Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Mallow General Hospital
Address of healthcare service:	Limerick Road Ashgrove Mallow Co. Cork P51 N288
Type of inspection:	Announced
Date(s) of inspection:	28 February 2023
Healthcare Service ID:	OSV-0001025
Fieldwork ID:	NS_0029

1.0 Model of Hospital and Profile

About the healthcare service

Mallow General Hospital is a Model 2* public acute hospital. It is a member of the Cork University Hospital Group and is managed by the South/South West Hospital Group† on behalf of the HSE. Services provided by the hospital include acute in-patient, outpatient and day patient services. The hospital also has an Urgent Care Centre incorporating a Medical Assessment Unit and a Local Injury Unit.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	37 inpatient beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the National Standards for Safer Better Healthcare as part of 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.

*A Model 2 hospital provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services, including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.

†The South/South West Hospital Group is made up of nine hospitals—Bantry General Hospital, Cork University Hospital, Mallow General Hospital, Mercy University Hospital, South Infirmary Victoria University Hospital, Tipperary General Hospital, University Hospital Kerry, University Hospital Waterford and Kilcrene Regional Orthopaedic Hospital.

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

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*.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
28 February 2023	08:55 – 17:30hrs	Aoife Healy	Lead
		Geraldine Ryan	Support
		Patricia Hughes	Support

Information about this inspection

An announced inspection of Mallow General Hospital was conducted on 28 February 2023.

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

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

The inspection team visited two clinical areas:

- St. Mary's ward (acute medical ward)
- conducted a walk- through of the Urgent Care Centre —Medical Assessment Unit and Local Injury Unit.

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

- representatives of the hospital's Senior Management Team:
  - hospital manager
  - director of nursing
  - risk manager
- Non-consultant hospital doctor (NCHD)
- representatives from each of the following hospital committees:
  - Quality Safety and Risk Committee
  - Infection Control and Hygiene Committee
  - Deteriorating Patient Committee
  - Medicines Management Committee.

Acknowledgements

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

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

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

St. Mary's ward was a 14-bedded ward consisting of two single en-suite rooms, one six-bedded room and three two-bedded rooms, one of which was en-suite. At the time of the inspection 12 beds were occupied. The Medical Assessment Unit comprised eight cubicles, two of which had been partitioned off during the COVID-19 pandemic and could be used as isolation cubicles and one en-suite isolation room. The Local Injury Unit comprised two cubicles.

On the day of inspection inspectors spoke with patients about the care they received in the hospital. Feedback was positive and patients reported that they were treated with kindness and respect and that they were happy with the level of care they received. When asked to describe their experience, patients commented, *'could not fault anything', 'they are wonderful'*, and *'meals are fantastic'*. When asked if there was anything that could be improved about their experience, patients commented that they were not dissatisfied with anything.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the patients spoken with. Patients' commented, staff *'come in and they cheer you up'* and that there was *'no delay in answering the bell',* when patients called for assistance. Patients spoken with knew who to speak to if they wished to raise an issue and commented that they could speak with staff if they had a concern or complaint.

Overall, there was consistency in what patients told inspectors about their experiences of the care they received and what inspectors observed in the clinical areas visited.

Capacity and Capability Dimension

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 was governed and managed by the hospital manager who was accountable to the Cork University Hospital Group (CUHG) operations manager, who in turn reported to chief executive officer (CEO) of the CUHG. However, inspectors found that some committees would benefit from having clearly defined, assigned time-bound actions.

Organisational charts setting out the hospital's reporting structures detailed the direct reporting arrangements for hospital management, governance and oversight committees. The hospital's reporting and accountability relationship to the CUHG and the South/Southwest Hospital Group (SSWHG) was also clearly outlined on the organisational charts and explained integrated corporate and clinical governance arrangements for Mallow General Hospital (MGH).

The clinical directors at Cork University Hospital (CUH) provided clinical oversight and leadership to consultants and NCHDs at MGH. The director of nursing (DON) was responsible for the organisation and management of nursing services at the hospital, as well as overseeing catering and household services from a human resources perspective.

Senior Management Team

MGH Senior Management Team (SMT) was established as the senior operational board of the hospital. Inspectors were provided with draft Terms of Reference (ToR) and minutes for the most recent meetings. This documentation detailed that the team, chaired by the operations manager of CUHG, met in line with their ToR. The SMT was accountable to the CUHG CEO, via the Cork University Hospital Executive Management Board, and responsible for the day-to-day operational and strategic management of MGH. SMT meetings were action orientated with actions assigned to members, however, actions were not always timebound.

Inspectors were informed that MGH was well supported by CUHG and that staff had good working relationships with colleagues in their respective fields in CUH. The links to CUHG were evident also whereby members of the hospital's SMT attended MGH Performance Meetings for the SSWHG. Meetings were action orientated with actions assigned to members, however, actions were not always time-bound.

Hospital Management had established several hospital committees through which to govern services and address matters in relation to the four key areas of risk: Infection Prevention and Control, Medication Safety, Deteriorating Patient and Transitions of Care.

Quality, Safety and Risk Committee

MGH Quality, Safety and Risk Committee (QSR) was assigned with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. The committee met quarterly in line with the ToR, was chaired by a medical consultant (cardiologist) and reported to the SMT. The committee also liaised with CUH Executive Quality and Safety Committee.

The QSR Committee had a standardised agenda and minutes were comprehensive and included time-bound, assigned actions and these along with interviews undertaken with key committee members on the day provided assurance of appropriate oversight of

quality and safety matters. There was evidence from SMT meetings reviewed that matters pertaining to quality, safety and risk were discussed at SMT.

Infection Prevention and Control Committee

The hospital's Infection Control and Hygiene Committee, responsible for the governance and oversight of infection prevention and control (IPC), was a multidisciplinary committee, chaired by the hospital manager, accountable to the hospital's SMT and had links with CUH Group Infection Prevention and Control Committee. The committee had a standing agenda and met in line with its ToR. It was evident from SMT meeting minutes that IPC updates were provided to this meeting.

