

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	St. Luke's General Hospital
service provider:	Kilkenny
Address of healthcare	Freshford Road
service:	Jamespark
	Kilkenny
	Eircode:R95 FY71
Type of inspection:	Unannounced
Date(s) of inspection:	09 and 10 April 2024
Healthcare Service ID:	OSV-0001042
Fieldwork ID:	NS 0073

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

About the healthcare service

St. Luke's General Hospital Kilkenny (SLGHK) is a Model 3^{*} public acute hospital. It is a member of the Ireland East Hospital Group.[†] Services provided by the hospital include:

- acute medical in-patient services
- elective and emergency surgery
- emergency care
- high-dependency care
- maternity and neonatal services
- paediatric services
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds Total of 289 beds as follows: • 242 inpatient beds plus 27 beds for overcapacity • A 10-bedded Day Services Unit	Model of Hospital	3
 242 inpatient beds plus 27 beds for overcapacity A 10-bedded Day Services Unit A 10-bedded 	Number of beds	Total of 289 beds as follows:
		 242 inpatient beds plus 27 beds for overcapacity A 10-bedded Day Services Unit A 10-bedded

^{*}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 Ireland East Hospital Group comprises eleven hospitals. These are St. Vincent's University Hospital, University Hospital Waterford, St Luke's General Hospital – Kilkenny, Tipperary University Hospital, Wexford General Hospital, St Columcille's Hospital – Loughlinstown, St Michael's Hospital – Dún Laoghaire, Kilcreene Regional Orthopaedic Hospital, National Maternity Hospital, National Rehabilitation Hospital and Royal Victoria Eye and Ear Hospital. The hospital group's academic partner is University College Dublin (UCD). The HSE is organising into six new health regions in 2024. As part of this process, IEHG will become part of the health region HSE Dublin and South East.

How we inspect

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

During the inspection, inspectors:

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

⁺ 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*.

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

2. Quality and safety of the service

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

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

Compliance classifications

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.

Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.

Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 April 2024	09.00 – 18.20hrs	Aoife O'Brien	Lead
		Denise Lawler	Support
10 April 2024	09.00 – 16.20hrs	Dolores Dempsey-Ryan	Support
		Bairbre Moynihan	Support

Information about this inspection

An unannounced inspection of St. Luke's General Hospital Kilkenny was conducted on 09 and 10 April 2024.

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:

- the acute floor (emergency department and acute medical assessment unit)
- Nore ward (a medical ward)
- Surgical 2 ward

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

** 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 <u>https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf</u>

[§] 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 improves 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.

- Hospital Manager
- Director of Nursing
- Clinical Director
- Operations Managers
- Consultant Emergency Department
- representatives of the Executive Management team
- representatives of the Quality and Patient Safety team
- representatives of the Consumer Affairs team, including the Complaints Officer
- a non-consultant hospital doctor (NCHD)
- representatives of the Human Resources department
- representatives from the following hospital committees and functions:
 - infection prevention and control
 - drugs and therapeutics
 - deteriorating patient
 - patient flow/ transitions of care
- staff from a range of disciplines in the various clinical areas inspected and management staff in the critical care unit (specific line of enquiry)

Acknowledgements

 HIQA would like to acknowledge the co-operation of the management team and staff at St. Luke's General Hospital Kilkenny 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 service told inspectors and what inspectors observed

Findings for emergency department

On the day of inspection, inspectors visited the emergency department (ED) and conducted a walk-through of other areas of the acute floor^{‡‡} including the acute medical assessment unit (AMAU) and minor injury unit (MIU).

The ED and AMAU functioned together as an acute floor with a total capacity for 27 patients. Shared areas such as stores, catering, a psychiatric assessment room and a dedicated general X-Ray service were co-located. However AMAU and ED were staffed separately. Patients attending each of those were triaged separately. When the AMAU was open, between 8.30am to 7pm daily, all medical patients presenting to the acute floor,

⁺⁺ Acute floor: the model of care for the efficient streaming and management at the front door of acute hospitals which may incorporate an emergency department, acute medical unit, acute surgical assessment unit, frailty teams and other services working in tandem with immediate streaming and access to senior relevant decision makers at the earliest opportunity.

apart from acutely unstable patients requiring resuscitation, were managed directly by the AMAU. The ED managed any patients presenting with a medical condition when the AMAU was closed.

The ED had a capacity of 17 patients. There were three resuscitation cubicles (with glass doors and positive pressure facilities) and 14 single cubicles with doors, one of which had ensuite toilet facilities. There was a triage assessment area and four assessment rooms, including a designated psychiatric assessment room. The ED also had a designated room for end of life care and family bereavement. The ED had a minor injuries unit (MIU) situated adjacent to the main department with capacity for three patients. The department had sufficient toilets but limited shower facilities for patients. Inspectors were told that patients were accommodated on additional trolleys in the corridor when demand exceeded capacity and there were a number of vacant trolleys with privacy screens in the corridor, but none were occupied at the time of inspection. There was a large waiting room area outside the ED, with separate seated waiting areas inside the ED for paediatric patients and patients with minor injuries. On the day of inspection, there were no patients on additional trolleys in the ED and AMAU and minimum physical spacing of one metre was maintained in line with national guidance. The ED environment was generally clean and well maintained but there were a number of areas of general wear and tear observed, with paint work and flooring, this did not facilitate effective cleaning.

The AMAU had a capacity of 10 patients in single occupancy rooms or cubicles. One room had an anteroom with positive pressure and the patient room had negative pressure ventilation^{§§}. There was also a triage area and a seated waiting area and ten separate patient areas.

At 11am on the first day of inspection the ED was operating well relative to its intended capacity and function. 18 patients were registered in the ED. There were no patients in the resuscitation areas. However, admitted patients were present in six of the 14 patient cubicles in the ED and the remaining five cubicles were full with new attendances. There were no patients on trolleys in the corridor in the ED. Inspectors were told that suitable patients were accommodated on chairs in the waiting room and were managed by a triage nurse using a triage handover tool and the 'fit to sit' policy in conjunction with national ambulance staff. There were no patients in the MIU at the time of inspection. The AMAU was accommodating six admitted patients and had four free cubicles, these were reserved for new attendances.

Inspectors observed staff actively engaging with patients in a respectful and kind manner ensuring patients' needs were responded to. Inspectors observed staff promoting and protecting patients' privacy and dignity. For example, curtains or blinds were pulled to

^{§§} A positive-pressure ventilation room helps prevent inward spread of airborne pathogens while a negative - pressure ventilation room helps prevent inward spread of airborne pathogens.

ensure privacy and dignity when patients were being clinically assessed and treatment administered.

Inspectors spoke with a number of patients in the ED and AMAU about their experience of care. A number of admitted patients had been in the department for over 24 hours. Overall, patients were complimentary about the staff and the care they had received. When asked what had been good about the care in the ED so far, patients commented that they were 'seen straight away', staff were 'fab', 'everyone was nice' and the 'food [was] lovely'.

When asked if anything could be improved, patients indicated they had a positive experience overall but commented that staff were '*under pressure*' and they would like staff to '*let you know what was happening [more]*'. One patient did outline that they were previously waiting on a chair and this was uncomfortable but that the '*place was full*' at the time and they were moved to a trolley later in their stay.

Patients who spoke with inspectors were not aware of the hospital's complaints process and said they had nothing to complain about at the time but they would speak to a nurse or send a '*letter to the HSE*'.

Findings for the wider hospital and clinical ward areas

Two wards were inspected. The Surgical 2 ward was a 28-bedded surgical ward separated into a 12-bedded open plan area and three five-bedded bays. There was one single room without ensuite facilities. There was adequate allocated toilet and shower facilities for each bay. All beds were occupied at the time of the inspection, apart from one bed that was kept vacant for emergency use. A further two trolleys were occupied on the corridor and were part of the surge capacity for the hospital.

The Nore Ward was a 24-bedded ward, specialising in care of older persons and had an additional two bariatric beds and a discharge lounge. All 24 rooms in the Nore ward were single occupancy rooms with ensuite bathroom facilities.

Inspectors observed effective communication between staff and patients in both wards. Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to patients. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care. This was validated by patients who described staff in the clinical areas visited as '*very good'*, '*very attentive'*, '*fantastic'*, '*very friendly' and 'kind'*. Inspectors spoke to a patient who was on a bed in the corridor who said they had no issues with privacy as privacy curtains were used when necessary. The patient said they expected to get a bed when other patients were discharged.

Staff were observed providing required assistance to patients and this was validated by a patient who told inspectors that they felt their symptoms were well managed and they received support when needed, especially with washing and mobilising and that staff

'listened to my concerns'. However, inspectors observed that call bells were not always answered in a timely way during the inspection. A number of patients did comment that more staff were needed as staff were *'very busy'* and there were *'not enough of them'* and the hospital *'should have more [staff]'.*

Patients who spoke to inspectors in the wards were not familiar with the hospital's complaints process but outlined that they would talk to a member of staff if they had a complaint.

Overall, there was consistency with what inspectors observed during inspection and what patients told inspectors about their experiences of care received.

Capacity and Capability Dimension

Inspection findings from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital under national standards 5.2, 5.5 and 5.8. Inspection findings from the theme of workforce are presented under national standard 6.1.

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. The hospital's organogram requires updating to include the Deteriorating Patient Improvement Programme Committee which was established in late 2022.

The Hospital Manager had overall responsibility for the governance of the hospital and reported to the Chief Operating Officer for the Ireland East Hospital Group (IEHG).

The Clinical Director provided clinical oversight and leadership at the hospital. The Director of Nursing was responsible for the organisation and management of nursing services at the hospital.

