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:	Mayo University Hospital
Address of Healthcare Service:	Castlebar Co. Mayo
Type of Inspection:	Announced
Date of Inspection:	16 and 17 August 2022
Healthcare Service ID:	OSV-0001056
Fieldwork ID:	NSSBH-0010

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Mayo University Hospital is a model 3* public acute hospital and is part of the Saolta Hospital Group. Mayo University Hospital provides 24/7 undifferentiated care and services to the population of Mayo and the extended population in parts of its border counties of Sligo, Galway and Roscommon.

The Hospital is comprised of five directorates including the Medical, Perioperative, Women's Health and Children, Radiology and Laboratory directorates which are complemented by the support services. It has an emergency department.

The following information outlines some additional data on this healthcare service.

Model of Hospital:	3
Number of beds:	313 beds including 40 beds on St John's Ward located within the nearby off-site Sacred Heart Hospital in Castlebar.

* The National Acute Medicine Programme model of hospitals describes four levels of hospitals as follows:
Model 1 hospitals: are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
Model 2 hospitals: can provide the majority of hospital activity including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus 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.
Model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute Medicine and critical care.
Model 4 hospitals: are tertiary hospitals and are similar to Model 3 hospitals, but also provide tertiary care and in certain locations, supra-regional care.

How we inspect

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

As part of the inspection, HIQA inspectors will, where possible:

- speak with people who use the service about their experience of the service
- talk with staff and management to find out how they plan, deliver and monitor the care and support that is provided to people who use the service
- observe care being delivered, interactions with people who use the service and other activities to see if it reflects what people tell the inspectors
- Review documents to see if appropriate records are kept and that they reflect practice and what people tell the inspectors.

About the inspection report

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

1. Capacity and capability of the service:

This section describes the governance, leadership and management arrangements in place in Mayo University Hospital. It considers how effective they are in ensuring that a good quality and safe service is being sustainably provided. It outlines how people who work in the service are managed and supported through education and training, and whether there is appropriate oversight and assurance arrangements in place to ensure high quality and safe delivery of care.

[†] 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).

2. Quality and safety of the service:

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

A full list of all standards reviewed as part of this inspection by themes and dimensions and the resulting compliance judgments are listed in Appendix 1**.**

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance has been made under each standard monitored on how the service performed. We include our monitoring judgments in the inspection report and where we identify partial or non-compliance with the standards, we will issue a compliance plan. It is the healthcare service provider's responsibility to ensure that it implements the actions in the compliance plan within the set time frames.

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.

This inspection was carried out during the following times:

Dates	Times of Inspection	Inspectors	Roles
16 August 2022 17 August 2022	0900 to 1700hrs 0900 to 1600hrs	Patricia Hughes Nora O' Mahony Denise Lawler	Lead inspector Support inspector Support inspector

Information about this inspection

This announced inspection of compliance against the national standards was undertaken on 16 and 17 August 2022 with a particular focus on four key areas of known healthcare risk:

- infection prevention and control
- medication safety
- the deteriorating patient ‡(Sepsis§)
- transitions of care**

Previous inspections of the hospital undertaken by HIQA included assessments of Nutrition and Hydration (January 2017), Medication Safety (November 2017) and Infection Prevention and Control (September 2020).

On this inspection, the following clinical areas were visited:

- emergency department
- 'A' ward - Medical
- 'D' ward – Surgical and some medical patients

The inspection team met with representatives of the following:

- the Hospital's Executive Management Team (the Hospital Manager, Director of Nursing, Director of Midwifery, Associate Clinical Directors for Medicine including Emergency Medicine, Women and Children's, Radiology and Perioperative).
- Quality and Patient Safety. This was covered by the Hospital Manager.
- Complaints. This was covered by the Hospital Manager.
- Non-consultant hospital doctors (NCHDs).
- Human Resource Manager and Medical Manpower Manager.
- Representatives leads for: infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. HIQA would also like to thank the 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 HSE. Early Warning Systems (EWS) improve recognition and response to signs of patient deterioration. A number of EWS designed to address individual patient needs are in place in acute hospitals.

§ 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

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

On the day of inspection, inspectors visited the main Emergency Department, the Ambulatory Emergency Department and the Acute Medical Assessment Unit. The emergency department provides care for undifferentiated adult and paediatric patients with acute and urgent illnesses or injuries. Attendees to the emergency department at Mayo University Hospital presented by ambulance, were referred directly by their general practitioner (GP) or self-referred.

The hospital's emergency department comprised of a total of 11 clinical spaces plus six other spaces for mixed use for example, the Adult Mental Health room, Treatment Rooms and Plaster Room. Three of the clinical spaces were isolation rooms and one of these had en-suite toilet facilities. There were two other toilets in the emergency department for use by patients.

Inspectors noted there was no audio-visual separation of children from adult emergency care in the emergency department, as recommended in the national model of care for paediatric healthcare services. HIQA was informed that an extension to the existing emergency department was planned as part of a major capital development project and this would then provide audio and visual separation for children in emergency care.

The waiting area in the emergency department comprised of 33 chairs. Inspectors observed that the minimum physical spacing of one metre was not maintained on the day of inspection. On arrival at the emergency department, inspectors noted and were informed that there was signage on the walls and doors advising patients to declare any symptoms suggestive of COVID -19, however there was no active streaming by hospital staff until patients were seen one at a time in the only triage room available. If a patient was noted to be COVID-19 positive or was suspected of having COVID-19, they were transferred to the red pathway and the triage room was taken out of use for the purpose of terminal cleaning[††]. This will be discussed in greater detail under national standard 3.1.

During the COVID-19 pandemic when physical spacing was implemented, the capacity in the waiting area was reduced to 18 chairs. Signage promoting the need to maintain social distancing was observed at the main entrance to the emergency department, but social distancing was not observed to be in practice within the waiting area. The 10 attendees in the waiting area were not observed to be wearing facial coverings.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the department. Staff were

[††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

observed wearing appropriate personal protective equipment (PPE) in line with current public health guidelines.

Inspectors observed staff actively engaging with patients in a respectful and kind way. Staff took the time to talk and listen to patients and encouraged patients to let them know if they felt unwell while waiting to be reviewed.

Inspectors spoke with a number of people using the emergency department services to hear about their experiences of care received. Patients who spoke with inspectors were waiting from one to 10 hours in the department from time of arrival at the hospital. They said that they had received meals and could get to the toilet themselves. The following comments were made in response to questions about what had been good about the service they had experienced so far and what areas did they think required improvements:

- *"I have been seen sooner than I expected to, given all you hear about waiting in ED, and I am just waiting to hear the results of my x-ray now"*
- "*The hospital is full….I don't know when I will get a bed"*
- "*Staff are doing their best but is there enough of them?* "
- "*the waiting is terrible but what can you do?* "
- "*there seems to be more patients here than I have seen before when I came to ED- there is no dignity in this…*"
- "*There needs to be more space, more staff and less waiting*"

When asked, patients were aware of how to make a complaint if they needed to.

These findings were consistent with the findings from the 2021 National Inpatient Experience Survey,[‡‡] where 48% of patients who completed the survey considered their overall experience of the hospital as very good. This was lower than the national average where 54% considered their overall experience as very good. This is discussed in further detail under national standard 1.6.

[‡‡] The National Care Experience Programme, was a joint initiative by the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care.

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

Inspectors visited two ward areas. Ward 'A' was a 33-bedded ward, which catered for the needs of patients with a variety of medical conditions. Two additional unoccupied trolleys were located within an indented space in the corridor. Inspectors were told that these trolleys are usually occupied by patients.

Ward 'D' was a 28-bedded ward which catered mainly for the needs of patients receiving surgical care. About 30% of patients present on the day were medical patients. Two additional beds were located on the corridor. These were occupied at the time of inspection. Screens were provided around these beds.

Inspectors observed that staff interactions with people using the service were kind, respectful and attentive to patient needs. Curtains were drawn around patients for privacy at appropriate times.

When asked to describe what had been good about their stay in the hospital, people were complimentary about the staff who cared for them and the experience of care they had received. They told inspectors, '*staff are lovely, they couldn't do enough for you', 'staff marvellous', 'very attentive', 'very approachable', 'staff are so nice'.* Patients also outlined how busy the staff were.

When asked what could be improved about the service or care they received, responses included '*everything was wonderful*', '*nothing', 'staff have time for you'.* Other patients outlined opportunities for improvement such as the timely answering of call bells, provision of information regarding when they will be seen by their doctor and more time being available to talk to their doctors about their symptoms and care.

Most people who spoke with inspectors knew how to raise a complaint, if required. However, they told inspectors they had no complaints. Your Service, Your Say' leaflets were observed by inspectors to be available on 'D' ward. Patient information boards on 'A' and 'D' wards had information displayed on:

- Protected meal times
- Slips, trips and falls data
- Pictures to help identify each staff role by staff uniforms

- Ward champions for infection prevention and control, dementia, pressure ulcers, falls and care bundles

Capacity and Capability Dimension

Inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the themes of leadership, governance and management, and workforce.

Inspection findings from the wider hospital and clinical areas visited related to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.4) also from the themes of leadership, governance and management, and workforce.

This next section reports on findings relating to national standard 5.2 which sets out the overall governance for the hospital and the findings relating to national standard 5.5 which are presented jointly in respect of the emergency department and the remaining clinical areas inspected.

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

Mayo University Hospital had formalised corporate and clinical governance arrangements in place to provide quality, safe and reliable healthcare. At executive level, the hospital had defined lines of responsibility and accountability for the governance and management of services. The Hospital Manager had overall responsibility for governance and management of the hospital and reported to the Chief Executive Officer of the Saolta Hospital Group.

The hospital had five directorates each of which was led by a consultant in the role of associate clinical director. The associate clinical directors were then members of the hospital management team. Each of the associate clinical directors also reported to a group clinical director for that directorate.

Risk and incident management was integrated within the directorate structures and directorate meetings were attended by quality and patient safety staff. At the time of inspection, the

hospital's quality and patient safety structures were under review and reform was in progress although not yet finalised or formalised.

Infection prevention and control (IPC)

The hospital had effective management arrangements in place to support the delivery of the infection prevention and control (IPC) programme. The IPC committee was responsible for the governance of IPC in the hospital and met monthly. The IPC committee reported to and presented monthly reports to the Hospital Management Team. It also reported to the Saolta IPC committee every three months. The IPC resources included the following:

- 2 WTE Consultant Microbiologist
- 1 WTE ADON
- 2 WTE Clinical Nurse Specialist plus 1 WTE CNM2 in training for CNS role
- 0.5 WTE Surveillance Scientist
- 2 WTE Antimicrobial Pharmacist
- 1 WTE NCHD in Microbiology
- 1 WTE Clerical Support.

Staff reported having 24-hour access to the microbiologist via telephone.

The IPC team review method statements before issuing an IPC permit enabling a building works project to commence. Quality and patient safety (QPS) is represented on the IPC Committee. IPC risks are reported to and discussed at the hospital's local risk meeting. An example of a complaint relating to IPC was outlined to inspectors where the IPC team were notified of the complaint and were involved in its resolution. The hospital had an Infection Control Programme and an Antimicrobial Stewardship Programme (AMS) with associated AMS Committee. The AMS Committee met every two months and had multidisciplinary membership with representation from medicine, surgery, anaesthetics, microbiology, IPC, surveillance scientist plus an AMS pharmacist. The IPC team provide education to new staff during induction and also provide in-service updates in IPC every week. Inspectors were told that a number of HSeLanD modules in IPC are highlighted as mandatory training for staff and the Human Resources department issue reminder notices about these. There was an Outbreak Prevention Committee and reports are completed at the end of an outbreak. Inspectors were told that during surges of outbreak activity, it has been challenging to complete reports in a timely manner. Inspectors viewed outbreak reports from the two wards inspected relating to outbreaks in March and April of this year. The IPC Committee provided oversight, direction and support to its decontamination, hygiene, outbreak prevention and antimicrobial surveillance subgroups.

