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:	Sligo University Hospital
Address of healthcare service:	The Mall Sligo F91 H684
Type of inspection:	Unannounced Inspection
Date(s) of inspection:	12 and 13 July 2023
Healthcare Service ID:	OSV-0001089
Fieldwork ID:	NS_0048

About the healthcare service

Model of Hospital and Profile

Sligo University Hospital is a model 3* public acute hospital. It is a member of and is managed by the Saolta University Health Care Group.† The hospital provides acute medical and surgical inpatient, outpatient, and day services as well as maternity services and regional specialty services in ophthalmology, neurology, dermatology, rheumatology and ear, nose and throat services. The hospital's catchment area includes Sligo, Leitrim, South Donegal and West Cavan.

Sligo University Hospital also has governance over 35 short-stay beds in Our Lady's Hospital Manorhamilton.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	342 inpatient beds which includes the 35 short stay beds in Our Lady's Hospital Manorhamilton. 59 day case 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

*A Model 3 hospital is a hospital that admits undifferentiated acute medical patients and provides 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 and Roscommon University Hospital. The Hospital Group's Academic Partner is the University of Galway.

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, 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
- 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

[‡] 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)

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
12 July 2023	09.00-18.00 hrs	Eileen O'Toole	Lead
		Patricia Hughes	Support
13 July 2023	09.00-16.00 hrs	Nora O'Mahony	Support
		Aoife O'Brien	Support

Information about this inspection

An unannounced inspection of Sligo University Hospital was conducted on 12 and 13 July 2023 as part of HIQA's statutory role to monitor the quality and safety of healthcare services and as a follow-up to HIQA's previous one-day unannounced inspection of the emergency department in September 2022. An assessment of compliance with four standards from the *National Standards for Safer Better Healthcare* found that that Sligo University Hospital was non-compliant in one standard and partially compliant in three standards in the emergency department. The hospital provided a compliance plan which set out actions and timeframes proposed by the hospital to bring the hospital back into compliance. The plan was included in HIQA's 2022 published report.

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 inspection team visited three clinical areas:

- emergency department
- medical south
- surgical north

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

- Representatives of the hospital's Executive Management team
  - Hospital Manager
  - Assistant General Manager (AGM)
  - Assistant Director of Nursing (ADON)
  - Associate Clinical Director (ACD) Medicine
- Quality and Risk Manager
- Human Resource Manager and Medical Manpower Manager
- A representative from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics

§ The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
** Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
†† Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Irish National Early Warning System (INEWS) and Sepsis
- Delayed Discharge and Bed Management.

Inspectors also spoke with medical staff, nursing management, staff nurses and people receiving care in the hospital. Inspectors reviewed a range of documentation, data and information received after the on-site inspection at Sligo University Hospital

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 told inspectors and what inspectors observed in the department

On the day of inspection, inspectors visited the emergency department (ED), which operates 365 days a year. The ED provided 24/7 access for undifferentiated emergency and urgent presentations for both adult and paediatric patients. Attendees to the ED presented by ambulance, were referred directly by a general practitioner (GP) or self-referred.

The emergency department had a planned capacity for 30 service users comprising:

- two triage rooms and one post triage room
- resuscitation area comprised four bays for the treatment of patients categorised as major. One double cubicle was set up for adult and paediatric resuscitation and there were two single cubicles
- fourteen adult 'major' bays, two of which are single rooms
- paediatric area comprising four cubicles, one of which was a single cubicle
- four bay ambulatory care area (one further bay used for storage of consumables)
- one room for eye examinations
- there were eight toilets in the emergency department for patients' use, two of which were located in the adult waiting area.

Renovations to the ED which had been completed in 2022 included a new area comprising four single rooms that were intended for use for patients with a communicable disease. This area was not in use by the ED but had a temporary dual purpose, as an interim space for the discharge lounge Monday to Wednesday and for review of patients from the acute

assessment unit (AAU) Thursday and Friday. The patients reviewed in the AAU were referred by GP or patients from the ED that met the criteria to be seen in AAU.

On arrival at the ED, patients checked in at reception and were directed to the adult or paediatric waiting areas to be called for triage. At the time of registration, if patients were symptomatic of any communicable infectious disease the Clinical Nurse Manager (CNM) in ED was alerted and the patient was shown to an alternate waiting area. Multidrug-resistant organism (MDRO) alerts were accessed on the patient management system and this information was communicated by use of a sticker placed on the chart and on the whiteboard (dashboard) in ED.

The adult waiting area in the emergency department comprised 35 chairs, inspectors noted that access to the ED area was via a security fob. Hospital management reported that a health care assistant performed regular observations within this area to ensure that patients were safe. Outside of these times, patients had to go outside and re-enter reception if assistance was required. A separate paediatric-friendly waiting area comprised 14 seats which provided audio-visual separation as recommended in the national model of care for paediatric healthcare services.[‡‡]

Although spacious, the layout of the various areas within the ED were quite spread out from each other. The single cubicles did not have en-suite facilities and there was no neutral or negative pressure rooms[§§] in the department. There no shower facilities within the ED but inspectors were told that patients could access shower facilities in the AAU by arrangement with staff.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment, in line with current public health guidelines.

On the day of inspection, at 10am, the emergency department appeared calm and controlled. Forty five patients were receiving care and treatment in the department, nine of these patients were admitted patients awaiting inpatient beds, six were attending a review clinic, seven were awaiting discharge, 23 not yet admitted, not yet discharged and three patients were awaiting triage.

Inspectors spoke with a number of patients in the emergency department to hear their experiences of the care received in the emergency department on the day of inspection. Patients stated that they had 'no complaints' and were 'seen quickly'. Patients' did speak about the difficulty of maintaining privacy and dignity and overhearing conversations

[‡‡] National Model of Care for Paediatric Healthcare (HSE). https://www.hse.ie/eng/about/who/cspd/ncps/paediatrics-neonatology/moc/chapters/

[§§] 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.

about past medical history. Their experiences were consistent with the hospital's overall 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 7.3, lower than the national average of 8.1.

Inspectors observed staff to be kind, caring and respectful to their patients.

Patients who spoke with inspectors did not know how to make a complaint, but said that they would contact a nurse if they needed to. Patient Advice and Liaison Service (PALS) leaflets were available in the ED department.

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

Capacity and Capability Dimension

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 hospital related to the capacity and capability dimension are presented under national standard 6.1 from the theme of workforce.

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

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

Inspectors found that the 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. Organisational charts setting out the hospital's reporting structures were submitted to HIQA, on day one of inspection. These charts detailed the direct reporting arrangements for hospital management and the governance and oversight committees. The hospital was governed and managed by the

*** 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 National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

Hospital Manager who reported to the Chief Operation Office of the Saolta University Health Care Group.

The hospital had a clinical directorate model and each of the hospital's directorates had an Associate Clinical Director (ACD) to provide oversight. The directorates included:

- Medical
- Peri-operative
- Laboratory
- Women's and Children's
- Radiology
- Cancer

The ACD's reported to the Hospital Manager on operational basis and on a professional basis to the Clinical Director of the Saolta University Health Care Group.

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

Executive Management Team

The Executive Management Team (EMT) has accountability for leading and overseeing all aspects of performance of the hospital and ensuring the delivery of high quality, safe care of patients using hospital services. Chaired by the hospital's Hospital Manager, the EMT met fortnightly and had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. Membership comprised the Hospital Manager (or deputy), Director of Nursing, Director of Midwifery, ACD's, Head of Finance, Head of Human Resources and health and social care professional representative. Minutes of committee meetings, submitted to HIQA, showed that the meetings followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting.

The ACD's give a six monthly update on their directorate as part of the structured service update.

A patient story was part of the standing agenda and was not discussed at all of the limited number of minutes reviewed which was a missed opportunity to focus on the quality and safety outcomes for people using the service.

The EMT reported to the Saolta University Health Care Group at alternative monthly performance meetings.

Quality and Safety Executive Committee

The Quality and Safety Executive Committee (QSEC) was responsible for planning and monitoring the strategic approach to quality, safety and risk management activities at Sligo University Hospital. The committee, chaired by medical consultant, met every month, in line with the terms of reference, and had appropriate membership.

The executive management team organogram details that the following committees reported into QSEC which in turn reported into the EMT:

- Infection Prevention and Control Committee
- COVID-19 Outbreak Committee
- Hygiene Services Committee
- Drugs and Therapeutics Committee
- Haemovigilance/Blood Transfusion Committee
- Radiation Safety Committee
- Healthcare Records Committee
- Health and Safety/Hospital Watch Committee
- Decontamination Subcommittee
- Medical Devices/Equipment Management Committee
- Resuscitation Committee
- Deteriorating Patient Group (incorporating sepsis management)
- Critically ill/Deteriorating Child Group

Minutes of meetings submitted to HIQA showed that the committee had oversight of the hospital's risk register, patient-safety incidents, the Health Service Executive's (HSE) hospital patient safety indicator report (HPSIR) and provided an update on implementation of patient safety quality improvements. QSEC also was responsible for the oversight and review of the patient experience of the quality of care provided. It was unclear, from the sample of meetings submitted, that QSEC discussed complaints management or feedback on patient experience which is an opportunity for improvement.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control (IPC) Committee was responsible for the governance and oversight of infection prevention and control at the hospital. The committee met quarterly and was chaired by the Assistant General Manager. Minutes of meetings reviewed demonstrated that meetings were well attended but not all items discussed were being progressed, and inspectors note that the minutes would benefit from having clearly defined time-bound actions.

The IPC Committee was operationally accountable to QSEC and was responsible for the provision of an annual report to the GM on the performance of the service. There was no infection prevention and control risk register but risks associated with infection prevention and control are contained in the hospital's risk register. The Hygiene Services Committee worked cohesively with the IPC committee in the development and improvement of hygiene practices and processes.

HIQA was satisfied with the governance and oversight of infection prevention and control practices, and identification and management of infection outbreaks at the hospital.

Drugs and Therapeutics Committee

The hospital had a Drugs and Therapeutics Committee with assigned responsibility for the governance and oversight of medication safety practices at the hospital. The committee was chaired by a medical consultant and the deputy chairperson was the chief pharmacist. The terms of reference submitted to HIQA post the onsite visit specified that the committee would meet every three months but minutes of meetings submitted did not support this. The committee had met once in 2023 (May) to year to date. This is an opportunity for improvement. The terms of reference were also noted to be out of date since 2021.

The committee was operationally accountable and reported to the EMT through QSEC. An annual report was to be filed annually from the Drugs and Therapeutics committee into QSEC and had not being completed since 2020, inspectors were informed that the 2022 report was currently being prepared. Minutes reviewed demonstrated good attendance and attempts to change timings of meetings to ensure key members' attendance. The minutes would benefit from having clearly defined time-bound actions. Antimicrobial stewardship was a standing item on the agenda and the antimicrobial pharmacist sent a report in advance of meetings and it was included in minutes. The medication safety pharmacist also prepared a report prior to meetings which included medication incident review and medication safety alerts.

Deteriorating Patient Improvement Programme (incorporating Sepsis management)

The hospital had a deteriorating patient improvement programme committee (DPIP) whose responsibility was to ensure appropriate robust structures, systems, processes and resources are available within the organisation to effectively manage the early recognition of clinical deterioration of patients. Both the Sepsis and Simulation Committees were a subgroup of the DPIP Committee. The DPIP committee had a set agenda which was aligned to the National Standards for Safer Better Healthcare, and which included Irish National Early Warning System (INEWS)[†††] and sepsis.

[†††] 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

The committee was chaired by a consultant physician and had good representation and attendance from the multidisciplinary team. The committee was set up in February 2023 and had met three times in total. There was evidence that items discussed were being progressed however, the minutes would benefit from having clearly defined time-bound actions. Meeting dates and times did not follow a set schedule but was to be set after discussion at each meeting of the committee. The committee would benefit from having a set schedule of meetings to ensure attendance and to ensure actions are followed up.