Executive Management Team

The Executive Management Team (EMT) for St. Luke's General Hospital Kilkenny was chaired by the Hospital Manager and met monthly according to its terms of reference. Inspectors noted that there was a gap in the frequency of EMT meetings lasting from October 2023 through to February 2024. The minutes of the March 2024 meeting referred to restrictions on operational activity during that period. The EMT had appropriate membership with senior managers representing clinical, nursing, midwifery, health and

social care professionals (HSCPs), quality and risk management, human resources, general and technical services and finance. The EMT had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. Minutes of EMT 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. In the case where a manager position was vacant, other members of staff from the relevant departments attended EMT meetings. Issues were escalated from the EMT at monthly performance meetings with IEHG.

Quality and Safety Executive

The Quality and Safety Executive Committee (QSEC) was the main committee assigned with overall responsibility for the overall governance, oversight and monitoring of quality, safety and risk processes at the hospital. The committee was chaired by a hospital consultant and reported to EMT. The QSEC met every six weeks according to its terms of reference. However there was a gap in the meeting records submitted to HIQA between October 2023 and January 2024. The committee had a comprehensive standard agenda and a broad membership including the Hospital Manager and senior representatives from a range of clinical and operational services.

The QSEC requested, received and considered reports, both verbal and written from the sub-committees that reported into it. Inspectors reviewed the reporting schedule to QSEC for 2024, which included 12 different committees including those for hygiene, decontamination, the deteriorating patient and sepsis. The topics of infection control and medication safety were part of the standard meeting agenda for all meetings and were discussed regularly.

The QSEC reviewed patient-safety incidents, complaints management, feedback on patient experiences and progress on the implementation of patient safety quality improvements. The committee provided reports to the EMT and performance meetings with IEHG including updates on activity, performance indicators, risks, incidents, infection prevention and control, and quality improvements.

The QSEC did not formally or routinely review the hospital's risk register. This represents an area for improvement for the hospital. At the time of inspection, the hospital was in the process of setting up a separate forum for the review and oversight of risk registers called the Risk Register Committee. Inspectors were provided with the draft terms of reference for this committee which, it was planned, would meet quarterly.

Infection Prevention and Control

The hospital's multidisciplinary Infection Prevention and Control Committee (IPCC) was responsible for the governance and oversight of infection prevention and control and antimicrobial stewardship at the hospital. The committee was chaired by the hospital's Operations Manager or Hospital Manager and met quarterly according to its terms of reference. However records submitted to HIQA showed that the IPCC had met less frequently in the past year. Membership was broad and multidisciplinary including IPC nurses, antimicrobial pharmacists, consultant microbiologists and senior management representatives. Meetings followed a structured agenda with actions monitored from meeting to meeting. The IPCC reported to QSEC where IPC updates were a standing agenda item, however the membership of QSEC did not explicitly include a representative for IPC.

The IPCC was responsible for oversight of the management of outbreaks of infection in the hospital. The hospital managed outbreaks in line with the latest guidance from the Health Protection Surveillance Centre (HPSC) and formed an outbreak control team in response to outbreaks. This will be discussed under national standard 5.5.

A number of sub-committees reported to the IPCC such as the decontamination committee and hygiene services committee. Inspectors were told that that due to vacancies in key posts, for example, the hygiene services coordinator, oversight and governance was a challenge. Inspectors were told that this meant that the IPCC had not received regular reports from a number of subcommittees at the time of inspection. This represents an area for improvement for the hospital. Inspectors saw evidence to show that subcommittees such as the hygiene services committee continued to meet and escalate concerns directly to QSEC when required.

Medication Safety

The hospital's Drugs and Therapeutics Committee (DTC) was assigned responsibility for the governance and oversight of medication management practices at the hospital, including antimicrobial stewardship and the review of medication safety incidents. At the time of inspection, the medication safety sub-committee had been merged with the DTC. The committee was chaired by a medical consultant and reported to the QSEC where medication safety updates were a standing agenda item. The DTC met quarterly and actions were monitored from meeting to meeting. The membership of the DTC was broad and included pharmacists, consultants, NCHDs, nursing and community representatives and representatives from quality and risk management. Inspectors were told that there was also an open invitation to all consultants circulated with the agenda in advance of meetings and additional staff would attend for agenda items of particular interest to their specialty. According to records submitted to HIQA, the membership of the DTC did not formally include a consultant microbiologist. This represents an area for improvement for the hospital. However inspectors saw evidence that a consultant microbiologist attended meetings and provided updates on antimicrobial stewardship.

Deteriorating Patient

The Deteriorating Patient Improvement Programme Committee (DPIPC) had oversight of the national deteriorating patient improvement programme for the hospital, including implementation of national early warning systems and sepsis management processes, in line with national guidance. The committee also had oversight of the use of Identify, Situation, Background, Assessment and Recommendation (ISBAR^{***}) communication tools, the development of care pathways for patients at end-of-life, training relevant to the deteriorating patient and relevant national and hospital audits and metrics and associated quality improvement plans.

The committee was co-chaired by the Assistant Director of Nursing (ADON) for Medicine and a medical consultant. The DPIPC met every two months, was action-oriented and had good attendance at meetings. The membership was multidisciplinary including management and nursing representation, consultant and NCHD leads, quality and risk representatives and representatives of the resuscitation and sepsis groups who reported to the DPIPC. The DPIPC reported to the EMT and to the national HSE deteriorating patient improvement programme. The DPIPC also reported to QSEC, however this was in the form of an annual scheduled update rather than as a standing agenda item at QSEC meetings. The DPIPC escalated issues directly to the EMT or the Hospital Manager. Inspectors were told that the DPIPC was in development during 2023 and had not yet produced an annual report. This represents an area for improvement for the hospital.

The implementation of sepsis management for adults was under the remit of the Sepsis Committee which was chaired by a consultant microbiologist, met quarterly and reported to QSEC and DPIPC as required. Membership was multidisciplinary and there was good attendance at meetings. The sepsis committee escalated issues directly to the Clinical Director. In addition the ADON for Medicine was a member of the DPIP committee for IEHG and the hospital participated in the national sepsis audit programme.

The Critical Care Governance Committee (CCC) provided overall governance and leadership for the management of quality, safety and risk related to critical care patients in the hospital, including oversight of quality improvement initiatives and review of activity, risk, patient-safety incidents and metrics related to critical care. This committee was chaired by the Hospital Manager or deputy and met monthly. Actions were monitored from meeting to meeting and the committee reported to the EMT.

Transitions of Care

The Unscheduled Care Governance Committee (USC) provided overall governance and leadership for unscheduled care, including the management of flow and experience of unscheduled patients through the hospital and onward into the community. It was also a forum for the management and review of activity, risk, patient-safety incidents and performance metrics, escalation processes and performance improvement initiatives related to unscheduled care within the hospital. This committee was chaired by the Hospital Manager or deputy and met monthly. Actions were monitored from meeting to meeting and the committee reported to the EMT.

^{***} ISBAR is a communication tool for clinical handover and escalation. It stands for Identify, Situation, Background, Assessment, Recommendation.

The Home First meeting provided governance and leadership for patient flow and discharge processes in the hospital and for escalation of complex discharge issues. Membership included the Hospital Manager, unscheduled care lead, discharge planners, geriatric emergency medicine service (GEMS) case manager and a range of health and social care managers and community support representatives. The group met weekly and discussed admitted patients with a length of stay (LOS) greater than 14 days. The group provided an update of community supports available and developed multidisciplinary integrated discharge action plans. The group also monitored wait times for both internal and external services.

Overall, the hospital had formalised corporate and clinical governance arrangements in place. These governance arrangements outlined the roles, accountability and responsibility for providing assurance of the quality and safety of services at the hospital. Governance arrangements in place at the hospital had a focus on the quality and safety outcomes for people using the service. However, several committees had not been meeting in line with their terms of reference.

Judgment: Substantially compliant

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

Findings relating to the emergency department

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. The ED and AMAU functioned together as an acute floor, underpinned by the hospitals acute floor admission criteria policy. The units were co-located and had access to a number of shared facilities such as the psychiatric assessment room, catering and some storage areas. The acute floor was under the governance of the Unscheduled Care Committee (USC) and Clinical Director. All medical presentations, apart from acutely unstable patients requiring resuscitation, were managed directly by the AMAU between 8.30am to 7pm daily, under the governance of the medical consultant on-call supported by four NCHDs, one of whom was at registrar level. This allowed the ED to focus on non-medical emergencies such as major trauma, resuscitation, factures and minor injuries under the governance of the clinical lead for emergency medicine. When the AMAU was closed, all new presentations were managed by the ED.

There was evidence of strong clinical and nursing leadership in the ED. An emergency medicine consultant was the lead consultant in the ED and provided operational

governance and day-to-day clinical oversight. Senior clinical decision-makers⁺⁺⁺ at consultant or registrar level were on-site in the ED at all times. Consultants in emergency medicine were on site during core working hours⁺⁺⁺, Monday to Saturday. Hospital management informed inspectors that clinical oversight of the ED was provided by the ED consultant on-call from 5pm Saurday until 9 am on Monday and by the surgical or Medical Consultant on call from Monday 5pm until Friday 9am.

A clinical nurse manager grade 3 (CNM3) had operational oversight of the acute floor during core working hours, Monday to Friday and reported to the ADON for unscheduled care. Outside core working hours, there was a clinical nurse manager grade 2 (CNM2) on duty in ED for each shift who had overall responsibility for the nursing services and any issues were escalated to the out-of-hours site manager. There was a CNM1 on duty in the AMAU.

In 2023, the overall attendance at the hospital's ED and AMAU was 47,910. This was higher than most other model 3 hospitals and equated to an average daily attendance rate of approximately 131 patients and a 6% increase compared to 2022. The increase in attendance of patients aged 75 years and over was 13%. Patients aged 75 years and over accounted for 14.7% of all attendances, which is just below the national average.