Minutes of meetings reviewed detailed that agenda items were discussed at the meetings, however the minutes would benefit from having clearly defined actions which are timebound and assigned to individuals. Meetings were well attended and there was evidence in meeting minutes to indicate that items discussed were being progressed and that an annual IPC Programme was in place and being implemented by the IPC nurse. HIQA was satisfied with the governance and oversight of infection prevention and control practices at MGH.

Medication Management Committee

The Medicines Management Committee was responsible for the governance and oversight of medication safety practices at the hospital. The committee, chaired by the senior pharmacist, was operationally accountable and reported to the QSR Committee. Minutes and agendas of meetings provided, showed that the committee met in line with its ToR. The ToR was in the process of being updated and was being presented at the next meeting. The committee also had links with the CUH Group Drugs and Therapeutic Committee.

The committee had a standardised agenda and minutes were action orientated and actions assigned to members, however, actions were not always timebound. Inspectors were informed that due to resourcing shortages, there was no formal medication safety plan in place for the hospital.

Deteriorating Patient Committee

The Deteriorating Patient Committee was responsible for driving change and continuous quality improvement in matters associated with the recognition and response to the deteriorating patient, including responsibility for the oversight of the implementation of the national Early Warning Systems — Irish National Early Warning System (INEWS)[‡‡] and

[‡‡] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

sepsis guidelines at the hospital. The committee, chaired by the medical consultant, lead for Sepsis and INEWS, reported to the hospital's SMT and met in line with the ToR.

The committee had a standardised agenda, however, while actions noted in the minutes of meetings were assigned to individuals, actions were not always timebound and completion dates were unclear.

Transitions of Care Committee

The hospital had a Transitions of Care (ToC) Committee, set up in August 2022, which to date had met four times. This committee was coordinated by the risk manager, with a medical consultant as lead. Inspectors met with members of the committee and it was evident that considerable work had been undertaken in relation to ToC, including review of handover documentation and implementation of ISBAR[§§] as part of the handover communication process. Committee members described the links with CUH in relation to Pre Hospital Emergency Care Council Protocol 37: The Emergency Inter-Hospital Transfer Policy[***], and described the clear processes in place in relation to the transfer of patients to CUH where a clinically time critical intervention required, was not available at the hospital.

In summary:

- Some committee meetings would benefit from having clearly defined, assigned time-bound actions that are assigned to individuals.
- The ToR for the medicines safety committee requires review.

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.

Effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm.

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

[***] Protocol 37 has been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility. https://www.phecit.ie/PHECC/Publications_and_Resources/Newsletters/Newsletter_Itmes/2017_Winter/100_percent_of_Irish_hospitals_now_accessing_Protocol_37.aspx

Findings relating to the Medical Assessment Unit and Local Injury Unit

Inspectors were satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the management of the Medical Assessment Unit (MAU) and the Local Injury Unit (LIU). It was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the MAU and the LIU and that operationally, the units were functioning well.

There was evidence of strong clinical and nursing leadership in both units. Operational oversight of day-to-day workings of the department was the responsibility of the onsite clinical nurse manager Grade 2 (CNM 2), who reported to the assistant director of nursing (ADON). Inspectors were informed that the pathway for referral to the MAU was through the patient's general practitioner (GP) and that the last admission to the MAU was at 6pm to be reviewed by 7pm at the latest. The LIU operated on a walk-in basis. Inspectors were informed that Protocol 37 was in place at the hospital to ensure that patients who were suitable for admission to an emergency department (ED) were taken directly to the nearest ED by ambulance.

On the day of inspection, inspectors observed eight patients listed as being seen in the MAU, (seven new presentations and one returning patient). Inspectors were informed that presentation to both the MAU and LIU had increased significantly over the past two years. The hospital performed better than the HSEs national KPI target of 75%:

- In 2021, the number of patients attending the MAU was 2984, with 89% of those patients being admitted or discharged within 6 hours of registration.
- In 2022 the number of patients attending the MAU increased to 3753, with 87.3% of patients admitted or discharged within 6 hours of registration.
  Additionally, in 2021 the number of patients attending the LIU was 7490, increasing to 9698 in 2022.

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 a formalised overarching infection prevention and control programme[†††] as per national standards, which contained detailed objectives which were timebound and

[†††] 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.

assigned to an individual or department within the hospital. [‡‡‡] It was evident from documentation received and communication with staff members in relation to IPC, that considerable work was being undertaken in relation to IPC onsite and inspectors were informed of the roll out of an annual audit plan to start in Q2 2023. This will be discussed further under Standard 3.1.

The hospital had clearly documented concerns in relation to the lack of a comprehensive antimicrobial stewardship (AMS) programme for MGH. This was further reiterated to inspectors through meetings held with leads for IPC and medication safety, as well as members of the SMT. The hospital had completed a risk assessment in relation to same. This is further discussed in Standard 3.1.

Medication safety

The hospital had a clinical pharmacy service,[§§§] which was led by the hospital's chief pharmacist. The hospital had;

- 2.5 WTE pharmacists, which included the chief pharmacist and two other clinical pharmacists
- 0.8 WTE pharmacy technician.

Hospital pharmacy services were available onsite Monday to Friday, 9.00am to 5.00pm. Outside of these hours, the ADON was the designated point of contact for access to pharmacy services and pharmacy support was available at all times from CUH. Inspectors were informed that formal arrangements were in place to access medications from local pharmacies, should a drug not be available in the hospital pharmacy when required.

There was no formal medication safety programme in the hospital, and this was in part due to staffing deficits in the pharmacy team in recent years. It was acknowledged on the day of inspection that the recent addition of a new clinical pharmacist to the team would allow further work to be undertaken, particularly in relation to medication reconciliation, which at the time of inspection was not being completed for all patients on admission. The hospital would benefit from having a formal structure in place to ensure medication reconciliation is undertaken on admission and discharge, for all patients.