Unscheduled Patient Pathway Group

The Unscheduled Patient Pathway Group (UPPG) was responsible for reviewing and improving the flow and experience of emergency patients through Sligo University Hospital and onward into the community. It reported directly into the EMT. This committee was chaired by the GM and membership included the ACD from medicine and peri-operative services, the clinical leads in ED and care of the older programme, General Practitioner (GP) representative, diagnostics representative and community services liaison officer Community Healthcare Organisation (CHO) 1, DON, ADON's, bed manager, discharge coordinator and National Ambulance Service (NAS) representative. The committee met monthly and minutes of meetings reviewed showed good attendance from all disciplines and community members which demonstrated commitment to support patient flow through the hospital and onward into the community. The hospital had achieved the goal of developing an integrated response to patient flow as per compliance plan following the previous inspection in September 2022.

The following data was reported on and discussed:

- trolley numbers
- AAU attendances and overnight numbers
- ED new attendances
- admission numbers
- bed occupancy
- average length of stay
- ED patient experience times for admitted and non-admitted patients
- delayed transfers of care
- home by 12 midday
- peak admission dates

have given birth or had a miscarriage within the previous 42 days and the Paediatric Early Warning systems (PEWS) (children).

- community intervention team service update
- discharge lounge numbers and hours saved

Minutes showed good collaboration and feedback from community partners and from NAS.

QSEC should ensure that review of patient complaints and patient feedback forms part of the standing agenda. Hospital management should ensure that the DPIP committee meeting schedule is more formalised and that the committee meets regularly. The Drugs and Therapeutics committee should review their terms of reference and should meet in line with the terms of reference.

Overall, it was clear to HIQA that the hospital had formalised corporate and clinical governance arrangements in place. There was evidence of an effective system of leadership and management at the hospital. A number of meeting minutes reviewed showed that meetings followed an agenda, however, some committees would benefit from having clearly defined, time-bound actions that are assigned to individuals for all committee meetings that take place.

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

Inspectors found that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of emergency care however there is scope for improved performance at operational level. There was some evidence of clinical leadership in the emergency department.

Emergency care at the hospital was led by the Speciality Lead for Emergency Medicine under the governance and leadership of the Medical Directorate, led by an ACD who in turn reported to the Medical Clinical Director of the Saolta University Health Care Group. There was evidence that this relationship had strengthened following last inspection by HIQA and the ACD now attended the emergency department's Speciality Management Team (SMT) committee meetings.

Operational governance and oversight of day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine supported by non-consultant hospital doctors. Consultant on-site cover was from 8am to 8pm Monday to Friday. Outside these times, medical oversight of the emergency department was provided by on-

call rota of six whole time equivalent (WTE)[‡‡‡] consultants in emergency medicine. Additional on-site 24-hour medical cover was provided through a rota of non-consultant hospital doctors (NCHDs).

The emergency department Speciality Management Team Committee was chaired by the Speciality Lead for emergency medicine. The function of the SMT was to manage ED in line with local, regional and national objectives ensuring the delivery of a high quality, patient-centred service in a safe, equitable and efficient manner. The committee reviewed the emergency department's activity and performance, risks, incidents, complaints, staffing and audits. In minutes reviewed by inspectors, the committee was well attended by appropriate personnel, with a set agenda. Required actions were outlined and assigned to a responsible person. The emergency department SMT was operationally accountable to the Executive Management Team (EMT). The chairperson on behalf of the emergency department SMT reported to the Hospital Manager or the ACD for medicine.

As discussed in standard 5.2, the Unscheduled Patient Pathway Group (UPPG) was responsible for reviewing and improving the flow and experience of emergency patients through Sligo University Hospital. The ED's activity, patient experience times and trolley numbers were further discussed at this forum and escalated to the EMT.

On arrival to the emergency department, self-presenting attendees checked in at reception, were assessed for communicable disease and waited to be called for triage. All patients were triaged and prioritised in line with the Manchester Triage System.[§§§]

On the first day of inspection, management at the hospital stated that it was in escalation[****] and the hospital manager outlined the additional actions taken to support patient flow in line with the hospital's escalation policy. At 11am, there were 36 patients registered in the emergency department. Of these 36 patients, 2 (2.7%) were aged 75 years or older. Twenty eight per cent had been referred by their GP, 54% had self-referred and 17% had arrived by ambulance.

From those 36 patients:

- 23 patients (64%) were in ED for more than six hours following registration
- 31 patients (86%) were in ED for more than nine hours following registration

[‡‡‡] 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.

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

[****] 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

- three patients (8%) were in ED for more than 24 hours following registration, the longest waiter was there for 45 hours (awaiting isolation bed)

Eight of the 36 patients registered in the ED were admitted but were awaiting a bed on a ward.

Compared with HIQA's findings during an inspection of the ED in September 2022, these times demonstrated a deterioration in waiting times for patients in the ED for more than nine hours and an improvement in the number of patients waiting in the ED for more than 24 hours.

On the day of the 2023 inspection:

- The wait timed from registration to triage was from four to 55 minutes with a mean wait of 22 minutes (HSE target is 15 minutes). This is a deterioration in the average wait of 17 minutes noted in 2022.
- The waiting time from triage to medical assessment ranged from 10 minutes to three hours and 53 minutes with a mean time of one hour 53 minutes. This was a substantial improvement in the average of four hours 14 minutes noted in 2022.
- The waiting time for medical assessment to decision to admit ranged from five hours and 55 minutes to 11 hours and 50 minutes with an average of six hours 48 minutes. This shows a slight deterioration in the average of six hours 35 minutes noted in 2022.

In 2019, the attendance rate at the hospital's emergency department was 41,126 which equated to an average attendance rate of 3,427 each month or 113 per day. In 2022, the attendance rate increased to 43,197, which equated to an average attendance rate of 3,600 each month or 118 per day demonstrating an increase of 262 people each month or an increase of 7.8%. In the first six months of 2023, the attendance rate was 21,601, which equated to an average attendance rate of 3,600 each month demonstrating no increase from 2022.

Inspectors were informed that the hospital's catchment area had an increasing elderly population with complex morbidities and challenging access to GP's which was resulting in increased attendances, increased trolley numbers and pressure on inpatient beds.

The conversion rate (rate of admission of patients to an inpatient ward) for the emergency department over a 12-month time frame in 2022 was 24.7% and in 2023 to time of inspection was 24%. As per previous inspection findings, the hospital indicated that these figures did not include the number of admitted patients who had their entire episode of inpatient care conducted within the ED. This needs attention to ensure accuracy of reporting and this had been highlighted as an issue during the last inspection in September 2022.

The average length of stay (ALOS) for medical patients for 2022 was non-compliant with national targets. The ALOS for medical patients was 8.1 (national target 7.0 days or less) which was among the highest in model three hospitals. On the day of inspection the ALOS for medical patients was six days. Hospital management attributed the longer 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 care.

The hospital had systems and processes in place to support continuous and effective patient flow through the emergency department. These included:

- progression of plans to build a 42-bed modular unit, with commencement of building works in quarter four, 2023
- a further 26 off-site beds had been identified and would be available by January 2024
- an ambulatory care unit which opened 8am to 8pm seven days a week. The service was staffed by advanced nurse practitioners and or registrars. Inspectors were informed that an emergency consultant was also allocated to the ambulatory care unit Monday to Friday.
- well-established patient pathways were in place for conditions such as: deep vein thrombosis, renal colic, chest pain, atrial fibrillation and syncope. These pathways expedited the patient's assessment, access to diagnostics and management, with the opportunity to return for further diagnostics and management avoiding an inpatient admission
- use of the 12-bedded AAU for admitted patients awaiting an inpatient bed. Inspectors were told that this then impacted the ability of GP's to refer directly to AAU resulting in direct referrals into the ED
- opening of a discharge lounge for three days per week- initially planned for an area adjacent to the main reception area. Inspectors were told that a longer term solution for the location of the discharge lounge with increased hours of operation is underway and is the responsibility of the ADON-patient flow
- a Hospital Ambulance Liaison Person (HALP) on site in ED (employed by NAS)
- the hospital's escalation policy detailed a key principle of a zero tolerance to breaches of the 24-hour trolley patient experience time. This was then escalated to the GM, highlighted on daily reports and discussed at navigational hub meetings
- an emergency department Frailty Intervention Therapy Team (FITT) comprised three WTE occupational therapists, two WTE physiotherapists, two WTE clinical nurse specialists, two WTE social worker practitioners, administration support and a dietitian. The team reviewed patients aged 65 years or more presenting to the ED

in line with national best practice guidance. The aim of the FITT was to undertake a comprehensive assessment and review, improve patient flow through the ED, reduce unnecessary hospital admission, decrease length of stay and liaise with community partners to optimise patient services in the home. The hours of operation were from Monday to Friday, 8am to 6pm.

From January 2023 to July 2023, the FITT saw an average of 70 patients per month which is an increase of 37% since 2021. Within this increased workload, the percentage of patients the FITT continued to assess, treat and discharge patients has remained steady at 53%. The length of stay of patients reviewed by FITT has increased from 7.5 days in 2021 to 8.5% in 2023, an analysis of this increase may present an opportunity for improvement.

The FITT had four WTE vacant posts which were a combination of positions that had been vacant since the previous inspection and newly approved posts. These posts included a therapy assistant (1 WTE), a speech and language therapist (1 WTE), a physiotherapist (0.5 WTE) and a pharmacist (1.5 WTE) Recruitment was ongoing. Of note, the FITT did not have a clinical pharmacist within their current team which was a resource deficit since HIQA's last inspection in September 2022. As part of the compliance plan following the last inspection by HIQA the hospital had undertaken to increase the FITT hours to cover the weekend by quarter one of 2023, this had not yet been achieved. Further vacancies existed in the integrated older persons team of a Consultant (0.5 WTE) and a NCHD (0.5 WTE).

Notwithstanding the above initiatives to support patient flow through the department, the hospital remained in escalation on day of inspection, admitted patients were boarded in the ED and one patient had remained there for more than 45 hours. The presence of admitted patients in the ED awaiting a bed was impacting on the ED's ability to manage their patient experience times in line with national targets. Delays to hospital inpatient admission for patients in excess of five hours from time of arrival at the ED are associated with a statistically significant linear increase in mortality.[††††]

On the first day of inspection, inspectors observed that the emergency equipment within the ED was not checked daily as per department policy. One trolley had not been checked since 30 June 2023 and another since 1 July 2023. This was brought to the immediate attention of the clinical nurse manager and a request that all emergency equipment receive an assessment to ensure the quality and safety of healthcare delivered to people who use the service.

Although the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department, inspectors noted that the hospital was challenged with capacity issues and limited isolation facilities which

[††††] Jones S, Moulton C, Swift S, Molyneux P, Black S, Mason N, Oakley R. Mann C. Association between delays to patient admission from the emergency department and all cause 30-day mortality. Emergency Medicine Journal 2022;3

contributed to admitted patients being accommodated in the ED whilst awaiting an inpatient bed.

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 for the wider hospital and clinical areas and these are discussed in more detail below.

Infection, prevention and control

The hospital had an infection prevention and control team comprising;

- two WTE consultant microbiologists
- one WTE assistant director of nursing
- four WTE clinical nurse specialists or clinical nurse managers grade 2 with one WTE based in Our Lady's, Manorhamilton
- one WTE surveillance scientist

The hospital had effective management arrangements in place to support the delivery of the IPC programme. Staff reported having 24-hour access to the consultant microbiologist via telephone and cover was also provided for patients being cared for in the 35 short-stay beds in Our Lady's Hospital, Manorhamilton. There was an Outbreak Committee convened as necessary and reports were completed at the end of an outbreak where learning was shared with staff.

The hospital had an antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship programme.[‡‡‡‡] The antimicrobial pharmacist prepared an antimicrobial stewardship activity update for the Drugs and Therapeutics Committee meetings. This report detailed audits, antimicrobial consumption and antimicrobial stewardship rounds.