The conversion rate (percentage of patients who attend the hospital who are admitted to an inpatient ward) in 2023 was 36.2% overall and 67.2% for patients aged 75 years and over. Hospital management told inspectors that their high conversion rate was led by all AMAU attendances being recorded as admissions. In 2024, up to the week of inspection, the overall attendance rate at the hospital's ED was 14,249, which was a further increase of 8% since the same time in 2023. There was a 15% increase in attendances of patients aged 75 years and over. The conversion rates were still the highest nationally, 38.6% overall and 70.0% for patients aged 75 years and over.

Inspectors were informed and saw some evidence to suggest that the hospital had a higher than average number of patients aged 90-100 years and over and staff said that the presentation of such patients to the ED impacted on the hospital's admission rates, patients' lengths of stay (LOS) and the levels of delayed transfers of care (DTOCs). Inspectors were also told that some admissions were required due to delays accessing diagnostics such as CT. Inspectors discussed the high conversion rates with members of the EMT and were told that there were a number of other factors contributing to the high conversion rates such as the increase in stroke patients attending the hospital since the closure of stroke units in neighbouring hospitals, changes in availability of GPs in the community with patients attending the ED instead of primary care services. Overcrowding on the acute floor was described as sometimes impacting the ability of

⁺⁺⁺ 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.

^{***} Core working hours at the hospital were considered to be Monday to Saturday.

staff to assess patients properly, leading to a decision to admit on safety grounds. This represents an area for improvement for the hospital.

On the day of inspection at 11.00am, the ED appeared to be functioning reasonably well. There were 18 patients registered in the ED. However there were also six admitted patients boarding in the ED and a further six admitted patients boarding in the AMAU. The admitted patients were awaiting an inpatient hospital bed and were under the care of the admitting specialist consultant.

All patients had been triaged and prioritised in line with the Manchester Triage System.^{§§§} The average waiting time from registration to triage was 2.88 minutes which was compliant with the 15 minutes triage time recommended by the HSE's emergency medicine programme. The average wait from triage to medical assessment was 90 minutes but ranged from 0 to 4.28 hours. Information was not available from the hospital on the times from medical assessment to decision to admit or from decision to admit to admission to an inpatient bed.

The hospital was compliant with the majority of the HSE's key performance indicators for patient experience times^{****}(PETs). However it was not fully compliant for patients aged 75 years or older, 40% of whom were waiting over six hours (two of five patients).

The hospital's key performance indicators for patient experience times (PETs)^{††††} from January to September 2023 were longer than the same time frame in 2022, but were still within the national targets and better than the national average for all hospitals. Patient flow, particularly in relation to admitted patients in the ED and AMAU needs to be monitored closely to ensure that PET times do not continue to lengthen.

- The hospital had systems and processes in place to support patient flow as outlined below. However at the time of inspection, due to the high numbers of inpatients and the use of surge capacity in both the ED and AMAU, these systems were not functioning as efficiently as intended.
- The AMAU operated from 8.30am to 7pm Monday to Friday. All medical patients, within a broad range of defined admission criteria, were streamed directly to AMAU following registration and were under the clinical governance of the medical consultant on-call and an AMAU medical team. The AMAU was also supported by three advanced nurse practitioners (ANPs) whose scope of practice included chest pain and deep vein thrombosis. On the day of inspection only four of the available 10 cubicles were available for new presentations, as six were occupied by admitted patients. However the broad acceptance criteria for the AMAU and efficient streaming directly to AMAU had a significant and positive role

^{§§§} 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.

^{****} Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

^{††††} Patient experience time (PET) measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

in improving flow on the acute floor and allowed the ED to focus on non-medical and unstable patients such as resuscitation cases, trauma, anaphylaxis, burns or back pain. This was echoed by staff who spoke to inspectors during inspection.

- The Minor Injuries Unit (MIU) was part of the ED, and situated adjacent to the main ED. The MIU was staffed by two ANPs and two physiotherapists during core hours, Monday to Friday. Patients were either referred directly by their GP or allocated to MIU following triage in the ED and were under the clinical governance of the emergency medicine consultant. The MIU managed approximately 140 patients per month. On the day of inspection all three cubicles were vacant. The MIU also conducted scheduled review clinics with consultants and ANPs throughout the week.
- The hospital had a paediatric assessment unit (PAU) which was situated in the paediatric ward and was not part of the acute floor. Medical paediatric patients and patients under two years of age presenting to the hospital were managed directly in the PAU. However surgical paediatric patients over two years of age were managed in the ED.
- The hospital had three discharge lounges situated throughout the hospital, however on the day of inspection these were in use for surge capacity and were accommodating admitted patients.
- The geriatric emergency medicine service (GEMS) team consisted of a nurse, occupational therapist, physiotherapist and ANP. This team assessed geriatric patients from the ED and AMAU to support admission avoidance or timely discharge with appropriate supports in place.
- The acute floor had a dedicated X-ray service which expedited access to general X-ray diagnostics.
- The hospital had a number of clinical pathways in place to streamline the patient journey through the acute floor such as — deep vein thrombosis, chest pain, major trauma and stroke pathways. The hospital also had a bypass pathway for suspected hip fractures which were taken directly to University Hospital Waterford by ambulance and a pathway to transfer patients with ST segment elevation myocardial infarction (STEMI) directly to St. James' Hospital.
- The hospital had a pathfinder service^{****}, which helped to reduce the number of presentations from patients over 65 years of age to the ED. However a previous hospital ambulance liaison person (HALP) role was no longer in place.

^{****} A Pathfinder service is a collaborative service staffed by health and social care professionals and the HSE's National Ambulance Service. The aim of this service is to avoid transfer to the emergency department following a 999 call for patients over 65 years of age with low acuity conditions, by providing treatment at the scene if appropriate, and or referral to community health and social care service.

Continuous and effective flow of patients within the hospital is essential for optimal service delivery in the ED. The average length of stay (ALOS) reported by the hospital for medical patients at the time of inspection was 8.17 days which was higher than the national target of 7 days or less. The ALOS for patients who had either emergency surgery or elective surgery was within the national targets. On the day of inspection, the hospital had 13 patients with delayed transfers of care (DTOC), which was higher than the hospital's average for 2023. This was discussed with representatives for patient flow who told inspectors that the higher level of DTOCs was due in part to the high number of patients over 80 years of age and a high number of older persons requiring residential disability services. Inspectors were told that the hospital was experiencing long wait times for access to rehabilitation and suitable step-down facilities.

Lack of adequate inpatient bed capacity impacted on the time patients spent in the ED and AMAU. Shift leaders (CNM2s) from the ED and AMAU attended a bed management hub meeting daily at 11am and provided feedback to the department on the bed allocation for admitted patients each day. On the day of inspection six admitted patients were accommodated in the AMAU and a further six admitted patients were accommodated in the ED. Delayed transfers of care further compounded the issue of availability of inpatient beds at the hospital and impacted on waiting times in the ED. On the day of inspection, the hospital had 13 delayed discharges. Hospital management attributed the delay in transferring patients mainly to the lack of availability of step down services in the community. Whilst the specific use of acute floor beds for surge capacity for admitted patients was effective during periods when the hospital was over capacity, the practice impacted significantly on the experiences of those patients presenting to the ED and on the capacity of existing staff to accommodate and treat patients safely. Inspectors were told on the final day of inspection that the hospital had received funding to allow the opening of an additional 18 beds.

A risk outlined on the corporate risk register related to the sustainability of a safe service in the ED and AMAU with inadequate space to meet demand due to increased attendances and an increasingly older frail population. This risk was a number of years old and a number of significant controls were established and observed at the time of inspection such as the GEMS service, an ADON for patient flow, and the opening of the 72-bedded Ormond Wing in 2022. However activity levels and space constraints were still challenging at the time of inspection. In particular, the use of ED and AMAU staff to care for a significant number of admitted patients on the acute floor is a specific risk to the sustainability of a safe service for both admitted and non-admitted patients. This represents an area for improvement for the hospital.

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

Infection, prevention and control

The hospital had an overarching infection prevention and control programme^{§§§§} as per national standards.^{*****} The infection prevention and control team had an annual work plan, approved by IPCC that set out objectives to be achieved in relation to infection prevention and control. These objectives included communication, training, audit programmes and provision of IPC services including surveillance and outbreak management.

The hospital had an antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship programme.⁺⁺⁺⁺⁺ The team included both consultant microbiologists and the antimicrobial pharmacist. This team was operationally accountable to the DTC. The team was also a member of the Regional Antimicrobial Stewardship Group. The antimicrobial pharmacist provided reports to both the DTC and IPCC.

Inspectors found that the management of infection outbreaks at the hospital was in line with national guidance. A multidisciplinary outbreak team was convened and met regularly to advise and oversee the management of outbreaks. A comprehensive report was produced at the end of each outbreak, however inspectors were told that there could be some delay in completion of outbreak reports, due to staffing challenges in the IPC team.

Medication safety

The hospital had a clinical pharmacy service^{‡‡‡‡‡} which was led by the hospital's chief pharmacist. There were a small number of unfilled vacancies for both pharmacist and pharmacy technician roles at the time of inspection, including the role of medication safety officer. The pharmacy department had responded by maximising impact with targeted, evidence-based and risk-based activity, such as prioritising clinical pharmacy services for patients with polypharmacy or high risk medications and by developing the scope of practice for pharmacy technicians to perform medication reconciliation.

Deteriorating patient

^{\$§§§} An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

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

^{*****} Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

^{*****} Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

The hospital had clinical leadership at consultant level for the implementation of early warning systems and for the management of sepsis in the hospital. The DPIPC had oversight of the implementation of national early warning systems, sepsis management guidelines and the provision of end-of-life pathways. This group also had oversight of relevant incidents, monitoring and quality improvement projects including training and resource planning in relation to the deteriorating patient.

A number of staff had specific roles relating to the deteriorating patient and sepsis. The clinical lead for the deteriorating patient conducted Irish National Early Warning System (INEWS) escalation and response audits with support from the clinical nurse managers. The hospital had a sepsis link nurse who provided sepsis training. The DPIPC had recently introduced an evening multidisciplinary safety pause which also included INEWS and sepsis prompts.