Deteriorating patient

Inspectors met with the recently appointed resus training officer and deteriorating patient CNM 2, who was the nominated lead for the deteriorating patient, a role previously filled by the Clinical Development Coordinator on a temporary basis. The medical consultant

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

[§§§] 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.

was the nominated clinical lead for Sepsis and INEWS v.2. The hospital's policy on escalation and response to the deteriorating patient was in the process of being updated. The hospital had implemented INEWS v.2 and it was evident that considerable work had been undertaken in relation to the implementation of these guidelines. There was evidence of a number of audits being undertaken in relation to INEWS documentation, as well as trending of incidents, which will be discussed further in Standard 2.8.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. Inspectors were satisfied that the hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. Lead representatives for transitions of care within the hospital stated that the hospital had good links with community services and that the arrangement was working well in supporting the patient discharge process. The hospital received a report from the community clinical team regarding availability of community beds. Management stated that the discharge coordinator and a community public health nurse (PHN) communicate weekly to discuss patients for discharge who might require community services. Inspectors were also informed about the hospital links with the Community Rehabilitation and Support Team (CRST), a community rehabilitation service for people who have been in hospital and met the criteria for rehabilitation services within the community upon discharge.

Management outlined a number of improvements implemented to support safe transitions of care, which included:

- the development of a safe transfer policy
- the update of a safe transfer letter to support the transfer of patients to another hospital
- multidisciplinary team (MDT) hubs now take place daily at 9am on wards.

In summary, while effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm, there was scope for improvement:

- There was no formal medication safety programme in the hospital. Having recently secured additional clinical pharmacy resources, this should support the hospital in putting a formal programme in place in relation to medication safety.
- The hospital would benefit from having a formal plan in place to guide work in relation to transitions of care.

Judgment: Substantially compliant

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

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. The hospital reported on a suite of key performance indicators, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks. There was oversight of the management of serious reportable events and serious incidents, in line with the HSE's Incident Management Framework.

Monitoring service's performance

The hospital collected data on a range of clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). This data was discussed at MGH QSR Committee meetings, as evidenced in meeting minutes and areas where indicators were outside of national targets were discussed and associated actions documented.

The hospital shared evidence of quality improvement plans (QIPs) associated with HSE key performance indicators (KPIs), linked to key risk areas, including:

- % of acute hospitals implementing the national policy on restricted antimicrobial agents
- Rate of medication incidents as reported to NIMS per 1,000 beds
- % of hospitals with implementation of INEWS in all clinical areas of acute hospitals (as per 2019 definition).

QIPs were assigned to named individuals, were timebound and there was evidence of progress against actions for each of the above.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risk. On review, the hospital's corporate risk register detailed existing controls and actions taken to date in response to identified risk, and actions were timebound and assigned to a risk owner.

From review of meeting minutes submitted to HIQA, it was clear that risks were discussed at the hospital's QSR Committee, and reviewed at the Performance Meeting for the South/Southwest Hospital Group. Risks are discussed further in Standard 3.1.

Audit activity

While the hospital did not have a clinical audit committee for oversight of all clinical audit activity, audit activity was overseen by the relevant governance committee. For example, infection prevention and control audits were overseen by the Infection Prevention and Control Committee. HIQA received a draft copy of the hospitals quality audit schedule for 2023. Audits will be discussed further in Standard 2.8.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT), reported to the CUH SIMT and had oversight of the management of serious reportable events (SREs) and serious incidents which occurred in the hospital. SIMT were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT was coordinated by the risk manager, chaired by the hospital's medical consultant and membership included the hospital manager, DoN, and the CUHG operations manager who was the chair of CUH's Incident Management Team. The minutes of SIMT detailed discussions in relation to serious incidents and SREs current at that time. Evidence from meeting minutes confirmed that SREs were also discussed at the Performance Meeting for the South/Southwest Hospital Group, evidencing good oversight of the hospital's SREs.

Management of patient-safety incidents

The hospital reported clinical incidents through the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. The risk manager was responsible for tracking and trending of incidents and inspectors observed copies of the quarterly incident dashboard on display in clinical areas visited, which included information on incidents related to infection prevention and control, medication safety, patient slips, trips and falls and pressure ulcers. It was evident that incidents are discussed at the hospital's SMT and Performance Meetings of the South/Southwest Hospital Group. The hospital also published a detailed Annual Incident Management Report (Draft) for 2022. Patient-safety incidents related to the four areas of harm are discussed further in national standard 3.3.

Feedback from people using the service

The hospital had a detailed QIP in place in response to the findings from the National Inpatient Experience Surveys (NIES), 2019-2022. This QIP was overseen by the hospital's QSR Committee and had clear, time-bound actions assigned to individuals, which at the time of inspection were on track.

The hospital manager was responsible for tracking and trending of complaints. Complaints were discussed at the hospital's QSR Committee and at the Performance Meeting South/Southwest Hospital Group. Complaints will be discussed in more detail in Standard 1.8.

Judgment: Compliant

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

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. Inspectors were informed that the hospital did not have onsite Human Resources (HR) staff and resultantly, day-to-day HR matters were the responsibility of the DoN and the hospital manager. Recruitment was coordinated through CUH.

Overall, HIQA found that hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare. The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care, and where there was a need for additional resources, this had been identified and escalated as required. There was evidence that staffing levels and vacancies were discussed at both the SMT and the Performance Meetings with the SSWHG. Inspectors were assured from meetings with lead representatives from Human Resources (HR) that arrangements were in place to ensure that deficits in care did not arise for patients where there were vacancies in posts within the hospital, with alternative arrangements in place for patients to attend for care at CUH in such instances.

The hospital's approved complement of nursing staffing was 113 WTEs. At the time of inspection, 107 WTEs nursing positions were filled, which represented a variance of 6 WTEs between the approved and actual nursing complement. Staffing was shared between the MAU and LIU. Both units operated from 8am to 8pm 7/7, with nursing staff working a rotating roster between the two units, which was reported to be working well. However, it was noted to inspectors that the CNM 2 covered for staff shortfalls when required which meant they were essentially removed from their defined management and oversight role during this time. Hospital management told inspectors that they were actively recruiting nursing staff to address the variance. The hospital's total approved posts for healthcare assistants (HCAs) was 25 WTEs and all 25 HCA posts were filled at the time of HIQA's inspection.