Medication safety

The hospital's pharmacy service was led by the hospital's chief pharmacist. At the time of inspection the hospital had an approved WTE of 24.91 WTE with 20.56 WTE pharmacists in post. A vacancy rate of 17.46%. The approved WTE for technicians was 19.51 WTE with 21.42 WTE pharmacy technicians in post. The over approved 1.91 WTE were temporary positions. There was ongoing recruitment to fill the vacant pharmacist posts but the hospital highlighted a current difficulty recruiting pharmacists, in particular for

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

temporary and part time positions. Hospital management should continue recruitment to fill vacant pharmacist posts to support medication safety.

There was no clinical pharmacy service in the ED, paediatrics, maternity or renal unit and there was no backfill for pharmacists on leave. The clinical pharmacy service within the areas that had this service provided a clinical review of all prescribed medicines and medicines reconciliation on admission but not necessarily on discharge. Admitted patients in the ED did not have medicines reconciliation completed.

The deteriorating patient

Inspectors were told that the directorate ACDs were the leads for each of the early warning systems in their areas of responsibility. The link nurse on each ward was the clinical nurse manager, grade 2 (CNM2). The Saolta University Health Care Group 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[§§§§] in line with national guidance. There was a sepsis ward champion on each of the wards inspected.

Transitions of care

HIQA was satisfied that the hospital had arrangements in place to monitor issues that impacted effective, safe transitions of care. Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge.

The Unscheduled Patient Pathway Group (UPPG) was responsible for reviewing and improving the flow and experience of emergency patients. A complex integrated discharge group met weekly to progress inpatient discharges. Bed management meetings were held on a twice daily basis to plan and manage all aspects of bed management and discharge planning. Navigational hub meetings occur twice daily which ward managers attend. The community intervention team (CIT)[*****] and public health nurse also attend this hub on occasions to aid complex discharge planning. Plans were in progress to increase the patient flow team so that the hours of operation would include evenings and weekend. A CIT coordinator had been recruited as per compliance plan.

Monthly meetings were held to discuss the patients that were experiencing delayed transfers of care (DTOC) where each individual case was discussed. Most recent published performance data[†††††] for 2022 shows that Sligo University Hospital's monthly average

[§§§§] 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.
[*****] 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
[†††††] ttps://www.hse.ie/eng/services/publications/performancereports/management-data-report-december-2022.pdf

number of beds subject to delayed transfer of care was 10 which compares very well to other model 3 hospitals. On the day of inspection there was 10 patients with DTOC in the hospital, and between January and April 2023 there were between six to 13 patients with DTOC in the hospital.

The hospital had rolled out a 'Model Ward' structure where ward processes are formalised, bringing all members of the interdisciplinary team together to ensure seamless patient care planning from admission to discharge. The current status of the patient's journey was recorded and updated on a ward whiteboard including the patient's predicted date of discharge (PDD).

Access and integration of services was a standing agenda item at the Saolta University Health Care Group level during bi-monthly performance meetings, which detailed issues relating to both scheduled and unscheduled care.

The safe inter-departmental and external transfer of patients within and outside the hospital was supported by two policies, Sligo University Hospital Admission, Transfer and Discharge Policy and the Sligo University Hospital Escalation Plan.

In summary, the hospital had defined management arrangements in the four areas of known harm to manage, support and oversee the delivery of safe and reliable healthcare in the wider hospital and clinical areas visited on the days of inspection. It was clear that hospital management were committed to supporting the transition of patients out of the hospital, had developed strong community links and were working collaboratively to improve patient outcomes. Despite this, on the days of inspection, the mismatch between the demand for inpatient beds and the hospital's overall capacity resulted in admitted patients being accommodated in the ED awaiting an inpatient bed. Some improvements in the patient experience times were seen but were not conclusive enough to represent a true improvement for patients. Hospital management need to improve the operational oversight and management to address the patient flow issues in a timely manner and reduce the risk of admitted patients experiencing prolonged delays in accessing a hospital bed, a delay which is associated with an increased risk of morbidity and mortality for patients.

Judgment: Partially Compliant

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

Findings relating to the emergency department

The hospital had some but not all of the workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare.

A senior clinical decision-maker,[‡‡‡‡‡] consultant or registrar, was available on-site in the emergency department 24/7. Consultants were on-site 8am to 8pm, Monday to Friday, and one consultant provided on-call cover out-of-hours. The ED had approval for eight WTE consultants in emergency medicine at time of inspection with six WTE in position. There was a vacancy of two WTE (25%) however, a further one WTE consultant in emergency medicine was due to start in September 2023. A locum consultant was currently in post (covering sabbatical). All but one of the consultants was on the specialist register with the Irish Medical Council, inspectors were told that appropriate supervision and support was in place, in line with current HSE guidance.

One of the consultants in emergency medicine was the assigned clinical lead for the department who provided leadership in clinical and operational matters. Concerns were escalated, in the main, to the GM of the hospital. Attendees to the ED were assigned to the consultant on-call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the ED while awaiting an inpatient bed.

The consultants in emergency medicine at Sligo University Hospital were supported by non-consultant hospital doctors who provided on-site medical cover 24/7/365:

- Approved for 10 WTE registrars. 8.46 WTE registrar grade of which 4 WTE were at specialist registrar grade were in post (15.4% vacancy)
- Approved for 8 WTE Senior house officers. 12 WTE in post
- Approved for 1 WTE intern. 0.9 WTE in post

Inspectors were informed of the difficulty in recruiting NCHD's at registrar grade and given that 1.54 WTE positions were not filled, the hospital had over recruited by 4 WTE at senior house officer grade to minimise the risk. The hospital was an approved training site for non-consultant doctors on the basic training scheme and higher specialist training scheme in emergency medicine.

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 unscheduled care. Issues such as staffing shortages were escalated to the operational ADON. A CNM2 or shift leader was on duty each shift and had responsibility for nursing services out-of-hours and at weekends in the ED. The CNM2 escalated issues to the operational ADON outside core working hours. Staff responsible for paediatric patients were rostered on duty between the hours of 8am and 8pm Monday to Sunday. The department had recently recruited two new

‡‡‡‡‡ 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.

advanced nurse practitioner (ANP)[§§§§§] candidates, one for general ED and one for paediatric patients.

The emergency department had an approved complement of 66.31 WTEs nursing staff, with 57.31 WTEs (86.4%) nursing positions filled on day of inspection. The variance between the approved and actual nurse staff complement was nine WTEs (13.6%). This does not represent an improvement since last inspection in September 2022. The approved complement for healthcare assistants was 8.73 WTE which reflected an uplift of one WTE since the previous inspection. All healthcare assistant posts were filled. Inspectors were told that the hospital management were actively recruiting to fill nursing vacancies.

The staffing with paediatric experience and or training had increased since the time of the last inspection by one staff nurse and there was a total of two CNM2's and a staff nurse. Inspectors were also informed of the successful recruitment of an ANP candidate which was yet to start. The hours of operation were 8am to 8pm seven days a week. Inspectors noted (from the updated compliance plan received at the time of inspection) that the hospital was planning to have at least one nurse with paediatric training or experience on duty in the emergency department 24/7/365 by quarter three, 2023.

The staff complement included one CNM 2 to care for admitted patients boarded in the ED awaiting an inpatient bed, during core hours Monday to Friday. There was no further dedicated resource for this cohort of patients. The staff complement intended for the ED were also used to provide care for admitted patients. This resulted in a dilution of ED staff resources.

On the day of inspection inspectors were informed that the department did not have its full complement of nursing staff rostered, of the 12 rostered there was only 10 on duty. Rosters reviewed for the four week period prior to inspection showed that 54% of shifts were short nursing staff ranging from a shortfall of one nurse to three nurses from the 12 rostered. Agency staff were used to supplement the nursing workforce on approximately 50% of all the shifts. Inspectors were informed that the hospital were committed to providing four healthcare assistants per shift to assist with the care of the admitted patients in ED which was above their current budgeted complement of healthcare assistants.

Following reconfiguration of the ED and an increase in the clinical space, an external review of nurse staffing levels highlighted the need for an extra 15 WTE nurses in 2022. Inspectors had been informed at the inspection in September 2022 that five of these posts had been approved for 2022 by the Saolta University Health Care Group but there was no evidence of an increase in the approved posts at the time of this inspection. Senior management informed inspectors that in addition to that staffing review, the first

[§§§§§] 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.

assessment phase of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings[******] in Ireland was also undertaken but they had yet to be informed of the outcome. Inspectors were told that approval for any recommended posts would need submission through the estimates process in 2024. Staff nurse numbers will be increased in line with recommendations of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings.

Staff in the emergency department had access to an ED assigned infection prevention and control nurse Monday to Friday. Staff also had access to an antimicrobial pharmacist and to an antimicrobial microbiologist 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 they were in ED. Inspectors were informed that the ED staff had telephone access to pharmacy staff for advice. A pharmacy technician visited the department daily to top-up the medicine stock. Inspectors noted that security staff were on duty in the emergency department on the day of inspection.

Uptake of key and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years.

During HIQA's inspection in September 2022 it was identified that the percentage of staff attendance and uptake at key and essential training could be improved. Hospital management committed to improving uptake of this within their compliance plan following the HIQA inspection in 2022. Inspectors, however found that attendance levels had further reduced since the last inspection. Hospital management need to ensure that uptake of training, in particular, on all early warning systems, basic life support and infection prevention and control is monitored and managed for all relevant staff groups to ensure that it is in line with guidance and at the recommended intervals. This represents an area for immediate improvement.

Training records for nursing staff showed that:

- 62% of nurses were compliant with hand hygiene practices – below the HSE's target of 90%
- 59% nurses were up-to-date in basic life support training
- 47% nurses were up-to-date with training on the Irish National Early Warning System
- 33% of nurses were up-to-date with Paediatric Early Warning System
- 47% of nurses were up-to-date with Irish Maternity Early Warning System

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

- 67% of eligible nurses were up-to-date in training on the Manchester Triage System.

At the time of inspection the hospital had started training on the roll-out of the Emergency Medicine Early Warning System (EMEWS) and 13% of nurses had undertaken the training to date.

Findings relating to the wider hospital

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

The hospital's total approved complement of staff at the time of inspection was 1988.1 WTE. This included 192.87 WTE vacancies (9.7%), of which, 76 WTE (3.8%) represented a recent uplift in approved posts.

The hospital had a total of 772.62 WTE nursing and midwifery posts of various grades in post at the time of inspection with a total of 96.3 WTE vacant posts (11%). Clinical areas most affected by vacancies included the ED, intensive care unit and the coronary care unit. Inspectors were informed that the hospital were actively recruiting nursing staff to address the vacancies.

Inspectors were told that the hospital was experiencing difficulty in filling 23 WTE medical scientist positions (approximately 25% of the complement) so were now seeking to hire 12 WTE medical laboratory aides who the hospital planned to support undertaking a new academic pathway to gain scientist qualification.

The hospital had stated that that there were approximately 100 WTE approved consultant posts of which there were one WTE vacancy (1%) at the time of inspection. Consultant staff were supported by an approved complement of 218 WTE NCHDs, with 215 WTE in post and three WTE vacancies (1.37%) at the time of inspection which was commendable. Five consultants were not registered on the relevant Specialist Division of the Irish Medical Council. Inspectors were told that each consultant was working through the process to gain registration, and in the interim appropriate supports with clinical and corporate oversight in line with national guidance were in place.

The ED FITT had approval for 1.5 WTE pharmacists. Attempts to fill these positions was unsuccessful to date, inspectors were informed that the one WTE position was temporary, and was difficult to fill. Other high risk areas including paediatrics, maternity and renal were also without designated pharmacists.

The hospital had systems in place to monitor and review absenteeism. The hospital's reported absenteeism rate for May 2023 was 6.5%, which was above the HSE target of 4% or less. Inspectors were told that absenteeism is a concern and is a key focus within the

hospital. A key performance indicator being monitored is the rate of 'return to work' manager meetings with staff post absenteeism which was indicated to be at 50% at the time of inspection.