Staff who spoke with inspectors described additional processes in place to monitor patients, including a system for monitoring patients in the waiting room after triage, by a triage nurse and supported by a triage shift handover tool. The level of monitoring was based on the categorisation from the Manchester Triage System. Patients were also assessed for their suitability to wait in the waiting room using the 'fit to sit' pathway for handover from the National Ambulance Service.

Transitions of care

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 hospital had a bed management team led by an ADON for patient flow. The team had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital. The team worked closely with the onsite hospital transport coordinator when ambulance transport was required for people being transferred out to other hospitals or being discharged from the hospital. Inspectors were told that, at the time of inspection, additional acting roles were in place to assist in the management of patient flow due to surge activity.

Operational issues relating to inpatient bed capacity, patient discharge and transfers into and out of the hospital were discussed at a range of meetings including, daily morning site handover meetings, multi-disciplinary (MDT) hub meetings and afternoon bed management meetings depending on the level of escalation in the hospital and underpinned by the hospital's escalation framework policy. Patient flow and bed management issues, including cases where a patient's length of stay (LOS) was greater than 14 days were also discussed weekly at the 'Home First' meetings with representatives from CHO 5 §§§§§ community services. Representatives of the patient

^{§§§§§§} Community Health Organisation – services offering healthcare outside of acute hospitals, such as primary care, social care, mental health and other health and well-being services.

flow team also provided updates at weekly IEHG Virtual Hospital meetings. The team reported daily on bed occupancy metrics and monthly breaches were reviewed at the USC.

In summary, while the hospital had defined management arrangements in place to manage and oversee the delivery of care, these were not fully effective in the support and promotion of the delivery of high quality, safe and reliable healthcare services. In particular, there has been a reduction in performance with patient experience times (PET) from 2022 to 2023. There was only 60% compliance with the patient experience times for patients aged 75 years or more. This together with the high conversion rates in the hospital, resulted in admitted patients being accommodated on trolleys in the ED, the AMAU and on corridors in wards. This represents a decrease in effectiveness and an increase in the risk to patients.

Judgment: Partially compliant

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

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

Monitoring service performance

The hospital collected and collated data related to the quality and safety of healthcare services such as, patient-safety incidents, complaints and compliments, nursing care, patient surveys, workforce and risks that had the potential to impact on the quality and safety of services. A range of national key performance indicators (KPIs)****** related to the quality and safety of the services were measured and published⁺⁺⁺⁺⁺.

Collated performance data and KPIs such as unscheduled and scheduled attendances, patient experience times (PETs), bed occupancy rate, average length of stay (ALOS), scheduled admissions and delayed transfers of care (DTOCs), were monitored at

^{*******} HSE Acute Division Metadata. 2023. Available online from:

https://www.hse.ie/eng/services/publications/kpis/key-performance-indicator-metadata-2023.html/ ⁺⁺⁺⁺⁺⁺ The HSE's Performance Assurance Report (PAR) provides an overall analysis of key performance data from Divisions, such as Acute, Mental Health, Social Care, Primary Care, Health and Wellbeing as well as Finance and HR. The activity data reported is based on Performance Activity and Key Performance Indicators outlined in the current National Service Plan. <u>Performance Reports - HSE.ie</u>

department level meetings, governance committee meetings and reported at meetings of the EMT, QSEC and at performance meetings between the hospital and IEHG.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. Inspectors were told that departmental risk registers were managed locally, reviewed twice a year and risks were escalated to the relevant representative at EMT via line management structures. However inspectors found that risk registers were overdue for review in some clinical areas visited.

Risks from the hospital's corporate risk register were discussed at individual governance meetings and inspectors saw evidence that risks were escalated as required to the EMT and to the IEHG. Management described a plan to form a risk register committee with quarterly meetings and a comprehensive draft terms of reference for this group was provided.

Documentation submitted to HIQA described the risks that were recorded on the hospital's corporate risk register in relation to the four key areas of known harm, along with the controls and actions implemented to mitigate the risks. These risks are outlined further in national standard 3.1.

Audit activity

The hospital had an annual audit schedule and inspectors saw evidence of audit activity which will be discussed in national standard 2.8. Oversight of audit activity was provided by individual operational groups such as the IPCC, DTC, DPIPC, sepsis committee and QSEC. Quality improvement plans for audit recommendations and re-audit plans were seen for some but not all of the audits reviewed by HIQA. These were not always time-bound or assigned to a specific individual. This represents an area for improvement for the hospital.

Management of serious reportable events and patient safety incidents

The hospital had systems in place to identify, monitor and analyse patient-safety incidents with appropriate oversights in place, in line with the HSE's Incident Management Framework 2020. Examples of shared learning from incidents, including serious reportable incidents (SREs), to improve the quality and safety of services, were provided during the inspection. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3.

Complaints, compliments and feedback

Complaints and compliments were tracked and trended by the consumer affairs office. The QSEC had oversight of the hospital's complaints management process, including the implementation of any quality improvement plans related to feedback and complaints. Findings from the national surveys, such as the national inpatient experience survey and the national end of life survey were also discussed at meetings of the QSEC and inspectors saw evidence of quality improvement plans arising in response to results. This is discussed in more detail under national standard 1.8.

In summary, the hospital had several systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Oversight of the use and maintenance of risk registers in the hospital represents an area for improvement as does the oversight of monitoring and audit activity to ensure that plans are time-bound and assigned to specific individuals.

Judgment: Substantially compliant

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

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

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. The position of Human Resources manager was vacant at the time of inspection. However, a senior member of the HR team attended EMT meetings and inspectors were told that the human resources team reported directly to the Hospital Manager.

Findings from the emergency department and AMAU

The consultants in emergency medicine were supported by 1.0 WTE associate specialist and 19.0 WTE non-consultant hospital doctors (NCHDs), seven of whom were at registrar

^{*******} 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.

grade. At the time of inspection, one of these registrar positions was vacant. The hospital was not an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine. Hospital management discussed challenges and active measures they were taking to improve the recruitment of non-consultant hospital doctors to the hospital's ED.

The ED had an approved complement of 44.29 WTE nursing staff, including nurse management and specialist grades. All but 0.22 WTE nursing positions were filled on the day of inspection. Inspectors were told that a number of shift leader positions at CNM2 grade were backfilled with staff nurses at the time of inspection. On the day of inspection, the ED had a full complement (9.0 WTE) of nursing staff rostered on duty, this included 7.0 WTE staff nurses and 2.0 WTE CNM2s. Nursing staff were supported by 4.0 WTE healthcare assistants, a fifth healthcare assistant post was unfilled at the time of inspection.

Medical staffing for the AMAU consisted of 4.0 NCHDs, one of whom was at registrar level. These positions were filled by staff from the hospital's medical teams and rotated weekly. There was no dedicated consultant for the AMAU, the medical consultant on-call each day had responsibility for the AMAU.

The AMAU had an approved complement of 19.6 WTE nursing staff, including nurse management and specialist grades. All but 0.72 WTE nursing positions were filled on the day of inspection and there was a full complement of nursing staff rostered on duty on the day of inspection. Nursing staff were supported by their full approved complement of 2.0 WTE healthcare assistants. The AMAU was open from 8.30am to 7pm daily.

A clinical nurse manager grade 3 (CNM3) was rostered on duty on the day of inspection and had overall nursing responsibility for the acute floor (ED and AMAU).

There were no additional staff allocated for the care of admitted patients who were boarded in the ED and AMAU while waiting for an inpatient bed in the main hospital. Inspectors spoke to a number of admitted patients who had presented to the ED the previous day but had remained on the acute floor overnight. During a previous HIQA inspection, a CNM2 was in place to manage admitted patients in an ED overcapacity area but inspectors were told that this post had been redeployed to manage surge activity in another area of the hospital. The risks associated with the boarding of patients and the increased activity in the ED and AMAU were recorded on the hospital's corporate and local risk registers in the ED and AMAU and inspectors discussed the controls and measures in place to minimise this risk. On the final day of inspection, inspectors were told that the hospital had received approval to open and staff a further 18 beds and that this would positively impact the ED and AMAU and allow management to reduce the level of admitted patients in the ED and AMAU.

The hospital's corporate risk register included risks related to the limited availability of consultant cover in emergency medicine and paediatric psychiatry out-of-hours for the ED

and the lack of dedicated medical consultant cover for the AMAU, particularly in the context of increasing activity in the ED and AMAU. Inspectors discussed the controls and measures in place to minimise this risk with management and staff during inspection and risks had been escalated to IEHG as appropriate. Inspectors were told that it was envisioned that some of this risk would be reduced in a matter of weeks, pending the arrival of an additional emergency medicine consultant.

Staff in the ED had access to support from the IPC team and inspectors were told that they visited daily and as required. Staff also had access to advice from an antimicrobial pharmacist and a microbiologist. There was a dedicated clinical pharmacy service daily including a pharmacy technician service. Medication reconciliation was performed for admitted patients and staff had access to medication vending machines out of hours. Security staff were on duty in the main reception area 24/7.

Uptake of mandatory and essential staff training in the emergency department and AMAU

It was evident from staff training records reviewed by inspectors that nursing staff in the ED and AMAU undertook multidisciplinary team training appropriate to their scope of practice. The ED had a system in place to monitor and record staff attendance at mandatory and essential training. The CNM3 and clinical skills facilitator had oversight of training records. However, HIQA found that there were some deficits in the staff attendance and uptake at mandatory and essential training in relation to infection prevention and control and the early warning score systems.

Findings from the wider hospital and clinical ward areas

The hospital had arrangements in place to plan, organise and manage the workforce. The hospital's total staff was 1416 WTEs which was an increase of almost 10 WTE from January 2024.

The hospital had adequate workforce management arrangements in place to support dayto-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care.

