this compared well to other model 3 hospitals and was within the HSE target of less than 6.5%. The hospital had a quality and safety initiative in place whereby an emergency medicine consultant contacted all patients who left the department before completion of treatment to discuss symptoms and provide guidance on the need for further management. The emergency medicine consultant also reviewed the diagnostic results of patients treated and discharged from the department to ensure appropriate care and management had been provided. A daily consultant led review clinic allowed opportunity for patients to be discharged from the ED, especially out of hours, and return for a consultant review as required. These initiatives provided assurance of the quality and safety of the care in the ED.

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to service users and staff in the emergency department. Risks were managed at department level with oversight of the process undertaken by the ED Clinical Operational Group and at Medical Directorate meetings.

Risks related to the emergency department were recorded on the ED risk register. Existing controls and additional requirements to mitigate the risks were documented. All current risks on the ED risk register were escalated to the General Manager and Associate Clinical Director. The high-rated risks were outlined by staff on the day of inspection and evidence of existing controls in place was provided during the inspection. Additional controls to mitigate the risks were actively managed at the ED Clinical Operational Group meeting. The ED risk register provided to HIQA had the 'date of assessment' and the 'updated date' as August 2022. However, the hospital informed HIQA that the risk register had been reviewed in April 2023. All risks assigned a status of 'open' which are being actively managed at governance meetings should have relevant updates documented and dated on the risk register.

The highest rated risks identified by the hospitals for patients attending the ED were: the risk of a delay in the delivery of services, increased morbidity and mortality, increased complaints and patients leaving the ED department untreated. These cause of these risks were outlined as related to ED overcrowding, poor infrastructure, insufficient clinical space, increased attendance and lack of inpatient beds. These risks had been escalated to the hospital's risk register. Medium and long term plans to mitigate the risks were included in the risk register and outlined to inspectors on the day of inspection, these included: a 12 - bedded ward expected to be operational in quarter three of 2023, a 50-bedded replacement block with additional isolation facilities expected to be operational in quarter 4

2024 and a new modular building for ED which had been referred to national estates for capital funding approval.

Another risk on the hospital's risk register related to the risk of harm to persons in the hospital due to exposure to violence or aggressive behaviour in the work place. This risk was being actively managed by the hospital. At the time of inspection security personnel were present in the ED 8pm to 8am with a plan in place to extend this service to 24/7.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were screened for signs and symptoms of confirmed or suspected COVID-19. If symptomatic or COVID-19 positive, the attendee was cared for in the ED2 (respiratory ED).

Staff had access to the Infection Prevention and Control Clinical Nurse Specialist daily for advice and support. The emergency department environment was generally clean and well maintained. The department had a cleaner allocated to the department 24/7 and terminal cleaning was performed following discharge or transfer of all patients with communicable infectious diseases.

Infection prevention and control risks were present due to the lack of isolation facilities within the hospital resulting in patients requiring isolation being accommodated in the ED while awaiting an inpatient bed. The demand for isolation facilities frequently exceeded the isolation facilities available both within the ED and the hospital. Patients accommodated on trolleys located on the ED corridor were not maintaining minimum distance of 1 metre between patients which also posed an infection risk.

Medication safety

A pharmacist was not assigned to the emergency department so clinical medication review or medicine reconciliation was not undertaken for inpatients while accommodated in the ED. Inspectors were informed that pharmacists were available for advice as required. A pharmacy technician visited the department daily to review the medicine stock. Inspectors observed a high-risk medication list with risk-reduction strategies in place to mitigate risks and support the safe selection of medicines. A poster to alert staff to SALADs********* was displayed in the medicine room in the emergency department.

Staff in the department had access to a 0.5 WTE antimicrobial pharmacist and an antimicrobial microbiologist on site three days per month. Staff could obtain advice and support from the microbiology team in Galway University Hospital 24/7.

********* SALADS are 'Sound-alike look-alike drugs'. The existence of similar drug and medication names is one of the most common causes of medication error and is of concern worldwide. With tens of thousands of drugs currently on the market, the potential for error due to confusing drug names is significant.

Deteriorating patient

The hospital was using the appropriate early warning system[†††††††††] relevant to the different cohorts of admitted patients[‡‡‡‡‡‡‡‡‡] to support the recognition and response to a deteriorating patient in the emergency department. The hospital had not implemented the Emergency Medicine Early Warning System (EMEWS).

Safety pauses were held in the emergency department to discuss the status of all patients in the department and identify patients of concern or issues of concern. Inspectors were informed that risks, incidents or complaints relevant to the department would be communicated at this time.

Transitions of care

The $ISBAR_3$ communication tool was used for internal and external patient transfers from the emergency department.

Management of patient-safety incidents

HIQA was satisfied that patient-safety incidents occurring in the emergency department were reported directly onto the National Incident Management System (NIMS),[§§§§§§§§§] using the electronic point of entry[**********] (ePOE). Incident reports were circulated weekly for review to Senior Clinicians, the ADON and the CNM3. Updates on investigation into incidents conducted by the ED team were discussed at the monthly incident management meeting. Real-time data on incidents or near misses was now available in the hospital with the NIMS ePOE. The system prompted a review and commencement of risk-mitigation processes.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally, in line with the hospital's complaints policy. The hospital's Complaints Officer met with the CNM3, the ADON for patient flow and emergency medicine consultants to discuss and respond to complaints relevant to the ED. The hospital's patient advice and liaison service was available to support patients who had issues or wished to make a complaint. On the day of inspection, the patients who spoke with inspectors did not know how to

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

[‡‡‡‡‡‡‡‡‡] Early Warning Systems include: Irish National Early Warning System (INEWS) (adults), Irish Maternity Early Warning Systems (IMEWS) for use on all women who are currently pregnant or who have given birth or had a miscarriage within the previous 42 days and the Paediatric Early Warning systems (PEWS) (children).

[§§§§§§§§§] 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).

[**********] The electronic point of entry (ePOE) reporting is where frontline line staff enter incidents directly onto the National Incident Management Framework System eliminating the need for paper reporting.

make a formal complaint but outlined that if they had an issue they would speak to a member of staff.

Overall, on the day of inspection HIQA were not fully assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm. At 11am on the day of inspection 39% of patients were in the department over nine hours. There were 14 admitted patients accommodated in the ED which is symptomatic of ineffective patient flow and insufficient bed capacity. Prolonged waiting times in the emergency department are associated with increased frequency of exposure to error, increased inpatient length of stay, increased morbidity and mortality. ††††††††††

Patients were accommodated in an overcrowded ED environment, there was restricted access through the ED corridors, trolleys were in close proximity and patients requiring isolation were accommodated in the ED awaiting an inpatient bed with potential IPC risks. There was a lack of access to a clinical pharmacist service for admitted patients accommodated in the ED to support safe medication practices in the emergency department.

Judgment: Partially compliant

†††††††††† Paling S., Lambert J., Clouting J., Gonzalez-Esquerre J. and Auterson T. *Waiting times in emergency departments: exploring the factors associated with longer patient waits for emergency care in England using routinely collected daily data*. Emergency Medicine Journal. 2020. 37:781-786. Available online from: https://emj.bmj.com/content/37/12/781

Inspection findings related to the wider hospital and clinical areas.