Infection prevention and control

The hospital's infection prevention and control (IPC) team comprised:

- 2 WTE consultant microbiologists
- 1 WTE IPC ADON
- 4 WTE clinical nurse specialists (CNS) or CNM 2 (1 WTE based in Our Lady's Manorhamilton)
- 1 WTE antimicrobial pharmacista
- 1 WTE surveillance scientist

Medication safety

The hospital had 24.91 WTE approved pharmacists, of which there was 4.35 WTE (17.5%) vacant posts. Inspectors were told that they expecting two new pharmacists to take up posts in July and September 2023 respectively. The remaining 2.35 WTE were in the process of recruitment which included 0.5 WTE for Frailty Intervention Team (FITT) in ED.

Deteriorating patients

The ACD was usually the consultant lead for the EWS in their respective areas of responsibility. The link nurse on each ward is the clinical nurse manager, grade 2. The Group ADON for sepsis and the deteriorating patient was shared with other hospitals within the Saolta University Health Care Group.

Transitions of care

Transitions of care within the hospital were managed by the Patient Flow team which comprised a discharge coordinator, patient flow coordinator, ADON for patient flow and bed managers. The patient flow team operated during core hours only. Inspectors noted that according to the hospital's compliance plan, hours of operation were due to be extended by last quarter in 2023.

Uptake of key and essential training in the wider hospital

The hospital had training programmes for infection prevention and control, medication safety and national early warning systems. The hospital provided a corporate induction every quarter or more frequently if required and all employees attended a localised line manager induction. The NCHD's had just started their placement in Sligo University Hospital during the week of inspection and had undertaken a comprehensive induction programme. Training records for new NCHD's were incomplete and because of the timeframe of inspection, they had not been included in the report.

HIQA found that the uptake of key training was very good within both ward areas visited, the lowest being compliance with basic life support at 72%. On one ward, 100% of staff had attended all training for infection prevention and control, including key and essential training on hand hygiene and standard and transmission based precautions. Staff had individual training records which were self-maintained with no oversight from the clinical nurse manager. Hospital management should have systems in place to monitor and manage the uptake of key and essential training by the relevant staff groupings.

Overall, inspectors found that hospital management were striving to organise and manage their workforce to support the provision of high-quality, safe healthcare. However, management must prioritise recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients. Shortfalls in the nurse staffing rosters in ED were having a significant impact on the ability to provide the required staffing complement for day and night shifts. The EMT had recognised that the nurse staffing within ED was not sufficient at the time of last inspection and no improvement was seen within this timeframe. A comprehensive clinical pharmacy services for all clinical areas at the hospital including the admitted patients in ED should also be prioritised. It is essential that hospital management ensure that all clinical staff in ED undertake key and essential training appropriate to their scope of practice and at the required frequency, in line with national standards and in line with their submitted compliance plan. These issues require a key focus for early improvement efforts following HIQA's inspection.

Judgment: Partially Compliant

Inspection findings relating to the Emergency Department

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.

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[††††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department, and to be responsive to their individual needs. Staff provided assistance and information to patients in a kind and caring manner.

Curtains were secured around patients in designated bays to provide privacy and protect their dignity when providing personal care. Inspectors were informed that patients on trolleys were brought to designated bays for examinations or personal care. Screens were available for use with trolleys outside designated areas. There were no shower facilities within the emergency department and inspectors were informed that patients would be offered these facilities in AAU and that a healthcare assistant would accompany any patient wishing to avail of same. This initiative was part of the quality improvement plan following the previous HIQA inspection in September 2022.

All patients waiting in the ED over 24 hours were reported to the Hospital Manager in line with the hospital's escalation policy. The Hospital Manager's role was to review the actions that had been taken to provide a bed and to give direction for any further actions required. The Frailty Intervention Therapy Team reviewed older persons in the ED, to improve their patient experience time, provide them with necessary assistance and where possible, avoid unnecessary hospital admissions. A patient advice and liaison service (PALS) was available for all patients within the department and made daily rounds in ED to improve communication.

As part of the compliance plan submitted to HIQA following the previous inspection in September 2022, hospital management had undertaken to provide patient information screens in ED within the waiting room by quarter four, 2022. At the time of inspection the screens were not in place and were due for completion by end of 2023 according to the updated compliance plan submitted to HIQA during the inspection.

An audit of the nursing care provided to admitted patients on trolleys in Sligo University Hospital was conducted in late 2022 by the ADON for quality improvement from the Saolta University Health Care Group. The aim was to identify any risk or patient safety issues and to establish a baseline of the quality of nursing care provided to this cohort of patients. Patients surveyed gave an average rate of 8.2 out of a score of 10 for their experience of

[††††††] 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

care and 88.9% said that they had been informed about where they were in their stage of care.

On the first day of inspection the emergency department appeared calm and in control. Inspectors noted that there were eight admitted patients that were awaiting an inpatient bed on trolleys on narrow busy corridors while there were vacant cubicles within the 'majors' area. Staff explained that the decision to keep these patients on corridors was taken as the cubicles would fill up later and movement of patients caused disruption and discontent. The narrow emergency department corridor was a busy thoroughfare for all ED activity which had an adverse impact on the opportunity to provide dignity and privacy for these patients.

A lack of dignity and privacy was validated by patients who spoke with inspectors and was consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 7.9 of patients who completed the survey considered their overall experience of the hospital as below average (national score was 8.1). Also in that year, the hospital fell below the national average score in survey questions related to the emergency department. More specifically, with regard to:

- privacy when being examined or treated in the emergency department, the hospital scored 7.3 (national average – 8.1)
- being treated with respect and dignity in the emergency department, the hospital scored 8.4 (national average – 8.7)
- communication with doctors and nurses in the emergency department, the hospital scored 7.7 (national average – 7.9).

Inspectors were informed that a patient at end-of-life would be accommodated in the single room within the emergency department. The department also had a relative's room for privacy and sharing of bad news.

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. There was no significant improvement in this environment where patients were cared for since HIQA's last inspection in September 2022.

Judgment: Non-compliant

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

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 however there was scope for improvement in some areas in order to protect service users from the risk of harm associated with design and delivery of healthcare services. The hospital collected data on a range of different quality and safety indicators related to the ED in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times.

Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at the emergency department's Speciality Management Team (SMT) committee meetings and the Unscheduled Patient Pathway Group (UPPG).

At 11am on the first day of inspection there was 36 patients in the department of which:

- 23 (64%) patients 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.
- 31 (86%) patients 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.
- Three (8%) patients were in the emergency department for more than 24 hours after registration – not 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 aged 75 years or more were not discharged or admitted within six hours — not compliant with the national target that 95% of all ED attendees aged 75 years or more are discharged or admitted within six hours of registration.
- No patient aged 75 years or more was in the ED for over 9 hours — compliant with the national target that 99% of all ED attendees aged 75 years or more are discharged or admitted within 9 hours of registration.

Compared with HIQA's findings during an inspection of the ED in September 2022, these times demonstrated a deterioration in waiting times for patients in the ED for more than

nine hours and an improvement in the number of patients waiting in the ED for more than 24 hours.

Most recent published performance data for year 2022 showed that 43.1% of patients who attended the department between January and December 2022 were discharged or admitted within 6 hours (HSE target:70%), 61.6% within 9 hours (HSE target: 85%) and 92.8% within 24 hours (HSE target: 99%).

Findings from the 2022 National Inpatient Experience Survey showed that:

- The national average score 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 Sligo University Hospital was 27.1%.
- The national average score for people waiting 6-12 hours in the emergency department before being admitted to an inpatient bed was 32.9%. The rate for the emergency department at Sligo University Hospital was 29.5%.
- The national average score for people waiting 12-24 hours in the emergency department before being admitted to an inpatient bed was 23.9%. The rate for the emergency department at Sligo University Hospital was 29.1%.

According to published data, the percentage of ED patients who left the department before completion of treatment in 2022 was 5.5% (total of 2,371 or average of 197 per month), which was within the HSE target of less than 6.5%. On review of the minutes of the ED SMT, it was noted that patients leaving the department before being seen was of concern to the clinical team as they had noted an increase in this over recent months. The number reported was 127 patients in February 2023 and 282 in March 2023 which they report as a significant increase.

Most recent published performance data for year 2022, reports the percentage of ambulance that had a time interval of 30 minutes or less from arrival to when the ambulance crew declared readiness of the ambulance to accept another call was 6.6% in Sligo University Hospital (HSE target: 80%). Within the minutes of the ED SMT, the clinical team acknowledged that deficits in relation to ambulance turnaround times by providing the following example relating to February 2023. Out of a total of 809 ambulance calls:

- 7.95% were cleared at the hospital in less than 20 minutes
- 23.14% were cleared between 1 and 2 hours
- 0.55% cleared between 3 and 4 hours
- On 16 occasions it took between 5 and 6 hours to clear

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were recorded on the emergency department's risk register which was reviewed and managed by the ED SMT. The QSEC Committee had oversight of the hospital's risk register.

The ED risk register, provided to HIQA, was updated in June 2023, had existing controls and actions required documented. The highest rated risks identified by the hospitals for patients attending the ED were:

- increased activity levels and overcrowding in ED
- admitted patients boarded in ED at risk of 'below-standard' levels of care
- staff and patients at risk of violence and aggression in ED
- risk of reduced standards of care for patients due to severe staffing shortages in ED.

The causes of these risks were documented as local population increase, increasing numbers of older patients, lack of bed capacity at ward level, a large disjointed ED and no extra staff provided for admitted patients in ED. The actions required were outlined to inspectors during the inspection, as an increase in nursing staff (allocation for staff to care for admitted patients), increase in healthcare assistant numbers (to assist with care of admitted patients), utilisation of single rooms currently used as a discharge lounge and increase inpatient bed capacity. The risk of violence and aggression had been managed by hospital management by increasing security presence to three security staff working 24/7 and increased presence in ED department. The hospital is also providing Safety Intervention Training for all staff.

In June 2023, the National Performance Oversight Group (NPOG) had requested an improvement plan to reduce time breaches in relation to the emergency department's patient experience times of less than 24 hours for patients aged 75 years or more. Sligo University Hospital had been identified as having continued significant breaches in this metric. The quality improvement plan was focused on three specific areas: admitted patients, non-admitted patients and data quality improvement. It aimed to ensure that there were no patients aged 75 years or more waiting more than 24 hours. Process, outcomes and risks were all detailed and the improvement plan was ongoing at the time of inspection.

Infection prevention and control

On arrival to the ED, attendees were promptly screened for signs and symptoms of infections at the time of registration. Patients presenting with respiratory symptoms and suspected infection were highlighted by the ED registration staff to the triage nurse or shift leader. The patient would then be placed in the post-triage room awaiting nursing assessment. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single

cubicles and isolation room. A nurse from the infection prevention and control team was accessible to staff in the ED during core working hours. Staff had access to an onsite consultant microbiologist.

The ED environment was generally clean. Storage of medical supplies and equipment however, was noted to be stored in boxes on the floor in multiple areas throughout the department. This was brought to the attention of the CMM on duty. Of note, one of the cubicles within the five bay ambulatory care area designed for treatment of patients was being used instead for storage. Following HIQA's inspection in September 2022, hospital management, as part of their compliance plan, had committed to conducting a lean§§§§§§ project to ensure the effective use of space within the ED incorporating trolley placement, storage facilities and implementation of storage. This was due to be completed by end of 2022. Inspectors noted only minimal improvement during this inspection.

Inspectors observed that the minimum physical spacing of one metre between trolleys was not maintained in most cases. Insufficient spacing of trolleys potentially increases the risk of cross infection. Hospital management need to ensure minimal distancing between people receiving care is in line with national guidance.

An audit of the nursing care provided to admitted patients on trolleys in Sligo University Hospital was conducted in late 2022 by the ADON for quality improvement from the Saolta University Health Care Group. The audit found that the lack of space and inadequate hygiene facilities was impacting on infection control practices and on the ability of staff to provide good standards of care. The audit had a time bound plan with assigned responsible persons identified.