The infection prevention and control team comprised:

- 0.5 and 0.1 whole-time equivalent (WTE)^{§§§§§§} consultant microbiologists
- 2.0 WTE clinical nurse specialists (CNS)
- 1.0 WTE clinical nurse manager grade 2 (CNM2)
- 0.8 WTE antimicrobial pharmacist
- 0.5 WTE surveillance scientist (based in University Hospital Waterford)

^{\$\$\$\$\$\$\$} WTE – whole-time equivalent, this is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

2.0 WTE administrative support

In relation to medication safety, the hospital had a blended work arrangement with some commitments to regional community pharmacy services in Carlow and Kilkenny and included;

- 13 WTE pharmacists, which included the chief pharmacist and three clinical pharmacists
- 13 WTE pharmacy technicians.

Management representatives reported recruitment challenges in a range of disciplines including health and social care practitioners, medical staff (particularly at NCHD grade) and nursing staff, with a high reliance on overseas recruitment.

At the time of inspection, the safe staffing frameworks for ED and medical and surgical wards were implemented in the areas visited, apart from the AMAU. However inspectors were told that a number of CNM posts were backfilled with staff nurses at the time of inspection. Documentation submitted to inspectors outlined that the clinical areas visited on the day of inspection had, for the most part, their full approved complement of nurses. There was a mechanism in place for CNMs to request additional staff for enhanced care as required. Inspectors were told that management were actively recruiting local nursing staff to address the variance following recent IEHG approval.

The corporate risk register included a risk related to national staffing shortages, the vacancy rate in the hospital and more recently, the impact of the current HSE recruitment embargo. The impact included extended waiting times for a number of services, overcapacity in the hospital and decreased patient experiences. Inspectors were told of an 8% vacancy rate in the hospital. The vacancies were reviewed monthly through relevant governance groups with ongoing national and international recruitment where appropriate. All vacancies were risk rated and staffing trends were reported monthly to IEHG.

The hospital's reported absenteeism rate for 2023 was 8.38%, which was above the HSE target of 4%. Absenteeism rates ranged from 1.79% among medical and dental staff, to over 10% for nursing and midwifery, HSCP and general support staff. Covid-19 related sick leave accounted for 12.61% of sick leave. Inspectors discussed the absenteeism rates with management representatives who confirmed that occupational health supports were provided to staff and back to work interviews were promoted from EMT level. However, inspectors were told that there was a waiting time of approximately seven weeks for occupational health referrals at the time of inspection.

Uptake of mandatory and essential training from the wider hospital and clinical ward areas

Nursing and healthcare assistant staff attendance at mandatory and essential training was monitored by the respective ward clinical nurse managers. Inspectors found that staff attendance and uptake at mandatory and essential training required improvement, especially training on infection prevention and control and hand hygiene practices and clinical handover using ISBAR tools.

While the attendance and uptake of mandatory and essential training was being recorded by individual managers, there was limited information provided in relation to overall staff uptake of mandatory and essential training for the hospital. Essential and mandatory training attendance by non-consultant doctors although requested was not provided to inspectors. This represents an area for improvement by the hospital.

Overall inspectors found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare. The risks related to staffing were documented by the hospital on the corporate risk register and ongoing recruitment and alternative strategies were in place to mitigate risks. Monitoring of and compliance with staff attendance at mandatory and essential training requires improvement as outlined.

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.

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.

^{*******} 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: <u>https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services</u>

Findings from the emergency department and AMAU

Patient's privacy and dignity in the ED was supported for patients accommodated in individual cubicles and privacy curtains were observed to be pulled when staff were providing care. However where patients were accommodated on chairs or trolleys in the corridor, their dignity and privacy and confidentially was compromised. One patient in a cubicle told inspectors that they were previously accommodated on a chair and this was uncomfortable but that the *'place was full'* at the time. A number of patients spoken to in the ED and AMAU were admitted patients. The ED and AMAU had sufficient toilets but limited shower facilities for admitted patients.

Staff working in the hospital's ED and AMAU were observed providing a person-centred approach to care. Staff in the ED were observed actively engaging and communicating with patients in a respectful, kind and sensitive way. Staff were observed to be kind and caring towards patients in the department when providing information and assistance with care needs and with meals. This was validated by patients who spoke with inspectors who said staff were 'good to me' and that 'everyone is nice'. The majority of patients who spoke with inspectors were aware of their plan of care but a number of patients remarked that staff were 'under pressure' and one patient said they would like staff to 'let you know what was happening'.

The hospital had a number of initiatives in place to support patients' dignity and improve the patient experience within the acute floor. For example, there was a separate waiting areas for paediatric patients, a dementia-friendly cubicle and dementia-friendly visual aids in place for use. There was a designated room adjacent to the resuscitation area, with access to a courtyard area, for use by family members of patients at end-of-life.

Patient records were observed to be protected in the ED and AMAU.

Findings from the wider hospital and clinical ward areas

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful towards patients and communicated with patients in a manner that respected their dignity and privacy.

There was evidence that patients' autonomy and independence was promoted, for example, patients told inspectors that they were kept informed and updated about their plan of care. Staff were observed providing required assistance to patients and this was validated by a patient who told inspectors that they felt their symptoms were well managed and they received support when needed, especially with washing and mobilising and that staff *'listened to my concerns'*. The hospital promoted mobility and independence for patients where appropriate and this was based on the '*End PJ Paralysis'* initiative. Leaflets providing information to patients about particular medical conditions were on display in the ward areas.

However inspectors observed that call bells were not always answered in a timely way. A number of patients did comment that more staff were needed as staff were '*very busy*' and there were '*not enough of them*' and '*should have more'*.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, through the use of single rooms and ensuite bathroom facilities and the use of one-to-one care when required. Privacy curtains were used in multi-occupancy rooms, and inspectors noted that risk assessments were completed and appropriate controls were in place regarding patient placement, such as asking patients for consent to be placed in a mixed ward. There were adequate toilet and shower facilities in the two inpatient wards visited. A small number of admitted patients were observed on trolleys in the corridor in one of the wards visited and a further patient was cared for in the discharge lounge on another ward.

Patients' personal information was not always observed to be protected and stored appropriately. Inspectors observed patients' healthcare records in unsecure trolleys on the corridor in one of the wards visited and patients' personal identifiable information was visible on white boards and outside the rooms of patients requiring isolation. This was brought to the attention of management by inspectors and addressed on the day.

Overall, there was evidence that hospital management and staff respected and promoted the dignity, privacy and autonomy of people receiving care at the hospital. The accommodation of patients on chairs in the ED and on trolleys in ward corridors and in discharge lounges does impact on a meaningful promotion of the dignity and privacy for all patients and while there was a valid explanation for such placements given the overall occupancy level of the hospital at that time, it is not consistent with the human rightsbased approach to care supported and promoted by HIQA.

Judgment: Substantially Compliant

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

Findings from the wider hospital and clinical ward areas

Inspectors observed staff actively listening and communicating in a kind, caring and empathetic way with patients, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors who said that staff were *'phenomenal'* and *'approachable'*, that they *'answered all my questions'* and provided timely pain relief.

In response to the results of the 2022 national inpatient experience survey, the hospital implemented a volunteer support programme to improve patient experiences by providing

a '*meet, greet and guide*' service for patients and families located at the main hospital reception. Inspectors spoke with a hospital volunteer in one of the clinical areas who described their role in the programme.

Patients spoke positively about meals. Staff who spoke with inspectors were aware of patients' special dietary needs and how to provide assistance at mealtimes.

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

Judgment: Compliant

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

The hospital had a complaints management system in place and used the HSE's complaints management policy 'Your Service Your Say.'^{††††††††} The designated complaints officer was a member of the hospital's consumer affairs office and reported to the General Services Manager. The complaints officer had responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of complaints resolution in the clinical areas visited.

The hospital reported on the number and type of formal and informal (verbal) complaints received annually. In 2023, 158 formal written complaints, 12 verbal complaints and 280 compliments were recorded. Just under 60% of complaints were upheld and the majority of complaints related to the ED. On average, 74% of formal complaints were resolved within 30 working days, which is close to the national HSE target of 75%.

In the first three months of 2024, 45 formal written complaints and 103 compliments were recorded and, on average, 73% of formal complaints were resolved within 30 working days. Inspectors were told that the hospital's ability to reach the HSE target was in part due to an additional post which was created following an external review of the department in 2023.

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

The QSEC had oversight of the effectiveness of the hospital's complaints management process. Verbal and written complaints were tracked and trended to identify the emerging themes and actions were reviewed at QSEC meetings. Evidence of sharing of learning and quality improvements implemented in response to complaints and surveys was provided. Feedback on complaints was provided at relevant governance meetings and to the clinical nurse managers of the wards or areas which were related to the complaint. A summary was also presented at IEHG performance meetings as required.

Inspectors were told that information about independent advocacy services was given to patients by nursing staff when required. The hospital had a volunteer support programme to improve patient experiences by providing a '*meet, greet and guide*' service, for patients and families, located at the main hospital reception.

Staff who spoke to inspectors were aware of the complaints management process and received relevant feedback and learning from line management and at safety huddles. Inspectors were told that complaints management training for clinical nurse managers was provided recently by the IEHG.

Although there were systems in place for patients to raise a concern, make a complaint and provide feedback, on the day of inspection, patients who spoke with inspectors were not familiar with the hospital's complaints process or external advocacy services but outlined that if they had a complaint they would speak to a member of staff. Inspectors did not observe patient information leaflets about the hospital's complaints, feedback or advocacy services in the clinical areas visited.

Overall, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service however provision of information for patients on how to make a complaint represents an area for improvement by the hospital.

Judgment: Substantially Compliant

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

On the day of inspection, inspectors visited two clinical ward areas. Overall the hospital's physical environment was well maintained apart from some evidence of general wear and tear such as loose wall edging and cracked floor coverings. This did not facilitate effective cleaning. The environment, including toilets, bathrooms and privacy curtains, was generally clean. However, in some areas visited, patient equipment was observed to have considerable wear and tear and some equipment also required cleaning.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical areas. Hand hygiene sinks conformed to national requirements.^{######} Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited. The clinical areas were observed to be secure, with security code or card access in use at main access and exit points.