This section of the report describes findings and judgments against selected national standards from the themes of leadership, governance and management (5.8), workforce (6.1), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3) related to the wider hospital and clinical areas.

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

St. Francis's ward was a 29-bedded ward consisting of one two-bedded room, one three-bedded room, one four-bedded room, three five-bedded rooms and five single rooms. There were no toilet or shower facilities in the multi-occupancy rooms and only one of the single rooms had en-suite facilities. The ward toilet and shower facilities were located on the corridor. The ward catered for patients with surgical and medical conditions. At the time of inspection 28 ward beds were occupied with one bed blocked for infection prevention and control measures.

St Joseph's ward was a 33-bedded ward consisting of one six-bedded multi-occupancy room, three five-bedded rooms, one-four-bedded room, one three-bedded room, two two-bedded rooms and one single room. There were no toilet or shower facilities in the multi-occupancy rooms or single rooms. The ward toilet and showers facilities were located on the corridor. The ward catered for patients with medical conditions. At the time of inspection all 33 beds were occupied.

Inspectors observed effective communication between staff and patients. Staff were observed actively engaging with patients in a respectful and kind way, taking time to talk and listen to patients and attend to their needs. This was validated by patients who described staff in the clinical areas visited as *'excellent and friendly'* and '*brilliant'*. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff as curtains were secured around patients when providing personal care.

Staff were focused on ensuring patients' needs were promptly responded to. For example, patients recounted how their needs were met quickly, telling inspectors '*staff are responsive to calls but might not stay too long with you as they had other call bells to answer'.* Patients did not know how to make a formal complaint, but told inspectors that they would be comfortable to speak with the ward staff if they had a complaint. When asked if there was anything that could be improved about their experience, patients commented that they were not dissatisfied with anything. 'Your Service Your Say' and advocacy information leaflets were observed on wards visited by inspectors.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 82% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, which was just above the national average of 81.9%.

Overall, there was consistency with what inspectors observed in the clinical areas visited, what patients told inspectors about their experiences of receiving care in those areas and the findings from the 2022 National Inpatient Experience Survey.

Capacity and capability dimensions

Inspection findings from the wider hospital and clinical areas visited and related to the capacity and capability dimension, are presented under national standard 5.8 from the theme of leadership, governance and management, and 6.1 from the theme workforce.

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

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

Monitoring service's performance

The hospital collected data on a range of national key performance indicators‡‡‡‡‡‡‡‡‡‡ related to the quality and safety of healthcare services. The hospital also collected and collated data relating to patient-safety incidents, feedback, complaints and compliments, surveillance, workforce and risks that had the potential to impact on the quality and safety of services.

Collated performance data was reviewed at meetings of the Hospital Management Team and the Quality and Safety Governance Group and at performance meetings between the hospital and hospital group. Relevant data was also discussed at Clinical Operational Group and Directorate meetings. Key performance indicators were reported nationally and

‡‡‡‡‡‡‡‡‡‡ HSE Acute Division Metadata. 2023. Available online from: https://www.hse.ie/eng/services/publications/kpis/key-performance-indicator-metadata-2023.html/

published by the HSE through quarterly Performance Assurance Reports §§§§§§§§§ and monthly Hospital Patient Safety Indicator Report (HPSIR).**********

As outlined in section 3.1 emergency department, ED Patient Experience Time data was not reported in line with Acute Division Metadata†††††††††† key performance indicator descriptions. This should be reviewed by the hospital as a priority to ensure accuracy of HSE Performance Assurance Reports.

Patient safety indicator related to 'the rate of clinical incidents as reported to NIMS per 1000 Bed Days' was also not included on HPSIR published data year to date, this is discussed further under standard 3.3.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospital's corporate risk register was reviewed at the Quality and Safety Governance Group with risks escalated as required to the bi-monthly performance meetings with the Saolta University Health Care Group. Documentation submitted to HIQA showed that risks identified in relation to IPC and medications safety were recorded on the hospital's corporate risk register with the controls and actions required to mitigate the identified risks. These risks are outlined further in national standard 3.1.

Audit activity

The hospital Clinical Audit Committee had oversight of audit activity to support the completion all stages of clinical audit.‡‡‡‡‡‡‡‡‡‡ The committee was co-chaired by a medical consultant and the Clinical Audit Coordinator. The hospital had an audit plan and a central repository for clinical audits. The hospital's recently appointed clinical audit coordinator had set objectives and goals for clinical audit for 2023. The Clinical Audit Coordinator worked closed with the quality and safety team to support the implementation of audit recommendation and time-bound action plans. Time-bound action plans for audit recommendations and re audit plans were not seen for some audits

§§§§§§§§§ The HSE's Performance Assurance Report (PAR) provides an overall analysis of key performance data from Divisions, such as Acute, Mental Health, Social Care, Primary Care, Health and Wellbeing as well as Finance and HR. The activity data reported is based on Performance Activity and Key Performance Indicators outlined in the current National Service Plan. Performance Reports - HSE.ie

********** The Hospital Patient Safety Indicator Report (HPSIR) is a monthly report that collates a range of patient safety indicators. The purpose of the HPSIR is to assure the public that the indicators selected and published in this report are monitored by senior management of both the hospital and hospital group on a monthly basis, as a key component of clinical governance. Hospital Patient Safety Indicators Reports - HSE.ie

‡‡‡‡‡‡‡‡‡‡ Seven stages of clinical audit – Select topic, set criteria and standard, design clinical audit tool and collection data, analyse data and compare results to standards, complete an audit report, based on findings and conclusion develop and implement a quality improvement plan and action to improve care and re-audit.

reviewed by HIQA on the day of inspection. This is an area for improvement for the hospital.

Hospital staff were supported to undertake audit by the Clinical Audit Coordinator though provision of education sessions and drop in audit clinics, and by participating in the hospital's Clinical Audit Days, where staff presented completed audits to share findings and learning.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events were reported in line with the HSE's Incident Management Framework. All incidents were reported directly to the NIMS using electronic point of entry. The hospital's quality and risk manager tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the Quality and Safety Governing Group and the HMT. All incidents and SRE were discussed at bi-monthly performance meeting with the Saolta University Health Care Group.

The Saolta University Health Care Group Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework.

Feedback on patient-safety incidents was provided weekly to directorate representatives by the Quality and Patient Safety Manager. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.1.

Feedback from people using the service

Compliments and complaints from service users and findings from the National Inpatient Experience Survey were reviewed at meetings of the Quality and Safety Governance Group. Areas for improvement had been highlighted by the hospital and a time-bound quality improvement plan was developed.

In summary, the hospital had systems in place to monitor performance against key performance indicators in the four areas of known harm which were the focus of this inspection and there was evidence that information from this process was being used to improve the quality and safety of healthcare services.

Inspectors were assured that the hospital management had systems and processes in place to identify and act on opportunities to continually improve the quality and safety of healthcare services at the hospital. However, the hospital should ensure that all stages of clinical audit are completed and that all national performance indicators are collected and reported in line with national guidance and descriptors.