Medication safety

There was no pharmacist assigned to the emergency department so clinical pharmacist review or medicine reconciliation was not undertaken for inpatients while accommodated in the ED. Inspectors were informed that staff could access help and advice from pharmacists as needed. A pharmacy technician visited the department daily to replace pharmacy stock. Inspectors did not observe a high-risk medication list displayed in the medicine room in the emergency department. The pharmacy department did not have a SALAD******* list but instead sends photographic evidence of any SALAD medication to all departments to highlight the risk. Staff in the department had access to an antimicrobial pharmacist.

Sligo University Hospital were using a commercially available injectable medicines guide website which contained monographs that gave information on the recommended methods of preparing and administering intravenous injections and infusions. Monographs from this

§§§§§§Lean Six Sigma is a team-focused managerial approach that seeks to improve performance by eliminating resource waste and defects

******* 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.

site were noted to be printed and placed in a folder in the ED which posed a potential risk of use of out-dated information in the absence of up to date information. These risks were highlighted to EMT at the time of inspection.

The 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 ED. The hospital had not yet implemented the Emergency Medicine Early Warning System (EMEWS) but training of staff had commenced and it was indicated on the updated compliance plan received at the time of this inspection that EMEWS would be introduced in quarter four, 2023.

One multidisciplinary safety huddle was held in the emergency department daily at 8am, just before clinical handover, to discuss the status of all patients in the department and identify patients that were 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. Delayed transfer of care further compounded the issue of availability of inpatient beds at the hospital and impacted on waiting times in the emergency department. On the day of inspection, the hospital had 10 patients with delayed discharges. Hospital management attributed the delay in transferring patients mainly to the reported lack of availability of home-help staff in the community, lack of community beds and difficulty in accessing care places for the patients and in particular, those in the 65 -74 year age group.

Management of patient-safety incidents

HIQA was satisfied that patient-safety incidents and serious reportable events related to the ED were reported to the National Incident Management System (NIMS),[§§§§§§§] in line with the HSE's incident management framework. Feedback on patient-safety incidents was provided to the CNM3, by the quality and risk manager.

[†††††††] 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).

[‡‡‡‡‡‡‡] ISBAR3 Communication Tool for Inter-departmental Handover- Identify, Situation, Background, Assessment, Recommendation

[§§§§§§§] 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).

Management of complaints

Complaints related to the ED were managed locally with oversight from the CNM3 and clinical lead. Complaints relating to the department were not tracked and trended at the hospital. Inspectors were informed that complaints primarily related to delays and lack of communication and that information about complaints and their resolution was shared with staff in the ED at daily safety huddles. Complaints management training was not provided to staff in ED. Of note, on the day of inspection, the patients who spoke with inspectors did not know how to 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 assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm. The patient experience times breached most of the HSE targets and this represented no improvement compared to previous inspection findings. There had been a recent increase in the number of patients who left the ED before completion of their treatment and the hospital reported prolonged ambulance turnaround times.

As previously identified at inspection in September 2022, hospital management need to ensure that the environment for the treatment and accommodation of patients is safe and that medical supplies and equipment are stored appropriately. The hospital should ensure minimal distancing between people receiving care in line with national guidance. Access to a clinical pharmacist service for admitted patients accommodated in the ED would support safe medication practice.

These issues were highlighted in the previous HIQA inspection and now require concerted effort by hospital management to bring the hospital into compliance with this standard.

Judgment: Non-compliant

Inspection findings relating 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), 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).

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

Medical South was a 29-bedded ward comprised three six-bedded rooms, one five-bedded room, five single rooms and one isolation room with an ante-room.******** All of the single rooms had en-suite bathroom facilities and each of the multi-occupancy rooms had a toilet and shower facilities. The ward also had two patients on trolleys and two unoccupied trolleys. All trolleys were placed along the corridor. The ward was a medical ward and cared for patients with respiratory or endocrine conditions and included older persons. At the time of inspection, 31 patients were been cared for on Medical South.

Surgical North was a 28-bedded ward consisting of one four-bedded room, one five-bedded room, three six-bedded rooms and one isolation room with an ante-room. All rooms had bathroom facilities and the ward had adequate toilet and bathroom facilities for patients. The ward was a surgical ward caring for patients with ear, nose and throat conditions and general surgical patients. At the time of inspection, 25 beds were occupied with three vacancies in the elective surgical bay.

Inspectors observed effective communication between staff and patients in both inpatient clinical areas visited. Inspectors also observed how interactions between staff and patients were very kind, respectful, reassuring and not hurried. This was confirmed by patients who described staff in the clinical areas visited as 'very good' and 'couldn't do enough for you' and 'very nice altogether'. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care. When speaking with patients about their experiences, inspectors heard that they had received a 'reasonable level of privacy'. Inspectors were also told of some frustration experienced by patients who had been admitted via the ED and the AAU noting that the communication regarding this process and being kept up to date on their conditions could be improved.

Inspectors observed staff responding to patients needs in a timely manner in both of the clinical areas inspected. Patients recounted how their needs were met quickly, telling inspectors that they 'were well looked after' and 'get assistance as required'. Overall patients, who spoke to inspectors, were not aware of how to make a complaint if the need arose but did say that they would talk to a member of staff if needed.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey where 7.9 of people who were admitted to Sligo University Hospital said that they had a good to very good experience in hospital which is just below the national average of 8.1. 'Care on the ward' was the highest-rated stage of care for the hospital.

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.

******** Ante-room is defined as a small room between areas of contamination and treatment areas.

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.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. In the main, data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR) with some exceptions. Patient safety indicator reports related to the rate of clinical incidents as reported to NIMS per 1000 bed days was not reported monthly. 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. This will be discussed further under NS 3.3.

The hospital collated performance data for unscheduled and scheduled care, including data on ED attendances and patient experience times, average length of stay, scheduled admissions and DTOC.

The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, 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 EMT and QSEC and performance meetings between the hospital and the hospital group.

As discussed in standard 5.5, the conversion rate (rate of admission of patients to an inpatient ward) did not include the number of admitted patients who had their entire episode of inpatient care conducted within the ED. Hospital management are responsible for ensuring accurate and comprehensive reporting of this cohort of patients in line with national guidance. This requires attention to ensure accuracy of HSE Performance Assurance Reports.

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 QSEC quarterly, or more often if required, 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 medication safety were recorded on the hospital's corporate risk register with the

actions required to mitigate the identified risks. These risks are outlined further in national standard 3.1.

Audit activity

The QSEC had responsibility for oversight and review of the annual audit plan and had responsibility to ensure that a structured programme of clinical audit was in place. The hospital had a clinical audit coordinator in post. The hospital had a yearly audit plan which was a list of audit activity within directorates. The nursing and midwifery department held monthly clinical audit presentations from different directorates and the nurse practice development unit (NPDU) also had a yearly clinical audit schedule. The hospital also took part in group and national audits.

Management of patient-safety incidents and Serious Reportable Events

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. Monthly incident reporting data was presented at the monthly QSEC meetings and the top three incident types were identified alongside the location of incidents. An update of the serious incident log was also presented at this forum. Serious reportable events (SRE) were discussed at bi-monthly performance meeting with the Saolta University Health Care Group. All ward managers received monthly report of incidents relating to their ward from quality and patient safety department. All incidents were discussed every two to three months at a nurse manager meeting.

The Saolta University Health Care Group Serious Incident Management Team (SIMT) was a multidisciplinary group that meets on a monthly basis to manage and monitor serious incidents from all hospitals in the Saolta Group. SIMT was chaired by the Clinical Director of Quality and Patient Safety and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework.

Feedback from people using the service

The hospital had completed a self-assessment compliance and action plan 'Learning to Get Better' based on findings from the National Inpatient Experience Survey. The GM was assigned responsibility for overseeing the actions required. The self-assessment had been completed in February 2023 but there were no identified time bound actions at the time of inspection. The Drugs and Therapeutics committee discussed the National Patient Satisfaction Survey and a quality improvement project arising from the feedback was the creation of an information pack on discharge as patients had identified lack of information on medication at the time of discharge as an issue.

There was no record of discussion related to complaints or patient feedback noted in any of the minutes of meetings submitted to HIQA at the time of inspection.

In summary, the hospital were monitoring performance against key performance indicators in the four areas of known harm and there was evidence that information from this process was being used to improve the quality and safety of healthcare services. There is scope for improvement in the management of complaints and patient feedback. This is discussed further in NS 1.8. Hospital management also need to ensure collection and reporting of data relating to the number of admitted patients, who completed their episode of care within the ED without having been allocated a bed on the ward is accurate and complete.

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.

The medical ward, visited on inspection, had one patient on a trolley in the corridor, one patient being cared for on a trolley in the treatment room and a further two unoccupied trolleys. On the surgical ward visited there was capacity for four trolleys on the corridors which were not being used on day of inspection. Activation of the hospital's escalation protocol involved the use of trolleys placed in the inpatient wards to accommodate patients when all of the approved bed complement was in use. While it is acknowledged that use of the escalation protocol is a means to assist patient flow from a congested ED, the use of trolleys on corridors to accommodate patients adversely impacts the ability to promote and ensure respect, dignity, privacy and autonomy for people using the service.

Staff interviewed on wards were aware of the challenges relating to the provision of privacy and dignity for patients when placed on the corridors. Screens for patient privacy were provided for patients in the corridors. Inspectors were informed that patients on trolleys were brought to the treatment room for physical examinations and in cases where the treatment room was in use then the patients were brought to the day room or nursing office if possible.

During the inspection, there were men and women allocated to beds in a multio-ccupancy room within the respiratory unit. Inspectors were told that staff seek to avoid a gender mix in bays and where it has to occur, staff seek to revert to single sex bays as soon as possible. Risk assessments were not routinely carried out in such instances.

Staff endeavoured to promote staff privacy through the use of privacy curtains. Staff were observed promoting a person-centred approach to care and all staff conversation with patients was noted to be kind and respectful. Patients reported to inspectors that they were kept informed of their plan of care.

Patient's personal information in the clinical areas visited, during the inspection, was observed to be fully protected and stored appropriately. Inspectors were informed that the PALS coordinator provided support to patients, and patient information leaflets about this support were available on the ward. The PALS coordinator had been a newly appointed position since the previous inspection in September 2022.

When staff were asked by inspectors about the 2022 National Inpatient Experience Survey (NIES) results, some staff were not aware of the results but they told inspectors that they encouraged patients to take part in the surveys. One staff member informed inspectors that an improvement on their ward following the 2022 results was that discharge letters were being done promptly at the time of discharge.

In the NIES 2022, people who had used the service were asked, if they were given enough privacy when discussing their condition or treatment while in the hospital. The hospital had scored 7.5 (national average 8.2). When asked if they were given enough privacy while being examined or treated in the hospital, Sligo University Hospital scored 8.4 (national average 9.1). Areas for improvement within the survey included, being given enough privacy on the ward when discussing conditions or treatments, and when being examined or treated.

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 is consistent with the human rights-based approach to care promoted by HIQA. However, the accommodation of patients on trolleys negatively impacts the ability to promote and ensure respect, dignity and privacy.

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 as 'unbelievable', 'first class' and 'nice and dignified to me'.

Patients said that the nursing staff were 'very busy' and 'do not get paid enough', and that they were 'doing all they can for me'. Patients described that they were assisted as needed and that they were kept up to date on their plan of care.

HIQA found evidence of a person-centred approach to care, especially for vulnerable patients receiving care. Inspectors observed library pictures placed on the exit door to avoid confused patients recognising the way out and so reduce the risk of patients attempting to leave unattended in one of the clinical areas visited on day of inspection.

Overall, HIQA was assured 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.

There were systems and processes in place at the hospital to respond to complaints and concerns received from patients and their families. There was a designated Complaints Officer assigned with responsibility for managing complaints. The hospital used the HSE's complaints management policy 'Your Service Your Say'[††††††††] and inspectors observed a Sligo University Hospital comment card for patients to provide written feedback. There was a culture of complaints resolution in the clinical areas visited whereby verbal and formal complaints were managed at local clinical area level by the CNM.