Medication safety

The hospital had effective management arrangements in place to support the delivery of medication safety. The Drugs and Therapeutics Committee (DTC) had overall resoinsibility for

the governance of medication safety in the hospital and met every two months. The DTC reported to and presented monthly reports to the Hospital Management Team. It also reported to the Saolta DTC although inspectors were informed that it had not been operational over the last year. The Medication Safety Committee is chaired by a clinician. The Chief 2 Pharmacist is on the committee. The post of Medication Safety Pharmacist was vacant at the time of inspection.

Inspectors were told that medicine reconciliation by a pharmacist was only undertaken on admission for medical patients admitted under a medical consultant and that there was no routine comprehensive medicine reconciliation by a pharmacist being undertaken at the point of discharge. Although there was an electronic discharge summary in place at the hospital, inspectors were told that it is not reviewed by pharmacists due to a lack of resources.

The HSE leaflets '*Know, Check, Ask'*[§§] were noted on display in the wards inspected. Inspectors viewed an example of an audit undertaken on the use of proton inhibitor pumps. Risks associated with medication safety were identified through the directorate structure and action plans were implemented in conjunction with ongoing education. Risks were documented on the hospital risk register and reviewed monthly by the Hospital Management Team. Inspectors were told of an increase in the number of insulin-related incidents between October 2021 and March 2022. While it could not yet be clarified whether this represented an increase in reporting rather than an increase in the occurrence of incidents, close monitoring and analysis was being undertaken by pharmacists and action plans were being initiated in conjunction with education for medical and nursing staff. The hospital had identified that about half of the medication safety issues arose with prescribing and half with administration aspects. In relation to high-risk medicines, medication safety notice boards were observed to be in each ward area inspected and risk reduction strategies were on display. Inspectors were informed of the use of check lists and education relating to the appropriate use of certain medications. In relation to alerts, recalls and recommendations, these were reported to be circulated to relevant personnel by pharmacy staff and a member of the pharmacy staff would then go to the wards to withdraw retracted medicines.

Members of the Drugs and Therapeutics Committee (DTC) told inspectors that opportunities for registered nurse prescribers to become involved in prescribing insulin are under consideration. New drug charts were being developed in an effort to address some of the issues relating to medication safety incidents.

The hospital had approval and funding for 29.75 WTE[***] pharmacy staff. At the time of inspection, 22.75 WTE of these posts were filled resulting in a shortfall of 7 WTE (23.5%). Inspectors were told that the pharmacy also supplied a dispensing service to a large local

[§§] The 'Know, Check, Ask' is a campaign led by the HSE, aimed at encouraging health care professionals to discuss medication and empowering people to become more informed about their medication and its use.
[***] WTE, whole time equivalent. Indicates the proportion of full-time hours a person is contracted to work based on the nationally agreed working week for that grade or discipline.

nursing home and to mental health services. These staffing issues were documented on the hospital's risk register. At the time of inspection, the critical care areas including emergency department, AMAU and four medical wards had assigned cover from a pharmacist. D ward which was inspected did not have an assigned clinical pharmacist but inspectors were told that the wards receive support from pharmacy technicians in aspects of work such as the top-up of supplies. Inspectors were also told that requests to the pharmacy to undertake medicine reconciliation for complex patients are facilitated where possible. Inspectors were told that recruitment was ongoing for all posts and that staffing levels were impacted by various types of leave. Notwithstanding those issues, HIQA is concerned by the deficit in the approved staffing level.

The deteriorating patient

Inspectors met with members of the Deteriorating Patient Management Committee (DPMC). It had multidisciplinary membership, was chaired by a consultant anaesthetist and met every 2 months. It reported to the hospital management team and provided reviews of quarterly audits of escalation. Incidents are reported to the quality and safety department using the hospital's electronic management system where they are tracked and trended.

Inspectors were told that simulation and scenario-based skills training were provided at designated times up to four times per week covering use of each of the early warning systems (INEWS, IMEWS, PEWS) and the identification and management of sepsis. Inspectors viewed audits conducted on the use of INEWS escalation.

Although training had begun on the proposed use of the Emergency Medicine Early Warning Score (EMEWS), no date had been set for implementation. An initiative was reported and observed to be in place in the ED where a 'blue card' was in use at triage which prompted staff to 'think sepsis first'.

The hospital had an eight bed combined ICU and CCU and now has a separate CCU with four beds resulting in the hospital having access to 12 critical care beds.

Inspectors were also told of a situation involving anaesthetic staffing deficits at the hospital. The Royal College of Anaesthetists requires specific staffing levels to be in place to meet the standards required for training. The hospital was seeking funding for the required staffing through the hospital group, however inspectors were informed that there is a risk that the hospital will only be enabled to take on half its normal number of trainees. This may pose serious consequences for the hospital's ability to support critical care services. This risk was listed on the hospital's risk register.

Transitions of Care

In relation to transitions of care, staff were told that the hospital uses the ISBAR (**I**dentify, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) technique when transferring patient

care between health care professionals as in clinical handover. Inspectors were told of and they observed the whiteboards and the staff group reviewing these at handovers on the ward areas. The whiteboard was a dashboard of key information relating to a patient stay. It included a Predicted Date of Discharge (PDD).

The average length of stay (AvLOS) for medical patients was 13.2 days (above the HSE national target of 7 days) and AvLOS for surgical patients was 8.6 days (above the HSE national target of 5.2 days). Inspectors were told that on-call teams conduct ward rounds in each specialty at weekends to see all new admitted patients, review patients of concern and patients who had been previously considered suitable for possible weekend discharge. On the day of inspection however, there were discrepancies noted in reports from staff as to whether this happens consistently in all wards. While reasons for average length of stay can be multifactorial, the hospital should continue to review its systems in place to assist in timely decision-making, so that the use of beds is effective and efficient throughout the 24/7 cycle in the interests of people using the service. This would be especially important at times of surge and while the hospital is in escalation.

Daily patient safety flow meetings are held hospital wide at 9am and 2.30pm. The CNM could access this meeting virtually from the ward office. Inspectors were told that the meetings were attended by the Director of Nursing (DON), Director of Midwifery (DOM), ward managers, central nursing office, the ADON, bed manager and discharge coordinator, health and social care professional leads and diagnostic leads for the site including radiology, laboratory and cardiology. The infection prevention and control team also dial in for the safety huddle meeting as well as the hospital ,anager.

Issues raised include activity levels, staffing issues, escalating of EWS, transfers awaited, patients with one to one care needs, delayed discharges, delayed diagnostics, recent incidents or risks. Actions were assigned to specific personnel for example, cases concerning delayed diagnostics or delayed transfers may be allocated to central nursing office personnel or the Assistant Director of Nursing (ADON) to follow up.

In relation to discharge home or transfer to residential care, inspectors were told that the hospital aims to provide discharge letters to GPs for all patients discharged home or transferred to residential care or other hospitals. Inspectors were told that there can be a delays in preparation of these letters. Inspectors observed 25 charts being held on one ward and 15 on another awaiting a discharge letter. Inspectors were told that this is monitored daily at ward level and is reported weekly to the hospital manager. A delay in the standard of communicating with a person's primary health care provider at the point of discharge poses a potential risk to their safety and quality of care. The hospital should ensure that primary health care providers have access to timely and up-to-date information on their patients who have been transferred or discharged.

The hospital employs 2 WTE discharge coordinators. They report to the ADON for 'Medicine - Scheduled Care'. When asked about the higher average length of stay for medical and surgical patients compared with national targets, hospital management cited an ageing population and reduced access to beds in the community (district hospitals and nursing homes).

The discharge coordinators assist patients who have complex discharge needs or situations. On the day of inspection, eighteen people were identified as delayed discharges for various reasons including availability of stepdown beds, home care packages, social housing needs and other reasons. To manage this situation, the discharge coordinators hold a delayed transfer meeting once a week. It was attended by the director of nursing, the assistant director of nursing and a social worker where cases of delayed transfer or discharge are reviewed. Following that, the discharge coordinators liaise with their three district hospitals using online meetings to ascertain how transfers may be facilitated as soon as possible. Inspectors were told of a significant reduction in beds across the three district hospitals which are also impacting on delayed discharges.

The Mayo Egress Group (MEG) meeting is held twice a week to escalate any unresolved issues following the first meeting as above. It has a wider attendance including the membership from the initial meeting plus a Clinical Nurse Manager level 3 (CNM3), the community intervention team (CIT) including representatives from physiotherapy, dietetics, occupational therapy (OT) and representation from the community health office (CHO). The hospital also monitors its length of stay 'greater than 14 days' internally and reports this to the Saolta Hospital Group.

In summary, while inspectors note that the hospital met some of the requirements of this national standard in relation to the formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare, it was not in full compliance with the national standard. The hospital should work towards an urgent resolution of the anaesthetic staffing situation, improving patient safety through the expedient use of available risk-reduction strategies, the filling of approved vacancies and continuing to actively address the cause and impact of delayed discharges and transfers including clinical decision-making.

Judgment: Partially compliant

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

Findings relating to the emergency department

On the day of HIQA's inspection, the hospital had defined integrated corporate and clinical strategic and operational governance arrangements in place to manage and oversee the performance and quality of unscheduled and emergency care at the hospital.

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 emergency care. Operational governance and oversight of day-to-day workings of the department was the responsibility of the Associate Clinical Director for Medicine — a consultant in emergency medicine, who reported to the hospital's general manager.

On arrival at the emergency department, all self-presenting attendees checked in at reception and waited to be called for triage where they were then screened for signs and symptoms of COVID-19. This was not in line with national guidance. This was raised with both members of the infection prevention and control team and with hospital management on the first day of the inspection. Inspectors were told that this would be corrected. Inspectors checked and noted that attendees to the emergency department on the second day of inspection were streamed for COVID-19 at the point of registration and before triage. HIQA was concerned that there was a potential risk for patient safety if this change in practice was not sustained. Following the inspection, HIQA issued a high-risk letter to hospital management seeking assurances on infection streaming practices, waiting times and staffing levels in the department. HIQA was assured by hospital management's response that COVID-19 streaming practices were now aligned with national guidance and that contingencies were implemented to address issues with staffing to ensure the timely triage of patients.

On the day of inspection, the hospital management had enacted the full escalation protocol.[†††] The emergency department was busy and overcrowded. At 11.00am there were 35 patients in various stages of the care journey from registration to either discharge or admission. Eleven (31%) of the 35 attendees were over 75 years of age. Eight (23%) people were admitted, but remained within the emergency department waiting on a bed in the ward. These patients were accommodated on trolleys on a corridor within the emergency department where the minimum of one metre physical spacing between trolleys (sides and end to end) was not maintained. This was a risk to effective infection prevention and control practices.

Patients were triaged and assigned to the relevant prioritisation category levels 1-5 in line with the Manchester Triage System.[‡‡‡] Staff could view the status of all patients in the department — their prioritisation category levels and waiting times — via the hospital's electronic operating system.

[†††] Full capacity protocol is the final step in a hospital's escalation plans where extra beds are placed in inpatient wards and corridors of hospitals as a measure to address emergency department overcrowding.

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

On the day of HIQA's inspection:

- the waiting time from registration to triage ranged from 17 minutes to 3 hours 35 minutes, with an average wait time of 1 hour 23 minutes
- the waiting time from triage to medical review ranged from 20 minutes to 13 hours 11 minutes, with an average wait of 5 hours 5 minutes
- the average waiting time from decision to admit to admission in an inpatient ward was 1 hour 30 minutes. However, one patient was waiting in the emergency department for 17 hours while waiting on an inpatient surgical bed after the decision to admit was made.

Information supplied to inspectors included an audit of registration to triage times during the period 15 – 21 July 2022. The audit involved an assessment of registration to triage interval times using fifteen patient records randomly chosen for each 24-hour period for seven consecutive days. The mean triage time was found to be 29 minutes and the range was 9-50 minutes.