The hospital had an approved complement of 9.5 WTE consultants. At the time of inspection, there was one vacant post. All consultants were on the specialist register with the Irish Medical Council at the time of inspection. The consultant staff were supported by 8 non-consultant hospital doctors (NCHD) at registrar grade, 9 WTE at senior house officer

(SHO) grade and 5 WTE at intern grade. On the day of inspection, all posts at NCHD, SHO and intern grades were filled.

Staff training

Staff attendance and uptake of mandatory and essential training could be improved. Training records provided to inspectors for the hospital demonstrate that improvements are required in staff training compliance across all areas. Of note is that training compliance differed somewhat when broken down by clinical areas inspected. In particular medication safety training compliance was 12% for nursing staff at hospital level, and was 100% for one clinical area inspected and 15.3% for the second clinical area inspected.

Hospital- wide compliance for training in relation to IPC, specifically standard based precautions, transmission based precautions, donning and doffing and hand hygiene requires improvement. Compliance was 61% for nursing staff, 76% for HCAs, 40% for doctors, 78% for housekeeping/cleaning staff and 71% for health and social care professionals. This requires improvement, being well below the HSE's target of 90%. However, in the clinical areas inspected, compliance with hand hygiene training was higher than the hospital average for nursing, HCAs and household/cleaning staff and above the HSE target of 90%.

Training compliance on INEWS v.2 was 100% and 92.3% respectively, for the clinical areas inspected. ISBAR training was included as part of the INEWS v.2 training. Training on Basic Life Support was better than the hospital average of 51% for nursing staff, for the clinical areas inspected, with 82% of nursing in one area and 61.5% of nursing staff in the second clinical area and 100% of HCAs having completed the training. Data was also submitted for dementia and end-of-life training undertaken. Compliance was low for this training.

Training records were overseen by the CNM 2 in each clinical area. It was noted in minutes of the QSR Committee minutes that a training needs assessment was to be updated and circulated to staff. Lead representatives from HR informed inspectors that this training needs assessment had been completed and was in the process of being reviewed and finalised before it would be circulated to staff.

It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement efforts following HIQA's inspection.

In summary:

- While completion of mandatory and essential training was recorded and there was oversight of training compliance at a local level, uptake of training requires improvement. The completion of a training needs analysis will support oversight of training levels in the hospital.

Judgment: Substantially compliant

Quality and Safety Dimension

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. The ward, MAU and LIU were observed to be busy, but calm environments.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, patients were accommodated in individual cubicles surrounded by privacy curtains or in single rooms where available. Inspectors did not observe any patients being accommodated on trolleys on the ward or in the MAU or LIU during the inspection. Where patients required support in accessing toilet facilities, inspectors were told that staff offered patients the option of a wheelchair to bring them to the nearest toilet rather than the use of a commode, as this offered greater privacy to patients. What inspectors heard and observed in the clinical areas in terms of patients' privacy being upheld aligned with the findings from the 2022 National Inpatient Experience Survey, where, with regard to the following questions:

- 'Were you given enough privacy while you were on the ward?', the hospital scored 9.5 which was above the national average of 8.6
- 'Were you given enough privacy when discussing your condition or treatment?' the hospital scored the same as the national average of 8.2
- 'Were you given enough privacy when being examined or treated?', the hospital scored the same as the national average of 9.1
- 'Did the staff treating and examining you introduce themselves?', the hospital scored 9.0 which was above the national average of 8.7.

Patient's personal information in the clinical areas visited, during the inspection, was not observed to be protected and stored appropriately in some instances. For example, in the ward area visited, patient charts were observed to be stored on windowsills in the corridor of the ward, and although the charts were stored facing downwards, there was a risk that charts could be accessed by passers-by. This was brought to the attention of staff.

In the MAU, whiteboards were used to display relevant clinical information and although attempts had been made by staff to protect patients' privacy by only displaying patient surnames, there was no facility to fully conceal patient names. This was brought to the

attention of the CNM 2 on the day of inspection. In the ward area visited, patients' personal details were not on display on the whiteboard.

In summary:

- Patients' personal information in the clinical areas visited, during the inspection, was not observed to be protected and stored appropriately in some instances.

Judgment: Substantially compliant

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

It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients who inspectors met with were complimentary of the staff and the care provided to them. The results of the NIES 2022 found that 81.4% of patients reported overall they had a 'very good' experience while in the hospital, which was above the national average of 53.1%. This aligned to what inspectors were told by patients they spoke with on the day of inspection. One patient described the staff as *'wonderful'*, noting that there was no delay in staff responding to the call bell when they called for assistance. Another patient communicated to an inspector that everything was *'fantastic'* in terms of their stay in the hospital so far, explaining that *staff really make an effort to cheer them up during their stay*.

The hospital scored the same as the national average for the following:

- 'Overall, did you feel you were treated with respect and dignity while you were in the hospital?', scoring 8.9.

Patients were aware of the complaints process and knew that they could raise a concern with the person in charge, or other staff members if required. Inspectors observed information leaflets on display for patients in relation to IPC.

Inspectors were informed of quality improvement initiatives implemented as a result of feedback from patients, for example, food choices and timing of meals and snacks. Feedback from patients in relation to these changes was reported to be positive. Inspectors were informed that patients attending the MAU and LIU were offered meals and snacks also, regardless of whether they were being admitted or not to a ward.

HIQA was provided with a copy of a QIP which detailed opportunities for improvement from the findings of the NIES 2019-2022. A number of these opportunities for improvement related to promoting a culture of kindness, consideration and respect, included:

- information for patients about support services available to them during their hospital stay will continue as a priority in 2022. A campaign of awareness raising

amongst patients about sharing concerns and speaking to staff about anything that they are worried about will continue to be promoted

- ongoing series of education programmes focusing on communication and information, and including topics such as bereavement, end-of-life care, breaking bad news, is available for staff and staff area actively encouraged to part-take in this training.