The hospital did not track or trend complaints. There was no evidence of discussion requarding patient feedback identified in any of the minutes of meetings submitted to HIQA. The ward manager received information from the complaints manager about individual complaints and discussed these complaints with their line manager as necessary.

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 PALS Coordinator assisted patients through the complaints process and also supported patients as required.

[††††††††] 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.

'Your Service Your Say' leaflets were available in the hospital. Inspectors saw information about independent advocacy services displayed outside one of the clinical areas visited during inspection.

Staff outlined a change in practice following a patient complaint. A patient complained that their call bell was not working and so could not alert staff if they required any assistance, a daily check to ensure that all the call bells were working was introduced.

Data submitted to HIQA outlined the number of complaints received each year and the percentage of complaints resolved within the 30 day timeframe. In 2022, the hospital received 183 written complaints, of which, 53% were resolved within 30 days. In the first quarter of 2023, 56 written complaints were received and 61% were resolved within 30 days, both lower than the HSE's target of 75%. While this progress was noted, further work is required to ensure compliance with the national target.

Staff who spoke with inspectors reported that they did not get feedback from the tracking and trending of complaints for their clinical areas and that learning from complaints or the complaints resolution process was not shared with staff, which is an opportunity missed. Verbal complaints, received at ward level, were not recorded and this is a missed opportunity for shared learning and quality improvement.

The hospital formally reported on the number and type of complaints, verbal and written, received annually by the complaints department. The HSE 'Your Service Your Say' annual feedback report‡‡‡‡‡‡‡‡ (2021) showed that of the 78 formal complaints received in 2021 (excluding withdrawn or anonymous complaints), 42 (54%) of them were resolved within 30 working days, below the national HSE target of 75% for investigating complaints.

At the time of inspection the hospital was not using the National Complaints Management System (CMS) which facilitates the capture and grouping of complaints data to enable analysis and comparison but inspectors were informed of plans to start using the CMS for their complaints management.

‡‡‡‡‡‡‡‡ Health Service Executive. *Managing Feedback within the Health Service. 'Your Service Your Say'*; 2021. Available on line from: https://www.hse.ie/eng/about/who/complaints/ncglt/your-service-your-say-2021.pdf

Overall, while there were systems and processes in place at the hospital to respond to complaints and concerns raised by people who use their services, complaints should be tracked and trended to identify the emerging themes, categories and departments involved. A formal standardised system should also be implemented at the hospital to facilitate the sharing of learning from complaints and the complaints resolution process to help reduce recurrence of the same issues for people using their services. Hospital management should continue to implement measures to support the prompt, open and effective resolution of complaints within HSE targets so as to improve the experience of people using the service. Inspectors found that in general, patients using the service were not fully aware of how to make a complaint. These represent areas for attention by hospital management.

Judgment: Partially 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.

On the day of inspection, one of the wards visited was well maintained and corridors were clean and tidy. One ward visited by inspectors had multiple small storage areas which were congested and did not facilitate appropriate storage of equipment and supplies. A number of storage boxes were observed on the floor of the storage rooms which did not facilitate cleaning underneath. Storage of equipment should be reviewed following this inspection. On both wards, there was evidence of general wear and tear observed, with cracks on the floor, which did not facilitate effective cleaning.

Security swipe access cards were required to enter the wards and a code was required to exit the surgical ward.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) clearly displayed throughout the clinical areas. Inspectors noted that hand hygiene sinks throughout the clinical areas did not conform to HBN requirements.§§§§§§§§ Physical distancing of one metre was observed to be maintained between beds in the multi-occupancy rooms.

There was a lack of isolation facilities to accommodate placement of people who required transmission-based precautions. Patients were isolated in line with the hospital isolation prioritisation policy and with IPC advice. Inspectors were informed that cohorting of patients with the same micro-organism was facilitated following consultation with the IPC

§§§§§§§§ Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

team and based on a risk assessment. However, during inspection, inspectors noted that patients with different micro-organisms were cared for in multi-occupancy rooms on the medical ward. When questioned, staff appeared unaware of the implications for patients who were cared for in these rooms. There was no signage observed on the door of the multi-occupancy rooms for patients with a communicable infectious disease. On discussion with staff, inspectors were informed that a yellow dot was to be ticked on the notice board at the patient bedside if a patient with transmission based precaution requirements were being cared for in a multi-occupancy room but this was not observed on all occasions. Hospital management should ensure that appropriate signage is in place at all times, in line with national guidance. This is an opportunity for improvement.

Infection status of patients was observed on the ward's white board. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited outside single isolation rooms but some doors were observed to be left open********* in both clinical areas visited. Ward staff reported that IPC staff would visit the ward daily if any issues but usually two to three times a week to discuss alerts, surveillance or patients as required.

The inadequate capacity and infrastructure deficiencies was identified on the corporate risk register along with actions required to mitigate the risks associated with the hospital infrastructure and the requirement for additional single room capacity in the hospital. Inspectors were informed that plans were in progress for the building of a 42-bed modular unit and that contractors would be appointed and on site by end of quarter four 2023. A further 26 offsite beds had been identified and had received approval for infrastructure work required. Hospital management were awaiting approval for funding and were optimistic that these beds would be open by January 2024.

Environmental cleaning was carried out by designated cleaning staff from 8am to 4pm daily. Terminal cleaning was carried out by designated cleaning staff if within hours of operation or otherwise, by on-call staff. Cleaning supervisors had oversight of the cleaning and cleaning schedules in the clinical areas visited and signed off on schedules monthly and performed spot checks. Clinical nurse managers were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe.

Cleaning of equipment was assigned to healthcare assistants and staff. Review of the cleaning schedules by the CNM was found to be irregular and on an ad hoc basis. In clinical areas visited, there was a green tagging system in place to identity equipment that had been cleaned. One ward reported that, although they used the tagging system it was not routinely upheld. Equipment seen by inspectors appeared clean on visual inspection. Hospital management should ensure that there is an effective system in place to clearly identify clean and decontaminated equipment from used equipment. Hazardous material

********* Where there is an exceptional reason for the door to be open, this must be accompanied by a bespoke risk assessment for the particular situation.

and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed.

The clinical nurse manager and household staff on the wards completed monthly local hygiene observational assessments. Inspectors noted compliance rates ranging from 75% to 88% for the wards visited during the inspection. Action plans were developed which included issues identified, action, progress, person responsible and timeframe. Senior Managerial Hygiene Observational Assessments were also completed every three months in each of the clinical areas with clear identification of main issues found.

Inspectors noted that a patient was cared for on a trolley in a treatment room which contained a considerable level of medical supplies. The potential for contamination of this supply had the patient presented with a transmission-based infection was raised with the CNM2 at the time of inspection.

In summary, there was insufficient isolation facilities available leading to cohorting of patients with different micro-organisms in multi-occupancy rooms. Inconsistencies in practices such as compliance with signage and closed doors were noted. There was a lack of storage facilities for equipment, resulting in congestion of narrow ward corridors and inappropriate storage of materials. The hand hygiene sinks throughout the clinical areas did not conform to HBN requirements. HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe and reliable care.

Judgment: Partially compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to ensure continuous improvement of services. HIQA found that the hospital had monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints and risk assessments.

Infection prevention and control monitoring

HIQA was satisfied that the IPC Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from hand hygiene audits, environmental audits (including commode and hepa filter audits) and audits of compliance with infection prevention guidelines and protocols.

Infection prevention and control audit summary reports submitted to HIQA showed that the clinical areas visited on the day of inspection had compliance rates ranging from 75% to 88% in environmental and patient equipment hygiene during the months prior to

inspection. There was evidence that audit findings were shared with clinical staff and time-bound action plans developed to address areas requiring improvement.

Clinical areas visited were not compliant with the HSE's target of 90% for hand hygiene practices. The medical ward was 63% compliant and the surgical ward was 70% compliant. IPC committee minutes reviewed demonstrated that there was an ongoing issue with hand hygiene compliance hospital wide. In February 2023, 16 wards were non-compliant and in May 2023 it was reported that 13 wards had not gained the target of 90%. Extra training was rolled out and re-auditing was scheduled. The poor compliance figures indicates a need for focussed actions and potential requirement for escalation to QSEC for review and support to achieve compliance with the HSE target of at least 90%. This will be discussed further under NS 3.1.

The IPC team prepared a quarterly Infection Prevention and Control Report which included IPC audits and training, information on outbreaks, compliance with care bundles and rates of healthcare-associated infections. These reports were also shared with the Saolta Group Infection and Prevention Control Committee. Staff on the wards reported that they completed care bundles in relation to catheter and intravenous cannula care.

The hospital reported on rates of healthcare-acquired infection[††††††††] data in line with the HSE's national reporting requirements on *Clostridioides difficile* infection, Carbapenemase Enterobacterales[‡‡‡‡‡‡‡‡] (CPE) and hospital-acquired *Staphylococcus aureus* blood stream infections. The overall rate of hospital acquired *Clostridioides difficile* infection for quarter one, 2023 was 3.5/10,000 bed days used (this was above the national HSE's target of less than 2 per 10,000 bed days). This was a continuation of a trend first noted in December 2022. There was evidence that recommendations were being progressed and followed by the IPC team.

The hospital was screening for CPE in line with national guidelines and there were no cases of CPE infection reported at the hospital for 2023. Audits of compliance with CPE screening were being carried out however inspectors noted a large degree of variance, 0% to 100% in May 2023. This variability was ongoing and had been discussed at committee meetings. Hospital management need to ascertain the reasons for such variances and seek to address these so that patients can be assured that the prevalence of CPE is being monitored and managed appropriately at the hospital. This will be discussed further under NS 3.1.

Antimicrobial stewardship monitoring

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

[‡‡‡‡‡‡‡‡] Carbapenemase Enterobacterales (CPE) are bacteria (bugs) that live in the gut. CPE are a type of superbug which are resistant to many antibiotics. This means that some antibiotics that were used to treat them no longer work very well

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. Antimicrobial consumption had increased in the first half of 2022 but was similar to that of 2019 (the most recent pre COVID-19 year). It remains below the national average and is one of the lowest levels nationally. The hospitals' performance with key performance indicators were reviewed at the Drugs and Therapeutics Safety Committee.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices. Nursing and Midwifery Quality Care Metrics were performed throughout the hospital and results reviewed in 2022 and the first six months of 2023 showed good overall compliance. Multiple action plans arising from these metrics were viewed by inspectors. Results of metrics were noted to be on display within the clinical area.

Examples of audits undertaken by the hospital included:

- Discharge prescription audits
- Controlled drugs audit
- Antipsychotic prescribing in dementia audit

Inspectors noted that recommendations were outlined on audit results but time-bound action plans with re-audit plans were not seen.

Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital were auditing healthcare records for compliance against national guidance on utilisation and accuracy of completion of the INEWS patient observation chart. An audit of compliance of the INEWS chart from 74 patients from six inpatient wards, was undertaken in February 2023. A further 24 charts were audited in May 2023. Audit results were discussed at the DPIP committee and it was reported that findings were sent to ward managers, discussed at safety pauses and that an improvement plan was necessary.

A deteriorating patient quarterly report included the findings of audits on the use of INEWS, IMEWS and Paediatric Early Warning Score (PEWS) performed at Sligo University Hospital in quarter two, 2023. Within each of the early warning scores audit, the hospital identified deficits or gaps which had been formulated into an improvement plan with key actions and timeframes identified and reported on quarterly to the GM, CEO, and Clinical Director of Saolta University Health Care Group.

The hospital performed a clinical audit of the handover tool in June 2023 including the use of the Identify, Situation, Background, Assessment and Recommendation (ISBAR)

communication tool. This audit was carried out in 11 clinical areas in total. Again, areas for potential improvement was noted but no action plan was seen by inspectors.

An audit of nursing care provided to admitted patients on trolleys in Sligo University Hospital was conducted in late 2022 by the ADON for quality improvement from the Saolta University Health Care Group. The aim was to identify any risk or patient safety issues and to establish a baseline of the quality of nursing care provided to this cohort of patients. Ninety percent of all patients notes audited had their baseline physiological measurements recorded on admission and at regular intervals while 10% did not have INEWS implemented. The actions required did not reference any actions in relation to this finding and hospital management need to ensure that all patients receive the required standard of nursing care irrespective of location within the hospital.