Other systems and processes in the hospital were not functioning as they should to support continuous and effective patient flow through the emergency department. The hospital's Acute Medical Assessment Unit was not functioning as designed, as an alternate flow pathway for patients in order to take pressure from the emergency department. Patients were not being directly referred to the AMAU. On the day of inspection, it was used as an overflow from the emergency department for patients awaiting admission to an inpatient bed. Inspectors were told that this was because their full escalation plan incorporated the AMAU for escalation. This indicated to HIQA that the normal means of facilitating patient flow at the hospital were not as effective as they should be.

The issue of effective patient flow through the emergency department was further compounded by the hospital's rate of delayed transfers, a high average length of stay (AvLOS) and a relatively high admission rate (conversion rate) of 31-35% from the emergency department for adult patients and 18% for paediatric patients. There was 18 delayed transfers from the hospital, on the day of inspection. The AvLOS for medical stay was 13.2 days (above the HSE national target of 7 days) and AvLOS for surgical stay was 8.6 days (above the HSE national target of 5.2 days). In addition, HIQA was told that during the COVID-19 pandemic, there was a significant reduction in beds within the *Community Healthcare Organisation* CHO Area 2, which reduced the availability of transitional, rehabilitation and step down beds in the community.

Hospital management had or were implementing measures to improve and support effective patient flow in the emergency department. This included the:

- establishment of the ambulatory emergency department where patients prioritised as categories 3, 4 and 5 (yellow, green and blue colour-coded categories) were seen and where treatment was commenced within 30- 90 minutes, less urgent cases). The

ambulatory emergency department had a planned capacity of five bays and operates Monday - Friday, between the hours of 9 am -8 pm. At 8pm, patients in the ambulatory emergency department where their care has not yet been concluded plus patients who have been admitted, but who are waiting on an inpatient bed are transferred to the hospital's main emergency department. On the day of inspection, there was 10 patients receiving care in the ambulatory emergency department.

- implementation of three operational meetings:
    - a meeting held every week at hospital level
    - a meeting held every week with local community hospitals
    - a meeting held every week with representatives from the *Community Healthcare Organisation* Area 2
- a multidisciplinary team meeting (flow board meeting), which included the community integration team and public Hhealth representatives, held every two weeks.

Overall, the hospital had defined management arrangements in place to manage and oversee delivery of care in the emergency department. However, on the day of inspection, the department was running at greater than its intended capacity, and there were issues with surge capacity and ineffective patient flow, which significantly impacted on the continuous and effective flow of patients through the emergency department.

The practice of boarding admitted patients in the emergency department impacts on the service's ability to maintain, promote and protect the patients' dignity, privacy and confidentiality, and a human rights based approach to care. Delays in the patient journey from registration to triage, assessment and decision-making readmission and ultimate placement in a ward-based bed or discharge home increases the risk to that patient and to others seeking to use the services. Such delays may also hamper efforts to maintain a safe environment for both patients and staff. Hospital management were aware of the situation and had implemented measures to improve the issue of patient flow. However, it was evident from findings on the day of inspection, that the measures implemented to date were not fully effective in managing the potential patient safety risks associated with crowding of the department, such as long waiting times for triage and from triage to medical review. In addition, the hospital's COVID-19 streaming practices were not aligned with national guidance.

Findings relating to the wider hospital and other clinical areas assessed

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

Human resources and medical manpower departments were responsible for workforce management in the hospital. Staffing levels and absenteeism rates were tracked and trended by

the departments and reviewed and reported at hospital management team meetings and at monthly performance meetings with the Saolta Hospital Group. Absenteeism rates over the three months prior to the inspection averaged 8% including absences associated with COVID-19. The national HSE target for absenteeism (in place prior to the impact of COVID) is 3.5% or less.

The hospital's approved wholetime equivalent (WTE) in July 2022 was 1154 WTE. The hospital reported employment figures of 1388 WTE, an excess of 234 WTE posts. Notwithstanding this, there was a 10% deficit in medical staffing, 14% deficit in nursing staffing, 15% deficit in health care assistant staffing and 23% deficit in pharmacy staffing across the hospital. Inspectors found that 'A' ward had 90% of its approved complement in post while D ward had six percent over its approved complement. Staffing in the emergency department is discussed further under national standard 6.1.

Inspectors were told that there was an increase in the turnover of NCHDs at registrar level in July 2022 compared to the last two to three years. The doctors were travelling abroad to work and this turnover was also associated with an earlier than expected leaving time. Due to COVID-19 restrictions on travel, the staff due to change over in July 2022 had gained up to three years' experience in the hospital and were now largely being replaced by more junior staff. Hospital management explained that some of them had opted to leave in May to June for overseas work. This resulted in a period of time where there were fewer than planned numbers of staff in post prior to the usual changeover dates. At the time of inspection, some posts were yet to be filled. The impact of this has resulted in a greater reliance on consultant staff to support and enhance decision-making during the 24/7 cycle over the last few months. This will be discussed more under national standards 6.1.

Both wards visited by inspectors had full complements of staff on day duty during the inspection. Review of the rostered versus actual staffing levels for those wards for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses and healthcare assistants on night duty had been consistently met on 'D' ward. There were only two days in the four week period however, where the rostered staffing on day duty was achieved. Shortages on the remaining days ranged from being one out of nine staff short to being four out of eleven rostered staff short.

Review of the rostered versus actual staffing levels for 'A' ward for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses and healthcare assistants on night duty had been met on all but one of the 28 nights reviewed. Full cover on day duty was achieved on 19 of the 28 days reviewed. Staff shortages on the remaining days ranged from one out of eight staff short to three out of eight staff short.

Inspectors were told that the Clinical Nurse Manager escalated staff shortages to the assistant director of nursing (ADON) or central nursing office (CNO) and that in such cases, the shortage may be covered by staff working additional shifts or redeployment from less busy areas.

However, short-term sick leave was not always covered. Ward staff meetings with the CNM2 were scheduled to take place every 6-8 weeks, the last one recorded as being held on one of the two wards was in May 2022.

Inspectors were informed by management that they had a number of consultants employed in the hospital who were not on the relevant specialist division of the register of the Irish Medical Council. This equated to 9 Consultants (8.5 WTE) of whom half are on agency contracts. Senior hospital management stated that they had discussed the requirements to register on the specialist register with the consultants in question, and supports were in place to progress registration with appropriate support and oversight in place, in line with HSE guidance. Hospital management stated that up to a quarter of the consultants not currently on the register were expected to be able to be be registered by the end of 2022.

The impact of the 23% shortfall in pharmacy staffing despite ongoing recruitment efforts was evident to inspectors in the lack of comprehensive clinical pharmacy and medication reconciliation services in some clinical areas of the hospital.

The hospital had listed both pharmacy staffing and anaesthetic staffing as potential risks on the risk register. Feedback received from the hospital clarified that concerns relating to recruitment of pharmacists are associated with the challenges of recruitment into approved posts. Concerns relating to anaesthetic staffing are associated with a request to have additional posts approved, so that the hospital can meet the standard of staffing required by the training colleges for the granting of training posts at the hospital. These are discussed further under national standard 6.1.

While the Employment Assistance Programme and occupational health services were available to staff, inspectors were told that long waits (several months) had been experienced in obtaining an appointment with occupational health. Inspectors were told that the legacy of those extended waiting times had since been reduced to a maximum of one month and that some people are seen within one week of referral.

The NIES 2021 for overall experience for Mayo University Hospital was 6.9 compared to the national score of 7.2. This score had fallen further from the hospital's own scores of 7.4 and 7.1 in 2018 and 2019 respectively. The hospital had an established Patient and Family Experience Advisory Council in place. According to the most recent monthly report of the council viewed by inspectors, which was dated July 2022 and submitted to the hospital management team, the process of recruiting new members was beginning and agenda items for the council included emergency department quality improvements plans around family presence, get up, get dressed, get moving greenway and a patient information booklet.

In summary, there are a number of key areas for the hospital to address to bring it into full compliance with this standard. The hospital's COVID-19 streaming practices were not aligned with national guidance. The measures implemented in relation to patient flow through the

emergency department to date were not fully effective in managing the potential patient safety risks associated with crowding of the department, such as long waiting times for triage and from triage to medical review. Notwithstanding that support and oversight in place is in line with HSE guidance for consultants who are not currently on the Specialist Register, management should continue to advance arrangements to ensure all consultants are appropriately registered on the specialist division of the register of medical practitioners, maintained by the Medical Council in the relevant speciality. While the hospital outlined that significant investment has been made in staffing in recent years, HIQA is concerned that significant medical, nursing and pharmacy staff shortages exist in some of the inspected areas. Inspectors were informed that recruitment is ongoing, however the extent of those deficits exacerbate the potential risks to quality and patient safety and so there is an imperative to fill those posts in a timely manner. Where there is a critical shortfall in staffing across a range of disciplines, exceptional contingency arrangements should be explored to ensure that patient safety is prioritised. Inspectors found that overall, Mayo University Hospital had partially met the standard requiring service providers to have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

Judgment: Partially Compliant

Inspection findings relating to the Emergency Department

This section outlines findings from the inspection as they related to the Emergency Department. Findings and judgments are presented under three national standards (6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare* relating to the themes of workforce, person-centred care and support, and safe care and support.

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

For a service to achieve high-quality, safe and reliable healthcare it needs to have sufficient staff with the required skill-mix and competencies to respond to the needs of the population it serves. Mayo University Hospital had ongoing staffing issues. In particular, these related to medical and pharmacy staffing across the hospital while nurse staffing was a particular issue in the emergency department. 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.

Staffing levels for medical staff in the emergency department were being maintained at levels to support the provision of 24/7 emergency care, however this was challenging and was only achieved through the appointment of junior non-consultant hospital doctors (year 1 registrar grade). Inspectors were told that a significant number of NCHD's resigned at least a month before changeover earlier in the year (changeover typically happens in mid-January and mid-July each year). This situation resulted in a shortfall of available staff for that period prior to the usual changeover time. At the time of inspection, significant deficits in the number of NCHDs in the emergency department remained. Where new staff had joined the hospital, many were less experienced than the outgoing cohort and so required greater levels of support and input around decision-making from existing senior staff.

At the time of inspection, the hospital had an approved complement of 4.6WTE[§§§] consultants in emergency medicine. 2.6 WTE of these positions were filled on a permanent basis and 2 WTE on temporary locum contracts. Inspectors were informed that interviews for the filling of the 2 WTE posts on a permanent basis were being scheduled. All five consultants in emergency medicine were on the specialist register with the Irish Medical Council. The consultants are operationally accountable and reported to the associate clinical director for medicine. A senior

[§§§] Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half of the full-time hours.

clinical decision-maker[****] at consultant level was on site in the hospital's emergency department each day, with availability on a 24/7 basis. At the time of inspection, consultants in the emergency department were supported by 18 WTE non-consultant hospital doctors at registrar (9 WTE) and senior house officer (9 WTE) grades providing 24/7 medical cover in the department. A further 6 WTE posts within the approved complement of 24 WTE NCHD posts within the emergency department remained vacant at the time of inspection, a 25% shortfall.

Four of the nine registrar grade posts were filled by agency staff. Ongoing use of agency staffing is not cost efficient or conducive to the provision of safe and effective care. The department had its full complement of nine senior house officers. Three of those were completing GP training schemes.

The phased introduction of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland[††††] was ongoing at the time of inspection, so the nurse staff complement for safe care in the emergency department had yet to be determined. The approved nursing staff complement for the emergency department was reported to be 49 WTE. Inspectors were told that all of the permanent posts were filled to the approved WTE. On the day of inspection, the actual nursing staff complement available to the emergency department was 38.61 WTEs. This represented a shortfall of 10.39 WTE (21%) between the actual in post versus the available nursing staff complement for the department. Inspectors were told that while the department had lost a number of skilled emergency nurses over the past six months, there were 10 nurses on leave (including maternity or long-term sick leave). Such deficits in available staffing impacted on the nursing skill-mix and further challenged the delivery of high-quality, safe healthcare.