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 manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. The hospitals QSR Committee had oversight of hospital complaints. Formal complaints were also discussed at the SMT and the hospital's Performance Meeting with the South/Southwest Hospital Group.

Inspectors were informed during a meeting with the lead for complaints management that the hospital had plans in place for all complaints to be managed through a computerised system from July 2023 onwards. All complaints were managed in line with the HSE's complaints management policy 'Your Service Your Say.' (YSYS) [****] The hospital formally reported on the number and type of written complaints, received annually. The HSE 'Your Service Your Say' annual feedback report[††††] (2021), which is the most recent publicly available data, showed that the hospital received one formal complaint in 2021, which was resolved within the required timeframe of 30 working days. Inspectors observed YSYS information posters on display throughout the hospital as well as information on advocacy services for patients. Patients who spoke with inspectors said they would talk to staff if they wanted to make a complaint and had knowledge of the YSYS complaints management process.

[****] 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.

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

There was a culture of complaints resolution at a local level in the clinical areas visited and this process was described to the inspector in the clinical areas visited. Data on formal complaints was being captured by the hospital, however, verbal complaints were not being tracked and trended at the time of inspection. Feedback on complaints was generally provided to staff in the clinical area that were the subject of the complaint. However, inspectors were informed that there was no formal process in place to provide feedback to staff on complaints, at the time of inspection.

The hospital manager and the risk manager had both completed HSE training on 'Effective Complaints Investigation', and the risk manager had completed training also on 'Effective Complaints Handling' and 'Your Service Your Say: Complaints Handling Guidance for Clinical Staff'. At the time of inspection, staff in clinical areas had not received any formal complaints management training, and this concurred with the training records submitted to HIQA.

Following the inspection, HIQA received documentation, which included a QIP to improve and enhance the hospital's complaints management process. This QIP included a number of time-bound actions to address identified areas for improvement in relation to the management of complaints at the hospital, including staff training, recording of verbal complaints, continued tracking and trending of all complaints and sharing of learning.

In summary:

- The hospital would benefit from recording, tracking and trending information on verbal complaints.
- A formal process of providing feedback to staff on complaints would enhance staff knowledge on the effective management of complaints.

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 areas and observed that overall the hospital's physical environment was clean and well maintained. In the 2022 NIES, the hospital scored 9.0, the same as the national average, in relation to the cleanliness of the hospital room or ward.

In the LIU and MAU, inspectors observed cleaning in progress and the staff were complementary of the high standard of cleaning and prompt response from the hospital's maintenance service. Inspectors were informed that cleaning services were available at all times. Inspectors observed the use of the green clean tagging system in clinical areas and were informed that all equipment in the MAU and LIU was cleaned by HCAs and nursing

staff, and green tagged, each evening before the unit closed. Terminal cleaning was carried out by cleaning staff. Inspectors were informed that environmental audits were undertaken in the ward area on a quarterly basis and HCAs conducted a weekly audit of equipment to check that it has been cleaned to the required standard.

Staff were observed to be wearing appropriate personal protective equipment (PPE) in line with current public health guidelines. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available in clinical areas and hand hygiene signage was clearly displayed throughout the clinical areas. Inspectors noted that some hand hygiene sinks did not conform to national requirements.[‡‡‡‡] Physical distancing of one metre was observed to be maintained between beds in all clinical areas visited and privacy curtains were clean and changed as required. Inspectors were informed that sufficient storage space was an issue in the MAU, and it was noted that this had been escalated and was recorded as a risk on the hospital's risk register.

The clinical area visited had limited isolation facilities to accommodate placement of people who required transmission- based precautions. Isolation facilities on the ward comprised of two single en-suite rooms. One of the three two-bedded rooms had en-suite facilities. Patients occupying the remaining eight beds on the 14-bedded ward, shared bathroom and shower facilities.

There was one designated isolation room with en-suite facilities and an anti-room in the MAU, as well as two cubicles which were put in place as a temporary measure in response to the COVID-19 pandemic. These cubicles did not have en-suite facilities.

The following risks were noted on the hospital's risk register:

- the limited availability of isolation rooms
- the lack of adequate toilet facilities throughout the hospital

It was noted that the clinical room on the ward was small and staff had a workaround in place to address this, with only two people permitted in the room at a time. The CNM 2 informed the inspector that a risk assessment was completed in relation to infrastructural concerns on the ward, and that concerns had been escalated to the DoN. Of note was that there were no hand-washing facilities in the clinical room, however, alcohol-based hand rub was available outside the door of the room.

At the time of inspection, a new 44-bedded unit was under construction and management proposed that this would address risks identified in relation to infrastructure. The lack of available isolation rooms should be a key area for improvement by hospital management.

Judgment: Partially compliant

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

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services. This provided assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level.

National performance indicators and benchmarks in line with HSE national reporting requirements were used by the hospital to measure the quality and safety of the service it provided.

Infection prevention and control monitoring

HIQA was satisfied that the IPC Committee were actively monitoring and evaluating infection prevention practices in clinical areas. It was evident that the COVID-19 pandemic had an impact on the overall IPC programme, which inspectors were informed was in the process of getting back on track, including the roll out of an IPC annual audit plan, to begin in quarter 1 of 2023. It was evident from meetings with IPC leads and staff in clinical areas that some IPC related audits were being undertaken.

In line with the HSE national reporting requirements, the hospital was submitting the following data as part of the national HPSIR.

Indicators included:

- rates of *Clostridium difficile* infection (public report November 2022- 22.5 cases/10,000 bed days)
- hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) blood stream infections (public report November 2022 – 0 cases/10,000 bed days)
- number of Carbapenemase-producing *Enterobacterales* (CPE) cases (public report November 2022 – 0 cases).

Inspectors were informed that an annual audit of CPE screening was undertaken in 2022, with the most recent results finding 100% compliance with CPE screening requirements.