Judgment: Substantially compliant

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

Findings relating to the wider hospital

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

HIQA found that the hospital had arrangements in place to plan, organise and manage the workforce. The hospital had systems in place to coordinate, monitor, report and review human resource and medical manpower issues.

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital's total approved complement of staff (all staff) at the time of inspection was 1022.6 WTE.

The hospital's approved complement for nursing and midwifery was 418.69 WTEs. At the time of inspection there were 14 WTEs nursing and one WTE midwifery positions vacant. Inspectors were informed that they were actively recruiting nursing staff to address the vacancies. All consultants post were filled at the time of inspection and the hospital had three additional joint community posts approved for endocrinology, respiratory and ICPOP which were under recruitment. There were four vacant non-consultant hospital doctor's posts-three registrars and one senior house officer.

Three consultants were not registered on the relevant Specialist Division of the Irish Medical Council. Each position was risk assessed and business cases approved as required. Each consultant was working through the process to gain registration, and in the interim appropriate supports with clinical and corporate oversight were in place.

The hospital had systems in place to monitor and review absenteeism. The hospital's reported absenteeism rate for March 2023 was 4.73%, which was just above the HSE target of less than or equal to 4%.

Infection prevention and control

The hospital's infection prevention and control (IPC) team comprised of 0.6 WTE consultant microbiologist, with 0.3 of the post vacant at the time of inspection due to planned leave. This level of consultant microbiologist cover was low in comparison to other model 3 hospitals inspected by HIQA. This arrangement might benefit from review by management. The hospital had one WTE IPC clinical nurse specialist, a newly appointed IPC clinical nurse manager 2 (one WTE), a 0.5 WTE antimicrobial pharmacist and a WTE surveillance scientist.

Medication safety

The hospital had 13 WTE pharmacists, which included the chief pharmacist and three clinical pharmacists. At the time of inspection there were four vacant posts due to leave which were not filled. There were five newly approved pharmacists' posts under recruitment but inspector were informed that despite recent recruitment drives the hospital had been unable to fill these posts.

Deteriorating patients

The hospital's resuscitation officer was the hospital's INEWS, PEWS and Sepsis Nurse Lead and there was a consultant lead for each of the early warning systems in use in the hospital. The Group ADON for sepsis and the deteriorating patient was shared with other hospitals within the Saolta University Health Care Group.

Transition of care

Transition of care within the hospital were managed by the Patient Flow team which comprised of a WTE Inpatient Coordinator, a WTE Discharge Co-ordinator and the ADON for patient follow who also had responsibility for other areas such as radiology and the emergency department. A new Patient flow CNM3 had just been appointment and was to take up the post the week following the inspection.

Staff training in the wider hospital

It was evident from staff training records reviewed by inspectors that hospital staff undertook training appropriate to their scope of practice. Staff attendance at training was recorded and monitored at ward or department level. Some mandatory training was recorded at hospital level by the human resource department, but there was opportunity for improvement in the recording of attendance at training at hospital level.

HIQA found that staff attendance and uptake at mandatory and essential training could be improved, especially training on hand hygiene and basic life support and infection prevention and control.

Training records for hospital staff varied for attendance at mandatory training for example:

- 70% nurses, 80% healthcare assistants and 60% of doctors were compliant with hand hygiene training which was below the HSE's target of 90%
- 81% nurses and 48% of doctors were up to date in basic life support training
- 87% of nurses and 80% of doctors were up to date with training on the national early warning system

Training records for infection prevention and control on wards visited by inspectors varied across disciplines with compliance with standard and transmission based precautions from 37% to 84% which represents a key area for improvement. Compliance with training in donning and doffing personal protective equipment varied from 73% to 83%.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. The hospital was actively recruiting to fill vacant posts, although some positions such as pharmacists were difficult to recruit despite national recruitment.

While attendance and uptake of mandatory and essential training was recorded at local clinical area level, a greater level of oversight of staff uptake of mandatory and essential training, particularly in relation to NCHDs is needed by the senior management team.

Judgment: Substantially compliant

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. Key inspection findings leading to these judgments are described in the following sections.

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

During this inspection staff in the clinical areas visited by inspectors demonstrated a person-centred approach to care and made every effort to maintain their patient's dignity, privacy and autonomy. The design of the physical environment of the wards visited by inspectors did not support patient's dignity or privacy but staff endeavoured to promote staff privacy through the use of privacy curtains and communicated with patients in a manner that respected their dignity and privacy.

Patients were kept informed of their plan of care and translations services were used for patients whose first language was not english to ensure that their autonomy was promoted and supported while receiving care and treatment. The clinical ward's white boards which contained patient's personal information was used by staff for clinical handovers and safety pauses. The white boards were located in the ward's meetings room to protect and maintain patient privacy. However, patient's personal information was not consistently protected and stored appropriately, in that inspectors observed patients healthcare records left on trolleys in the corridor accessible by members of the public and staff passing by. The hospital should ensure that patient's personal information is protected at all times in line with legislation and best available evidence.

Inspectors were informed that the Patient Advice and Liaison Service (PALS) Coordinator provided support to patients, and patient information leaflets about the PALS were available on the ward. Patients at end of life were cared for with compassion and kindness in single rooms when possible, with support from the palliative care nurse. The hospital promoted and applied the hospice friendly hospital approach to end-of-life care in so far as possible within the confines of the current hospital infrastructure. The wards also had dementia friendly colours on bathrooms doors and hand rails to support patient's autonomy and independence. Staff were observed protecting patient's dignity through the use of privacy curtains, responding promptly to patients needs and communicating with patients in a respectful manner. Patients who spoke with staff outlined that 'staff are very good at explaining' and 'staff answer call bells well'

These findings were consistent with the finding from the 2022 National Inpatient Experience Survey, where the hospital scored higher than the national average score with regard to:

- privacy in the clinical area, the hospital scored 9.0 (national average – 8.6)
- staff introducing themselves when treating and examining the patient, the hospital scored 8.8 (national average – 8.7).

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this was consistent with the human rights-based approach to care promoted by HIQA. However, the physical environment in the clinical wards visited did not support the promotion of privacy and dignity. The physical environment is discussed further under national standard 2.7. The hospital should ensure that patient personal information is protected at all times in line with legislation and best available evidence.

Judgment: Substantially compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors. Staff were described by patients as 'very nice' and 'excellent and friendly'.

An example of good practice observed by inspectors was the placement of writing desks along the corridor enabling staff to complete their clinical notes. This supported a visible presence for patients if they needed support.

HIQA found evidence of a person-centred approach to care that included meal choices. Inspectors, whilst speaking to staff found that most patients mentioned their satisfaction with their meals and one patient stated that 'food is excellent'. Patients also articulated that they were kept up to date with their treatment plan.

Overall, assurance was provided that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

Portiuncula University Hospital had a designated Complaints Officer in-post assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of complaints resolution in the clinical areas visited.

The Complaints Officer had oversight of the hospital's complaints management process and reported to the Quality and Patient Safety Manager. The hospital used the HSE's complaints management policy 'Your Service Your Say.'§§§§§§§§§§ The hospital tracked and trended written complaints by HSE category. Complaints and compliments and findings from the National Inpatient Experience Survey were reported and reviewed at the hospital's Quality and Safety Governance Group and learning from complaints was used to help drive improvements at an organisational level. Feedback on complaints was provided to representatives of each Directorate and to staff in the related clinical areas. Evidence was provided by the hospital to demonstrate that learning from complaints was used to help drive improvements at an organisational level.