Review of the rostered versus actual staffing levels for emergency department for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses, multi task attendants and healthcare assistants was achieved on just over a quarter of the night shifts. Shortages ranged from one out of seven staff short to three out of eight staff short. Full rostered staffing was not achieved on any of the 28 day duty shifts reviewed. Shortages ranged from one out of ten staff short to four out of ten staff short.

Hospital management were managing the difference in nurse staffing levels through an ongoing recruitment campaign, the use of agency nurses and or the use of overtime by staff from the department. On the day of inspection, the department was one nurse short of its full rostered complement of 17 nursing staff (including management grades 8am - 8pm) on day duty. The full rostered complement of six nursing staff (including management grades) was on night duty

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

(8pm 8am). There was no replacement or redeployment of staff to the department to fill the deficit of one nurse on the day shift. An assistant director of nursing had overall nursing responsibility for the emergency department. An assistant director of nursing and a CNM3 were rostered on duty Monday – Friday during core working hours (8am - 6pm).

Nursing staff in the emergency department were supported by a healthcare assistant and a multi-task assistant on day duty and by a healthcare assistant on night duty. Administrative support was provided by a ward clerk for 8 hours a day, four days a week (lunchtime to 9 pm).

The multidisciplinary team in the emergency department also comprised two advanced nurse practitioners. Staff in the department had access to an infection prevention and control nurse who visited the department a few times per week. There is one WTE senior pharmacist allocated to the Home First service for older persons in the emergency department for reconciliation of drugs and general advice and safety management Mon – Fri. There is supportive cover when that person is on leave. A pharmacy technician reviewed the medication stock control daily (Mon - Fri). Staff reported access to an antimicrobial pharmacist who visited the emergency department on a weekly basis.

Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

Uptake of mandatory and essential staff training

It was evident from staff training records reviewed by inspectors that nursing and medical staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice. The emergency department had a system in place to monitor and report staff attendance at mandatory and essential training. This was overseen by the CNM3. HIQA found that the percentage of staff attendance and uptake at mandatory and essential training could be improved. Training records showed that the following percentages of nursing staff in the emergency department were up to date in their training for :

- 67% - standard based precautions and transmission-based precautions
- 47% - hand hygiene
- 80% - basic life support
- 58% - Irish National Early Warning System (INEWS)
- 37% - Irish Maternity Early Warning System (IMEWS)
- 79% - Irish Paediatric Early Warning System (IPEWS)
- 67% - Manchester Triage System (applies to those eligible to undertake this training).

Training on the emergency medicine early warning system[‡‡‡‡] was reported as being rolled out to staff at the time of HIQA's inspection.

Training records showed that the following percentages of medical staff had up-to-date training in:

- 79% - basic life support
- 60% - Irish National Early Warning System (INEWS)
- 71% - Irish Maternity Early Warning System (IMEWS).

Information was not available for compliance levels with training on the Irish Paediatric Early Warning System (IPEWS)

The national Emergency Early Warning System had not yet been implemented at the Mayo University Hospital.

Overall, the medical resourcing of the department and nursing staff levels were insufficient to meet the needs of the emergency department on the day of inspection. Immediate risks to patients posed by this deficit were being prevented by the use of agency or locum staff to maintain the medical and nursing rosters which is not sustainable. There was an overreliance on junior non-consultant hospital doctors in the service which had the potential to impact on the timely review, assessment and provision of care.

Risk assessments had been documented by the hospital in July 2022 in relation to staffing numbers (medical and nursing), skill-mix and level of experience of staff, as well as the lack of physical capacity in the emergency department and orthopaedic and surgical pathways. Furthermore, staff attendance at and uptake of mandatory and essential training is an area that needs to be improved. 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 should be a key focus for early improvements following this inspection.

Judgment: Non-compliant

‡‡‡‡ The Emergency Medicine Early Warning System is recommended for use in all emergency departments to support the recognition of, and appropriate response to, the deteriorating patient as required by the *National Standards for Safer Better Healthcare*.

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. The environment in which care is delivered should also promote and protect the patient's dignity and privacy, and protect the personal information of people who use the service.

At 11.00am on the first day of inspection, there were 35 patients in various stages of the care journey from registration to either discharge or admission. Eleven (31%) of the 35 attendees were over 75 years of age. Eight patients, almost a quarter (23%) of those present were admitted and remained within the emergency department while waiting access to an inpatient bed. This situation directly contributed to crowding of the department. This together with the increased volume of presentations to the department impacted on the timely triage and medical review of patients. The practice of placing admitted patients on corridors, especially near fire door exits created a potential patient safety risk, which inspectors raised with hospital management on the day of inspection and was subsequently addressed.

Staff working in the hospital's emergency department were committed and dedicated to promoting person-centred care. Staff were observed to be kind and caring towards patients in the department, and tried to respond to their individual needs, which was challenging in an overcrowded department.

Patients were accommodated in multi-occupancy cubicles, single rooms and on trolleys on the main corridor. It was clear that in single rooms, the confidentiality, dignity and respect of patients was promoted and protected. However, notwithstanding the efforts of staff, the privacy and dignity could not be protected in the same way for patients accommodated on trolleys on the main corridor and maintenance of confidentiality was a challenge. Inspectors observed clinical consultations, assessments and the exchange of information being undertaken on the corridor. People (patients, visitors and staff) using the corridor could overhear patient-clinician conversations and personal information being exchanged between patients, medical and nursing staff. This is not in line with the human rights-based approach to healthcare as promoted and supported by HIQA.

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

These findings were consistent with the findings from the 2021 National Inpatient Experience Survey,[*****] where 48% of patients who completed the survey considered their overall experience of the hospital as very good. This was lower than the national score of 54%. Also in that year, the hospital scored lower than the national average score in survey questions related to the emergency department. More specifically, with regard to:

- communication with doctors and nurses in the emergency department, the hospital scored 7.7 (national average - 8.0)
- privacy when being examined or treated in the emergency department, the hospital scored 7.4 (national average - 8.3)
- being treated with respect and dignity in the emergency department, the hospital scored 8.3 (national average - 8.8).

Hospital management had developed a quality improvement plan to address findings of the National Inpatient Experience Survey relevant to the emergency department. Actions included:

- introducing focused training on communication for staff
- ensuring the timely movement of admitted patients to the most appropriate areas for care and treatment
- providing comfort packs for patients in the emergency department.

There was evidence that the hospital were engaging with community services to implement measures to support and improve patient flow in the emergency department. These included a:

- Community Intervention Team[†††††] to identify those patients who would benefit from enhanced services or acute intervention for a defined short period of time, and which could be provided at home, in a residential setting or in the community, as deemed appropriate, thereby facilitating early discharge from hospital.
- Virtual Ward Initiative[‡‡‡‡‡] whereby eligible patients with chronic illnesses were discharged early from the hospital and their subsequent care was delivered in their own homes.

[*****] The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/

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

[‡‡‡‡‡] The objective of the Virtual Ward Initiative is to facilitate a sustainable shift from care in an acute setting to the community setting to support the implementation of new approaches to chronic condition management in line with Sláintecare.

- Home First Team – this multidisciplinary team is a specialist team supporting patients over the age of 75 years who were being treated in the hospital's emergency department and or the Acute Medical Assessment Unit. The team meets and assesses patients in the emergency department and the Acute Medical Assessment Unit to identify any needs that would delay them from being discharged from the hospital after treatment, in order to minimise any delays. The team comprises a physiotherapist, an occupational therapist, a medical social worker, a clinical pharmacist and a clinical nurse manager.

Overall, the environment posed a significant risk to the quality of healthcare provided and to the health and welfare of patients attending the emergency department. Notwithstanding the initiatives implemented, the practice of boarding admitted patients in the emergency department contributed to overcrowding of the department. In such settings, it was impossible to maintain, promote and protect patients' dignity, privacy and confidentiality, which impacted on the meaningful promotion of the patient's human rights especially those accommodated on trolleys on corridors. Inspectors did not find sufficient evidence that actions taken by management sufficiently addressed deficits of service users' dignity, privacy and autonomy on the day of inspection.

Judgment: Non-compliant

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

To protect people who use the service from the risk of harm associated with the design and delivery of healthcare, services must proactively monitor, analyse and respond to information relevant to the provision of care.

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality safe services in the emergency department.

The hospital collected data on a range of different quality and safety indicators related to the emergency department, in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times. Collated performance data and compliance with relevant national key performance indicators was reviewed at meetings of the hospital's executive management team and performance meetings with the Saolta University Health Care Group.

Performance data on the patient experience time collected on the day of HIQA's inspection showed the following:

- 8 (23%) attendees to the emergency department were in the department for more than six hours after registration. This was in line with the national target, which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 8 (23%) attendees to the emergency department were in the department for more than nine hours after registration. This was not in line with the national target, which requires that 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- All attendees to the emergency department were admitted to a hospital bed or discharged within 24 hours of registration.
- 11 (31%) attendees to the emergency department were aged 75 years and over. 82% of attendees aged 75 years and over were admitted to a hospital bed or discharged within nine hours of registration, which was not in line with the national target of 99%.
- All attendees to the emergency department aged 75 years and over were discharged or admitted to a hospital bed within 24 hours of registration, which is in line with the national target of 99%.

Findings on patient experience time were consistent with the findings from the 2021 National Inpatient Experience Survey, where the hospital scored below the national average for people waiting in the emergency department less than six hours and over 24 hours before being admitted to an inpatient ward. However, in relation to people waiting 6-12 hours and 12-24 hours, the hospital scored above the national average.

Inspectors were told that the number of admitted patients on trolleys in the emergency department awaiting an inpatient bed (eight on day 1 of the inspection and 10 on day 2 of the inspection) was not uncommon and that it had been higher than that on occasions. There were two areas marked out with tape on the floor and labelled 'ambulance trolleys'. Neither was occupied at the time of inspection, however, in the event of these being occupied, access to supplies and equipment and egress from the department was reported as being hampered.

The hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In 2021, 90% of the ambulances who attended the emergency department did not meet the turnaround time interval of less than 30 minutes. This further demonstrates how insufficient capacity and ineffective patient flow in the department affects the timely offload and review of patients in the emergency department.

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at department level with oversight of the process assigned to the clinical nurse manager grade three (CNM3).

Risks related to the emergency department were recorded on the hospital's corporate risk register. The hospital's executive management team had oversight of the risks recorded on this register. The effectiveness of actions and controls implemented to manage and mitigate risks were reviewed and updated at the relevant directorate meetings where risk management and quality and patient safety is an agenda item monthly. Risks not manageable at hospital level were escalated to the Saolta University Health Care Group.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. As previously stated, inspectors found that patients presenting to the emergency department were not promptly streamed for COVID-19 until at the point of triage which was an average of 30-60 minutes following registration. The issue was raised with both the Infection Prevention and Control team representatives and with the Hospital Manager on the first day of inspection. By the second day of the inspection, streaming was noted to be taking place at the point of registration which was in line with national guidance.

Symptomatic patients had access to COVID-19 rapid testing. A prioritisation system was used to allocate patients to the single cubicles and isolation room. Staff confirmed that terminal cleaning[§§§§§] of the triage room was carried out following suspected or confirmed cases of COVID-19. Minimum physical spacing of one metre in line with national guidance was not being maintained in the waiting area or in the main emergency department. Inspectors noted the limited storage space in the department with essential equipment and supplies stored on corridors, which further contributed to congestion of the department.

Medication safety

There was one clinical pharmacist allocated to the emergency department Home First initiative and their main focus was older persons over the age of 75. The emergency department also had a pharmacist come to the department when available or requested for all other patients. A pharmacy technician visited the department daily (Mon-Fri). Staff in the department had access to an antimicrobial pharmacist. They reported that they also had access to the antimicrobial microbiologist 24/7.

[§§§§§] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

Deteriorating patient

The hospital had implemented the national early warning system to support the recognition and response to a deteriorating patient in the emergency department. The paediatric early warning system was used for paediatric patients. The Identify, Situation, Background, Assessment, Recommendation (ISBAR)[******] communication tool was used as a communication tool for escalation of care. Hospital management were planning to introduce the emergency medicine early warning system when staff training on the system was completed.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers. This was supplemented with a nursing transfer letter if the patient was going to another residential unit and a GP discharge letter for any patients either being transferred to another site or discharged home.