Environmental and terminal cleaning was carried out by dedicated cleaning staff in each clinical area during core working hours and cover was provided by hospital cleaners out-of -hours. Cleaning supervisors had oversight of the cleaning and cleaning schedules in the clinical areas visited and CNMs indicated to inspectors that they were satisfied with the level of cleaning staff in place. Inspectors observed evidence of regular and up-to-date environmental cleaning schedules and evidence of enhanced cleaning in response to an active infection outbreak. Cleaning staff who spoke with inspectors were knowledgeable and indicated that they had received appropriate training. Inspectors observed inappropriate placement of clinical waste bins outside some patient rooms. This was brought to the attention of the CNM on the day of inspection.

Cleaning of patient equipment was assigned to healthcare assistants (HCAs) with oversight from the CNMs. In the clinical areas visited, patient equipment was observed to be generally clean but with a number of exceptions which inspectors brought to the attention of the CNM on the day of inspection. The hospital had a system in place to identify equipment that had been cleaned using green tags, however inspectors observed that this system was not used consistently in the clinical areas visited. This was also brought to the attention of the CNM on the day of inspection.

The hospital had implemented processes to ensure appropriate placement of patients. Inspectors were told that some areas of the hospital did not have sufficient single rooms to allow optimal placement of patients requiring isolation. Inspectors saw evidence that the hospital had analysed data relating to recent outbreaks and found that in 2023, healthcare acquired infections (HCAIs) in the hospital occurred even with single room isolation. This risk was escalated to the corporate risk register with controls in place to mitigate the risks, in so far as possible. The infection prevention and control team liaised daily with bed management and clinical areas on the placement of patients, underpinned by the hospital's isolation policy. Hospital management told inspectors that the new Ormonde wing had single, ensuite patient rooms which could be used for isolation of patients with communicable infectious disease and protect those vulnerable to infection.

In summary, on the day of inspection, inspectors noted that the physical environment broadly supported the delivery of high quality, safe, reliable care and protected the health

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

and welfare of service users however there were opportunities to improve the both the maintenance of the physical environment and compliance with the system in place to identify equipment that had been cleaned.

Judgment: Substantially 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. Information was used to inform continuous improvement of services and provide assurances to hospital management, and to IEHG on the quality and safety of the services provided in the hospital. Inspectors found that hospital management monitored and reviewed information from multiple sources that included; audit results, performance metrics, patient-safety incident reviews, complaints, risk assessments and patient experience surveys. Inspectors observed '*quality notice boards*' in clinical areas visited, which displayed information on compliance with monitoring and audits. The hospital had an annual audit schedule which outlined priority audits for the year. The oversight of audit activity was devolved to a range of relevant governance groups.

Infection prevention and control monitoring

The IPC team submitted a HCAI surveillance report to the EMT every month which was also circulated to relevant staff and shared at performance meetings with IEHG. The IPCC had oversight of IPC and AMS audit and monitoring. Results from IPC audits and monitoring were tracked and trended on a monthly basis. Quarterly updates were provided at IPCC meetings. Performance indicators in relation to the prevention and control of healthcare-associated infections (HCAIs)^{§§§§§§§} were monitored and regularly reviewed at relevant governance committees.

Environmental and equipment hygiene audits for clinical and non-clinical areas were undertaken by the hospital. Five hand-hygiene audits were undertaken in the ED in 2023. The average compliance rate was 80% which is below the national HSE target of 90%. A hand-hygiene audit undertaken in the AMAU in March 2024 had a compliance rate of

^{\$\$\$\$\$\$\$} 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: <u>https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-</u> programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf 90%. Inspectors saw evidence of feedback to staff and the implementation of an action plan to address compliance.

High risk areas such as critical care and areas with an outbreak of infection were audited most frequently. Both Surgical 2 and Nore ward are listed on the 'departmental hygiene audit' list with Nore ward scoring over 90 % in the three audits undertaken in February, August and November 2023 respectively while Surgical 2 ward achieved scores of over 95% in the five audits undertaken in April, May, July, September and November 2023 respectively. Audit findings were shared with clinical staff at the time of audit and inspectors saw evidence that time-bound action plans were developed to address areas requiring improvement.

The hospital compliance with screening recommendations for Carbapenemase-Producing Enterobacterales^{********} (CPE) decreased in September 2023, when audit results showed that overall, only 24% of patients who met the criteria for screening in the hospital were screened. Inspectors noted that compliance varied significantly between different clinical areas in the hospital with some areas achieving 100% compliance while the inspected wards, Nore and Surgical 2 demonstrated 23% and 18% compliance respectively with the hospital's CPE screening recommendations. On discussion with management representatives, inspectors were told that one factor contributing to low compliance was related to the level of staffing in the ED and AMAU at the time of audit, where CPE screening was required for boarded patients. Inspectors saw evidence of recommendations and actions arising from this audit to improve compliance, including the development of a new admission IPC assessment tool dated March 2024. Inspectors were told that some measures were still in the pilot phase and so no further audit results were available at the time of inspection to demonstrate the effectiveness of this tool or the impact on compliance with CPE screening through an increase in the staffing level in the ED.

Information submitted to HIQA showed that the frequency of hand hygiene audits varied, with some areas audited only once in 2023. Both Nore and Surgical 2 wards had each undertaken two hand hygiene audits in the period from November to March 2024. Inspectors saw evidence that the frequency of audits in individual areas was increased following poor compliance results which is good practice. A summary of audits provided to inspectors indicated that compliance with the five moments of hand-hygiene in the clinical areas visited varied from 60% to 100%. In clinical areas that did not meet the HSE target of 90% for hand hygiene practices, inspectors saw evidence of feedback to staff and actions taken to improve compliance.

^{********} Carbapenemase Producing Enterobacterales (CPE) are a particular variant of gut bacteria that have become resistant to a critical group of antibiotics, the carbapenemens and are often also resistant to many other antibiotics. Detection of asymptomatic colonisation with CPE is of benefit to the wider community because it supports measures to control the spread of CPE in the acute hospital setting. A screening programme for CPE is offered on the basis that people are entitled to decline testing without prejudice to their access to care.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. Antimicrobial consumption data was recorded and submitted to hospital management, the IPCC, DTC and nationally to the HPSC to allow comparison with national trends. Inspectors saw evidence of actions taken in response to poor compliance with antimicrobial prescribing practices in surgical patients following an audit in 2023, this included recommendations and interventions suggested to medical teams regarding dose, frequency, route and spectrum of use. Inspectors also saw evidence of increased, targeted auditing and monitoring during outbreaks of infection, including the introduction of antimicrobial stewardship ward rounds in response to a recent CPE outbreak.

The hospital participated in national and EU point prevalence surveys of healthcareassociated infections and antimicrobial use, as appropriate. The hospital had recently received a report on the most recent survey in 2023 and inspectors saw evidence that that staff were in the process of reviewing the findings and developing actions. The report showed a number of areas for improvement that should be an area of focus for hospital management.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices, supported by a pharmacy audit schedule. Inspectors reviewed audit results related to medication reconciliation, risk assessments for venous thrombosis embolism prophylaxis, and direct oral anticoagulants. The hospital was monitoring nursing and midwifery quality care metrics on a monthly basis which included a component of medication safety. Results provided demonstrated good compliance in the hospital against the medication safety metrics. Nursing Metrics for medication safety on Nore ward showed that the ward achieved 94%, 89% and 94% in January, February and March 2024 respectively. Nursing metrics for medication safety on Surgical 2 ward showed that the ward achieved scores of 90% or more in January, February and March 2024 respectively.

There was evidence that targeted, evidence-based initiatives and action plans were used to improve medication safety practices at the hospital. This included the introduction of out-of-hours medication vending equipment, enhanced access to medication safety information via electronic tablets in prescribing areas, redesign of documentation and the development of a programme of training to expand the scope of practice for pharmacy technicians to perform medication reconciliation. Additional risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital was monitoring monthly nursing and midwifery quality care metrics which included a component on patient monitoring and escalation. This included the Irish National Early Warning Score (INEWS), the ISBAR (Identify, Situation, Background, Assessment, Recommendation) communication tool for the deteriorating patient and the

Sepsis 6 care bundle^{/+++++++}. Nore ward achieved scores of 90%, 87% and 84% in the first three months of 2024 while Surgical 2 ward scored 100% on each of the first three months of 2024. Action plans were not provided although the written recommendation on the results sheet was that one should be created for scores less than 90%. The hospital also audited compliance with INEWS escalation and response and inspectors viewed action plans to address deficits. Inspectors discussed audit results with representatives from the DPIPC who described ongoing efforts to improve compliance, such as focusing on particular wards, staff training, simulation training and the introduction of a new 'Interdisciplinary Safety Pause' at 9pm using the new ISBAR+ format. Representatives also described how the current staffing levels of NCHDs presented a challenge to meeting the full requirements of the INEWS escalation and response protocol. Clinical representatives told inspectors that the presence of senior nursing staff, trained in patient management and the lack of increased ICU admissions or adverse outcomes, as detailed in audits such as the Irish national ICU audit (conducted by the National Office of Clinical Audit), provided assurances to management regarding the quality and safety of care for the deteriorating patient.

Transitions of care monitoring

Performance in relation to patient 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 ED every month. The performance data was reported and discussed at relevant governance meetings as discussed in national standard 5.8. The bed management team monitored patient flow daily at a range of meetings as discussed in national standard 5.5 and reported daily on bed occupancy metrics.

Overall, inspectors found evidence to broadly demonstrate that the effectiveness of healthcare was being systematically monitored and evaluated. Continuous improvement based on audit findings remains an area for improvement by the hospital.