The IPC team had oversight of hand hygiene compliance at ward level. Minutes from the MGH Infection Control and Hygiene meeting, December 2022, noted the hospital scored 91% in the national hand hygiene audit completed in October 2022.

Inspectors were told that environmental audits were undertaken quarterly for the ward inspected. The green clean equipment tagging system was in place in clinical areas and inspectors were informed that HCAs undertook additional weekly checks to ensure

equipment was clean. Inspectors observed IPC Dashboard data on quality boards in clinical areas inspected, which included data on hand hygiene compliance.

The IPC team monitored outbreaks and inspectors reviewed documented evidence of outbreak reports being completed. While it was evident that work was being undertaken to audit IPC practices within the hospital, the IPC programme would benefit from having formalised QIPs with time-bound actions to address audit findings.

Antimicrobial stewardship monitoring

As noted in Standard 5.5 the hospital did not have an AMS programme in place. As a result, audits in relation to antimicrobial stewardship practices were not undertaken. Inspectors were informed that the hospital pharmacy had developed a questionnaire outlining the rationale for using Meropenam[§§§§], which is stocked onsite by pharmacy. The hospital has documented evidence that it was not compliant with the following national KPI:

- % of acute hospitals implementing the national policy on restricted antimicrobials.

HIQA was provided with a risk assessment which documents the risks identified with the absence of an AMS programme. This will be discussed further in Standard 3.1.

Medication safety monitoring

There was some evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were undertaken for the medicines prescription administration record and insulin charts.

Findings from the audits undertaken indicate that there was room for improvement in relation to medication documentation. For example, from the insulin chart audit, only 50% of charts had the patient allergies section completed and time of administration of medications was often not recorded.

On review of healthcare records, it was noted that one of three healthcare records reviewed did not have the patient's allergy recorded. The audit also highlighted that medication reconciliation was not being completed outside of the MAU, which as noted in Standard 5.5, was primarily as a result of clinical pharmacy staffing deficits. In relation to the drug kardex, inspectors were informed through conversations with lead representatives for medication safety that the drug kardex for the hospital had been adapted to align to that used in CUH. It was hoped that this standardisation would support staff who work across both hospitals.

Medication safety week was planned for April 2023, providing an opportunity to engage with staff and deliver informal training on medication safety. Inspectors were told of work

[§§§§] Health Service Executive. *Note on use of meropenem-vaborbactam from HSE Antimicrobial Resistance Infection Control Team (version 2, January 2022), 2022.* Available online from: meropenem-vaborbactam-prescribing-advice-january-2022.pdf (hse.ie)

undertaken by the pharmacy department to track medications requested from the hospital pharmacy out of hours, the aim being to create a more efficient system whereby gaps in stock that are regularly required by a clinical area would be stocked in that clinical area going forward. HIQA received a time-bound action plan in relation to that audit, with timeframes for completion date October 2022, but noted as ongoing at the time of inspection.

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

Deteriorating patient monitoring

The Deteriorating Patient Committee had oversight of audit of compliance with national guidance on INEWS v.2 and compliance with national guidance on clinical handover or the use of the ISBAR communication tool.

The hospital took part in a HSE audit of compliance with national clinical guideline No. 1 INEWS v.2, in September 2022. Findings highlighted a number of areas of good practice regarding completion of INEWS documentation, as well as areas for improvement, including:

- an updated policy to support the implementation of INEWS v.2
- that all relevant staff have completed the mandatory INEWS training
- that the minimum standard of assessment of observations is implemented as per guidelines
- that all events surrounding a call for assistance (time of call, response, plan of care and outcome) are documented in the nursing and medical notes of the healthcare record.

HIQA received an update of the time-bound quality improvement plan, with actions assigned to individuals. At the time of inspection, all actions were progressing as planned.

HIQA also received a copy of INEWS Patient Observation Chart Completion and Escalation and Response Protocol Report 2022. This report highlighted that improvements were required on completion of INEWS V.2 documentation, including recording of the healthcare worker/patient/family concern section. Inspectors were informed of a quality improvement initiative that was implemented, via pop-up information sessions on wards, to raise awareness of the need to complete this aspect of documentation. A re-audit of compliance with completion of documentation had found a noticeable improvement in completion of this element of the INEWS chart. Inspectors observed evidence of the results of INEWS audits on display in the ward area which displayed findings from an audit in January 2023, where parameters recorded included 'INEWS score initialled every time'- 97% compliance, 'INEWS score totalled for each set of observations'- 95%, and 'INEWS score calculated correctly each time'- 100%.

Inspectors received a QIP which detailed that Monthly Patient Healthcare Record (HCR) audits were to commence to assess the HCR content and the completeness of the HCR. This quality improvement initiative was assigned to the risk manager and documented as being in progress. It was noted that an audit tool to support this QIP needed to be developed.

Transitions of care monitoring

While the ToC Group was only operational since August 2022, significant efforts were being made to drive improvements in this area of work. Inspectors were informed that while no formal audit plan in relation to ToC was in place, elements of this work were taking place in the absence of a formal plan. The hospital was monitoring KPIs in relation to ToC, including Average Length of Stay (ALOS) for all inpatients, which was 3.2 days (September 2022, most recent data publicly available), which was below the target set by the HSE of 4.2 days.

Inspectors were told that there were quality improvement plans in place in relation to ToC, and documentary evidence of this plan was shared with inspectors. The document included QIPs/action items, including:

- nursing transfer documentation currently being reviewed
- nursing handover policy and processes to be reviewed to ensure uniformity across the hospital's wards
- NCHD induction booklet to be updated to include instructions on Clinical Handover processes and tools i.e. ISBAR 3, Medical Handover folders, Medical Take Inpatient list and National Clinical Guidelines No. 11 recommendations and requirements
- MGH Clinical Handover Policy/ Procedure to be drafted, reviewed and approved
- the commencement of routine auditing of clinical handover practice

There was evidence that actions were being reviewed at each meeting and progress was being made in relation to some actions, with other actions documented as completed. However, there was evidence of limited progress against some actions identified, with due dates being moved forwards from meeting to meeting.