Audit of compliance with the 'National Compliance Audit of Medical and Surgical Sepsis' was completed in February 2023 by the Group ADON for sepsis and the deteriorating patient. Recommendations, areas of good practice and areas in need of improvement were identified within the report. Hospital management should ensure that there is an action plan to implement recommendations.

Transitions of care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's hospital patient safety indicators. The hospital reported on the number of inpatient discharges, number of beds subjected to delayed transfer of care and the number of new attendances to the emergency department every month. Performance data was reported and discussed at UPGG, QSEC and at performance meetings in the Saolta University Health Care Group. As part of the model ward initiative, the recording of a predicted date of discharge was audited monthly. However, the accuracy of the recorded PDD was not audited, and this represents a missed opportunity for improvement.

Inspectors viewed a range of audits and found that although areas for potential improvement were noted, there were no time bound action plans developed or responsible persons identified. Hospital management need to ensure completion of the audit cycle for it to be effective.

Overall, HIQA was broadly satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital. However, inspectors were not fully assured that the audit cycle was effective in that it was incomplete and therefore it was not possible to see how the audits were supporting changes or improvements. Hospital management 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 improvement in practice occurs. An audit plan for all key risk areas would support the hospital's work in relation to audit. Auditing of clinical practice is essential to

provide hospital management and people who use the service with assurances on the quality and safety of the care and services provided

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

The hospital did not have fully effective systems in place to identify, evaluate and manage risks to people using the service in the four areas of known harm which are the focus of this inspection. The QSEC had responsibility to review and manage those risks. 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 required actions to manage and reduce these risks.

Infection prevention and control

Risks in relation to infection control were recorded on the hospital's corporate risk register. Insufficient capacity, insufficient isolation facilities, infrastructure deficiencies and increased numbers of patients on trolleys were the highest rated risks. These risks were expressed by staff and management on the day of inspection and observed by inspectors.

The actions required to reduce these risks were documented on the register. The hospital had progressed plans for the building of a 42-bed modular unit. They had also received approval for infrastructure work required to enable the use of a further 26 offsite beds by quarter one 2024.

HIQA was satisfied that the hospital screened patients for multi-drug resistant organisms. Due to limited numbers of single isolation rooms at the hospital, all patients with an infective status were not isolated within 24 hours of admission or diagnosis as per national guidance. The hospital had an isolation prioritisation policy and patients were isolated in line with the hospital policy and infection prevention and control advice. Inspectors, however, observed some non-compliance with practices such as open doors where infectious patients were being either cohorted or isolated and with the placement of appropriate signage alerting staff to the fact that additional precautions were required. Hospital staff need to ensure that such practices are embedded in line with national guidance.

Hand hygiene compliance was not maintained consistently at or above the HSE National target of 90%. This poses a risk of healthcare infections and the findings indicate a need for prompt and focussed actions by hospital management to achieve compliance with the HSE target of at least 90%.

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

Medication safety

The Drugs and Therapeutics Committee monitored and discussed any risks related to medication safety. Inspectors noted that actions were awaited for items identified on the hospital risk register and relating to medication safety, for example, the need to improve the aseptic compounding unit.

HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a high alert medication list and high risk situations list as per their policy but the list was not seen in any of the clinical areas visited. Inspectors observed the use of risk reduction strategies to support safe use of medicines in relation to insulin and opioids. Inspectors also observed the rationalisation of high risk medicines. Inspectors observed inappropriate storage of a medication which was contrary to the hospital policy and was brought to the attention of the CMM2.

Sligo University Hospital were using a commercially available injectable medicines guide website which contained monographs that gave information on the recommended methods of preparing and administering intravenous injections and infusions. Inspectors noted that staff did not appear aware of how to access this information in the clinical areas visited. Staff said that they would access help from the pharmacy department if they were unfamiliar with how to prepare intravenous medications but this poses a potential risk for preparation and administration of medication outside of core hours.

The hospital had developed a medication prescription and administration record which had a dedicated colour coded section for safe prescribing of anticoagulants.

Medication reconciliation was undertaken by pharmacists for newly admitted patients on both wards visited by inspectors. Pharmacists were visible on one of wards visited but on the other ward the pharmacist was on annual leave and not replaced for periods of leave. Staff said that they could access pharmacy staff if needed urgently. Medication reconciliation was not routinely carried out at the time of discharge. There were pharmacy technician services available at ward level to support medication stock control.

Deteriorating patient

The INEWS-version 2, observation chart for adult' patients was in use at the hospital and the ISBAR communication tool was used when staff were escalating care. Inspectors reviewed a sample of healthcare records and found that all INEWS charts were complete and the escalation protocol was followed.

Safe 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. The hospital had a number of transfer and discharge templates to facilitate safe transitions of care which utilised the $ISBAR_3$ communication tool. The patient's infection status was recorded on the discharge and transfer templates.

Inspectors noted that there was no copy retained in the chart of the transfer letter sent with patients moving to a nursing home. This resulted in incomplete patient records and posed a potential risk in terms of auditing best practice related to transitions of care, for example, it was not possible to audit if all of the required information had actually been conveyed to the nursing home. Inspectors also noted that there were delays in issuing discharge letters to the patients' primary health care teams on the day of discharge. In one ward, 14 discharge letters had been delayed. Both of these issues were highlighted to the EMT at the time of inspection. It is essential that the primary health care team are notified with the updated information on their patients on the day of discharge in order to provide safe care.

Sligo University hospital had progressed the SAFER§§§§§§§§§ patient care bundle and Model Ward where ward processes are formalised, bringing all members of the interdisciplinary team together to support seamless patient care planning from admission to discharge. Staff reported an improvement with team communication through this initiative and found the weekly team meetings beneficial. The PDD was discussed at this forum. As part of this process wards were monitoring the number of 'green days'********** on the wards as part of their safety pause.

At the time of inspection, the hospital had an admission, transfer and discharge policy. It outlined the principles that the patients must be accommodated in the most appropriate setting and that the most efficient and effective use of bed capacity and prioritisation of bed usage be implemented.

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

§§§§§§§§§ 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.

********** 'Red and green bed days' system is a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to inpatient clinical areas in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle

transmission based precautions, outbreak management, management of patients in isolation and equipment decontamination.

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 and high-alert medicines. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care. All policies, procedures, protocols and guidelines were accessible to staff via a management information system.

In summary, although 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, inspectors found that these were not fully effective in protecting service users from the risk of harm. Inspectors identified a number of areas requiring prompt attention by hospital management to ensure compliance:

- hand hygiene compliance (found to be below the HSE target of 90%)
- IPC controls such as open doors on isolation rooms in use and the placement of signage as appropriate in line with national guidance
- appropriate storage of medication at ward level in line with hospital policy
- staff to have access to up-to-date medicine guidance and at the point of preparation of medicines 24/7/365
- timely preparation and sending of transfer and discharge letters to the primary healthcare team on the same day as discharge or transfer and copies of such information to be retained as part of the patient's health care record for reference and for audit purpose.

Achievement of those objectives will help the hospital achieve a higher rating of compliance with this standard in a future inspection.

Judgment: Partially compliant

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

The hospital had patient-safety incident management 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's rate of reporting of clinical incidents into the NIMS was approximately 300 per month which compares well with other model three hospitals. Although the hospital reports and monitors incidents, the 'rate of clinical incidents reports to NIMS per 1000 bed days' was not reported each month in the published Hospital Patient Safety Incident Reports (HPSIR). The last published record in HPSIR for this value was January 2022 – 17 months prior to this inspection. A co-ordinated approach with support from Saolta University Health Care Group and HSE should be undertaken to ensure timeliness of publication of local HPSIR data.

The hospital tracked and trended patient-safety incidents and an incident summary report was submitted at the monthly Quality and Safety Executive Committee (QSEC) and at bi-monthly Saolta Performance meetings. A Hospital Patient Safety Metrics annual report was prepared which identified extreme and or major incidents as a percentage of all incidents. Incidents specific to each directorate were trended and discussed at governance group meetings such as the Emergency Department Specialty Management Team meetings.

In the main, staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident. The clinical nurse manager received a report of all incidents related to their area on a monthly basis from the quality and patient safety department. The nurse management team then met every two or three months and all incidents were discussed at this forum. Nurse managers' reported that the learning was shared with staff at the two safety huddles carried out daily in the clinical areas. Inspectors also noticed information in relation to incidents displayed at clinical area level on noticeboards. Staff gave examples to inspectors of quality initiatives from reported incidents. Patients that are assessed to be at risk of falls have falls alarms, orange bands and falls socks.

Medication patient-safety incidents were reviewed by the medication safety pharmacist who categorised the incidents in terms of severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. A report was prepared for the Drugs and Therapeutics committee detailing incidents, process, problem or cause and medications involved. In 2022, the hospital had 131 medication patient-safety incidents and in the first quarter in 2023 there were 30. Protected time is given to nurses that are undertaking medication rounds.

Overall, 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 within the directorate structure which included infection prevention and control patient-safety incidents, medication incident and incidents related to transitions of care. There was evidence that the QSEC had oversight of the management of these incidents and that the Senior Incident Management Team and the EMT had oversight of serious incidents and reportable events. Hospital management in conjunction with the Saolta

Hospital Group and the HSE need to ensure that the HPSIR data is complete and up to date at the time of the monthly publication for all items listed.
Judgment: Substantially Compliant

Conclusion

HIQA carried out an unannounced inspection of Sligo University Hospital on 12 and 13 of July 2023 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. The inspection included follow-up of the compliance plan submitted by the hospital in respect of partial and non-compliances as found in four national standards during the unannounced emergency department inspection in September 2022.

An update on progress of the compliance plan was submitted to HIQA on day one of inspection and hospital management reported a 56% completion of tasks to date at time of this inspection. Whilst there was evidence of progress and commitment by the hospital management team to achieve their objectives and an understanding that further work remained there was not enough progress to positively impact on the hospital's compliance with the *National Standards for Safer Better Health*.

Capacity and Capability

Sligo University Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, actions arising from meetings of all committees should be time-bound, assigned to individuals, implemented and the progress of implementation monitored frequently.

There was evidence of devolved accountability and responsibility within the emergency department however, there is scope for improved performance. Hospital management need to improve the operational oversight and management to address the patient flow issues in a timely manner and reduce the risk of admitted patients experiencing prolonged delays in accessing a hospital bed. Attendees to the department were waiting for long periods to be triaged and or medically reviewed and the ED was not compliant with national HSE targets related to patient experience times.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. However, complaints and patient feedback must be trended, discussed and reviewed to ensure that all opportunities are taken to review and improve care for patients.

Management must prioritise recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients with current vacancy rate of 9.7%. The hospital had made improvements within the medical staffing in the ED which will have a significant positive impact. However, shortfalls in the nurse staffing in ED, and in particular having no approved staff nurses for the admitted patients, is having an impact on the required staffing complement for day and night shifts and no improvement was seen from the last inspection in September 2022. Significant work was required to meet national targets for mandatory and essential training, within the ED across nursing and healthcare assistants which was highlighted at last inspection and must be prioritised. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

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. In the main, patients who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff. However, despite staff efforts to maintain patients dignity and respect, the practice of accommodating inpatients on trolleys on the ED corridor and on ward corridors and or treatment rooms 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 hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. Insufficient isolation rooms resulted in cohorting of patients with different micro-organisms in multioccupancy rooms and a lack of storage facilities for equipment, resulted in narrow ward corridors congested with equipment. Hand hygiene sinks throughout the hospital did not conform to national requirements.

HIQA was not fully satisfied that the hospital had comprehensive systems in place to monitor and improve services. Hospital management 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 improvement in practice occurs. The audit cycle was incomplete and therefore it was not possible to see how the audits were supporting changes or improvements.