Judgment: Substantially compliant

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

Management of patient-safety incidents

^{********} Sepsis 6 is a care bundle comprising six time-bound tasks, take three (blood cultures, lactate and urine output monitoring) and give three (fluids, antibiotics and oxygen), all to be instituted within one hour of recognition of the potential condition.

Patient-safety incidents and serious reportable events were reported directly to the National Incident Management System (NIMS),^{#########} in line with the HSE's incident management framework. The hospital used a paper based system. The CNM3 in ED had oversight of those generated from the ED and responded to incident forms prior to submission to the clinical risk manager and also had access to a shared electronic file containing details and status updates for each incident over time. Feedback on patient-safety incidents relevant to the area was provided to the CNM3 by the clinical risk manager, and also discussed at meetings of the USC. Learning from incidents was shared with staffing directly involved or via staff huddles as appropriate.

Management of complaints

Complaints were managed locally, in line with the hospital's complaints policy by nurse management with oversight from the shift leader, CNM or clinical lead as appropriate. Inspectors were told that since training on open disclosure, staff were more skilled in how to disclose an issue and immediately engage with patients at the point of care and that this had a positive impact on complaints management on the acute floor. Complaints were tracked and trended by the complaints officer and feedback was provided to staff.

Risk Management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm which were the focus of this inspection. High-rated active risks recorded on the hospital's corporate risk register included a range of staffing shortages and delays with recruitment, patient flow pressure and overcapacity, ageing infrastructure and the lack of a formal transfer pathway at regional level for the transfer of patients from ICU. The hospital's corporate risk register had existing controls in place and outlined additional actions required to manage and reduce these risks. Significant risks were escalated to IEHG. Inspectors were told that, at the time of inspection, departmental risk registers were reviewed at departmental level by the relevant clinical nurse manager, assistant director of nursing and consultant with escalation to the EMT via the relevant senior representative. However, inspectors found that a number of risk registers were overdue for review in the clinical areas visited. The hospital was in the process of setting up a separate forum for the review and oversight of risk registers which should improve governance and oversight of risks. Oversight in the ED and AMAU was provided at the USC and QSEC and risks not managed at hospital level were escalated to IEHG as discussed under national standard 5.8. Risks relating to sustainability of service, increased activity, staffing and the boarding of admitted patients in the ED and AMAU were recorded on the hospital's corporate risk register and have been discussed under national standards 5.5 and 6.1.

^{********} 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).

As outlined under national standard 5.5, the PETs for January to September 2023 were compliant with national targets but demonstrated a reduction in performance since 2022. Data submitted by the hospital for 2024 showed that the ED and AMAU were not consistently meeting national targets for the number of patients waiting less than six or nine hours and for patients aged 75 years and over. On the day of inspection, at 11am, the hospital was compliant with all but one of the national PET targets. Forty per cent of patients aged 75 years or older were waiting over six hours (two of five patients). There were no breaches in the nine-hour or 24-hours targets for patient experience times.

The percentage of patients who left the ED before completion of treatment was within the national target. The hospital had a system in place to follow up patients who left the ED prior to completion of treatment.

Infection prevention and control

The hospital had a system in place to assess patients for communicable infectious diseases on arrival at the ED and AMAU. The hospital used a newly developed IPC admission assessment tool which was used by ED and AMAU staff at the time of decision to admit a patient. A prioritisation system was used to allocate patients to single and isolation cubicles in the ED and AMAU, supported by the IPC team. Infection prevention and control nurses visited the department daily. Staff had 24/7 access to a consultant microbiologist for advice.

The IPC team maintained a risk register of potential infection risks, however the document provided to inspectors did not appear to be reviewed or updated regularly. The highest rated risks on the infection prevention and control risk register related to microbiologist and IPC nurse staffing and infrastructure. The associated controls in place to mitigate the risks and additional actions required were recorded on the IPC risk register. However, there was no due date recorded for the associated actions. Risks that could not be managed locally by the infection prevention and control team were escalated to the hospital's EMT and recorded on the hospital's corporate risk register.

Inspectors reviewed three COVID-19 outbreak reports relating to outbreaks from December 2023 to February 2024. Reports were comprehensive and outlined control measures and recommendations that were implemented in response to the outbreaks. There was an ongoing CPE outbreak in one ward at the time of inspection and inspectors saw evidence that an outbreak control team had met twice and implemented appropriate measures in response to the outbreak, including enhanced CPE screening and enhanced surveillance and auditing during the outbreak. Staff had access to consultant microbiologist support 24/7.

Medication safety

The wards visited during inspection had pharmacy technician services for medication stock control. Clinical pharmacy services were also available daily, on request. Risk based medication reconciliation was undertaken on admission, for example for patients with

polypharmacy or cognitive impairment. Rates of medication reconciliation had increased significantly since 2022 when only 50% of patients aged over 70 years had received medication reconciliation to 70-80% in the months prior to inspection. Inspectors were told that this was in part, due to a hospital initiative to develop a new training plan to expand the scope of practice for pharmacy technicians to perform medication reconciliation.

Inspectors observed the use of risk reduction strategies to support the safe use of medicines in relation to high-risk medicines in the clinical areas visited. Staff had access to prescribing guidelines at the point of preparation (via touch screen tablets or phone app). The hospital had a list of high-risk medications and a list of sound-alike look-alike medications (SALADs), however inspectors did not see this on display in the clinical areas visited. Inspectors informed the CNMs of anomalies in labelling and storage of medication for single patient use on each of the two wards inspected and these were addressed on the day.

Deteriorating patient

The hospital had systems in place to recognise, respond to and manage the deteriorating patient with oversight provided by the DPIPC. The INEWS version 2, including the Sepsis 6 care bundle was used for all non-pregnant adult patients in the ED, AMAU and in the clinical areas visited to support the recognition and response to a deteriorating patient. Patients were monitored using INEWS version 2 from the time of triage. Staff were also trained in and used the Irish Maternity Early Warning System (IMEWS) and the Irish Paediatric Early Warning System (PEWS) as appropriate. Inspectors were told that the implementation of the Emergency Medicine Early Warning System (EMEWS) was in planning at time of the inspection but was dependent on additional staffing levels. The ISBAR₃ communication tool was used when requesting reviews of patients. Patients that were of concern or at risk of deterioration were identified during multidisciplinary safety huddles daily using a standardised prompt sheet.

Staff on the wards who spoke with inspectors were aware of the processes in place to recognise, respond to and manage the deteriorating patient using early warning scores and escalation and response protocols. During inspection, inspectors also saw evidence of the use of the Sepsis 6 care bundle and the implementation of key recommendations in response to an audit of compliance with National Clinical Guideline No. 26 – Sepsis Management. An ISBAR communication tool was used to escalate care, although inspectors observed that this was not consistently used in the healthcare records reviewed during inspection. The hospital had a 12-bedded critical care unit which included six intensive care and six high dependency beds and transfers to specialist hospitals were arranged using Protocol 37^{§§§§§§§§§} when required. The Emergency Response Team was available to review, manage and escalate care of the deteriorating patient.

Safe transitions of care

^{§§§§§§§§} Protocol 37 is the name used to describe the HSE's emergency inter-hospital transfer policy.

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 to support safe and effective discharge planning. The hospital had a number of transfer and discharge templates to facilitate safe transitions of care, underpinned by the hospital's communication and clinical handover guideline. Staff who spoke with inspectors in two clinical areas said that there were some delays when issuing discharge summaries which could be attributed to the high workload for NCHDs.

At the time of inspection, inspectors were told that new clinical handover documentation using ISBAR was being piloted in one of the wards visited during inspection. The DPIPC was responsible for implementing the National Clinical Guideline No. 11 – Clinical Handover and were actively progressing a 27-point quality improvement plan including the use of ISBAR₃ for nursing and medical handover. Multidisciplinary safety huddles were held at 9am in the ED and 11.30am in the AMAU to discuss the status of all patients. The CNM3 recorded information on a standardised prompt sheet. An additional evening multidisciplinary safety pause for the hospital took place at 9pm in the AMAU using the ISBAR₊******** communication tool for each patient.

Inspectors were informed that the ISBAR communication tool was used for most aspects of internal and external patient transfers from the ED and AMAU for example, for nurse handover from the ED or AMAU to a hospital ward and also for escalation of concerns to medical teams. Additional transfer documentation shown to inspectors was under review and development at the time of inspection.

Policies, procedures and guidelines

Inspectors reviewed a selection of policies, procedures and guidelines (PPG) relevant to the focus of this inspection. Policies reviewed were, for the most part, up to date. A number of policies relating to IPC and medication safety were overdue for review. Staff were able to access relevant policies via computer in the clinical areas visited.

In summary, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. However some areas required improvement. The hospital was achieving most of the national targets for PETs which is commendable. However there was scope for improvement, for example, PETs for patient aged 75 years old or more.

Judgment: Substantially compliant

^{********} ISBAR $_+$ is an enhanced version of the ISBAR communication tool where the +' represents the actions taken for implementation

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 the HSE's Incident Management Framework, 2020.

Patient-safety incidents and serious reportable events were reported to the National Incident Management System (NIMS). The average monthly rate of reporting clinical incidents to NIMS was 17.93 per 1000 bed days in 2023. It averaged 17.4 per 1000 bed days for the first five months of 2024. A higher rate of incident reporting is generally considered reflective of a positive safety culture. At the time of inspection, the percentage of incidents reported onto NIMS within 30 days of notification of the incident was below the HSE target of 70%. Inspectors discussed this with management representatives who described a number of factors that were impacting on the ability to meet this target including staffing challenges and the use of paper-based incident reports with off-site data entry on to NIMS which led to a high number of forms returned to the hospital for clarification prior to entry. Inspectors were told that that staffing had improved in recent months, and that there was a plan to increase access to training for staff on the completion of incident report forms.