Management of patient-safety incidents

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

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally, by nurse management with oversight from the CNM3 in accordance with the hospital's complaints policy. Staff were provided with training on how to manage a complaint. Complaints relating to the department were tracked and trended by the quality and risk manager and feedback on emerging trends and themes was provided to the nurse manager.

Complaints related to the emergency department were also tracked and trended locally by nurse management and the Emergency Department Clinical Operations Group. The hospital had developed a patient information booklet on emergency care that is given to attendees to the department. HIQA noted there was no audiovisual separation of children from adult emergency care as recommended in the national model of care for paediatric healthcare services. The absence of such separation was a concern for HIQA.

[******] Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.
[††††††] The National Incident Management System is the single designated system for reporting of all incidents in the public healthcare system.

Overall, based on the composite of evidence relating to key performance indicators and deficits in COVID-19 streaming on the day of inspection, inspectors found that management at MUH must sustain immediate and sustainable improvements to protect service users from harm.
Judgment: Non-compliant

Inspection findings relating to the wider hospital and clinical areas assessed

This section of the report describes findings and judgments against selected national standards (from the themes of leadership, governance and management (5.8), workforce (6.4), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3) as they pertained to the ward areas inspected.

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.
At the time of inspection, Mayo University Hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided. There were risk management structures in place to proactively identify and manage risk. Risks were tracked and trended in the hospital's risk register. The hospital identified, documented reviewed and monitored patient safety incidents in line with national guidance. There was a complaints process in place in line with national guidance. There were processes in place to share learning from patient safety incidents and complaints through line managers, daily safety huddles, consultant handovers and newsletters. **Infection prevention and control** Key performance indicators were reported monthly on blood stream infections, Clostridium Difficile, and Carbapenemase Enterobacterales‡‡‡‡‡‡ (CPE) screening. Hand hygiene audits

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

conducted and reviewed at local were also reported to and reviewed at Saolta hospital group level. Route cause analysis was conducted on non-compliances. Results were sent to ward managers and shared electronically and via the staff newsletter. Quality improvement plans were discussed and agreed with ward managers. The IPC team audited hand hygiene, transmission based infection, sharps injuries, and urinary catheter care bundles. At the time of inspection, the IPC team were auditing compliance with CPE screening of all new admissions within 24 hours of admission.

Medication safety

The hospital stated that although there was no national pharmacy key performance indicators, the hospital had developed its own KPI's which they were monitoring. These included anti-microbial KPI's and KPI's around medicine reconciliation. The hospital was responsive to an increase noted in the reporting of medication errors and was instituting a number of measures including education, redrafting of drug chart templates and exploration of expanding the prescribing range of registered nurse prescribers. Staff outlined a situation where a number of audit cycles and education were used to increase the practice of recording patient weights in an accessible or visible location on the patient record.

Deteriorating patient

Audits on the use of the INEWS V2, which has been in use since March 2022, were undertaken quarterly using the NOCA (National Office Clinical Audit) tool. These were reported to the Hospital Management Team and the Business Intelligence Unit. Reports were also shared with the Saolta Hospital Group. Non-compliances were communicated back to the relevant manager of the clinical ward area and where required, the resuscitation officer and clinical skills facilitator worked with the team to bring about improvement to return to compliance. Wards identified INEWS nurse champions on their staff who were involved in training. Changes to the Safety Huddle were also undertaken in response to audit findings. As part of the Safety Huddle, the early warning score (EWS) is now addressed for every patient including scores of zero.

Transitions of care

While the hospital was engaging in a number of activities to help avoid or reduce delayed discharges, the hospital had not conducted any specific audits in relation to transitions of care. This represents a missed opportunity for learning that could enhance and strengthen the quality of communication and minimise the risk of lapses in communication. An example of this was the delay, noted in both wards inspected, in completing discharge summaries for a person's primary healthcare team by the time they are leaving the hospital.

In summary, while HIQA was assured that information from monitoring was used to improve the quality and safety of services within the Mayo University Hospital there is scope to build on the work already undertaken. In particular, the hospital should consider use of an annual audit

plan to focus on key areas of risk including medication safety, the deteriorating patient and transitions of care in particular.

Judgment: Substantially Compliant

Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare.

Supporting the workforce involves supporting and promoting a culture that values, respects and actively listens to and responds to the views and feedback from all members of the workforce.

Staff who spoke with inspectors were complimentary about the hospital and the support they received from colleagues and management. Recently recruited medical and nursing staff to the hospital described their satisfaction with induction training and the learning environment in their clinical areas. A member of staff highlighted the online induction, but added that COVID-19 had affected the 'in person' element of induction. Furthermore, additional consideration should be given to allocated time given to integrate new staff into the work environment. For example, inspectors were told that although there was a morning breakfast welcome event planned for new NCHDs recently, that it coincided with the commencement of theatre lists and so NCHDs in surgery were unable to attend.

Inspectors were told by staff that the past two years had been very difficult for staff and that it was the support of colleagues that assisted them through that period. While the Employment Assistance Programme and occupational health services were available to staff, inspectors were told that long waits (several months) had been experienced in obtaining an appointment with Occupational Health. Inspectors were told that the legacy of those extended waiting times had since been reduced to a maximum of one month and that urgent referrals are seen within one week of referral. Inspectors were told that staff can self-refer to either service. EAP contact details were noted to be have been displayed at ward level.

Inspectors were told that debriefing is undertaken following incidents and serious events. An example was given of an informal debriefing by the CNM2 and resuscitation officer following a cardiac arrest. An example of a more formal debriefing was outlined and had been organised through the QPS department following a serious event.

Inspectors were informed and documentation was reviewed in relation to onboarding, induction programmes for new staff and the ongoing in-service educational programmes for all staff. Inspectors noted evidence of a suite of policies, procedures and guidelines being available to staff online. Although there was reference in the documentation to training via HSeLanD on

aspects such as IPC and medication safety, some staff said that they were not provided with specific training in each of the 4 key areas of known risk.

Inspectors were informed and viewed documentation relating to a 'Staff Engagement Forum'. established in 2017 which was re-activated at the end of 2021. The terms of reference for the Steering Group – Strategy for Staff Engagement and Staff Wellbeing indicated that since 2018, staff in the Saolta Hospital Group had been invited to participate in up to six staff surveys and that these had provided specific information on what staff required. Inspectors on 'D' ward were told that a member of staff from each ward was invited to attend the 'Mayo University Hospital Staff Engagement' to bring ideas about improvements that could be made to support staff. An example of the local staff appreciation awards was described.

In summary, notwithstanding the reported deficits in staffing as outlined under national standards 5.5 and 6.1, inspectors were largely assured through evidence gathered during this inspection and from discussion with staff members who met with HIQA inspectors, that the hospital supported their workforce in delivering high-quality, safe and reliable healthcare.

Judgment: 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 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.

A small number of trolleys and beds (some of which were occupied) were located in corridors on the wards visited by inspectors. This was in line with the rollout of the full capacity protocol arising from an overcrowded emergency department and no empty beds being available in the hospital. While such a practice is required as part of the full capacity protocol, it does not promote respect, dignity, privacy and autonomy for people using the service. Despite this, inspectors observed staff promoting a person-centred approach to care in the manner of communication with patients and attempts to provide some privacy with the use of screens

around the bed or trolley. Inspectors were informed that patients on trolleys were brought to the treatment room for physical examinations.

During the inspection, there were men and women allocated to beds in one bay on 'D' ward. Inspectors were told that staff seek to avoid a gender mix in wards and where it has to occur, staff seek to revert to single sex bays as soon as possible. Risk assessments were not routinely carried out in such instances. At the time of inspection, there was no gender mixing noted on 'A' ward.

Inspectors observed staff familiarising patients with their surroundings and attending to individual needs in a dignified and respectful manner. Single rooms were used for people who were receiving end-of-life care and inspectors were told that staff would bring a patient to a quiet place such as the palliative room which was a room for relatives of patients at end of life, to share bad news. Discrete symbols were used to denote particular needs of patients. An example of this was the 'Butterfly' symbol which was used where people have dementia.

When asked about visiting, inspectors were told about a 'partner in care' initiative being explored at hospital level, where patients can nominate a person to stay with them and be involved in their care. It was yet to be finalised before it could be launched. Protected mealtimes were noted to be in place for patients.

When staff were asked by inspectors about the 2021 NIES results, some staff were not aware of the results but they told inspectors that they encouraged patients to take part in the surveys. An example of a patient information booklet updated in response to the NIES results was shown to HIQA inspectors by staff.

In the National Inpatient Experience Survey (NIES) in 2021, people who had used the service were asked, if overall they felt they were treated with dignity and respect while in the hospital. The hospital had scored 8.7 (national average 9.0). When asked if they were given enough privacy while in the hospital, Mayo University Hospital scored 8 (national average 8.7).

In summary, on the day of inspection, while inspectors were assured that the staff of the hospital promote and respect the dignity and privacy of the people who use the service, there is scope for improvement in ensuring privacy and dignity for people who use the services at all times.

Judgment: Substantially compliant

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

Inspectors observed a range of staff interactions with people using the service and their visitors. These were noted to be kind, considerate and respectful. For example, inspectors observed and heard people entering the hospital via the main entrance being reminded to wear face masks (as per national guidance at the time of inspection) in a respectful manner by security staff.

Care and attention was taken to ensure privacy at ward level for people being cared for in beds on corridors and throughout the wards. Despite best efforts by staff, privacy was more challenging when patients were being cared for in beds and trolleys placed on the corridors due to the lack of available bed space.

Initiatives being undertaken by the hospital relating to the experience of people using the service (surveys and quality improvement plans) indicated a hospital wide approach of kindness, consideration and respect. For example, the development of a hospital information booklet for people using the service in 2020 following the results of the previous National Inpatient Survey results in 2019 on the need for improved communication.

The hospital had an established Patient and Family Experience Advisory Council. According to the most recent monthly report of the council dated July 2022 and submitted to the Hospital Management Team, the process of recruiting new members was beginning and agenda items for the council included quality improvements plans around the emergency department, family presence, 'get up, get dressed, get moving greenway' and a patient information booklet.

In summary, inspectors were assured that service providers promote a culture of kindness, consideration and respect. This was observed by inspectors and reported by people who use the service.

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 systems in place to respond to complaints and concerns in line with national guidance and the hospital manager described how they have end-to-end oversight of the receipt and management of complaints. Inspectors were told and they viewed documentation in respect of the following: complaints are acknowledged within the required timelines and escalated as appropriate, approximately 60% of complaints came via the HSE 'Your Service Your Say' route

and 40% came to the hospital directly from people who use the service. A significant proportion of complaints arose in relation to the emergency department. This is similar to findings in other hospitals. Tracking and trending showed long timelines in relation to the close out on some complaints. Breaches in the 125 day complaint management timeline had occurred in six of the seven months of 2022 to date.

Inspectors were told that staffing deficits in the quality and patient safety department were impacting upon the hospital's ability to meet all timelines in the process following initial acknowledgment. At the time of inspection, the staffing of the QPS department was being reconfigured to provide senior oversight with a grade 8 manager, a patient advocacy and liaison service and other defined responsibilities being allocated across a number of additional staff. The hospital confirmed that it expected to have the new QPS structure and staff in place by September 2022.

Inspectors were told at ward level that verbal complaints were resolved at local level when possible or referred to quality and patient safety (QPS) where a local solution was not possible. Verbal complaints were recorded, tracked and trended on the hospital's electronic system which was good practice however, inspectors were told that not all verbal complaints are recorded. The hospital clarified that in relation to the complaints, all verbal complaints received either at hospital management level or QPS department are recorded as a verbal complaint. Verbal complaints that are addressed at ward level and not escalated are not recorded. The hospital stated that they would not be aware of many of those (issues that could happen at ward level and are resolved).