HIQA received a draft copy of the hospital's quality audit schedule for 2023 which included a number of audits in relation to the four key risk areas, such as nursing documentation, hand hygiene, medication rounds-red apron and audits of the resuscitation trolley.

In summary:

- The IPC programme would benefit from having formalised QIPs with time-bound actions to address audit findings.
- Compliance with completion of medication safety documentation requires improvement.

- Further work is required to continue to drive improvements regarding completion of INEWS documentation, and an up-to-date hospital policy is required to guide staff in relation to the implementation of INEWS v.2 and ISBAR.
- While the ToC Group is in its infancy and a number of clear, time-bound actions have been identified and assigned to individuals, a programme of audit is required to assess if progress is being made in relation to all aspects of transitions of care.

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.

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. The QSR Committee had oversight of risks. Risk management was a standing item on the agenda of meetings and there was evidence in meeting minutes that risks were discussed. There was evidence that the risk register was discussed at SMT level from meeting minutes reviewed by inspectors. Risks that could not be managed at hospital level were escalated to the CUH Executive Management Board.

Risks noted on the hospital's risk register included risk to patient and staff safety due to poor infrastructure including lack of isolation rooms, COVID-19, staffing levels in the laboratory and risk relating to the vacant diabetic CNS post. Risks identified had controls and time-bound actions were assigned to individuals.

Infection prevention and control

The hospital had a number of policies and procedures and guidelines in place in relation to IPC, however some of these required review. Risk was a standing item on the agenda of Infection Control and Hygiene meetings.

Inspectors were informed that patients were assessed for COVID-19 symptoms by their GP, prior to arrival at the MAU. Patients presenting to the LIU did not complete a respiratory questionnaire. Patients awaiting treatment in the MAU and LIU shared the same waiting room area and there was sufficient spacing in the waiting area to accommodate all patients on the day of inspection. Patients with signs and symptoms of COVID-19 were placed in one of two isolation rooms on presentation to the MAU, and had a COVID-19 test. Inspectors reviewed a COVID-19 outbreak management report submitted to HIQA. The report was comprehensive, outlined control measures and actions taken to mitigate the risk to patient safety, and recommendations to reduce the risk of reoccurrence of an outbreak. The hospital received microbiology support through CUH and also had links to Public Health where required. There was opportunity for sharing of learning from outbreaks with clinical nurse managers (CNMs) at the CNM meetings, as

detailed in the agendas of CNM meetings. Of note, patient charts reviewed by inspectors had patient's Multidrug-resistant organisms (MDRO) status or other transmissible infection status recorded in the nursing notes. It was noted also that COVID-19 vaccination status was not recorded on one of the three patients' charts reviewed.

As noted under Standard 2.7, there were limited isolation facilities in clinical areas visited, and a prioritisation system was in place for allocating patients who required isolation to single rooms. Documentary evidence of control measures to address the risk of infection from a biological agent due to non-compliance with infection control policy (lack of isolation rooms), was provided to inspectors on the day of inspection. An inspector observed cohorting of patients in a clinical area, where isolation rooms were unavailable.

As noted under Standard 5.5, the hospital had completed a risk assessment regarding the absence of an AMS programme for the hospital. The risk assessment detailed existing control measures including the use of regional antimicrobial prescribing guidelines, the introduction of a restricted antimicrobial order form to act as a quality assurance measure to ensure appropriate authorisation for prescribing of antimicrobial agents and the inclusion of AMS in the induction and annual IPC training for staff. The risk assessment identified the need for additional qualified resources in the area of AMS to support the hospitals ability to put in place an AMS programme. This risk assessment was regularly reviewed.

The hospital was following national guidance in relation to screening for CPE. All patients with a history of CPE were screened on admission and patients who were known contacts of CPE case were screened weekly for one month.

Staff uptake of flu vaccination for nurses and HCAs was below the HSE's target of 75%, at 67% and 52% respectively.

Medication safety

As noted in Standard 5.5 a clinical pharmacy service was available at the hospital. However, it was acknowledged that the service was restricted due to staffing deficits in recent times. Notwithstanding this deficit, staff who spoke with inspectors in the clinical areas visited stated that they felt supported by clinical pharmacists and the pharmacy technician.

The hospital would benefit from having a formal medication safety plan in place to guide activity in relation to medication safety. Inspectors observed the use of risk reduction strategies to support safe medication practices, including segregated storage of potassium, the use of APINCH***** classification and the application of 'please note strength' labels on some medications. The pharmacy service had a suite of policies and

***** An acronym representing medicines known to be associated with high potential for medication-related harm:Antimicrobials, Potassium and other electrolytes, Insulin, Narcotics (opioids) and other sedatives, Chemotherapeutic agents, Heparin and other anticoagulants.

guidelines to support medication safety, which were available for staff through a shared folder. The hospital had also developed a list of sound-alike look-alike medications (SALADs), which were on display in medication preparation areas.

Medication reconciliation was an area which required improvement and this was acknowledged by the lead representatives for medication safety also. Medication reconciliation was undertaken in the MAU, but generally not in other clinical areas as standard. It was noted in the meeting with lead representatives for medication safety that there were plans to reintroduce medication reconciliation, in line with the recruitment of an additional clinical pharmacist who had joined the team on the week of the inspection. This additional capacity would allow the team to undertake work that had previously been ceased due to staffing deficits. Medication stock control was carried out by the pharmacy technician.

Deteriorating patient

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose condition acutely deteriorates. Inspectors were informed that the early warning system, INEWS v.2 was implemented on wards and all staff spoken with were aware of the system and described when and to whom to escalate care of a patient. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating.

A sample of healthcare records reviewed on inspection showed that in the case where care of a patient was escalated, it was done so in line with protocol. The ISBAR communication tool was used to support communication between staff in relation to a patients care. Evidence of this was observed on the ward.

Inspectors were informed that the policy to support the implementation of INEWS v2, the Escalation and Response Policy, was in the process of being updated at the time of inspection.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. However, not all patient healthcare records and discharge documentation included the patient's healthcare associated infection and or vaccination status.