Management of patient-safety incidents

Inspectors were told that the hospital tracked and trended patient-safety incidents in relation to the four key areas of harm and that the clinical risk manager provided summary reports to the QSEC, EMT and hospital governance groups (including the unscheduled care governance committee and the critical care governance committee). The clinical risk manager or quality officer also attended these meetings in person. There was an escalation pathway to the EMT via the relevant governance representative. Patient-safety incidents were also discussed at monthly performance meetings with IEHG. The hospital produced a comprehensive annual report of incidents in the hospital. Incidents were presented by date, time of day, location, specialty, gender, severity, category and the category of person reporting. This allowed a wide range of comparative analysis.

There was a mechanism for oversight of all patient-safety incidents by the clinical risk manager and the QSEC. The standing agenda for QSEC included specific updates relating to IPC, medication safety and category $1^{\dagger\dagger\dagger\dagger\dagger\dagger\dagger\dagger\dagger\dagger}$ incidents. However incidents relating to the deteriorating patient or transitions of care were not discussed routinely. This represents an area for improvement and shared learning by the hospital.

Inspectors saw evidence that patient-safety incidents and trends were routinely reviewed and discussed by relevant hospital governance groups and some committees, such as the

⁺⁺⁺⁺⁺⁺⁺⁺ Category one incidents are clinical and non-clinical incidents rated as major or extreme as per the HSE's risk impact table.

sepsis committee and hygiene services committee. However patient-safety incidents did not form part of the standing agenda for the committees with oversight of the four key areas of harm. Inspectors were told that representatives from quality and risk management attended these committee meetings and that incidents would be reviewed when relevant by subject matter experts.

Inspectors reviewed documentation on the reported patient-safety incidents in 2023. The majority of incidents reported were rated minor or negligible. Extreme and major incidents accounted for 0.8% of all reported incidents, this was compliant with the national target of less than 1%.

Staff who spoke with HIQA were aware of the incident management process in the hospital and knowledgeable about how to report a patient-safety incident. Staff were aware of the most common patient-safety incidents reported — slips, trips and falls and care management. Staff could describe actions that were implemented in response to incidents and evidence of learning from incidents was provided to inspectors. Inspectors also observed shared learning notices displayed in clinical areas. Feedback on specific incidents was shared with staff at ward meetings and safety huddles. Inspectors were told that each individual clinical area was provided with a summary incident report every six months, however some staff who spoke with inspectors said they did not receive feedback on overall trends relating to patient safety incidents.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious incidents that occurred at the hospital and responsibility for ensuring that all serious patient-safety incidents were managed in line with the HSE's Incident Management Framework, 2020. The SIMT was chaired by the Hospital Manager. Documentation reviewed by inspectors showed that the SIMT met frequently, reviewed new and ongoing serious incidents, had time-bound actions and ensured that learning and recommendations arising from reviews were implemented. Serious incidents and serious reportable events were also discussed at QSEC and EMT meetings and escalated to IEHG as appropriate.

The hospital experienced an increase in serious reportable events in 2023. Inspectors discussed this with management representatives and saw evidence of policies, processes and initiatives in place aimed at reducing the risk of falls in the hospital.

Overall, the hospital had a system in place to identify, report, manage and respond to patient-safety incidents. The hospital were tracking and trending patient-safety incidents. The SIMT and EMT had oversight of serious incidents. Governance committees had oversight of the management of these incidents although the deteriorating patient and transitions of care were not recorded as standing agenda items. The hospital is not yet meeting the standard of reporting at least 70% of incidents to NIMs within 30 days. These represent areas for improvement by the hospital.

Conclusion

HIQA carried out an unannounced inspection of St. Luke's General Hospital Kilkenny to assess compliance with 11 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. Overall, the hospital was found to be:

- compliant in one national standard assessed (1.7)
- substantially compliant in nine national standards assessed (1.6, 1.8, 2.7, 2.8, 3.1, 3.3, 5.2, 5.8, 6.1)
- partially compliant in one national standard assessed (5.5).

Capacity and Capability

Inspectors found that St. Luke's General Hospital Kilkenny had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, several committees had not been meeting in line with their terms of reference. There were defined management arrangements in place at the hospital to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. However, patient flow within the hospital was not functioning as it should. The mismatch between availability and demand for inpatient beds resulted in admitted patients being accommodated in the emergency department, AMAU and on trolleys in corridors in ward areas.

The hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. While the hospital had defined management arrangements in place to manage and oversee the delivery of care, these were not fully effective in the support and promotion of the delivery of high quality, safe and reliable healthcare services. In particular, there has been a reduction in performance with patient experience times (PET) from 2022 to 2023. There was only 60% compliance with the patient experience times for patients aged 75 years or more. This, together with the high conversion rates in the hospital, resulted in admitted patients being accommodated on trolleys in the ED, the AMAU and on corridors in wards. This represents a decrease in effectiveness and an increase in the risk to patients.

The hospital had several systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Oversight of the use and maintenance of risk registers in the hospital represents an area for improvement as does the oversight of monitoring and audit activity to ensure that plans are time-bound and assigned to specific individuals.

The absence rate for the hospital in 2023 was 8.38% (HSE target 4% or less) with about one eighth of that being related to COVID-19. The risks related to staffing were documented by the hospital on the corporate risk register and ongoing recruitment and alternative strategies were in place to mitigate risks. Monitoring and compliance with staff attendance at mandatory and essential training represents an area for improvement.

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 in the clinical areas visited. However, staff were challenged to maintain privacy and dignity for all admitted patients in the ED when the hospital exceeded capacity. Hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. People 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.

The hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service however provision of information for patients on how to make a complaint represents an area for improvement by the hospital. Inspectors noted that the physical environment broadly supported the delivery of high quality, safe, reliable care and protected the health and welfare of service users however, there were opportunities to improve both the maintenance of the physical environment and compliance with the system in place to identify equipment that had been cleaned.

The hospital had systems in place to monitor, evaluate and improve healthcare services. Continuous improvement based on audit findings remains an area for improvement by the hospital. The hospital also had systems in place to identify and manage potential risk associated with the four areas of known harm that were the focus of this inspection. However, potential risks remain, such as, in the design and delivery of healthcare services in the ED and AMAU to fully protect people awaiting review or patients who were admitted and boarding on trolleys. Compliance with recommended screening for CPE remains an area for continuous improvement at the hospital. The hospital did not have a full clinical pharmacy service but it had targeted and prioritised higher risk activities. Continued work is required to fully develop ISBAR protocols in the hospital in line with national guidance and to meet the full requirements of the INEWS escalation and response protocol. The hospital was achieving most of the national targets for PETs which is commendable. However there was scope for improvement, for example, PETs for patient aged 75 years old or more.

The hospital had systems in place to identify, report, manage and respond to patientsafety incidents. The hospital were tracking and trending patient safety incidents and there was evidence that the relevant committees had oversight of the management of these incidents.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress of the healthcare service.

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

Theme 5: Leadership, Governance and Management

National Standard	Judgment
Standard 5.2: Service providers have formalised	Substantially compliant
governance arrangements for assuring the delivery	
of high quality, safe and reliable healthcare	
Standard 5.5: Service providers have effective	Partially compliant
management arrangements to support and promote	
the delivery of high quality, safe and reliable	
healthcare services.	
Standard 5.8: Service providers have systematic	Substantially compliant
monitoring arrangements for identifying and acting	, ,
on opportunities to continually improve the quality.	
safety and reliability of healthcare services.	
Theme 6: Workforce	
National Standard	Judament
Standard 6.1. Convice providere plan, erganice and	Substantially compliant
Standard 6.1: Service providers plan, organise and	Substantially compliant
manage their workforce to achieve the service	
objectives for high quality, safe and reliable	
healthcare	
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Netlined Chendrud	2
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	Compliant
kindness, consideration and respect.	
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	
National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
National Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Compliance Plan for St Luke's General Hospital, Kilkenny

OSV-0001042

Inspection ID: NS_0073

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 noncompliance with standards.

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

The high conversion rate – listed as nationally highest. It is relative to note that in St Luke's General Hospital that the AMAU attendances are captured on IPMS as admissions. Therefore add to an increased overall conversion rate. The current IT data infrastructure does not allow the capability to separate these fields.

Actions and measures to mitigate risks

Monitoring of data. Discussed daily at visual hub meetings

Derogation continually being sought for vacant IPMS manager post which is vital for compliance and data management and validation

Inpatients in Acute floor

Introduction of patient flow led huddles on the Acute Floor each morning. This particular focus on previous day PETs and breaches. This is attended by all relevant stakeholders. The use of the live Systems View provides detailed information that staff, in particular shift-leaders and consultants on the floor can access at point-of-care.

Unscheduled Care data is reviewed and discussed monthly at Unscheduled Care Governance meeting in particular capturing the breaches in KPIs e.g. AVLOS. These are put forward for actioning. By monitoring this data it allows forecasting for times of seasonal surge. The approval for further 16 surge beds will become available Q1 2025, which will aid and support the reduction of inpatient within the Acute Floor.

DTOC – a comprehensive discharge plan for all patients in conjunction with our colleagues in Community is consistently monitored by the Patient Flow Team and discussed at the weekly meeting with actioned outcomes. We have seen a significant improvement each month with the MDT approach.

The activity levels for the ED showed an increase of attendances from 8pm. This was resulting in an impact on decisions to admit and discharge. The review of NCHD allocation within the Acute Floor was necessary. Altered rota allocation from 2000hrs as well as the addition of 3 extra NCHDs in ED has shown an improvement in timely PETs

Access to diagnostics

In line with the visual hospital hub, access to diagnostics is part of the patient flow journey. Delays in diagnostics has not proven to be an experience that we encounter on a

daily basis. However, on days of high activity, and to meet other diagnostic demands, it would be optimal that the hospital has a second operational CT scanner. A business case has been submitted to the CEO of IEHG and the REO of RHA Area C to support this project. This would be in line with other Model 3 hospitals that currently have a second CT scanner. The requirement for a second CT scanner sits on the Hospital Risk Register.