Staff strived to resolve complaints received at first point of contact. If complaints could not be managed at first point of contact, they were escalated to the complaints officer. The hospital's Patient Advice and Liaison Service (PALS) Coordinator********** assisted patients through the complaints process and also supported patients in seeking further advocacy from other organisations such as the Sage support and advocacy service and the National Patient Advocacy Service.

§§§§§§§§§§ 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.

********** The Patient Advice and Liaison Service Co-ordinator acts as the main contact between patients, their families, carers and the hospital. They ensure that the patient voice is heard either through the patient directly or through a nominated representative

'Your Service Your Say' leaflets were available in the hospital and patients received a copy of the Patient Advice and Liaison Service information leaflet on admission.

The PALS coordinator recorded verbal complaints and escalated complaints to relevant managers as appropriate. Complaints were discussed at the Patient Experience Committees and nurse management meetings. However, the hospital did not have a system to record all verbal complaints and this is a missed opportunity for shared learning and quality improvement.

At the time of inspection the hospital was not formally monitoring or reporting national metrics such as the percentage of complaints resolved within 30 working days (Target 75%). The hospital did inform inspectors that they were about to commence the use of the National Complaints Management System (CMS) to manage complaints and formally report on the number and type of complaints received with retrospective uploading of all complaints received year to date. The hospital did track and report management of complaints monthly. Inspectors were informed that some complex complaints did fall outside national timeframes, but complainants were kept informed as per national timelines.

Overall, HIQA was assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and noted good a response to findings from the National Inpatient Experience Survey. However, the hospital would benefit from a process to record, track and trend verbal complaints to sharing learning and help reduce risk of reoccurrence. The hospital should progress their plans to commence use of the CMS to support the monitoring and reporting of complaints in line with national metrics to provide assurance of the quality and safety of the hospital's complaints management's process.

Judgment: Substantially compliant

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

The hospital was challenged with an old infrastructure with limited single rooms with en suite facilities, and multiple-bedded rooms without shower and toilet facilities. The narrow ward corridors were extremely congested with equipment due to lack of space and adequate storage facilities on the wards visited by inspectors.

There was a lack of isolation facilities to accommodate placement of people who required transmission-based precautions. The hospital had an isolation prioritisation policy and patients were isolated in line with the hospital policy with infection prevention and control advice. Inspectors were informed that cohorting of patients with the same micro-

organism was facilitated following consultation with the IPC team and based on a risk assessment.

The inadequate capacity and infrastructure was placed on the corporate risk register along with many control measures to mitigate the risks associated with the hospital infrastructure. A 12-bedded ward with 8 single ensuite rooms was in progress and due to open in quarter three 2023. A further 50-bedded replacement block with single ensuite rooms was in progress with expected completion in quarter 4 2024.

Despite the infrastructure, the wards visited on the day of inspection were well maintained and clean with few exceptions. The staff on the ward and the infection prevention and control (IPC) team completed monthly environmental audits which resulted in monthly reports with compliance rates ranging between 75-85% for wards visited on day on inspection for the months prior to inspection. Action plans were developed for areas requiring improvements. The clinical nurse manager (CNM) could articulate the outstanding items that required action from the last monthly audit.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand-hygiene signage clearly displayed throughout the clinical areas. Ward areas were noted to be congested with equipment.

Staff were observed wearing appropriate personal protective equipment (PPE) in line with current public health guidelines. Bare below elbow was also observed when the staff were not wearing PPE.

Environmental cleaning was carried out by ward-based cleaners during the daytime and by contract cleaners at night-time. There was enhanced cleaning schedules in place in the hospital during outbreaks. Cleaning supervisors and clinical nurse managers had oversight of cleaning in the clinical areas visited, and the CNM was satisfied with the level of cleaning staff in place.

Cleaning of equipment was assigned to healthcare assistants and nursing staff. In the clinical areas visited, the equipment was observed to be clean and there was a tagging system in place to identity equipment that had been cleaned. There was a lack of dedicated areas for short-term storage of healthcare and risk waste on the wards. Healthcare waste was observed on the corridor of St Francis Ward awaiting collection. The lack of sluice rooms was identified as a risk by IPC and escalated to management. Inspectors were informed that there was a plan to build a new enclosed storage area at the start of the ward following completion of a new corridor to radiology. Appropriate segregation of clean and used linen was observed, and used linen was stored appropriately.

In summary, there was a distinct lack of single rooms and ensuite facilities in the hospital. There was only one negative pressure isolation room in the hospital and this was located in the ED. There was a lack of storage facilities for equipment and waste, resulting in narrow ward corridors congested with equipment and waste for collection. The

infrastructure on the wards visited on the day of inspection was outdated and not in line with modern day specifications and standards for a healthcare facility. This did not support the delivery of high-quality, safe, reliable care and protect the health and welfare of patients.

Judgment: Non-compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level. HIQA found that the hospital monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments, patient experience surveys, audit and monitoring of key performance metrics.

Infection prevention and control

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Alert organism surveillance was also monitored by the IPC team and reported locally, at group level and nationally in line with national guidance.

Infection prevention and control audit summary reports submitted to HIQA showed opportunity for improvement in the overall hospital environment and equipment audits in areas related to the infrastructures of the wards, but also deficits in cleaning. The hospital shared findings with clinical staff and action plans were developed and implemented by the hospital to address areas requiring improvement.

The overall hospital and clinical areas visited on the day of inspection were not compliant with the HSE's target of 90% for hand hygiene practices in audits carried out year to date 2023. The average overall compliance rate for hand hygiene audits for the hospital year to date was 81%, for St Francis's ward was 74% and for St Joseph's ward was 83%.

The risk of healthcare associated infection to patients due to local hand hygiene compliance not consistently being above the HSE National Standard of 90% and the decontamination of the environment and equipment were highlighted by IPC as a risk, and entered on the IPC risk register with existing and additional controls required outlined.

Results of IPC audits were reported on the quarterly Infection Prevention and Control Report and the hospital monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection. The infection prevention and control team submitted a healthcare-associated infection surveillance report to the Infection Prevention and Control Committee every quarter. These reports were also shared with Quality and Safety Governance Group and the Hospital Management Team. The hospital reported healthcare associated infection data in line with HSE's national reporting requirements.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study and reporting on compliance with antimicrobial stewardship key performance indicators. The antimicrobial consumption per 100 bed days used was higher in 2022 than 2021 per 100 bed days used. The risk of harm to patients of acquiring a multi-drug resistant organism and communicable infectious disease due to inappropriate prescribing of antimicrobial agents was documented on the IPC risk register with additional control required outlined including the requirement or additional onsite microbiology consultant cover. The hospitals' performance with key performance indicators were reviewed at the Infection Prevention and Control Committee every quarter. These reports were also shared with the Quality, Safety Governance Group and Hospital Management Team. Quality improvements to address deficits in antimicrobial stewardship surveillance were not seen by inspectors during this inspection and presents an opportunity for improvement.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication safety, storage and custody was monitored as part of the Nursing and Midwifery Quality Care Metrics and overall results viewed by inspectors for year to date demonstrated high compliance. Medication safety minutes were used as a mode for sharing of learning from monitoring and audits.