Feedback on complaints by directorate is provided to the relevant directorate and where relevant, across directorates and to the hospital management team. Complaints are also reported into the Saolta Hospital Group. Feedback is provided to ward areas in relation to complaints and compliments arising from individual ward areas. Ward managers are included in complaints resolution where appropriate. A ward manager outlined an example to inspectors where they had attended family meetings following a complaint. Quality improvement plans are assigned to specified personnel as appropriate. An example of this was when specific training in communication had been provided within the Women and Childrens Directorate following learning from an incident. Another example of this was the development of a patient property policy in response to reports of loss of items such as dentures and hearing aids.

In summary, inspectors were assured, notwithstanding the current short-term staffing deficits in the quality and patient safety department which were expected to be corrected by September 2022, that the hospital had the required structures and processes in place to receive, manage and respond to complaints in an open and transparent manner. The hospital was found to be substantially compliant with this national standard, noting that there is work to be done to ensure that complaints are closed out in a timely manner.

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.

Inspectors visited two clinical areas. Security swipe access cards were required to enter the wards.

'A' ward was a 33-bedded ward which catered for the care needs of medical patients. The ward had four 6-bedded bays, one 4-bedded bay and five single rooms, all with adjoining shower and toilet facilities. In addition to that, inspectors observed two unoccupied trolleys which were placed within indented areas on the corridor.

'D' ward was a 28-bedded ward comprised of three 6-bedded bays, one 4-bedded bay, four single rooms and one isolation room all with adjoining toilet and shower facilities. This ward had two additional beds on the corridor which were occupied at the time of inspection. Inspectors noted that one of the extra beds had the potential to be a physical obstruction to the fire exit at the end of the ward. This was brought to the attention of the ward staff and escalated to the ADON for immediate review. Inspectors were informed that the patient was being moved to an approved bed space and that this space would not be reused pending a review by the fire officer.

There was a notable lack of storage facilities at ward level. While corridors were wide, equipment such as hoists and linen trolleys were stored there. A number of storage boxes were observed on the floor of the storage room. This does not facilitate cleaning underneath and so should be reviewed.

Overall, the wards were noted to be clean, with some exceptions which were brought to the attention of the ward manager (CNM). Inspectors were informed that wards had adequate cleaning resources and that cleaning was supervised by a cleaning supervisor. Although the cleaning schedules were signed daily by staff, inspectors noted that they were not co-signed by the supervisor.

'A' ward used a green tagging system to identify cleaned equipment. 'D' ward staff were aware of the system, but inspectors found no evidence of it in use. Equipment seen by inspectors appeared clean on visual inspection. Inspectors noted the storage of patient's property (a wheelchair) and clothes in the linen room on 'D' ward. Mixing of such items with clean hospital supplies poses an infection control risk and should be reviewed.

In summary, inspectors found that on the basis of this inspection, while the service met some of the requirements of the standard, it was partially compliant with it overall. The hospital should

ensure that it carefully risk assesses and manages the placement of additional trolleys and beds for patients on ward areas. There should be systems in place throughout to clearly identify and store equipment that has been cleaned and decontaminated for next use. Storage at ward level should be organised in a manner that facilitates effective cleaning including that of floor space and minimises risk of cross contamination. There should be systems in place to quality assure the levels of cleaning of ward areas.

Judgment: Partially compliant

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

Inspectors found that 'Test your care' nursing quality metrics (NQM) were completed monthly by the clinical nurse manager (CNM). Eight records were reviewed per month. Aspects monitored included patient monitoring and early warning systems, medication safety, infection prevention and control, hand hygiene, use of care bundles, compliance with CPE surveillance and cleaning audits.

Inspectors observed the monthly results on display on ward noticeboards from January to date at the time of inspection. Most results across both wards were between 90% - 100%. 'D' ward reported an 81% compliance level with CPE surveillance (monitored weekly) and an 83% compliance level with recommended patient monitoring standards. Inspectors were told that once the results are displayed, they are discussed at the safety huddles, actions are planned to respond to non-compliances and further monitoring is undertaken.

Audits in relation to aspects of care related to the deteriorating patient were coordinated by members of the Deteriorating Patient Management Committee, although there had been no audit of identification of sepsis or its management to date. Inspectors did not see evidence of specific monitoring carried out in relation to transitions of care.

In summary, while inspectors were broadly assured that the hospital was substantially compliant with this national standard, there is scope to improve on this by monitoring compliance with clinical handover including the use of the ISBAR technique during transitions of care to identify any gaps and strengthen the quality of care afforded to people using the service.

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.

Risks identified at ward level were escalated to the CNM in charge of the ward who escalated them to the CNM3, ADON or Central Nursing Office (CNO) out of hours. Risks were also raised at ward-based safety huddles and at the patient flow meetings as relevant.

Inspectors viewed risk assessments at ward level relating to HIQA's four key areas of focus and noted the following:

A risk assessment in relation to the lack of isolation rooms was undertaken and the issue was listed on the hospital's risk register. Inspectors were told that risks associated with patients being cared for while located in the corridor on Ward D had been escalated as an incident on the hospital's quality and risk management system. This was listed on the hospital's risk register as being an issue in wards in general within the hospital.

Inspectors noted that the exit at the end of the ward which was also the fire exit, was blocked at the time of inspection with a patient bed, bed table and bed screen. This was brought to the attention of the staff and escalated to the ADON for immediate review. The inspector advised CNM and ADON that a risk assessment should be completed. Inspectors were informed that the patient was being allocated a ward bed and this space would be decommissioned pending a review to include the input of the Fire Officer.

Infection prevention and control (IPC)

Antimicrobial soap was available in addition to plain soap at a number of hand hygiene sinks throughout wards. This was highlighted in a previous inspection at the hospital in 2020 with advice to review.

Patients with vancomycin resistant enterococcus (VRE) and methicillin resistant staphylococcus aureus (MRSA) were located within multi-occupancy bays on both wards due to the lack of isolation facilities. Inspectors were informed that isolation prioritisation was discussed daily with the IPC nurse.

Beds were found to be a metre apart with two exceptions on 'A' ward. The minimum one metre separation was not met in two of the 6-bedded bays. There was a patient with a multidrug-resistant organism (MDRO) being cared for in one of those bays. This was brought to the attention of the CNM.

Inspectors were told of recent COVID-19 outbreaks on both 'A' and 'D' wards. Staff described the management of the outbreaks. These were in line with required standards (outbreak team, daily meetings, isolation, contacts cohorted, surveillance, PPE, including FFP2§§§§§§ masks.

Staff reported good access to the IPC nurse and to an antimicrobial pharmacist for advice and support at ward level. The restricted antimicrobial list was available and seen on both wards. The antimicrobial surveillance (AMS) team undertook patient reviews with the microbiologist.

The hospital had a system in place to identify patients with communicable infectious diseases (CID). There was a trigger on the integrated patient management system (IPMS) for MDROs for patients who had previously attended the hospital. Signage was observed on patient charts highlighting the risk and indicating the type of infection. This was evident in all three charts reviewed at random. Records of communicable infectious diseases in patients noted on the white board which was securely located within the ward staff offices, was observed by inspectors.

Carbapenemase producing enterobacterales (CPE) surveillance was reported to be carried out for all patients within 24 hours of admission and was supported and monitored by IPC nurses. Inspectors noted evidence that compliance with this practice was being audited weekly and that 'A' ward had a 90% compliance rate. The MDRO surveillance was in line with national guidance and COVID-19 swabs were being undertaken on patients prior to discharge to long-term residential care.

Hand hygiene audits results were displayed on the noticeboard in the ward corridor. Compliance rates were above 90%. Inspectors were told that attendance at training in IPC is monitored by the CNM and the training records were viewed on the wards. Attendance at hand hygiene training was noted to be 70% in August and inspectors were told that there was a drive to get staff retrained. At the time of inspection, this had increased to 88%.

Medication safety

There was no clinical pharmacist assigned to 'D' ward. Inspectors were told that a pharmacist undertakes medication reconciliation when requested based on a prioritisation list as seen by inspectors. Examples of medication reconciliation which was undertaken for two patients as per this prioritisation exercise was seen by inspectors.

Medication safety boards were noted to be in place on the wards. They contained information for staff such as:

- safety alerts (weight-based doses)
- 'sounds alike, looks alike drugs' (SALAD) list

§§§§§§ FFP2 mask =Filtering Face Piece. These masks filter out harmful microparticles and are used where there is a high risk of infection.

- medication incidents reporting pathway
- Mayo University Hospital medication safety update (April 2022)
- list of restricted antimicrobials
- Direct Oral Anticoagulants (DOAC) counselling availability
- High-risk medication list (this list had no date or details of organisation).

Staff were aware of high-risk reduction strategies in place for high-risk medications. Inspectors observed this awareness in practice where high-risk label drugs and insulin were stored appropriately in line with hospital policy. Inspectors also noted the storage of a group of two high-risk drugs in close proximity to each other, one of which was rarely used. This was brought to the attention of the CNM to escalate to pharmacy and to eliminate the risk. This represents an opportunity for the hospital to implement high-leverage strategies, such as the rationalisation of stock on wards to prevent mis-selection of high-risk medications.

Medication fridge temperatures were noted to be monitored electronically on both wards with inbuilt alarm systems in case of deviation. Medication safety training was mandatory and attendance levels were being monitored by the CNM. The training records at ward level were viewed by inspectors.

Deteriorating patient

The Irish National Early Warning System (INEWS) was found to be in place to anticipate, recognise, escalate and respond to the clinically deteriorating patient. Staff informed inspectors that ISBAR (**I**dentify, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) was being used for escalation of raised early warning scores. Inspectors did not see evidence of this being documented in the sample of ward charts examined.

The resuscitation officer was the lead for the hospital-wide coordination of the INEWS. Inspectors were informed that there was criteria in place to escalate abnormal blood results to wards. Ward staff were able to access the laboratory results on the computer. Inspectors noted that compliance with patient monitoring using the early warning systems (EWS) is audited as part of the nursing quality metrics (see national standard 2.8). Attendance at training in EWS and sepsis is mandatory and is monitored by the CNMs. The training records at ward level for these were reviewed by inspectors and showed that 100% of staff on 'A' ward had attended training in both EWS and in sepsis while these were attended by 96% and 65% respectively on 'D' ward. Inspectors were told that there was no records of specific training relating to clinical handover.

Transitions of care

Inspectors noted the use of names of nurses being displayed at each bay to support communication around transitions of care. Patient flow meetings and daily whiteboard reviews were used to support progression towards predicted and planned date of discharge and transfer. The discharge co-ordinator and CNM reviewed the patient flow board daily to identify and progress any issue to support discharge or transfer and the discharge coordinator is involved in complex cases of discharge or transfer.

A transfer form was completed by nurses for patients transferring to nursing homes. This was supplemented with a verbal handover. Public health nurse referrals were completed as appropriate. Inspectors were informed that the hospital would order equipment such as commodes to facilitate and enhance discharge home.

Inspectors noted that patient charts were being held awaiting the completion of discharge letters by doctors. Twenty five letters were due on 'D' ward and 15 on 'A' ward. Inspectors were told that these volumes were being tracked daily and provided to the hospital manager each week. Such delays in providing the primary healthcare team including the GP with timely and accurate information has the potential to pose risks for patient safety. The hospital should address this need as a priority for all patients. Inspectors were told that ISBAR was not used during all transitions of care from ward level. This, together with a need to provide training on standards of clinical handover in line with national guidance, should be addressed by the hospital.

Inspectors followed up on issues referred to in minutes of hospital meetings relating to the placement of adult patients in a paediatric setting. Inspectors were provided with assurance that each case is based on an individual assessment of the person and their needs. Furthermore, this situation pertains to people who have had chronic conditions and or disability from childhood and possible multiple and extended hospitalisations receiving care from a specific team.