The ISBAR tool was in use in the hospital and inspectors saw evidence in patients' charts of ISBAR being used where patients are admitted from the MAU to the wards. ISBAR was also used for clinical handover and safety huddles were scheduled for 16:00 and 23:30 daily, where any issues that may impact on patient safety and a patient's care plan were discussed.

The hospital had a clear protocol in place to transfer patients to model 4 hospitals, including CUH, where additional specialist care could be provided when not available at MGH. Staff in clinical areas and lead representatives for the deteriorating patient and transitions of care described the Protocol 37 arrangements that are in place which are guided by 'Protocol 37 The Emergency Inter-Hospital Transfer Policy'. Inspectors viewed this document as part of the onsite DDR.

In summary:

- a number of hospital policies required review.
- medication reconciliation arrangements for patients on admission and discharge requires implementation.
- the hospital would benefit from having a formal medication safety plan in place to guide medication safety activity.
- not all patient healthcare records and discharge documentation included the patient's healthcare associated infection and or vaccination status.

Judgment: Substantially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospitals SIMT provided a governance structure to the hospital's management of category one incidents and other SREs which occur in the hospital to ensure that all incidents were managed in line with the HSE Incident Management Framework 2020. Meeting minutes and annual incident management reports reviewed by inspectors indicated that incidents were managed appropriately, and with the required level of oversight.

The SIMT reported to the Cork University Hospital Serious Incident Management Team. Minutes reviewed indicated that SREs were discussed. The SIMT ToR, clearly outlined its objectives, roles and responsibilities. Once immediate safety issues were satisfactorily addressed, meetings were held monthly while reviews were ongoing.

Inspectors reviewed a copy of the Annual Incident Management Report 2022 (Draft) for the hospital, which gave a detailed breakdown of the incidents that occurred in the hospital between January and December 2022. Incidents were broken down into categories and the report provided an overview of where clinical incidents occurred within the hospital. Documentary evidence of dashboard reports relating to medication safety incidents and infection prevention and control incidents was also shared with HIQA.

Staff who spoke with HIQA were knowledgeable about the incident reporting process in place within the hospital. Staff described the process to inspectors, including the sharing of incident data in the form of a quarterly dashboard report. Incidents were discussed at CNM meetings and inspectors were informed that learning from incidents was then shared by CNMs at staff huddles, with NCHDs at bi-weekly NCHD meetings and through quarterly incident reports which inspectors noted were displayed on quality boards in the clinical areas inspected.

Where incidents occurred in relation to one of the four key risk areas, inspectors reviewed documentary evidence that incidents were discussed at the relative meetings and measures were taken to address any immediate risks, and where necessary quality improvement initiatives were undertaken. Examples of such initiatives include the placement of education stands in the main hallway to provide further information to staff on a particular topic and the facilitation of a medication safety week within the hospital.

Overall, inspectors were satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm.

Judgment: Compliant

Conclusion

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

- compliant in three national standards (1.7, 3.3 and 5.8)
- substantially compliant in seven national standards (1.6, 1.8, 2.8, 3.1, 5.2, 5.5 and 6.1)
- partially compliant in one national standard (2.7)

Capacity and Capability

While MGH had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare, attention is required to ensure that actions arising from meetings of all committees are time-bound and are assigned to individuals and ToRs are reviewed as required.

The hospital had effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. The hospital had defined

lines of responsibility and accountability with devolved autonomy and decision-making for the management of clinical areas visited during the inspection. It was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care of patients and that operationally, the clinical areas were functioning well. The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas.

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. The hospital reported on a suite of key performance indicators, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks. There was oversight of the management of serious reportable events and serious incidents, in line with the HSE's Incident Management Framework.

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. However, the uptake of essential and mandatory training required improvement. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

The hospital promoted a person-centred approach to care.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. However, improvements in practice were required in order to ensure that patients' personal information is protected at all times in clinical areas.

Inspectors observed staff being kind, caring and respectful towards patients. It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients who inspectors met with were complimentary of the staff and the care provided to them. Inspectors found that service users' complaints and concerns were responded to promptly, openly and effectively and that complaints were managed in line with the HSE's complaints management policy 'Your Service Your Say.' The hospital would benefit from recording verbal complaints and the hospital had a QIP in place to improve and enhance the hospitals complaints management process.

The clinical areas visited were found to be clean and well maintained. However, the physical environment posed a number of challenges to staff and patients, including the limited isolation, en-suite and toilet facilities throughout the hospital. At the time of inspection, a new 44-bedded unit was under construction and due for completion in 2023.

Management envisaged that this would address risks identified in relation to infrastructure.

The hospital had systems in place to monitor, evaluate and continuously improve services. Audits were being undertaken across the four key risk areas, however the hospital would benefit from ensuring that time-bound action plans were developed as standard in response to audit findings and that each risk area has a clear programme of audit in place to guide activity.

Inspectors were satisfied that there were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm, and that there was oversight of risks. However, some improvements were required, particularly in relation to medication reconciliation and completion of elements of healthcare records and discharge documentation.

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the *National Standards for Safer Better Healthcare.*

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially 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.	Compliant

Compliance Plan for: Mallow General Hospital

Inspection ID: NS_0029

Date of inspection: 28 February 2023

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

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

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

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

(A) Interim Measures:

Patients requiring isolation on St. Mary's Ward will be risk assessed and prioritised for single rooms or for single rooms on other wards in the hospital.

Enhanced cleaning and infection prevention and control measures will be provided on St. Mary's Ward until the ward closes in August / September 2023.

(B) Long-term Measures:

St. Mary's Ward is due to close to overnight inpatients in August / September 2023.

St. Mary's Ward will relocate to the new 48 bed extension currently in progress on the site.

The vacated ward footprint will be refurbished and repurposed for alternative use thereafter.

Timescale:

Interim Measures for immediate implementation (May 2023)

Long-term Measures for implementation subject to vacating St. Mary's Ward (estimated September 2023)