Examples of audits undertaken by the hospital included:

- Discharge prescribing audits
- Appropriate documentation of antibiotic indications in medicine prescription and administration records for patient admitted under care of surgical team at the hospital.
- Antimicrobial prescribing – have we progressed
- Audit of medicine information included in GP referral letters
- Prophylaxis of venous thromboembolism in Portiuncula University Hospital and audit of current practice.

For audit reports seen by inspectors, recommendations were outlined but time-bound action plans with re-audit plans were not seen by inspectors. There was evidence

however that initiatives were introduced to improve medication safety practices at the hospital for example a discharge medication safety working group was established to oversee areas for improvement in relation to discharge prescribing.

Inspectors were informed that implementation of audit recommendations was overseen by the Clinical Audit Coordinator, and that there was a system in place to allocate audited completed to new medical staff to re-audit following implementation of the recommendations. It is important that all stages of the clinical audit cycle are completed including– implementation of a time-bound quality improvement plan and re-audit to ensure improvements in care are achieved.

Deteriorating patient monitoring

The hospital collated performance data through Nursing and Midwifery Quality Care Metrics relating to patient monitoring and surveillance. The hospital were auditing healthcare records for compliance against national guidance on utilisation and accuracy of completion of the INEWS patient observation chart. Audit compliance for inpatient wards of the INEWS patient observation chart completed in January 2023 ranged from 82.5%-98% compliance, with patient monitoring and surveillance ranging from 88%-97% in 2022.

Audits of compliance with the 'National Compliance Audit of Medical and Surgical Sepsis' was completed in January 2023, and audit of compliance with Paediatrics sepsis was carried out in November 2022. These audits were undertaken by the Group ADON for sepsis and the deteriorating patient, assisted locally by the sepsis nurse lead for the hospital and a CNM3 in paediatrics. Areas in need of improvement were identified by the hospital but a time-bound action plan was not in place at the time of inspection. Inspectors were informed that this was in progress and was due to be discussed at the next DPIP meetings.

Transitions of care monitoring

Performance in relation to admission, transfers and discharges was monitored using the HSE's hospital patient safety indicators and management data. Performance data was reported and discussed at relevant Clinical Operational Group meetings with issues escalated to Directorate meetings, Hospital Management Team meetings and at performance meetings with the Saolta University Health Care Group.

An audit of compliance with the *National Clinical Guideline No. 11 – Communication (clinical handover) in acute and children's hospital services* ††††††††††††(2015) was undertaken by external auditor in July 2022 and areas for improvement were identified and a quality improvement plan implemented by the hospital. Four of the seven

†††††††††††† National Clinical Guideline no. 11 – Communication (clinical handover) in Acute and Children's Hospital Services (2015). Available online from: gov.ie - Clinical Handover in Acute and Children's Hospital Services (www.gov.ie)

recommendations were closed at the time of inspection with a further three recommendations in progress by the hospital. The hospital should ensure that clinical handover practice is monitored and audited regularly by the hospital, in line with national guidelines, to assure senior managers that the quality improvements are in place.

Overall, HIQA was satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital relevant to the size and scope of the service provided. However, the hospital needs to ensure that recommendations and areas for improvement identified by all audit and monitoring activity have time-bound action plans in place with re-audit plans to ensure improvements in practice occurs.

Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with standards and guidance, audits identify areas for improvement and provide hospital management and people who use the service with assurances on the quality and safety of the care and services provided.

Judgment: Substantially compliant

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

The hospital had systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. The Quality and Patient Safety Committee was assigned with responsibility to review and manage risks that impact the quality and safety of healthcare services. Risks that could not be managed at hospital level were escalated to the Saolta University Health Care Group. Risks were recorded on the hospital's risk register with existing controls and additional required actions to manage and reduce these risks. High-rated risks on the hospital's risk register relevant to the areas of focus of this inspection are outlined below.

Infection prevention and control

The infection prevention and control team maintained a local risk register of potential infection risks. The hospital's inadequate capacity and infrastructure such as, inadequate single rooms, lack of en-suite facilities, limited airborne isolation facilities and inadequate bed spacing, was the highest rated risks recorded on the local infection prevention and control risk register. These risks were expressed by staff and management on the day of inspection and observed by inspectors

The existing and additional controls required to mitigate the risks were outlined. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register. Evidence of existing controls in place was provided during the inspection, and additional controls to

mitigate the risks were advanced where possible. For example the hospital was well advanced with plans to open a 12-bedded ward with 8 en-suite single rooms in quarter three 2023 and had plans for a new build containing a 50-bedded replacement block with single en-suite rooms.

HIQA was satisfied that the hospital screened patients for multi-drug resistant organisms as per national guidance and identified patients requiring isolations facilities. However, the demand for isolation rooms far exceeded the requirement on a daily basis. The hospital had an isolation prioritisation policy and patients were isolated in line with hospital policy with infection prevention and control advice. The hospital had a designated ward for confirmed cases of COVID-19.

Hand hygiene compliance was not consistently above the HSE National Standard of 90%, this risk was identified by IPC and escalated to management. The additional controls required to improve compliance should be supported by management.

A multidisciplinary outbreak control team was convened to advise and oversee the management of outbreaks in the hospital. Outbreak summary reports were developed with detailed action plans outlining the required actions, the person responsible and updates on actions. HIQA was satisfied with outbreak control management at the hospital.

The sharps bins used in the hospital had recently been changed which resulted in an alteration to the colour of the sharps bins in use. Staff who spoke with inspectors were not updated or informed about this change. The sharps bins were being used appropriately on the day of inspection, but management should consider communication and training for staff when changes occur to reduce any risks associate with the change.

Medication safety

Risk related to medication safety were risk assessed and monitored by the Drugs and Therapeutics Committee with risk assessment undertaken for identified medication-safety risks.

For example, prescribing guidelines approved for use in the hospital had been adopted from Galway University Hospital (GUH). GUH had recently moved to an online electronic version with printed versions no longer provided or supported. At the time of inspection the Portiuncla University Hospital had printed versions of the guidance in use which were available to staff at the point of medicines preparation. However, this printed version was not updated in line with the electronic version. To mitigate the risk of using outdated versions of the guidelines, the hospital was in the process of introducing an electronic solution on which the online version could be accessed. This was demonstrated to inspectors on the day of inspection.

The hospital had also identified risks associated with the clinical information systems drug formulary and order sets introduced in the hospital's intensive care unit. Existing control measures were in place with additional requirements outlined and escalated to

management. The hospital outlined actions taken to mitigate the risks identified. This risk was due for review in June 2023, and the hospital needs to ensure that the additional controls required are implemented to mitigate the risks identified.

The hospital had identified high-risk medications and had implemented risk-reduction strategies for high-risk medicines. The hospital supported the HSE's 'Know Check Ask Campaign.‡‡‡‡‡‡‡‡‡‡‡‡

A clinical pharmacist was assigned to the clinical areas visited by inspectors on the day of inspection and pharmacists were accessible to staff for advice and support. Clinical pharmacists reviewed inpatient medication prescription charts to prevent, identify, intercept, and report medication prescribing-related incidents. Clinical pharmacist completed medication reconciliation for patient on admission and on discharge when possible. Medicine reconciliation on discharge was prioritised for patients with high-risks or complex medicines when pharmacists experienced time or staffing constraints. International studies support the role of clinical pharmacists in hospital wards in preventing adverse drug events and the hospital should continue recruitment to fill vacant pharmacist posts as outlined in standards 5.5 to support medication safety.

The consultant microbiologist visited the hospital three days per month. The microbiology team in Galway University Hospital was accessible to staff by phone 24/7. Wards also had a pharmacy technician service for medicine stock control.

Deteriorating patient

The hospital had systems in place to manage patients whose early warning system was triggered. The INEWS version 2 observation chart for adult's patient was in use in the hospital and the $ISBAR_3$ communication tool was used when staff were escalating care. Inspectors reviewed a sample of healthcare records and found that of all INEWS charts were completed however, not all scores were calculated correctly. Inspectors were informed that the $ISBAR_3$ communication tool was used for clinical handover and escalation of care

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. Inspectors were informed that the $ISBAR_3$ communication tool was

‡‡‡‡‡‡‡‡‡‡‡‡ Know Check Ask– the aim of the campaign is to encourage those taking medication and their caregivers to take an active role in managing their medication. Healthcare staff are encouraged to help people to: **Know**: about each of their medicines and to keep an up-to-date medicines list. **Check**: they know how to use their medicines correctly. **Ask**: discussing medicines and answering any questions they may have.

used for clinical handover. Patient's infection status was recorded on the discharge and transfer letters reviewed by inspectors.

Policies, procedures and guidelines

The hospital had a suite of up-to-date 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. Some policies, procedures, protocols and guidelines were still in draft or overdue for review and this should be progressed following this inspection.

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of medication, labelling of high-alert medicines and sound alike look alike drugs. Policies, procedures, protocols and guidelines were accessible to staff via the hospital's document management system.

In summary, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm which were the focus of this inspection - infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, the hospital's inadequate capacity and infrastructure such as inadequate single rooms and lack of en-suite facilities posed a risk of patients acquiring hospital associated infections as the demand for isolation facilities far exceeded the available resources. The hospital needs to continue to monitor and review the medication-safety risk identified and implement the additional required action to reduce the risks.

HIQA will continue to monitor the hospital's progress in implementing actions identified by the hospital to address the risks of harm associated with the design and delivery of the services through the compliance plan submitted by the hospital as part of this monitoring activity following this inspection.

Judgment: Partially compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital used the NIMS electronic point of entry to reports incidents.

The hospital tracked and trended patient-safety incidents in relation to the four key areas of harm and an incident summary report was submitted at the monthly Hospital Management Team, the quarterly Quality and Safety Governance Group and at bi-monthly

Saolta Performance meetings. Regular updates on incidents was provided for directorates by the Quality and Safety department at incident review meeting attended by directorate staff such as the CNM, ADON and Associate Clinical Directorate. Incidents specific to each directorate were discussed at governance group meetings such as the ED Clinical Operational Group and at directorate meetings such as the Medical Directorate meetings.

Staff who spoke with HIQA were knowledgeable about the patient safety incident reporting system and could access incidents reports from the electronic NIMS system. Staff were aware of the most common patient-safety incidents reported and informed inspectors that patient safety information was shared at staff meetings and safety pauses

The hospital's rate of reporting of clinical incidents was approximately 230 per month which compare well to other model three hospitals. Although reported and monitored by the hospital, the 'rate of clinical incidents reports to NIMS per 1000 bed days' was not included in published Hospital Patient Safety Incident Reports (HPSIR) in 2022 and in 2023 year to date. A co-ordinated approach with support from Saolta University Health Care Group and HSE should be engaged to ensure timeliness of publication of local HPSIR data.

Medication safety incidents were tracked and trended by the medication safety committee with quarterly reports developed for the Drugs and Therapeutics Committee. A summary of all incidents was provided by medicine category, NIMS incident category, type of error and medicine process involved. Examples of shared learning notices distributed to staff were reviewed by inspectors.

A root cause analysis was undertaken for the top five medicine categories causing incidents. Information collated from incidents was used to identify actions required and areas for improvements. Medication safety moments were developed and disseminated to staff to share learning. Incident reports were summarised and shared with relevant staff including consultants, NCHD's and nurses. Education on medication safety and incident reporting was provided at a recent nurse's induction session, and targeted medication education was provided for staff in ED using examples of local incidents to share learning.

HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents. The hospital were tracking and trending incidents which were reviewed locally by directorate staff at weekly review meetings. There was evidence that the relevant committees had oversight of the management of these incidents and that the hospital's Quality Safety Governance Group and the Saolta Group's Senior Incident Management Team had oversight of serious incidents and reportable events. A co-ordinated approach with support from Saolta University Health Care Group and HSE should also be engaged to ensure timeliness of publication of local HPSIR data.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of Portiuncula University Hospital to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

Portiuncula University had integrated corporate and clinical arrangements in place which were appropriate to the size, scope and complexity of the services provided. Senior management and clinicians at the hospital had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital.

The hospital had effective management arrangement in place to support and promote the delivery of care in the emergency department. On the day of inspection, the hospital's emergency department (ED) was busy, relative to its intended capacity. The ED was not compliant with national HSE targets related to patient experience times. The hospital was challenged with capacity issues and lack of isolation facilities resulting in poor patient flow from the ED. The mismatch between demand for inpatient beds, especially isolation facilities, and the hospital's overall capacity resulted in 14 admitted patients being accommodated in the ED awaiting an inpatient bed. However new attendees to the department were triaged promptly and not waiting long periods for medical review.

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services for infection prevention and control, medication safety, the deteriorating patient and transitions of care in the wider hospital and clinical areas visited by inspectors on the day of inspection.

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality and safety of healthcare services at the hospital. However, the hospital should ensure that all national performance indicators are collected and reported in line with national guidance and descriptors.

Hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department and wider hospital to support the provision of high-quality, safe healthcare. The hospital was actively recruiting to fill vacant posts, and needs to continue recruitment activity to fill positions such as pharmacy vacancies which had been challenging to recruit. The uptake and oversight of essential and mandatory training required improvement across all professions and staff grades.

Quality and Safety

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. Inspectors observed staff being kind and caring towards people using the service. 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.

However, despite staff efforts to maintain patients dignity and respect, the practice of accommodating inpatients on trolleys on the ED corridor impacted on any meaningful promotion of the patient's dignity, privacy and autonomy and was not consistent with the human rights-based approach to care supported and promoted by HIQA. The physical environment in the clinical wards visited did not support the promotion of privacy and dignity. The hospital should ensure that patient's personal information is protected at all times in line with legislation and best available evidence.

The hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and noted good response to findings from the National Inpatient Experience Survey. However, the hospital would benefit from a process to record, track and trend all verbal complaints to share learning and help reduce the risk of reoccurrence. The hospital should progress the use of the CMS, as planned, to support the monitoring and reporting of complaints in line with national metrics, and to provide assurance of the quality and safety of the hospital's complaints management's process.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. Wards were congested, and there was a lack of isolation facilities and en-suite facilities which increases the risk of cross infection.