In summary, inspectors found that on the basis of this inspection, while the service met some of the requirements of the standard, the hospital should ensure that it addresses the placement of patients in suitable locations with adequate separation and which minimise the risk of cross-infection. Where patients are re-located to unofficial bed spaces, such locations should be carefully risk assessed. The hospital should also ensure adherence to medication safety strategies, audit compliance with national guidance on clinical handover, improve communication in relation to transitions of care and ensure provision of timely and up-to-date discharge summaries for the GP or primary healthcare team for all patients on discharge home or transfer onto other hospitals or residential care.

Judgment: Partially compliant

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

Inspectors were told that incidents at ward level were reported to the QPS team using the hospital's electronic management system and escalated them to the CNM3 and ADON. The QPS staff sought additional information if required, to prepare reports for the directorate meetings. Incidents were reviewed at the directorate meetings which are attended by quality and patient safety staff. The directorate reported on incidents to the Hospital Management Team. The hospital reported incidents to the National Incident Management System (NIMS) by QPS staff. Serious incidents were referred for review at hospital group level by the Serious Incident Management team (SIMT).

Inspectors viewed examples of anonymised incident reports submitted. Inspectors also viewed the breakdown of incidents reported from each of the three inspected areas during the period 1 January to 31 July 2022. Inspectors were told by staff that feedback on incidents was provided to the ward manager and discussed at safety huddles, CNM meetings and when relevant at the daily patient flow meetings. Inspectors found that CNMs had access to check the electronic system to review incidents reported. Newsletters and medication safety alerts were circulated regarding incidents. These were viewed by inspectors. Staff outlined an example of the value of sharing the learning in an effort to reduce the risk of recurrence of a particular incident.

In summary, HIQA was satisfied that patient safety incidents and serious reportable events related to the wards were reported to the National Incident Management System,******* in line with the HSE's incident management framework and that the structures and processes are in place to ensure that the hospital can effectively identify, manage, respond to and report on patient safety incidents.

Judgment: Compliant

Conclusion

This inspection was carried out at Mayo University Hospital on 16 and 17 August 2022 against the *National Standards for Safer Better Healthcare* (HIQA 2012) under the revised monitoring programme using a core set of standards. It involved:

- An overall assessment of compliance of the effectiveness of governance (national standards 5.2 and 5.5)

******* The National Incident Management System is the single designated system for reporting of all incidents in the public healthcare system.

- Compliance with three national standards (national standard 6.1 from the dimension of Capacity and Capability and national standards 1.6 and 3.1 from the dimension of Quality and Safety) as assessed in the emergency department.

- Compliance with national standards from the dimension of Capacity and Capability (5.8 and 6.4) and seven national standards from the dimension of Quality and Safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) as assessed on 'A' ward (Medical) and on 'D' ward (Surgical or Medical).

Capacity and Capability

Overall, inspectors found that Mayo University Hospital was compliant or substantially compliant in two national standards (5.8 and 6.4) and partially compliant or non-compliant in three national standards, (5.2, 5.5 and in the emergency department, 6.1), in terms of its capacity and capability.

Inspectors found that Mayo University Hospital was substantially compliant with national standard 5.8, as the service had monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided. There was scope to build on existing work, related in particular to medication safety, the deteriorating patient and transitions of care.

Inspectors found that Mayo University Hospital was compliant with national standard 6.4 in relation to its support of staff. Staff who spoke with inspectors commented favourably both on the induction and onboarding processes., by those who were recently recruited and by others in terms of the support they received from colleagues and management with particular reference to the last two years of the COVID-19 pandemic. Staff reported on feedback and debriefing processes in place. Inspectors saw and heard evidence of regular staff surveys and the staff engagement forum.

Inspectors found that Mayo University Hospital was partially compliant with national standard 5.5 in the overall assessment of the emergency department and two wards. While inspectors were satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of emergency care, a number of issues gave rise to concern and necessitated the issuing of a high- risk letter following the inspection. These included the streaming of patients for the risk of COVID-19 at the point of triage rather than 'promptly on arrival at the hospital' as per national guidance. While staff reported that patients who declare their infection status at the point of reception were streamed, there was no active assessment of this by staff until they were seen in triage. During the inspection, one patient was noted to have waited three hours and thirty five minutes between the time of first registering with reception and actual triage. The hospital reported an

average wait time of one hour and twenty three minutes for this interval for patients during the first day of the inspection.

The hospital was in full escalation on the day of the inspection. At 11.00am on the first day of inspection, there were 35 patients in various stages of the care journey from registration to either discharge or admission. Eleven (31%) of the 35 attendees were over 75 years of age. Eight (23%) people were admitted but remained within the emergency department waiting on a bed to become free on the wards. These admitted patients were accommodated on trolleys on a corridor within the emergency department where the minimum one metre physical spacing between trolleys (sides and end to end) was not maintained. This posed a risk to effective infection prevention and control.

Effective patient flow was also inhibited by delays in discharge and or transferring patients out of hospital. Inspectors noted that the average length of stay (AvLOS) for medical stay at Mayo University Hospital was 13.2 days (above the HSE national target of 7 days) and AvLOS for surgical stay was 8.6 days (above the HSE national target of 5.2 days).

In 2019, the hospital's emergency department had 39641 total attendances, 30,869 in 2020, and 32,817 in 2021. Compared to other hospitals in the Saolta Hospital Group, it ranked 4th highest after Galway, Letterkenny, and Sligo hospitals in the last two years. Compared to other Model 3 hospitals with at least 250 beds, it ranked 7th highest after all other hospitals in the category for total attendances over the last two years.

Hospital management cited a number of factors which they considered were contributing to the rise of presentations to the emergency department and the efficacy of patient flow. These included the distance to the nearest alternative minor injuries unit at Roscommon University Hospital which was 100 km away, patients self-referring reporting difficulties in accessing GP care, significantly reduced access and availability of beds across the three district hospitals within Mayo and Sligo particularly over the last 2 years. Furthermore, there was a substantial increase in staff turnover at Mayo University Hospital in May-July 2022. Replacement of experienced staff in a timely manner was reported to have been very challenging in recent months for the hospital. Inspectors were told that a number of experienced nursing staff from the emergency department had also recently left to work abroad.

In relation to national standard 6.1, the hospital reported a 23% deficit in pharmacy staffing and although efforts to fill posts was ongoing, inspectors were told that difficulties in filling these posts is a national issue. Such deficits over a prolonged period of time have the potential to impact negatively upon the quality and ultimately the safety of a service. Challenges in relation to filling permanent medical and nursing posts were also identified.

Under national standard 5.2, inspectors were told about deficits associated with overcrowding, fewer staff, and junior staff requiring additional support in conjunction with reported reduced access to senior clinical decision making at weekends in particular. Inspectors noted a delay in

provision of discharge letters to GP's. The hospital should review practices to ensure that patients who are fit for discharge are discharged across the 7 day week and that discharge summaries are provided to their primary healthcare teams in a timely manner. The hospital should also work towards improving patient safety through the expedient use of available risk-reduction strategies, such as the use of a revised drug chart, the filling of approved vacancies and actively addressing the cause and impact of delayed discharges and transfers including clinical decision-making particularly over weekends.

Quality and Safety

Overall, inspectors found that Mayo University Hospital was substantially compliant or compliant in five national standards (1.6, 1.7, 1.8, 2.8 and 3.3) and partially compliant or non-compliant in 4 national standards (1.6 and 3.1 in the emergency department and 2.7 and 3.1 in ward areas).

In relation to national standards 1.6 and 1.7, and despite challenges posed by overcrowding in particular, inspectors noted that staff were committed to the promotion and protection of the dignity, privacy and autonomy of patients. Staff were observed to be kind, respectful and considerate of people using the services. People who were using the services reported this too. Some commented on how busy staff were. Some people who used the service voiced their concern with the level of overcrowding and the waiting times.

In relation to national standard 1.8, the hospital was found to have structures and processes in place to manage complaints. There was evidence that timelines were exceeded in recent months and inspectors noted that the QPS department was undergoing staff reconfiguration at the time of inspection and it was expected that the staffing would be in place by September 2022.

In relation to national standard 2.8, inspectors noted that there was scope to improve monitoring compliance with clinical handover including the use of the ISBAR technique during transitions of care to identify any gaps and strengthen the quality of care afforded to people using the service. In relation to national standard 3.3, HIQA was satisfied that patient safety incidents and serious reportable events related to the wards were reported to the National Incident Management System,[†††††††] in line with the HSE's incident management framework and that the structures and processes are in place to ensure that the hospital can effectively identify, manage, respond to and report on patient safety incidents.

The hospital was found to be partially or non-compliant in a number of standards (1.6 and 3.1 in the emergency department and 2.7 and 3.1 on the wards). Firstly, inspectors found that there was the non-adherence to national guidance requiring patients to be streamed into

[†††††††] The National Incident Management System is the single designated system for reporting of all incidents in the public healthcare system.

COVID-19 or non-COVID-19 streams promptly on arrival at the hospital which was addressed on the day of inspection. Patient experience times were lengthy and admitted patients remained on trolleys in the emergency department for hours waiting on an inpatient bed. Some patients in the emergency department voiced their concerns with waiting times, overcrowding and lack of dignity. Overcrowding in any area of the hospital including the emergency department is unsustainable and adds to the risks to quality and safety of patient care. The hospital should also ensure adherence to medication safety strategies, audit of compliance with national guidance on clinical handover, improved communication in relation to transitions of care and provision of timely and up-to-date discharge summaries for the GP and primary healthcare team for all patients on discharge home or transfer onto other hospitals or residential care.

Overall, on the day of inspection, HIQA acknowledges the hospital management's efforts to address the issues identified. However, more sustainable work is required to ensure the care delivered in the hospital, in particular the emergency department, complies with the *National Standards for Safer Better Healthcare*. Although the challenges faced in the emergency department reflect similar recent findings in other emergency departments, more effective measures are required to address overcrowding, staffing issues, patient flow issues. This warrants concerted proactive short, medium and long-term plans by the HSE to address these issues.

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 the national standards assessed during this inspection at the Mayo University Hospital 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 non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management sets out the actions taken or planned in order for the healthcare service to come into compliance with the national standards judged to be non-compliant. It is the responsibility of the healthcare service provider to ensure that it implements the actions in the compliance plan within the set time frames to fully comply with the national standards.

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

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

Capacity and Capability Dimension	
Overall Governance	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	**Partially compliant**
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	**Partially compliant**
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	**Non-compliant**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Non-compliant**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Non-compliant**

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
National Standard	**Judgment**

Theme 5: Leadership, Governance and Management	
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	**Substantially compliant**
Theme 6: Workforce	
Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare	**Compliant**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
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	
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	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Partially Compliant**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	**Compliant**

Compliance Plan- Service Provider's Response to the findings in each of the following national standards

National Standard	Judgment
National Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. **Relates to Emergency Department and Wards**	**Partially compliant**

Action 1 immediate mitigation. (Timeframe November 2022)

Streaming in the ED, the process was redefined to ensure that MUH is fully compliant by ensuring all patients are asked on registration if they had symptoms, and these patients were then highlighted to the triage nurse.

Measurement for Action 1

Daily audits we initially carried out and now there is random Audits done a weekly basis by asking patients. The IPC Nursing team carries this out.

Action 2. Immediate mitigation. (Timeframe November 2022)

All patient to be triaged with 30min of arrival, this is monitored on an hourly basis with an escalation process in place when there are high number of attendances.

Measurement Action 2

1. Audit is completed weekly on compliance and shared with the management team, and the QI team in ED, the target time is set at 30min.
2. Audit outcome will be put on display in the ED waiting room.
3. The Management team Hospital manager, Deputy Hospital Manager and Director of Nursing also have access to the HPVP and can have oversight to moment in time compliance.

Action 3 immediate mitigation. (Timeframe End of Quarter 4 2022)

Full compliance with the use of the IPMS electronic tracker will be ensured this will give full visibility of all patient at all time in the Emergency department showing potential

delays in all KPI i.e. triage time and Triage category time to be seen by Doctor and general PET times.