Overall, while there were systems and processes in place at the hospital to respond to complaints and concerns raised by people who use their services, complaints should be tracked and trended to identify the emerging themes, categories and departments involved. Hospital management should continue to implement measures to support the

prompt, open and effective resolution of complaints within HSE targets so as to improve the experience of people using the service.

On the day of inspection HIQA were not fully assured that the design and delivery of healthcare services in the emergency department or wider hospital fully protected people who use the service from the risk of harm. Patients were accommodated in an overcrowded ED environment, trolleys were in close proximity and, as identified in the inspection in September 2022, the ED continues to need a review of all areas within ED to ensure the environment for the treatment and accommodation of patients is safe and that medical supplies and equipment are stored appropriately. 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. Within the wider hospital, hand hygiene compliance remains consistently low and hospital management need to ensure that all staff can access up-to-date medicine guidance and at the point of preparation of medicines 24/7/365.

Sligo University Hospital had a system in place to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm, with effective oversight from relevant governance structures.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to properly address inspectors' findings at the hospital, in the best interest of the patients that the hospital serves.

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.	**Partially 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.	**Non-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.	**Non-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**
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.	**Partially 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.	**Partially Compliant**
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	**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**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	**Substantially Compliant**

Compliance Plan

Compliance Plan Service Provider's Response

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

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

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

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

- A weekly report highlighting 14/7 LOS will be reviewed to ensure all efforts are made to correct patient flow and minimise delayed transfers of care, Q4 2023 (Responsible person: ADON Patient Flow/ Discharge Co-ord)
- FIT operational committee will assess the recruitment plans for the current vacancies i.e., 1 wte SLT and 1.5 wte Pharmacist on a monthly basis and agree daily work flows. SLT post advertised and interviews are planned for December 2023. Pharmacist (1wte) due to return to post in January 2024 with the .5wte Pharmacist post approved and proceeding to recruitment stage, Q1 2024
  (Responsible person: Asst General Manager / FIT Line Managers)
- An analysis of the FIT team impact in ED will be undertaken, looking at lengths of stay of patients reviewed by FIT, Q1 2024
  (Responsible person: FIT Team)
- A mapping exercise in relation to ED patient flow and Patient Experience Time (PET) was also undertaken at SUH on 25/07/2023 as part of a review of the ED patient pathway to ensure data is captured consistently on iPMS. In addition a report on the finding of Saolta Group level review is due before the end of the year which will provide recommendations for uniform data collection and interpretation across the group in relation to data capture of ED admitted patients, Q1 2024. (Responsible person: Clinical Project Manager /ADON Emergency Dept)
- An audit of all Hygiene practices in ED will be undertaken to ensure compliance with Hospital policy, Q4 2023
  (Responsible person: ADON Emergency Dept/ Hygiene Co-ord)
- Continuing recruitment to fill Pharmacy post in ED & FIT ED, Q4 2023
  (Responsible person: HR Manager/ Chief Pharmacist)
- To improve operational oversight and management of patient flow, SUH will recruit approved Patient Flow Co-ords Q1 2024

(Responsible person: ADON Patient Flow / DON)

- Recruitment of ED Phlebotomy post triage nurse to improve diagnostics, treatment and PET times, Q1 2024
  (Responsible person: CNM3 Emergency Dept)
- St Johns Acute Medical off site ward (26 beds), upgrade works be completed in Q2 2024 and recruitment of approved staffing with it operationalise in 2024
  (Responsible person: Hospital Manager / HSE Estates / HR Manager)
- 42 New Block development – capital project continuing with appointment of contractor in Q1 2024, funding dependent.
  (Responsible person: Hospital Manager/HSE Estates)

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

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

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

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

- ED training records will be monitored by the ED Clinical facilitator and result will be reviewed at ED Speciality Management meeting bi monthly, this will include protected time for mandatory training, Q4 2023
  (Responsible person: ED Clinical facilitator / ADON Emergency Dept)
- Hand Hygiene training plan will be implemented to ensure SUH is meeting national target
  (Responsible person: IPC team/ Heads of Service)
- Introduction of new nursing documentation to include care bundles, assessment of admitted patients and ISBAR to improve patient safety and outcomes, Q4 2023
  (Responsible person: ED Clinical facilitator / CNM2 Admitted Patients)
- The Hospital Management will continue to prioritise recruitment to address staff vacancies in line with HSE recruitment guidance for all approved positions in particular vacancies in ED, Q2 2024
  (Responsible person: Hospital Manager / HR Manager)

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

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

- Business case was submitted to secure additional staff for admitted patients in ED as a high risk area for the Hospital, Q4 2023
  (Responsible person: Director of Nursing /ADON Emergency Dept)
- Current staffing levels allow for paediatric nursing to be rostered every day and peak night shifts Recruitment and education of nurses to care of the child presenting to ED has been ongoing but is now subject to HSE recruitment pause.
  (Responsible person: Director of Nursing /ADON Emergency Dept)
- Electronic information will be available for patients and visitors via QR Codes / leaflets are now in place covering areas such as Emergency Dept – Information for patients and visitors; ANP Referred Care; PALS Information leaflet. This will replace information patient monitor screens, Q4 2023
  (Responsible person: Clinical Project Manager/ PALS Co-ord)
- To improve environment for patients, SUH has extended the ED waiting area, which now opens up into the reception area thus improving visibility of patients. Security office is now located in the waiting / reception area improving safety for patients. Mobile phone charging points are now in place in the waiting area.
  (Responsible person: Asst General Manager/PALS Co-ord)
- To utilise all areas in ED to maximise patient space and open remaining zone once staffing are in place, Q1 2024
  (Responsible person: Director of Nursing /ADON Emergency Dept)
- St Johns Acute Medical off site ward (26 beds), upgrade works be completed in Q2 2024 and recruitment of approved staffing with it operationalise in 2024
  (Responsible person: Hospital Manager / HSE Estates / HR Manager)

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.	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.

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

- New KPI to be introduced to monitor the release of ambulances / handover timing of patients, Q4 2023
  (Responsible person: NAS HALP Co-ord/ ADON Emergency Dept)
- ED working group to be established to rationalise stores and identify designated areas for equipment, Q1 2024
  (Responsible person: ADON Emergency Department/ Procurement Officer)
- Organising information sessions for all staff in the Emergency Department in relation to the handling of complaints, End of Nov 2023
  (Responsible person: Complaints Manager/PALS Co-ord)
- All hospital staff will receive complaints management at induction, Q2 2024
  (Responsible person: Complaints Manager /HR Manager)
- All ED patients will receive leaflets on arrival to ED on "How to make formal complaint" and "PALS Information", Q4 2023
  (Responsible person: Clerical Supervisor / PALS Co-ord)
- Emergency Early warning score (EMEWS) training and implementation to be completed, Q4 2023
  (Responsible person: CNM3 Emergency Dept)
- Roll out of TPro Voice recognition system which will allow for discharge letters to go to GPs electronically, Q4 2023
  (Responsible person: IT Manager/ Clerical Manager)
- Guidance on intravenous antimicrobials ("Reconstitution and Administration of Intravenous Antimicrobials for Adults") has been updated, and in the process of being rolled out to clinical areas. Laminated guidance will be available in all drug rooms as a reference. Information on accessing Medusa (the online injectable medicine guide) is included in education to nursing staff provided by the Medication Safety pharmacist, Q1 2024
  (Responsible person: ADON Nursing practice development / Medication Safety Pharmacist)
- SOP in place to address patients that leave the Emergency department before treatment has commenced/completed whereby the post call Consultant may contact

the patient if there are immediate concerns. GPs are advised of all patients who leave, Q4 2023
(Responsible person: ADON ED / ED Consultants)

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

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

- Complaints department will introduce a track & trending of complaints and provide this information to Departments and QualSec, Q2 2024
  (Responsible person: Quality & Safety Manager/Complaints Manager)
- Track & trend quarterly reports will be reviewed at ED Speciality management meetings, Q4 2023
  (Responsible person: Complaints Manager /Chair of ED SMT)
- Ensure patient complaints and feedback are incorporated into the agenda of the Patient engagement forum and Patients experience survey committee
  (Responsible person: Director of Nursing)
- All Consumer Services staff to be trained on the National Complaints Management System, Q4 2023
  (Responsible person: Complaints Manager)
- CSO staff will roll out targeted training with relevant departments to increase the awareness of the timeframe for responding to complaints and the expectation to meet that timeframe, Q4 2023 - Q1 2024
  (Responsible person: Complaints Manager)

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.	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.

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

- The introduction of Kanban (Stock Management system) into Medical South is planned for early November which will impact positively on storage and reduce congestion, Q4 2023
  (Responsible person: CNM3 Medical / Procurement Manager)
- Review and prioritise essential maintenance issues on the Medical South, Q1 2024
  (Responsible person: Maintenance Manager/ CNM3 Medical)
- Repair of swipe access to door of Medical South, Q4 2023
  (Responsible person: Maintenance Manager/ Security Manager)
- Installation of sinks as per HBN requirements, Q2 2024
  (Responsible person: ADON IPC / Maintenance Manager)
- Introduction of improved IPC signage (signage on doors and back of bed) for ward areas, Q1 2024
  (Responsible person: ADON IPC / ADON Medical)
- Reintroduce the green tagging system to identify what equipment is clean to be carried out on all wards, Q1 2024
  (Responsible person: Ward Managers / Hygiene Co-ord)
- Audit of cleaning schedules to be carried out on wards, Q1 2024
  (Responsible person: Hygiene Co-ord)
- IPC educational drive with staff on wards to heighten awareness of Standard of IPC/Hygiene, Q4 2023
  (Responsible person: ADON IPC / Hygiene Co-ord)
- Hospital wide plan to be implemented regarding mandatory training records for ease of monitoring compliance, Q2 2024
  (Responsible person: Asst General Manager / HR Manager)

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

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

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

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

- Hand Hygiene training to continue across all areas. Train the Trainer hand hygiene to be implemented. Issues for noncompliance to be escalated to QualSec Committee, Q4 2023
  (Responsible person: Asst General Manager / ADON IPC)
- Audit results will be time bound, with action plans including reaudit plans to ensure audit cycle is implemented. Education programme will be rolled out to support implementation of Audit cycles, Q1 2024
  (Responsible person: ADON Nurse practice development / Clinical Audit Co-ord)
- DPIP Committee will ensure that recent audits pertaining to Deteriorating patient monitoring will have actions plans developed, Q1 2024
  (Responsible person: Clinical Audit Co-ord / Chair of DPIP Committee)

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

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

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

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

- Briefing session to be organised with ADONs/Ward Managers/Consultants/Bed Managers/Patient Flow/ IPC team to review and understand the national guidance on managing and cohorting of patients with IPC alerts, Q4 2023
  (Responsible person: ADON Patient Flow / ADON IPC)
- Seek approval to initiate capital project to increase capacity of Aseptic Compounding Unit, Q1 2024
  (Responsible person: HSE Estates / Chief Pharmacist)
- The "high risk medication and high risk situation" guideline has been updated and is available to all staff on HCI. This has been incorporated into ongoing training provided by the Medication Safety pharmacist which includes reference to the use of Medusa, Q4 2023
  (Responsible person: ADON Nursing practice development / Medication Safety Pharmacist)
- The third cycle of audit of medication errors on discharge prescriptions in SUH has been recently completed. The results of this most recent cycle are available and are currently being evaluated, Q4 2023
  (Responsible person: ADON Nursing practice development / Medication Safety Pharmacist)
- A process will be developed to ensure that transfer letters are retained on file in respect of nursing home admissions. Roll out of TPro (Voice recognition system) will assist in this process, Q1 2024
  (Responsible person: Ward Managers / ADON Patient Flow)
- To address delays in issuing discharge letters, after one week the chart will be sent to Consultants office for action, also roll out of TPro will allow for discharge letters to go to GPs electronically, Q4 2023
  (Responsible person: Clerical Supervisor / Ward Managers)
- Training continues to be rolled out to staff in respect of violence and aggression, 10 further sessions are planned in Nov/Dec 2023
  (Responsible person: ADoN Nursing Practice Development)