HIQA was satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital relevant to the size and scope of the hospital. However, the hospital needs to ensure that recommendations and areas for improvement identified by audit activity have time-bound action plans in place with re-audit plans to ensure improvements in practice occurs.

On the day of inspection HIQA were not fully assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm. Patients were accommodated in an overcrowded ED environment, there was restricted access through the ED corridors, trolleys were in close proximity and patients requiring isolation were accommodated in the ED awaiting an inpatient bed with potential IPC risks. There was a lack of access to a clinical pharmacist service for admitted patients accommodated in the ED to support safe medication practices in the emergency department.

The hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, the hospitals inadequate capacity and infrastructure such as inadequate single rooms and lack of en-suite facilities posed serious risk to patient of acquiring hospital associated infection as the demand for isolation facilities far exceeded the available resources. The hospital needs to continue to monitor and mitigate the medication-safety risks identified through risk assessment.

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 relation to 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 selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the 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	
Overall Governance	
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	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Judgments relating to Emergency Department findings only	
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
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

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
Theme 5: Leadership, Governance and Management	
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.	Substantially compliant
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	Substantially 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.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
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
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.	Substantially compliant

Appendix 2 Compliance Plan

Compliance Plan for Portiuncula University Hospital

OSV-0001033

Inspection ID: NS_0041

Date of inspection: 09 and 10 May 2023

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* ***Emergency Department***.	Partially Compliant

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

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

Work Force Planning

Consultant in Emergency Medicine:

- The report noted that the achieved level of cover was due to additional overtime shifts by the three substantive Consultants in Emergency medicine and locum cover which might not be sustainable on a long term basis.
- In response to this report, a submission has been approved at Group level for a WTE 1.0 assigned to PUH for a Consultant in Emergency medicine. The application process to CACC is in process.
- Once successful recruitment has occurred, this will reduce the 1 in 3 on-call work schedule.
- On call commitment is 1 in 4 as the roster is supplemented by a regular locum Consultant in Emergency Medicine.

Emergency Medicine Nursing Staff.

- N=5 Vacant Nursing Posts on the day of inspection. The Director of Nursing reports on on-going recruitment campaign to fill all outstanding vacant Nursing post in the Emergency Department and across the wider hospital.

Clinical Pharmacy

- *Clinical Pharmacist in the ED setting* to undertake clinical pharmacy reviews and medicine reconciliation for patients accommodated in ED. Sanction approved to hire a Clinical Pharmacist to provide services to new 12 bedded (Dunlo) ward 50% (WTE 0.5) with the other 50% (WTE 0.5) assigned to the Emergency Department.
  Note: Pharmacy recruitment is difficult at this time due to a recognised shortage of qualified pharmacists. Replacing current vacancies has not been possible over the last few years with several campaigns yielding no replacements. Re-grading vacant posts is being pursued as a strategy to improve the chances of recruitment along with agency and EU recruitment.

Security Detail in the Emergency Department

- At the time of the inspection the security detail were providing cover from 8-8pm. This has been extended to 24 hour cover since June 2023.

Mandatory Training:

- Mandatory education record tool has been updated, Clinical Nurse Managers are been provided with education on its function supported by recorded YouTube clips. All nurse and HCA education will be recorded at department level on this system. Certs and sign in sheets will be sent to the HR department. HCW s have been educated and pre-recorded demonstrations are provided via password protected you tube clips. This is a bespoke system to PUH. AMRIC Hand Hygiene has been updated. This is not scheduled throughout the year but will be provided on a needs basis.

- The report states that records of attendance outlining the uptake of mandatory and essential training by medical staff in the ED were not submitted. Mandatory Training is improving across the site. Circulated to Hospital Management Team, monthly by Human Resources Learning and Development.

- **Response**: The Human Resource Manager, Medical Manpower Manager and the Director of Nursing to develop a system of recording ***mandatory training*** that provides organisational ***oversight of compliance***. At present mandatory training is recorded on the HR – SAP system, for all staff. Nursing and Midwifery also record on a department system (Mandatory education record tool). The NCHDs use the NER (National Employment Record) as they relocate frequently between sites and HR in PUH upload the training records onto the SAP system.

- Discussion ongoing with HSELand by the Saolta Group of merging data to SAP for mandatory training.

- Aim to increase compliance on Sepsis / INEWs Training. This will be monitored via the Mandatory education record tool – Aiming for 100% by End of November 2023.

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

Recruitment:

- In order to meet the required WTE in staffing, funding will be required to uphold recruitment campaigns to support the hospitals work force plan which is continually under review and based upon service needs as identified.

Security for the wider hospital

- Funding available for dedicated Security Personnel within PUH 24/7, tender specification awaiting upload to the National procurement system.

Mandatory Training: Organisational oversight across disciplines.
Discussion ongoing with HSELand by the Saolta Group of merging data to SAP.

Timescale:

PRIORITY	*OWNER*	*ASSIGNED*	*DUE*	*STATUS*
HIGH	General Manager	▪ Medical Manpower Manager ▪ HR Manager	Complete by: 31.10.23 (*Consultant Post*)	**30%** Ongoing
High	General Manager	Director of Nursing	Complete by: 31/12/2023 (Nursing Recruitment)	**80% Ongoing**
High	General Manager	General Manager	Complete Security Detail in ED over 24 hour period.	**100%**
High	General Manager	▪ Human Resource Manager, ▪ Medical Manpower Manager ▪ Director of Nursing	Complete by: 31/12/2023 (Mandatory Training monitoring)	**60%**
High	General Manager	▪ AGM ▪ Chief Pharmacist	Complete by:31/12/2023 (Clinical Pharmacist assigned to ED)	**30%**

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

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

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

Capacity in the current Emergency Department

- **Accommodation limitation in ED** led to use of trolleys in narrow ED spaces. Proximity of trolleys placed near to or outside toilets.

- ***Response:*** A floor plan for placement of trolleys within the ED was provided by the Fire Safety Officer HSE Estates West. This plan was reviewed by the Chief Fire Officer, Galway on an unannounced inspection in January 2023 and was subsequently revised to take into account the Chief Fire Officers recommendations. The revised plan was completed by the Fire Safety Officer HSE Estates West. The Health and Safety Authority are in receipt of the floor

plan and asked for a further revision of the floor plan which was carried out and is reflected in the PUH response to the HSA in May 2023.

- The report noted an **absence of patient toilets**, en-suite or shower facilities in ED-2, Commodes required or urinals. Number of toilets on ED-1 is inadequate. Toilet/Ensuite/Shower Facilities (ED)

  Response: The hospital is in the process of appointing a Design Team for a modular expansion build to the Emergency Department. This will improve the toilet facilities. The current ED ***2*** will be re-purposed for the provision of a minor injuries unit and emergency paediatric presentations.

Availability of comfort packs: None of the patient who spoke with the inspectors received one.

- **Response:** For a short period of time PUH didn't have comfort packs in stock, PUH now have the packs available to all patients admitted in ED and to any other patient within the hospital who may require one. Patient Advocacy and Liaison Officer (PALS) takes responsibility for ordering the required items via distributor and conducts supply checks of stock daily within departments.

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

Capital investment for expansion projects.

- 12 Additional Bed to open **September 2023**. This has 8 single en-suite rooms and two 2 bedded en-suite rooms. This development will provide additional beds and will accommodate service users requiring isolation rooms and end of life care. This will improve patient flow and reduce trolley occupancy in an inappropriate ED environment.

- The hospital is in the process of appointing a Design Team for a modular expansion build to the Emergency Department. Capital funding has been sanctioned for this expansion. This will improve the toilet facilities. This will have a direct impact on safeguarding patient care and offering Service users' dignity, privacy and autonomy.

Timescale:

PRIORITY	*OWNER*	*ASSIGNED*	*DUE*	*STATUS*
High	General Manager	*General Manager*	Complete by 09.23 (*12 Bedded*)	**90%**
High	General Manager	*General Manager*	Complete by 31.12.24 (ED Modular Build- as guided by HSE Estates)	**25%**
Low	General Manager	*PALS*	Complete: July 2023 (Comfort packs stock update)	**100%**

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. ***Emergency Department***	Partially Compliant

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

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

Patient Experience Times: ***Emergency Department***

- Patient admitted to the ED virtual ward were not included in Total Emergency Department Times (TEDT)**.**
  Response: ED Virtual Ward – in the future the recording of PET times will incorporate the virtual ward – the virtual ward needs to be changed to a lodged function on iPMS, this issue has been raised with the local iPMs co-ordinator and is progressing at group level. The General Manager for the BIU at group level who has responsibility for data collection is aware and will address this issue.

Recruitment: Clinical Pharmacist. See **Standard 6.1**

Security Detail in the Emergency Department

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

- **Recruitment**: In order to meet the required WTE in Clinical Pharmacy staffing, funding will need to be sanctioned at Saolta Group level to support the hospitals work force plan for roles as identified by the inspectors.

- **PET**: The recording of PET times is to incorporate the virtual ward (requires a Lodged function on iPMs). The General Manager for the BIU at group level who has responsibility for data collection is aware and will address this issue. At present it is unknown whether the configuration of this will have cost implications. The site will await updates.

Timescale:

PRIORITY	*OWNER*	*ASSIGNED*	*DUE*	*STATUS*
High	General Manager	*General Manager*	Complete by 31/12/2023 (Patient Experience Times)	**80%**
High	General Manager	*QPS Manager*	Complete (Risk Management	**100%**

			Updated Risk Register**)**	
High	General Manager	*General Manager*	Complete *(Violence and Aggression* Risk on both ED and Corporate Risk Register)	**100%**

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 standard. This should clearly outline:

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

Inadequate capacity and infrastructure:

- The replacement 50 bedded ward block is progressing with an expected completion date of August 2024. This will provide single room accommodation with ensuites. This block will ensure dignity and privacy for patients. In addition, it will also facilitate meeting areas for patients and clinical staff and improve the working environment
- 12 Additional Bed to open September 2023. This has 8 single en-suite rooms and two 2 bedded en-suite rooms. This development will provide additional beds and will accommodate service users requiring isolation rooms and end of life care. This will improve patient flow and reduce trolley occupancy in an unsafe environment.
- The hospital is in the process of appointing a Design Team for a modular expansion build to the Emergency Department. Capital funding has been sanctioned for this expansion. This will improve the toilet facilities. This will have a direct impact on safeguarding patient care and offering Service users' dignity, privacy and autonomy.

Waste Management:

- Risk Waste – collection and storage of all waste is currently being reviewed and this issue will be addressed by 31st October 2023.

Negative Pressure Rooms:

- Negative pressure rooms are available on St Johns ward (3), ED (1), Paediatric Ward (2) and in all of the ICU bays (8 – seven bays in use) . These negative pressure areas do not contain an anti-room with the exception of the negative pressure room in the Emergency Department. The new 50 bedded replacement ward block will have 2 compliant negative pressure rooms on each floor.

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

- The 50 bedded replacement ward block is progressing with an expected completion date of August 2024. This will provide single room accommodation with ensuites. The new 50 bedded ward block will have 2 compliant negative pressure rooms on each floor.
- Modular expansion build to the Emergency Department. Capital funding has been sanctioned for this expansion.
- The 12 bedded ward is due to open in September 2023. This ward include 8 single en-suite rooms and 2 twin rooms ensuite.

Timescale:

PRIORITY	*OWNER*	*ASSIGNED*	*DUE*	*STATUS*
High	General Manager	*General Manager*	Complete by 09.23 (*12 Bedded*)	**90%**
High	General Manager	*General Manager*	Complete by 08.24 The replacement 50 bedded ward block	**60%**
High	General Manager	*General Manager* Guided by HSE Estates	Complete by: 12.24 (ED Modular Build- as guided by HSE Estates)	**25%**
Mod	General Manager	*Estate Manager/IPC*	Complete: 30th November 2023 Hand Hygiene sinks Environmental Issues	**80%**
Mod	General Manager	*Service Manager*	Complete: 31st October 2023 Waste Management	**60%**

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. **Hospital Wide**	Partially compliant

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

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

Sharp bins:

- A full education programme has commenced in 2023 for the segregation and correct disposal of waste. This is provided to all staff and targeted on-going sessions in clinical areas. We have implemented the Biosystem for all departments in June 2023 and education and training has been provided to all staff by the Waste Co-ordinator and the contracting company.

Medication Safety.

- Medicine Preparation and printed versions of the guidance in use. An electronic solution is being progressed.
- First delivery of laptops installed and live, further delivery of touch screen units expected (for installation in locations where laptops could not be sited). Upon full roll out paper copies of resources will be removed.

Clinical Information System ICU:

- Extra expert resource identified and brought in to work with existing project team to work through the current ICCA implementation and review configuration and data with local site ICU pharmacist. Core formulary validation action plan produced and activity scheduled. Further external systems training arranged. Pending completion of these actions the risk is the same but will be reviewed

PPPG related to IPC.

- Infection Control policies updated and finalised.
- Draft Annual Report has been sent to the GM in May 2023.
- CNM 3 IPCT provided information regarding sharps buckets/safety via e-mail to HIQA.
- All IPCT Policies, Procedures, Protocols and Guidelines are up to date.

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

Clinical Information System ICU:

The configuration of the CIS to meet the service needs of the organisation may require upgrading based upon the outputs of the sites system analysis**.** At present it is unknown whether the configuration of this will have cost implications. The site will await updates.

Timescale:

PRIORITY	*OWNER*	*ASSIGNED*	*DUE*	*STATUS*
High	General Manager	*Director of Nursing*	Complete by 30th September 2023 (Sharp bins)	**90%**
High	General Manager	*AGM/Chief Pharmacist*	Complete by 30th September 2023 (Medication Safety./ Electronic solution)	**60%**
High	General Manager	*General Manager/ Chief Pharmacist*	Complete by: 31st December 2023 (Clinical Information System ICU	**25%**
Mod	General Manager	*DON/IPC Leads*	Complete: 30th September 2023 PPPG related to IPC	**80%**