Measurement Action 3

Reports from HPVP will be run and shared for learning and trending with ED QI team. This will incorporate all KIP including time to Triage, Triage time categories, Left before seen.

Action 4 immediate mitigation (Timeframe End of Quarter 2 2023)

Progress with the National safer staffing for ED Nursing. This will facilitate secondary triage increasing compliance with primary triage and patient waiting time generally.

Measurement Action 4.

It will be evident in rosters and increased nurse staffing on each shift.

This will be monitored with HR report and attendance management reports.

Action 5 immediate mitigation (Timeframe quarter 1 2023)

Reduction in the number of inpatient waiting in the ED for ward beds, this will be done with the following actions.

1. Open 4 more beds in St Johns ward bringing this to total of 33 beds. (November 2023)
2. Get AMAU fully functioning
3. Reduce LOS for all patient > 48 hr
   - (bed utilisation survey carried out and this will give a framework for action)
   - Set up LOS MDT QI working group.
   - Share daily LOS picture with safety huddle, wards, specialties and Consultants.
4. Open discharge lounge Monday - Friday (Jan 2023)
5. Open acute medical ambulatory clinic to promote early discharge. (Jan 2023)

Measurement of Action 5.

Weekly /Monthly reporting on MUH

1. PET 6hrs and 9hrs.
2. LOS Medical and Surgical
3. National AMP KPI

Action 6 immediate mitigation (Timeframe quarter 2 2023)

Reduce the conversion rate in ED by promoting alternative pathways resulting in reducing overcrowding.

1. Recruit GP Liaison nurse
2. Have GP rep on unscheduled team (November)
3. Promote direct access for radiological pathways.
4. Agree chest pain pathway and back pain pathway

Measurement of Action 6.

Reduction in conversion rate by 2% by March 2023

Action 7 immediate mitigation (Timeframe quarter 1 2023)

Progress with recruitment of all approved positions through the hospital looking at the pharmacy department in particular and put Management plans in place for absence management.

Continue to work with Saolta Executive team to progress the 2+2 anaesthetic rota for consultants and NCHD in 2023.

Progress with permanent replacement of all consultant posts ensure the management of risk management plans in place for consultant not currently on the specialist register.

Measurement Action 7

1. Monthly HR reporting
2. Safe roster across all department
3. Increase compliance in Audits in medication reconciliation compliance general medication safety
4. Safe outcomes for patients.

Action 8 immediate mitigation (Timeframe quarter 1 2023)

To get external support to put Quality improvement plan in place for internal ED flow to maximise the use of the ambulatory ED.

Measurement for action 8.

Improved Patient Experience Time for non-admitted patients.

Action 9 Long term

Opening of new ED AMAU 2025, which will

1. create audio visual separation for paediatrics
2. Increase space for both admitted and non-admitted patients
3. Double the Resuscitation bay capacity.
4. It will free up AMAU for full use reducing LOS increase standards of care for AMP.

Timescale:

National Standard	Judgment
National Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare. **Relates to ED**	**Non-compliant**

Action 1 immediate mitigation (Timeframe End of Quarter 2 2023)

Progress with the National safer staffing for ED Nursing. This will facilitate secondary triage increasing compliance with primary triage and patient waiting time generally.

Measurement Action 1.

It will be evident in rosters and increased nurse staffing on each shift.

This will be monitored with HR report and attendance management reports.

Action 2 immediate mitigation (Timeframe End of Quarter 2 2023)

To have 100% compliance with all relevant mandatory training for ED staff; Nursing and Medical

Triage training for eligible staff. This will be promoted by Clinical skills facilitator

Measurement 2.

Monthly report on performance via Line management and to directorate.

Action 3. Immediate mitigation (Timeframe End of Quarter 2 2023)

Implement the ED EWS in MUH this will be managed via the management of deteriorating patient committee.

Measurement Action 3.

100% training for medical and nursing staff.

Audit plan to be in place for compliance with the policy as part of the hospital audit plan 2023.

Action 4 immediate mitigation (timeframe December 2022)

Continue to safely manager the transfer of paediatric patients to the Paediatric decision unit reducing the time of shared space for child and adult patients. Quality improvement team in place to manage this.

Measurement action 4.

- Audit of time to include arrival, registration, triage and transfer to PDU.
- Training compliance in Paediatric triage.

Timescale:

National Standard	Judgment
National Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. **Relates to ED**	**Non-compliant**

Action 1 immediate mitigation (timeframe quarter 1 2023)

Reduction in the number of inpatient waiting in the ED for ward beds, this will be done with the following actions.

1 Open 4 more beds in St Johns ward bringing this to total of 33 beds. (Novembers 2023)

2 Get AMAU fully functioning
3 Reduce LOS for all patient > 48 hr
   - (bed utilisation survey carried out and this will give a framework for action)
   - Set up LOS MDT QI working group.
   - Share daily LOS picture with safety huddle, wards, specialties and Consultants.
4 Open discharge lounge Monday - Friday (Jan 2023)
5 Open acute medical ambulatory clinic to promote early discharge. (Jan 2023)

Measurement of Action 1.

Weekly /Monthly reporting on MUH

1 PET 6hrs and 9hrs.
2 LOS Medical and Surgical
3 National AMP KPI

Action 2 immediate mitigation (timeframe quarter 1 2023)

To get external support to put Quality improvement plan in place for internal ED flow to maximise the use of the ambulatory ED.

Measurement for action 2.

Improved Patient Experience Time for non-admitted patients.

Action 3 immediate (timeframe quarter 1 2023)

Multidisciplinary quality improvement plan for internal and external communication with patient and their families the public and internally with all the teams. This is to be started in the ED then rolled out to the entire site.

Measurement action 3.

1. Reduction in patient complaints
2. Reduction in incidents related to poor communications.
3. Better experience for patient and staff.

Timescale:

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 - related to **EMERGENCY DEPARTMENT**	**Non-compliant**

Action 1. Immediate mitigation (Timeframe quarter 2 2023)

Implement the ED EWS in MUH this will be managed via the management of deteriorating patient committee.

Measurement Action 1.

100% training for medical and nursing staff.

Audit plan to be in place for compliance with the policy as part of the hospital audit plan 2023.

Action 2 immediate mitigation (timeframe December 2022)

Continue to safely manager the transfer of paediatric patients to the Paediatric decision unit reducing the time of shared space for child and adult patients. Quality improvement team in place to manage this.

Measurement action 2

- Audit of time to include arrival, registration, triage and transfer to PDU.

Training compliance in Paediatric triage.

Action 3 immediate mitigation

Progress the winter 2022/ 2023 initiatives including

1 Open 4 more beds in St Johns ward bringing this to total of 33 beds. (November 2023)
2 Get AMAU fully functioning
3 Reduce LOS for all patient > 48 hr
   - (bed utilisation survey carried out and this will give a framework for action)
   - Set up LOS MDT QI working group.
   - Share daily LOS picture with safety huddle, wards, specialties and Consultants.

4 Open discharge lounge Monday - Friday (Jan 2023)
5 Open acute medical ambulatory clinic to promote early discharge. (Jan 2023)

Measurement of Action 3

Weekly /Monthly reporting on MUH

1 PET 6hrs and 9hrs.
2 LOS Medical and Surgical
3 National AMP KPI

Action 4 Long term

Opening of new ED AMAU 2025, which will

1 create audio visual separation for paediatrics
2 Increase space for both admitted and non-admitted patients
3 Double the Resuscitation bay capacity.
4 It will free up AMAU for full use reducing LOS increase standards of care for AMP.

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

Action 1 immediate mitigation (timeframe end of 2022)

To have full hospital Audit plan in place covering all the KPI relating to compliance requirement on transition of care incorporating clinical handover of patient internally and external to the hospital. This will be managed via the clinical handover committee.

Measurement action 1.

1. Compliance rate by ward on training discharge management and planning target ¼ 2 2023.
2. Compliance with on the day discharge letters being issued to patient by consultant team and by ward.
3. Full implementation of electronic discharge letters for all specialties

4. Implement electronic discharge letter in ED and OPD

Action 2 immediate mitigation (timeframe quarter 1 2023)

Reduction in the hospital LOS for all specialties by 1 day.

1. Reduce LOS for all patient > 48 hr
   - (bed utilisation survey carried out and this will give a framework for action)
   - Set up LOS MDT QI working group.
   - Share daily LOS picture with safety huddle, wards, specialties and Consultants.
2. Open acute medical ambulatory clinic to promote early discharge. (Jan 2023)

Measurement of Action 2.

Weekly /Monthly reporting on MUH

1. ALOS Medical and Surgical
2. National AMP KPI
3. Keep delayed discharges <=7 for MUH

Action 3 immediate mitigation (timeframe quarter 2 2023)

Continue with recruitment of all approved positions through the hospital looking at the pharmacy department in particular and put Management plans in place for absence management.

Continue to work with Executive team Saolta to progress the 2+2 anaesthetics rota for consultants and NCHD in 2023.

Progress with permanent replacement of all consultant posts ensure the management of risk management plans in place for consultant not currently on the specialist register.

Measurement Action 3

1. Monthly HR reporting
2. Safe roster across all department
3. Increase compliance in Audits in medication reconciliation compliance general medication safety
4. Safer outcomes for patients.

Timescale:

National Standard	Judgment
National 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. **Relates to WARDS**	**Partially compliant**

Action 1 immediate mitigation (timeframe quarter 1 2023)

Roll out "Green is clean Project across all wards in the hospital"

Measurement for Action 1

Audit of compliance against the Green is clean Programme target 100%. March 2023.

Action 2 immediate mitigation (Timeframe November 2022)

Ensure there is strong supervision of cleaning compliance and audits.

Measurement action 2

Audit to include assurance that supervision has signed off on cleaning ensuring standards are met.

Action 3 immediate mitigation (Timeframe November 2022)

Share existing risk assessment with all staff on each ward where placement of trolleys have been done to ensure shared understanding.

Ensure ward managers update the existing risk assessments on the placement of extra trolleys on each ward.

Measurement action 3

Line management repost to be issued via Senior nursing on EWS training and sepsis management training, this will be escalated at monthly HMT report from the chair of the deterioration management committee.

Action 4 immediate mitigation (Timeframe December 2022)

SOP to be formulated for wards based storage December 2022; this is then to be incorporated into the hospital Hygiene audits.

Measurement action 4

Audit all wards and ask for supplementary compliance on the SOP by each ward manager

Action 5 long term action

Progress with national approval for a 75 bedded ward block with 50 new 25 replacement beds.

Measurement action 5.

Capital plan approval.

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

Action 1 immediate mitigation (Timeframe quarter 1 2023)

Ensure clinical handover committee establish clear KPI with implementation and Audit plan.

This is to be presented to HMT with monthly compliance updates. All specialties, and professions to have formalised SOP on clinical handover in place by quarter 1 2023.

Measurement action 1

1. Audit of compliance in all specialties all wards and to be formally locked into the hospital audit plan.
2. Compliance rate on training on national clinical handover policy. By profession and y department and ward.

Action 2 immediate mitigation (Timeframe end of 2022)

To have full hospital Audit plan in place covering all the KPI relating to compliance requirement on transition of care incorporating clinical handover of patient internally and external to the hospital. This will be managed via the clinical handover committee.

Measurement action 2

3. Compliance rate by ward on training discharge management and planning target ¼ 2 2023.
4. Compliance with on the day discharge letters being issued to patient by consultant team and by ward.
5. Full implementation of electronic discharge letters for all specialties
6. Implement electronic discharge letter in ED and OPD

Action 3 immediate mitigation. (timeframe end of 2022)

Review all wards and all ward spaces and ensure when patients are sat out the spacing is not compromised. Continue to ensure good management of IPC in all wards continuing to prevent crosses infection. Maintain the hospital high standard in compliance on IPC KPI re hospital acquired infections.

Measurement action 3

1. National KPI on IPC

Action 4 long term action

Progress with national approval for a 75 bedded ward block with 50 new 25 replacement beds.

Measurement Action 4

Capital plan approval.

Timescale: