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:	Westport Road Curragh Castlebar Co. Mayo
Type of inspection:	Unannounced
Date(s) of inspection:	21 and 22 June 2023
Healthcare Service ID:	OSV-0001056
Fieldwork ID:	NS_0044

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Mayo University Hospital is a HSE Model 3* public acute hospital. It is one of six acute hospitals managed by the Saolta University Healthcare Group†. It provides 24/7 undifferentiated care and services to adults and children from Mayo and parts of its border counties of Sligo, Galway and Roscommon. The nearest Minor Injury Unit is located at Roscommon University Hospital 85km away.

Mayo University Hospital comprises four directorates, Medical, Perioperative, Radiology and Laboratory as well as two Hospital Group-wide Managed Clinical Academic Networks (MCAN), Cancer Care and Women and Childrens'.

Services provided by the hospital include:

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

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	323 including 28 beds off-site in St John's Ward, Sacred Heart Hospital, Castlebar.

A Model 3 hospital is a hospital that admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine, and critical care.

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

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 two-day unannounced inspection was carried out at Mayo University Hospital to assess compliance with the National Standards for Safer Better Healthcare as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare. The inspection was a follow-up to HIQA's two-day announced inspection which took place in August 2022 and was used to assess compliance with national standards and the effectiveness of measures implemented to address previous non-compliances including overcrowding of the emergency department and the factors associated with that. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings and the hospital's compliance plan, unsolicited[§] information and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

After the inspection, inspectors reviewed a range of documentation submitted to HIQA as requested.

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 assessed during this inspection are presented in the following sections under the two dimensions of *Capacity and*

[‡] 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).
[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

Capability and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

Compliance classifications

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
21 June 2023 22 June 2023	09.00 – 17.30hrs 09.00 – 16.30hrs	Patricia Hughes	Lead
		Nora O'Mahony	Support
		Eileen O'Toole	Support

Information about this inspection

This unannounced inspection of Mayo University Hospital was conducted on 21 and 22 June 2023 as part of HIQA's statutory role to monitor the quality and safety of healthcare services and as a follow-up to HIQA's previous two-day announced inspection of the hospital in August 2022. HIQA's previous inspection found the hospital to be partially or non-compliant in seven of the 14 national standards it was measured against.

This inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare* and follow-up on progress to date with implementation of the hospital's 2022 compliance plan. The inspection focused in particular, on four key areas of known harm, these being:

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

** The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs are in use in public acute hospitals across Ireland.

†† Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

‡‡ Transitions of Care includes internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

The inspection team visited three clinical areas:

- emergency department
- orthopaedic ward (predominantly orthopaedic surgery - trauma and elective, it also had some general surgical and medical patients)
- St John's ward (a step-down medical ward governed and managed by the acute service - located at the Sacred Heart Hospital which was two kilometres away).

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

Representatives of the Hospital Management team (HMT):

- Hospital Manager
- Director of Nursing
- Associate Clinical Director – Medical Directorate
- Quality and Patient Safety Manager and Quality and Patient Safety Co-ordinator
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager

Representatives from each of the following hospital committees:

- Infection Prevention and Control
- Drugs and Therapeutics
- Deteriorating Patient Improvement Programme including Early Warning Systems and Sepsis
- Discharge Co-ordination and Bed Management.

Acknowledgements

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

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

On the day of inspection, inspectors visited the emergency department (ED) which provides undifferentiated[§§] care for adults and children presenting with acute or urgent illness and or injury 24/7, 365 days a year. The hospital was reported to be in

[§§] Undifferentiated care: care provided to patients presenting to the emergency department with defined but various symptoms that do not fit into a defined diagnostic pattern.

escalation*** The emergency department comprised a main emergency department area and a more recent addition of an ambulatory emergency department known as ED-B, located in a portocabin external but close to the main emergency department. This had previously been used for the streaming and assessment of patients with known or suspected COVID-19.

The hospital also had an eight-bedded acute medical assessment unit (AMAU), which was used for emergency department overflow as part of the escalation plan. At the time of inspection there were seven admitted patients boarding in the AMAU. Hospital management reported that the AMAU had partially functioned as an AMAU for a period of about six weeks earlier in the year as it was otherwise being used for boarding admitted patients in line with the hospital's escalation plan. At the time of inspection there was also six admitted patients boarding in the Day Services Unit (DSU) which had a capacity for nine trolleys. Three trolleys in the DSU were being reserved for patients undergoing endoscopy procedures. The hospital did not have a discharge lounge but a space close to the reception area had been identified for this function and inspectors were told that hospital management planned to open it by July 2023 and that recruitment of staff for the lounge was ongoing.

On entry to the main emergency department, inspectors noted wall mounted alcohol-based hand sanitiser dispensers and masks strategically located with signage advising patients to report to reception if any suspicion of respiratory infection or if feeling unwell. The waiting area in the emergency department comprised 33 chairs. At 09.50am on the day of inspection, 13 patients were noted to be in the waiting room including five who were in a queue to register. Screens were mounted on the walls in the ED waiting area however these were not yet in use and inspectors were told that it is intended that they will be used for display of patient information but there was no agreed implementation date.

Staff were observed wearing appropriate personal protective equipment, in line with current public health guidelines. On review of the registered patients in the ED at 11 am on both days (31 and 23 patients respectively), inspectors noted that 68% had self-referred and 32% had been referred by their GP. Thirty per cent of the total had arrived via ambulance.

There were two staff working at the registration desk.

The emergency department had a planned capacity for 14 service users comprising:

- 1 triage room

*** HSE escalation plan is based on a process of moving through a series of timely incremental steps – and defined actions by named personnel with appropriate status and authority to address overcrowding in compliance with national performance indicators and Escalation Directive. https://www.hse.ie/eng/staff/resources/hr-circulars/hrcirc0012016-app1.pdf

- 4 single cubicles for the treatment of patients, categorised as major cases
- 2 isolation rooms, one of which had en-suite facilities
- 1 resuscitation area comprising 2 bays (used for adults and or children as required)
- 1 room used for gynaecology assessment
- 1 cubicle for eye assessment
- 1 paediatric assessment bay – which was not audio-visually separate. The National Model of Care for Paediatric Healthcare in Ireland recommends [†††] audio-visual separation of children and adults in emergency departments.
- 1 treatment room area used for minor injuries
- 1 plaster room area
- In addition to the en-suite isolation facility, there were three toilets in the emergency department for patients' use including one with wheelchair access which was located close to the waiting area.

There was no neutral or negative pressure rooms[‡‡‡] in the department.

By 11am on the first day of inspection, the emergency department was busy, relative to its intended capacity and function. Thirty one patients had registered and were at various points in their episode of care and treatment in the emergency department. Three patients (9.6%) had been referred by their GP, 28 patients (90.4%) had self-referred. Fourteen (45%) patients had arrived by ambulance.

Inspectors observed staff actively engaging with patients in a respectful and kind manner. Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received in the emergency department on the day of inspection. The feedback was generally positive. Inspectors were told that staff were '*kind*', '*very nice*', and that there was '*always someone about if you need help*'. One described how they were *'not waiting very long in the waiting room before being called'*. All stated that they had been provided with or had access to food and drinks as needed. One patient who had been in the department overnight described having received a *'comfort pack containing toiletries and an eye shield'*. Patients said

[†††] A National Model of Care for Paediatric Healthcare Services in Ireland – Paediatric Emergency Medicine (HSE and RCPI) https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/paediatric-emergency-medicine.pdf

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

that staff had kept them *'up to date'* on their conditions. They reported that screens were drawn around them for privacy during consultations and or examinations.

When asked about possible areas for improvement, patients commented on the noise levels within the department and one patient described how they had been moved around the department on their trolley to three different locations so far during their episode of care. Although inspectors noted the presence of the HSE *'Your Service Your Say'*[§§§] leaflets and the *'Mayo University Hospital Information booklet'* on display in the emergency department, inspectors found that some patients were unaware of how to make a complaint should they need to. These areas represent opportunities for improvement by the hospital.

The hospital's overall findings from the 2022 National Inpatient Experience Survey[****] (NIES), to which there was a 42% response rate (from a total of 545 patients invited to participate), indicated that 81% of respondents reported that they had been given enough privacy while being examined and or treated in the emergency department, 68% reported that they were always treated with respect and dignity while in the emergency department and overall 87% reported that they were treated with respect and dignity during their care at the hospital.

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

Inspectors inspected the orthopaedic ward in the main hospital block and St John's ward, a step-down medical ward which was located on the campus of the Sacred Heart Hospital in Castlebar which was under the governance and management of Mayo University Hospital.

The orthopaedic ward was a 32-bedded ward consisting of one four-bedded, one five-bedded, three six-bedded and five single rooms. Each multi-occupancy room had its

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§§§ Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf. and HSE *'Your Service Your Say'* *https://www2.hse.ie/complaints-feedback/*

******** The National Care Experience Programme is a joint initiative from the Health Information and Quality Authority, 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 (NIES) is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the NIES 2022 at Mayo General Hospital are available at: https://yourexperience.ie/wp-content/uploads/2022/12/NIES-2022-hospital-results_Mayo-University-Hospital.pdf

own separate toilet and shower facility. Each single room had en-suite bathroom facilities, one of which was designated an isolation room with an anteroom.[††††] The ward was primarily an orthopaedic ward for elective and trauma orthopaedic surgery but also accommodated general medical and surgical patients. At the time of inspection, all 32 beds were occupied and there were two additional patients accommodated on trolleys along the corridor as part of the escalation plan at the hospital.

St John's ward was a 28-bedded ward consisting of four six-bedded and four single rooms. Each multi-occupancy room had its own separate toilet and shower facility. Each single room had en-suite bathroom facilities. The ward was a medical ward used for patients with lower levels of acuity, who required additional rehabilitation or care before being deemed fit for medical discharge. The ward had documented inclusion and exclusion admission criteria. At the time of inspection, all 28 beds were occupied and three of those patients were being discharged that day.

Inspectors observed effective communication and kind and respectful interactions between staff and patients in both ward areas. This was validated by patients who described staff in the clinical areas as *'very nice, looking after me well', 'staff lovely', 'very professional'*. Inspectors observed that care was being taken by staff to protect and promote the privacy and dignity of patients when providing care. This included the use of privacy screens for the patients on trolleys on the orthopaedic ward and the practice of moving those patients into the treatment room for examinations. Inspectors were told by one patient that it was *'not ideal to be on the corridor but I would rather it be me on the corridor than an older person'*. Patients in St John's ward spoke positively about the ward environment, *'fabulous, airy, clean, quiet, pleasant'*. However others described some delay in responses to meeting their needs but added, *'you wait for things…… but it will come'* .

Not all patients spoken with said that they knew how to make a complaint if they needed to but those that didn't said that they would start by asking a staff member or else asking a family member to do so on their behalf. The HSE *'Your Service Your Say'*, leaflets were noted on display in the orthopaedic wards but these were not available on St John's ward. The recently published Mayo University Hospital Patient Information booklet dated March 2023 was on display in St John's ward but not on the orthopaedic ward.

The hospital's overall findings from the 2022 National Inpatient Experience Survey (NIES), indicated that 75% of respondents reported having had a *'good*" or `*very*

[††††] Isolation anterooms provide a permanent fixture to prevent or minimise escape of contaminated air from airborne infection isolation rooms when the doors are opened and closed. They also serve as a dedication location for healthcare personnel to don and doff personal protective equipment.

good' overall experience in the hospital, which was below the national average of 82%.

Overall, inspectors found that there was consistency with what inspectors observed in the clinical areas inspected and what patients told inspectors about their experiences of receiving care in those areas at the time of inspection.

Capacity and Capability Dimension

Findings from national standards 5.2 and 5.5 from the theme of leadership, governance and management are presented as general governance arrangements for the hospital and findings from national standard 6.1 from the theme of workforce relate to staffing of the inspected areas and overall at the hospital.

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

Inspectors found that the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services.

Organisational charts submitted to HIQA detailed the direct reporting arrangements of the governance and oversight committees at Mayo University Hospital. These arrangements aligned with inspector's findings on inspection. The hospital was governed and managed by the Hospital General Manager who reported to the Chief Operations Officer (COO) who in turn reported to the CEO of the Saolta University Healthcare Group. The Associate Clinical Directors in each of the four directorates and the two managed clinical academic networks (MCAN) provided clinical oversight and leadership at Mayo University Hospital. They reported to the Hospital General Manager and to their respective corresponding Group Directors who in turn reported to the Saolta University Healthcare Group Clinical Director. The Director of Nursing reported to the Hospital General Manager and was responsible for the organisation and management of nursing services at the hospital. The Director of Midwifery reported to the Hospital General Manager and was responsible for the organisation and management of midwifery and children's services at the hospital. The Director of Nursing and the Director of Midwifery also had a reporting line to the Chief Director of Nursing and Midwifery at Saolta University Healthcare Group level.

The Hospital Management Committee (HMT)

The HMT was the main governance structure at the hospital. Chaired by the hospital general manager, the HMT comprised the associate clinical directors, deputy hospital

manager, director of nursing, director of midwifery, finance manager, medical manpower manager, human resource manager, academic officer, health and social care professional's representative and the quality and patient safety manager. The HMT met weekly with a different focus per week, for example, Facilities focus, Clinical focus, Directorate focus, Leadership and Workforce focus. Each area of focus therefore, was reviewed on a monthly basis. The membership of the HMT had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. Although the terms of reference for the HMT were dated 2017 with a proposed review date of 2021, they contained a statement that they had been updated in July 2022 but there was no date included for future review. Hospital management should ensure that terms of reference for committees are scheduled in advance for review at regular intervals. Minutes of HMT meetings, submitted to HIQA, showed that the meetings were well attended, followed a structured format, were action orientated and progress in implementing actions was being monitored from meeting to meeting. Risk and incident management was integrated within both the HMT and the directorate and MCAN meetings which were held monthly and chaired by their respective associate clinical directors.

The HMT met with representatives of the Saolta University Healthcare Group every six to eight weeks at the Group's Performance meetings, where the following items were on a standard agenda: national service plan updates, scheduled and unscheduled care, quality and patient safety, patient experience and engagement, COVID-19 recovery planning, workforce, financial management, governance and compliance, strategic priorities and key critical issues. Minutes of performance meetings, submitted to HIQA, showed that the meetings were well attended, followed a structured format, were action orientated and progress in implementing actions was being monitored from meeting to meeting.

Quality and Patient Safety (QPS)

This department had been restructured since HIQA's last inspection in August 2022. There had been recent appointments of a QPS manager (Grade VIII) and a QPS co-ordinator (Grade VII) who was also the designated complaints officer for the hospital. A Patients Advice and Liaison Services (PALS) coordinator and a Patient Engagement coordinator had also been recruited. The hospital did not have a separate QPS committee. Instead, quality and patient safety was integrated within both the HMT meetings and the monthly directorate and MCAN meetings, each of which were attended by the QPS manager who provided updates on the hospital's risk register, patient-safety incidents, complaints management, feedback on patient experiences, and progress on implementation of patient safety quality improvements.

Infection Prevention and Control (IPC) Committee

The hospital's multidisciplinary Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control at

the hospital. It met monthly and was co-chaired by the Hospital General Manager and two Consultant Microbiologists. The terms of reference for the IPC committee were in draft format dated June 2023. Membership of the committee included medical, nursing, quality and patient safety, pharmacy and laboratory staff as well as other members co-opted as required from radiology, public health, environmental monitoring, occupational health, support services, catering and administration. The committee comprised a number of sub-committees that reported into it, these included the Hygiene Services Committee, Antimicrobial Stewardship Committee, the Decontamination Committee, the Environmental Monitoring Committee and the Outbreak Prevention Committee. Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA, were comprehensive and structured. They indicated that meetings were well attended and they showed progress on actions. The Infection Prevention and Control Committee was operationally accountable to the HMT and reported to it monthly.

Drugs and Therapeutics Committee

The Drugs and Therapeutics Committee had overall responsibility for the governance and oversight of medication safety practices at the hospital as set out in the terms of reference dated November 2022 which had been updated since the last HIQA inspection. The committee was chaired by a consultant anaesthesiologist. The deputy chair was the chief pharmacist. It was scheduled to meet six to eight times per annum. At the time of inspection (June 2023), the committee had met three times year to date. Membership of the committee included medical staff at consultant level from the range of disciplines, nursing, midwifery and pharmacy staff. Representatives from General Practice and the Medication Safety and Antimicrobial Stewardship sub-committees were invited to attend as required. The committee was operationally accountable to the Hospital Management Team (HMT) and it reported to it every two months. The Drugs and Therapeutics committee comprised a number of sub-committees that reported into it, these included the Medication Safety Committee, the Antimicrobial Stewardship Committee and the Nurse Prescriber Medicines Review Team. Minutes of meetings of the Drugs and Therapeutics Committee submitted to HIQA, were comprehensive and structured. They indicated that meetings were well attended and they showed progress on actions.

The Medication Safety Committee had terms of reference dated September 2022. It was chaired by a consultant physician and was co-chaired by the quality and patient safety manager. Membership included a consultant paediatrician, chief pharmacist, pharmacist with interest in medication safety, nursing and midwifery managers from practice development, the various directorates and the managed clinical academic networks, clinical nurse specialist (CNS) in pain management and a non-consultant hospital doctor (NCHD) representative. The committee met six weekly and reported to the Drugs and Therapeutics committee bi-monthly in line with the terms of reference. Minutes of meetings of the Medication Safety Committee submitted to HIQA, were

comprehensive and structured. They indicated that meetings were well attended and they showed progress on actions.

The Deteriorating Patient Management Committee (DPMC)

This committee was responsible for the provision of a local governance structure to support the implementation and monitoring of compliance of the INEWS, IMEWS, PEWS & EMEWS[‡‡‡‡] and the National Clinical Guideline on Sepsis Management systems as set out in its terms of reference dated November 2022. This had been updated since the last HIQA inspection and now encompassed responsibility for oversight of audit of the early warning systems. The committee was chaired by a consultant anaesthesiologist and the membership comprised the hospital manager, director of nursing, director of midwifery, a range of consultant staff, consultant microbiologist, lead NCHD, a range of nursing and midwifery managers, the resuscitation training officer and the ADON sepsis lead for Saolta. The committee met every two months and reported to the HMT after each meeting in line with its terms of reference. The Resuscitation Committee was a subcommittee to the DPMC. Minutes of meetings of the DPMC submitted to HIQA, were comprehensive and structured. They indicated that meetings were well attended and they showed progress on actions. In relation to the anaesthesiologist staffing situation as outlined in the 2022 HIQA report, inspectors were told that the situation is being resolved in that approval for the required posts as set out by the College of Anaesthesiologists of Ireland in relation to training, had been received and recruitment was now underway.

Transitions of Care

Transitions of Care includes internal transfers, external transfers, patient discharge, shift and interdepartmental handover. Mayo University Hospital had a number of structures and processes in place to help mitigate the risk in this area. A Clinical Handover[§§§§] Quality Improvement Group Committee with draft terms of reference dated April 2023 had been established for the purpose of 'implementing clinical

[‡‡‡‡] The Irish National Early Warning System (INEWS) is a system used to detect early signs of deterioration in physiology in non–pregnant and non-postnatal patients aged 16 years or over. It incorporates measurement of vital signs, calculation of scores and escalation in the event of deviation from the norm. The Irish Maternity Early Warning System (IMEWS) is the system used in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation or outcome of the pregnancy and irrespective of the presenting condition of the person. The Paediatric Early Warning System (PEWS) is the system used for children up to the age of 16. The Emergency Medicine Early Warning System (EMEWS) is a national clinical guideline developed by the HSE's National Clinical Programme for Emergency Medicine launched in 2018 by the Minister for Health. It applies to all non-pregnant, non-postnatal patients aged 16 years or more attending an emergency department in Ireland.

[§§§§] Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11 Summary November 2015. https://www.gov.ie/en/collection/006e63-clinical-handover-in-acute-and-childrens-hospital-services/

handover as a requirement under National Guideline Communication (clinical handover) at Mayo University Hospital'. It met monthly and was chaired by a consultant and co-chaired by the Director of Midwifery. It comprised multidisciplinary membership and reported to the HMT. Its stated purpose was to implement clinical handover processes in all departments of the hospital. Minutes of meetings submitted to HIQA, were comprehensive and structured. They indicated that meetings were well attended and they showed some progress on actions. Inspectors were told that the hospital used the Identification, Situation, Background, Assessment and Recommendation (ISBAR)***** technique when transferring patients either internally or externally. Minutes of the committee meetings referred to ongoing discussions to have ISBAR integrated within an electronic record as in another Saolta University Healthcare hospital. Inspectors were told of and they observed the use of dashboards (whiteboards containing standard information on each patient, including a predicted date of discharge).

The hospital also had an Unscheduled Care Group whose terms of reference were approved in September 2022 but labelled draft. The group, chaired by the hospital manager were scheduled to meet monthly and report to the HMT. Membership included associate clinical directors, director of nursing and director of midwifery, bed manager, CNM3 ED, discharge coordinators, health and social care professional (HSCP) representation and other nursing and medical personnel. Minutes of these meetings, submitted to HIQA, showed that the meetings were well attended, followed a structured format, were action orientated and progress in implementing actions was being monitored from meeting to meeting however the frequency of meetings was not in line with the term of reference with meetings held in October 2022 and February 2023.

In summary, HIQA inspectors found that Mayo University Hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. Several improvements were noted since the last inspection namely: the progression of the anaesthesiologist staffing situation - although this had yet to be fully concluded, reconfiguration of the quality and safety department and recruitment of QPS and PALS staff.

Judgment: Substantially compliant

***** Identify, Situation, Background, Assessment and Recommendation ($ISBAR_3$) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

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

Findings relating to the emergency department

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. The emergency department was within the medical directorate and the associate clinical director was an emergency medicine consultant. There was evidence of clinical and nursing leadership in the emergency department. Operational governance and oversight of day-to-day workings of the department was the responsibility of the on-site consultant in emergency medicine supported by non-consultant hospital doctors 24/7. There was a consultant in emergency medicine on-duty in the emergency department during core hours and over an extended working day up until 8 pm Monday to Friday and on-call remotely from home during out-of-hours and at weekends. On-site medical oversight was provided by registrars and senior house officers assigned to work in the department outside of the hours when the consultant was present on-site. Inspectors were told that consultants would also come in during on-call hours as appropriate. Inspectors were told that the hospital is being considered for training recognition in emergency medicine and that a site inspection by a delegation from the RCSI and the Advisory Committee on Emergency Medicine Training (ACEMT) was scheduled for September 2023.

However, the department continued to operate at levels beyond its intended physical capacity, with ineffective patient flow impacting on Patient Experience Times. There was evidence of adaption of space taking place in the main emergency department with the aim of making more effective use of the space. This had resulted, at least in the short-term, in the loss of the previous 'end of life' room. Inspectors were told that instead, a patient in this situation would be cared for in a single cubicle. Ensuring that patients at the end of life and their families are provided with a suitable space should be given consideration in the medium-term plans.

Documentation supplied by the hospital showed that there were 15,904 attendances at the hospital's emergency department from January – May inclusive in 2023, which averages at about 3,180 attendances per month or 107 per day. This was down from 2022, when the overall attendance rate[†††††] at the hospital's emergency department was 41,726 which equated to an average 114 attendances every day. The 2023

[†††††] HSE Management Data Report 2022 https://www.hse.ie/eng/services/publications/performancereports/management-data-report-december-2022.pdf

activity levels to date of the inspection were similar to pre COVID-19 levels when there were 39,024 and 39,641 attendances in 2018 and 2019 respectively. Attendance levels in 2020 and 2021 had decreased during the COVID-19 pandemic to 31,518 and 36,652 respectively. The percentage of patients who left the emergency department before completion of their treatment at 5.6 % was within the national target of 6.5%[‡‡‡‡‡].

Inspectors noted that the hospital had aligned its practices to the most recent national COVID-19 guidance. On inspection, the hospital was reported to be 'in escalation' at the highest level. It was busy and overcrowded. The eight-bedded acute medical assessment unit (AMAU) was used to accommodate seven admitted patients. This then impacted upon the ability of GPs to refer to the AMAU and so patients were referred instead to the emergency department. Inspectors were told that the emergency department staff could refer patients to the AMAU if and when there was capacity there. There was also six admitted patients in the nine-bedded day services unit (DSU) leaving three trolleys for day case endoscopies which complemented the six-bedded bay for inpatients requiring endoscopies. A further 13 admitted patients were being cared for on trolleys dispersed across four wards.

On inspection, the emergency department was overcrowded due to the lack of patient flow of admitted patients to ward beds. On arrival to the emergency department, self-presenting attendees checked in at reception and waited to be called for triage. At 11.00am on the first day of inspection, there were 31 patients registered in the emergency department. All patients had been triaged and prioritised in line with the Manchester Triage System.[§§§§§] Depending upon the triage categorisation, the lower acuity patients were directed to the external ambulatory emergency department known as ED-B. It was operational from 08.00 hrs -23.00 hrs seven days a week. Inspectors were told that up to 40 patients per day were being seen in this area and that this had helped to improve the overall patient experience times in the emergency department. Those who were not mobile and or were more ill were cared for in the main department. Eleven of the 31 (35%) patients registered in the emergency department had been admitted and eight of the 31 (25.8%) were aged 75 years or more. The time from registration to triage for the 31 patients ranged from two minutes to 40 minutes with an average of nine minutes (HSE target is 15 minutes or less). The time from triage to initial medical assessment for the 31 patients ranged from 19 minutes to one hour and 41 minutes with an average of 59.6 minutes. The time from initial medical assessment to decision to admit for the 31 patients ranged

[‡‡‡‡‡] HSE Acute Division Metadata 2023 details the key performance indicators for acute hospitals in the HSE in 2023. https://www.hse.ie/eng/services/publications/kpis/final-acute-metadat-2023.pdf

[§§§§§] 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.

from five hours and 14 minutes to five hours and 58 minutes with an average of five hours and 28 minutes. This interval was longer than that measured during the 2022 inspection. Overall however, these average times, although at a point in time, represent an improvement on the same waiting intervals as noted during the 2022 inspection.

Patient experience times are discussed under NS 3.1–ED. Inspectors noted compliance with HSE targets on day one but not on day 2 of the inspection indicating the need for more effective patient flow if patient experience times are to meet and be consistently maintained within HSE targets.

The conversion rate (the percentage of patients who present to the emergency department and who are subsequently admitted to the hospital) was reported to be 33.2% from 01 January to 06 May 2023. This was a reduction on the figure for 2022 when it was 35.6%. Inspectors were told that the conversion rate for patients aged 75 years or over was 60%, which was reported by hospital staff to be the fourth highest in the country and that this reflected the age profile of the population. Inspectors were told that on the day of inspection, 61% of inpatients were aged 75 years or more. There were 16 delayed transfers of care throughout the hospital on day one of the inspection. Delayed transfers of care[******] at the hospital in 2022 averaged at 12 per month and `between January and April 2023, they averaged 10-11 per month. The average length of stay for medical inpatients was 7.4 days (HSE target 5.1 days or less). This was up by 5.4% from 2022 data. The average length of stay for surgical patients was 4.9% (HSE target 5.3 days or less) and this was down by 7.5 % from 2022.

There was a Hospital Ambulance Liaison officer based at the hospital on an ad-hoc basis. The percentage of ambulances that had a turn-around time of 30 minutes or less was 7.4% on the first day of inspection and was noted to running at 9.2% for the year 2023, to date of inspection. It was 7.4% in 2022. The HSE target for this 30-minute standard is 80%. This level of compliance with the standard of 30 minutes is among the lowest level of compliance seen on inspection. The hospital also supplied data to HIQA which demonstrated that the percentage of ambulances that had a turn-around time of 60 minutes or less averaged out at 48% in 2022 and 51.6% for January to April 2023 inclusive. Hospital management need to review how full compliance with this HSE target can be achieved and maintained.

The hospital had established an emergency department quality improvement group with terms of reference approved in June 2023. The purpose of the group was 'to improve the patient experience and improve communication'. It was chaired by an emergency medicine consultant and membership comprised hospital management, medical, nursing, midwifery, QPS, HSCP, radiology and patient representation and

[******] Delayed transfers of care (HSE Management Data 2022) https://www.hse.ie/eng/services/publications/performancereports/management-data-report-december-2022.pdf

was scheduled to meet fortnightly. Minutes of meetings were reviewed and indicated that meetings were well attended and documented and there was evidence of progress of actions from one meeting to the next.

Although the hospital had systems and processes in place, not all were functioning effectively to support continuous and effective patient flow through the emergency department. For example, on the day of inspection, staff had access to the integrated patient management system but they did not have access to the hospital's proposed electronic operating system which had the potential to show the status of all patients in the department — their prioritisation category levels and waiting times. Inspectors were told that it was not always easy to determine the location of patients in the department due to the layout and overcrowding in the department / and that the hospital was seeking to enable access by ED staff to an up-to-date electronic dashboard. In the meantime however, staff relied on hard copy documents to chart and monitor patient activity, acuity and placement within the department while technical issues with the new system were being resolved. There was no agreed date for resolution of this issue.

Inspectors were told that there was good access to radiology during the day. At night however, because the protocol requires consultant to consultant referral, this had the potential to take longer. Inspectors were told that the referral system was under review in line with recently published evidence-based guidance from the National Institute for Health and Care Excellence (NICE)[††††††]. Inspectors were told that access to cardiac investigations was more problematic in that there were long waiting lists and GPs who were unable to access such tests were referring such patients to the emergency department in which case they may be admitted to access such investigations. This then impacted upon bed capacity. These issues need to be addressed by hospital management to enable effective of patient flow. Hospital management need to ensure that there are effective systems is place to support and enhance patient flow and mitigate overcrowding in the ED. The hospital had an Unscheduled Care Group chaired by the hospital manager, scheduled to meet monthly and report to the HMT. Membership included associate clinical directors, director of nursing and director of midwifery, bed manager, CNM3 ED, discharge coordinators, health and social care professional (HSCP) representation and other nursing and medical personnel.

Inspectors heard how the hospital had held a Patient Flow Focus day on 26 April 2023, in response to persistently high trolley counts in the preceding weeks. Led by a senior nursing team and including the Saolta University Healthcare Group Unscheduled Care Lead and the business manager, they reported that apart from one

[††††††] National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the department of Health and Social Care in England that publishes guidance on best available evidence in various aspects of healthcare (new and existing medicines, clinical practice- specific conditions / diseases, health promotion, illness avoidance).

ward, there were non-compliances in various aspects of the discharge planning processes including the recording of predicated dates of discharges (PDD) in patient records and on the IPMS. There was a focus on methodologies in use to ensure that every day in hospital for a patient was a day of value to their overall health and wellbeing and that days were not being spent waiting for tests or treatments. These were identified as green or red[‡‡‡‡‡‡] days with a focus on green days. The findings of the work conducted on the day were documented and disseminated and actions were to be progressed via the Length of Stay Working Team Group.

The hospital had a 'Home First'[§§§§§§] team in place for the over 75-year old patients. This team worked in the emergency department and across the hospital and comprised one WTE pharmacist, 1.5 WTE physiotherapist, one WTE occupational therapist, one WTE medical social worker and one WTE Clinical Nurse Manager 2 (CNM2).

Emergency department staff had access to the hospital-wide infection prevention and control team comprising 2 WTE consultant microbiologists, 1 WTE antimicrobial pharmacist and 3 WTE infection prevention and control nurses.

There was no dedicated comprehensive pharmacy service in the emergency department or in the AMAU however there was a pharmacist based in the 'Home First team and a pharmacy technician visited the department to do a daily top-up of medications. Inspectors were told that medicine reconciliation is undertaken on all patients aged 75 years and over attending either the ED or AMAU Monday to Friday. Medicine reconciliation for this group during the out-of-hours periods and for some patients under the age of 75 years is undertaken by medical staff where possible.

While the hospital had security staff on duty who were based in the main entrance of the hospital adjacent to the emergency department, security staff were not specifically designated for the emergency department.

Findings relating to the wider hospital and other clinical areas

Since HIQA's last inspection in 2022, there was continued use of the 28-bedded off-site satellite acute medical ward, governed and managed by Mayo University hospital which was located at the Sacred Heart Hospital, two kilometres away from the main hospital campus. Although the hospital had responded to last year's HIQA inspection with a compliance plan to increase this to 33 beds, this had not yet happened. The

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

[§§§§§§] The Home First Team was established in MUH in 2019 to support patients aged 75 or over who presented to either the emergency department or the Acute Medical Assessment Unit. The team met and assessed patients in the ED or AMAU to identify any needs that may delay their discharge from hospital after treatment.

hospital had undertaken a bed utilisation study (as set out in the compliance plan) over two days on 27 and 28 October 2022 to assess the appropriateness of admitted patients and to identify factors that impede flow through the hospital. It found that of the 228 patients in 11 ward areas at that time, up to 76% needed to be in an acute hospital leaving up to 24% where an alternate level of care would have been appropriate. Over half of the 228 patients were aged 75 years or more. Only 59% of all patients had a documented predicted date of discharge. Only 67% of the patients excluding those who were being discharged were having a 'green' day. Recommendations included the need for an ED assistant director of nursing (ADON) for patient flow, comprehensive support from consultant staff regarding the use of the predicted date of discharges, better distribution of medical patients across wards, standardised use of whiteboards and implementation of the SAFER[*******] bundle. At the time of the HIQA inspection, an ADON for patient flow had recently been recruited and areas for attention were being progressed through the Length of Stay Working Team Group.

The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas and these are discussed in more detail below.

Infection, prevention and control (IPC)

The infection prevention and control team had developed an infection prevention and control plan that set out objectives to be achieved in relation to infection prevention and control in 2023 and this was overseen by the IPC committee and was in line with the nationally recommended IPC programme[†††††††].

At the time of inspection, the IPC team comprised the following:

- 3 WTE consultant microbiologists,
- Approval for 1 WTE assistant director of nursing (ADON) and recruitment was underway
- 3 WTE infection prevention and control nurses (1 WTE clinical nurse manager level 2- CNM2 and 2 WTE clinical nurse specialists (CNS))
- 1 WTE antimicrobial pharmacist

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

[†††††††] National Clinical Effectiveness Committee (NCEC) Infection Prevention and Control (IPC) National Clinical Guideline No. 30 Department of Health Ireland. May 2023. https://assets.gov.ie/256804/bcdb62b1-94ae-42b0-ac9f-4e9a37caa3e7.pdf

The IPC team, chaired by the consultant microbiologist, met weekly. The consultant microbiologist and the general manager co-chaired the IPC committee which met monthly and the antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship committee was chaired by the antimicrobial pharmacist and met two monthly.‡‡‡‡‡‡‡ Outbreak committees were convened as necessary in line with national guidelines when an outbreak was declared and outbreak reports were completed on closure. There was a COVID-19 outbreak in the hospital at the time of inspection and inspectors were satisfied that all necessary actions had been taken and controls were in place.

The IPC team were included in review of method statements and risk assessments for aspergillosis and other infectious agents prior to proposed refurbishment and building works and provided sign-off of permits prior to commencement of works as viewed by inspectors. The IPC team were directly involved in the provision of education of staff on IPC related matters.

Medication safety

HIQA was broadly satisfied that the hospital had arrangements in place to monitor medication safety notwithstanding the ongoing deficit in pharmacy staffing as outlined below.§§§§§§§ At the time of inspection, the workforce comprised the following:

- 19 WTE pharmacists, which included the chief pharmacist and an antimicrobial pharmacist. At the time of inspection, five WTE senior pharmacy posts including the Medication Safety Pharmacist post remained vacant. Shortfalls in Pharmacy staffing was noted to be an issue nationally.
- 15 WTE pharmacy technicians- all posts were filled.

While all wards had some cover from a pharmacy technician, they did not all have cover from a designated clinical pharmacist. Inspectors were told that all staff can access pharmacy information and support by telephone Monday – Friday where required. A pharmacist attended the directorate meetings to support medication safety. While the hospital did not have a comprehensive clinical pharmacy service in place, inspectors were told that two ward-based technicians had recently been approved by the hospital to undertake additional training to assist pharmacists in protocol-guided medicine reconciliation for a limited cohort of patients.

HIQA was satisfied that hospital management were actively working to recruit pharmacists and but like other hospitals inspected by HIQA, they were encountering major challenges in their efforts to recruit such staff. The shortfall in pharmacy staff

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

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

impacted on the hospitals ability to provide a comprehensive clinical pharmacy service, §§§§§§§§§ which included a clinical pharmacist-led medication reconciliation service for all clinical areas. Pharmacy staffing levels was a high-rated risk recorded on the hospital's corporate risk register, with appropriate corrective actions and controls applied to mitigate the potential risk to patent safety arising from the shortfall in pharmacy staffing.

Inspectors viewed the 2023 Strategic Plan for Medication Safety and noted an increased focus on audit activity relating to medication safety and a plan to provide the Galway University intravenous (IV) drug guide in all medication treatment rooms.

The annual audit plan for medication safety was overseen by the Medication Safety Committee and escalated for governance to the Drugs and Therapeutics Committee if necessary. An audit of compliance with application of the risk assessment for veno-thrombo-embolism (VTE) showed poor compliance with completion of documentation. This was addressed by providing specific education within the induction programme for NCHDs. The audit plan and schedule also included use and management of controlled drugs, insulin and direct oral anti-coagulants among others. Although inspectors viewed a list of short, medium and long-term objectives set out for 2023 with assigned actions and owners, there were no dates and no status update documented on it. Inspectors were told of the challenges associated with ensuring staff undertake medication safety training including uptake of the online HSeLanD module. Training is discussed further under NS 3.1. Inspectors were told that the medication safety policy was currently being reviewed. Inspectors were told of the system in place to effectively manage safety alerts and recalls issued by the Health Products Regulatory Authority (HPRA).

Deteriorating patient management committee (DPMC)

HIQA noted that the hospital had some arrangements in place to oversee and monitor the implementation of the deteriorating patient improvement programme however, note that there is room for closer alignment and integration of the work of the DPMC and the clinical handover committee in particular to ensure safe systems of work. Inspectors met with the consultant anaesthesiologist who was the chairperson of the deteriorating patient committee (DPMC), and the resuscitation officer and were told of a number of changes which had taken place since the last inspection. These included:

- approval received in May 2023 to appoint the required number of anaesthetists to satisfy the requirements for training set down by the College of Anaesthesiologists of Ireland. These were being filled by use of locum staff while recruitment processes were underway-inspectors were told that the hospital expected to have such posts filled by October 2023
- improved monitoring of uptake of key and essential training by the medical manpower department

- ward audits of compliance with early warning scores which indicated that improvements in documentation were required and were escalated to the relevant ADON.

Inspectors noted that that the INEWS2, IMEWS, PEWS and ISBAR$_3$ were in use in the hospital, and that a consultant had been recently designated as lead for INEWS. Although training was ongoing for the use of the Emergency Medicine Early Warning System in the ED, there was no agreed date for its implementation. Inspectors were told that this was related to current staffing levels within the department. The DPMC had oversight of the implementation of national INEWS and sepsis guidelines at the hospital. The hospital had a separate Clinical Handover Committee with two working groups working on arrangements for external and internal transfers respectively. Given that transitions of care may apply in the management of the deteriorating patient, hospital management should ensure that the outcomes of these various committees are integrated in the interests of patient safety.

Inspectors were told of the audit report received in May 2023 from the ADON, Group Sepsis/Deteriorating Patient Lead, for the Saolta University Health Care Group who audited compliance with medical and surgical sepsis at the hospital. It was noted that there needed to be improvements. Recommendations included education on early warning systems, sepsis identification, the 'Sepsis 6' actions and correct use of the associated documentation at induction and regular in-service training of staff. Monitoring of this training at hospital level was also required. It was recommended that a quality improvement plan be devised to address the deficits and inspectors viewed a 'preliminary action plan' subject to agreement at an upcoming DPMC meeting in July 2023 in relation to this.

Transitions of care

HIQA was satisfied that the hospital had arrangements in place to monitor issues that impact transitions of care incorporating internal transfers (clinical handover), shift and interdepartmental handover and external transfer of patients and patient discharge. Inspectors were told of a number of changes which had taken place since the last inspection to enhance patient flow. These included:

- development of a patient flow team led by an assistant director of nursing for patient flow together with two patient flow co-ordinators at CNM2 level, one of which was in post and one had yet to commence
- increased communication with the three district hospitals,
- the 'red to green' project,
- focus by the 'Length of Stay Working Team Group' on the standardised use of the whiteboard and predicted date of discharge at ward level and other issues arising from the 'Bed Utilisation Study' conducted as part of the hospital's compliance plan

- a weekly integrated hospital and community patient round including representation from the Saolta University Healthcare Group

Patient flow meetings were held twice a day and safety pauses were held at ward level at least twice a day. The discharge co-ordinators worked with patients who had complex discharge needs. They held an internal weekly delayed transfer or discharge meeting which was also attended by the director and assistant directors of nursing and the medical social worker. This was followed up by communication with the local district hospitals as required. The Mayo Egress Group (MEG), chaired by the patient flow-assistant director of nursing and with representation from the hospital and wider community, met twice a week to review cases of delayed transfer of care, long term care and complex care needs. An undated draft standard operating procedure outlined the processes to be followed in the case of delays and complex care needs. Hospital management need to ensure that draft documents are processed, dated and approved in a timely manner.

The hospital held a multi-disciplinary 'Length of Stay Working Team Group' chaired by the hospital manager. It was focussed on the outcomes of the Bed Utilisation study including 'decreasing the ED conversion rate group to 25%', 'efficiency of ward rounds' and 'meeting inpatient and day case elective demand'. The Hospital monitored its 'greater than 14-day stay' data and reported this monthly to the Saolta University Healthcare Group. Minutes of meetings dated 05 April and 30 May 2023 reviewed, were comprehensive and structured. They indicated that meetings were well attended and they showed progress on actions.

The safe transfer of patients to the satellite ward was supported by a formalised patient referral form template and a draft standard operating procedure dated 2020 setting out the criteria for patients for transfer prior to 8 pm daily. Discharge letters were provided to GPs and to Public Health Nursing and long-term residential care as appropriate however as previously found on inspection, there were still some delays in issuing a discharge letter for each patient at the point of discharge. This will be discussed further under NS 3.1 (wards).

In summary, HIQA was assured that the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm in the emergency department, wider hospital and clinical areas visited on the day of inspection. Inspectors viewed evidence of work in progress in some areas since the last inspection. Operationally however, the emergency department was not functioning effectively. Overall patient experience times, while improved since last inspection and ambulance turn-around times remained outside of HSE targets. While HIQA notes and commends the improvements made since its last inspection, further improvements are required to achieve a higher rating of compliance with this standard. This includes access to a functioning AMAU, access to the electronic dashboard system enabling triage and other status of ED patients at a glance,

improved access to cardiac investigations for primary care, and improved timeliness of out-of-hours referrals for diagnostics which all require further attention to support and enhance effective patient flow throughout. Given that management of the deteriorating patient can include transitions of care, hospital management should ensure that the work of the Clinical Handover Committee and that of the Deteriorating Patient Committee are aligned and integrated in the interests of patient safety. Hospital management should also ensure that working groups and committees are working in line with approved and 'in-date' terms of reference which are subject to review in line with documented review dates. In terms of quality, hospital management should review the facility available for patients at the end of life in the overall reconfiguration of its ED.

Judgment: Partially compliant

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

Emergency Department

Medical staffing levels in the emergency department at Mayo University Hospital were maintained to support the provision of 24/7 emergency care. A senior clinical decision-maker******** at consultant level was on-site in the hospital's emergency department each day, Monday to Friday and was on-call, off-site during out-of-hours and at weekends.

The department had approval for five WTE emergency medicine consultants. At the time of inspection, 4.66 WTE were filled on a permanent basis by five consultants. There was a sixth consultant employed as a long-term locum covering the 0.3WTE vacancy and provided cover for leave. All consultants in this department were on the Specialist Register of the Irish Medical Council.

The consultant on-duty and on-call was responsible for the day-to-day functioning of the department and was operationally accountable and reported to the hospital general manager. There was consultant on-site presence over the seven-day week, on an extended working day until 8 pm Monday to Friday and during the day time over the weekends. Consultants were supported by non-consultant hospital doctors at registrar and senior house officer (SHO) grades and were present on-site 24/7/365. The hospital was not an approved training site for non-consultant doctors on the basic training scheme or the higher specialist training scheme in emergency medicine however inspectors were told that the hospital was scheduled to meet to have a site inspection

******** 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.

in September 2023 by a delegation from the RCSI and the Advisory Committee on Emergency Medicine Training (ACEMT).

The hospital had approval for 23 WTE non-consultant hospital doctors (NCHDs), 11 WTE at registrar level and 12 WTE at senior house officer level who reported to their team consultant(s). At the time of inspection, all of the posts were filled apart from one of the 11 registrar posts (9 % vacancy rate). This was a significant improvement compared to the 2022 inspection when there was a 25% vacancy rate in NCHDs.

Inspectors were told about weekly training sessions that were being held for the NCHDs and the six-weekly simulation training that was being held for the multidisciplinary team and included inviting involvement from paramedics from the National Ambulance Service.

The emergency department had an approved complement of 49 WTE nursing staff, four WTE healthcare assistants and two WTE multitask attendants. All of the nursing positions were filled on day of inspection apart from the CNM3 post which had been advertised. The variance between the approved and actual nurse staff complement was 0.47 WTE (1.5%) over the approved complement. Inspectors were told that 4.6 WTE (9.38%) nurses were on approved leave at the time of inspection, two of whom were due to return the following week. The breakdown of approved and in-post staffing covering both the main emergency department and the ambulatory ED (ED-B) was as follows:

- 1 WTE Assistant Director of Nursing (ADON)
- 1 WTE Clinical Nurse Manager, Level 3 (CNM3), this post was vacant and recruitment was underway.
- 7 WTE CMN2
- 1 WTE Clinical Skills Facilitator (CSF)
- 8 WTE CNM1
- 2 WTE Advanced Nurse Practitioners (ANP)
- 29 WTE Staff Nurses, there were 29.47 WTE in post
- 4 WTE Healthcare Assistants (HCA)
- 2 WTE Multi-task Attendants (MTA)

On the day of inspection, the emergency department including the ambulatory emergency department (ED-B) was one CNM2 short (11%) of its planned roster of two CNM2s and seven nurses on duty during the day shift. This allowed for one CNM2 and one nurse to be typically allocated to ED-B for the day shift. During the inspection, one clinical nurse manager grade 2 had nursing responsibility for the

department inclusive of ED-B. The full rostered complement for night duty was one CNM2 and five nurses, two of which work in the ED-B until it closes and until all remaining patients have been transferred back to the main ED or to their admitting ward(s), before returning to the main emergency department.

Two healthcare assistants were rostered for duty per day, with one covering the ED-B. Both healthcare assistants were on duty at the time of inspection. Inspectors were told that they would get an extra healthcare assistant if required based on activity levels. There was also a multi-task attendant employed in the emergency department, Monday to Friday providing 7.5 hours a day for the cleaning of equipment.

In addition to the staffing of the emergency department, 1 WTE CNM2 and two nurses were present as rostered, to care for admitted patients in the main emergency department. Outside of core hours, this was covered by two nurses additional to the emergency department staff.

Inspectors were told that the hospital had undergone Phase 1 of the *Framework for Safe Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland*[††††††††] led by the HSE. Hospital management were awaiting results of this at the time of inspection. Once known, inspectors were told that negotiations at hospital group level would be required to achieve approval for any recommended posts and depending on that, recruitment would commence. Phase 2 of the exercise was planned for 2024 where a further review would be undertaken on the complexity and acuity of patients attending the emergency department and where the approved complement may be further adjusted.

Nurse staffing at ward level

Orthopaedic ward:

There was one WTE Assistant Director of Nursing (ADON) and one WTE CNM3 in the Perioperative Directorate who had oversight of this ward and other areas of the directorate. The orthopaedic ward was fully staffed at the time of inspection. Although it had approval for 29 WTE nursing staff, inspectors note that there were 31.2 WTE assigned to the ward (two of whom were on approved leave). The breakdown of the approved and in-post was as follows:

- CNM2: 1 WTE and in post
- CNM1: 1 WTE and in post
- Nurses: 27 WTE posts approved, 29.2 WTE in post (over by 2.2 WTE)

[††††††††] 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

- Healthcare Assistants: 6 WTE and all in post.

There were four WTE consultants, seven WTE registrars and seven WTE Senior House Officers (SHO) assigned and available to the ward. There was one WTE senior grade physiotherapist, one WTE staff grade physiotherapist and one WTE physiotherapy assistant allocated to this orthopaedic ward.

St John's ward:

There was one WTE Assistant Director of Nursing (ADON) and one WTE CNM3 in the Medical Directorate - Scheduled Care who had oversight of this ward and other areas of the directorate. The breakdown of the 25 WTE approved and in-post was as follows:

- CNM2: 1 WTE and in post
- CNM1: 1 WTE and in post
- Nurses: 21.85 WTE in post of which 19.21 WTE available to the roster (2 WTE on approved leave) resulting in an overall shortfall of 17%* from the 23 WTE approved posts
- Healthcare Assistants: 8 WTE, none in post (100% deficit**).

* and ** inspectors were told that these vacancies were filled by agency staff while recruitment into permanent posts takes place.

There was one WTE consultant, one WTE registrar and six WTE Senior House Officers (SHO) assigned and available to the ward. There was one WTE senior physiotherapist approved but 0.5 WTE in post and 0.5 WTE Physiotherapy assistant approved and in post for this ward.

There was one CNM2 and four nurses rostered and on duty on the first day of inspection. There was one CNM2 and three out of the four nurses rostered on duty on the second day of inspection. Three nurses were rostered and on duty on both night shifts during the period of inspection.

Nursing, medical and support staff workforce arrangements- wider hospital

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place. The hospital's Director of Human Resources was operationally accountable and reported to the Hospital Manager. The Medical Manpower manager was responsible for the recruitment of the non-consultant hospital doctors (NCHDs).

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. The hospital had an overall

1443 WTE approved, funded and in post by the end of May 2023, representing an increase of 289 WTE (25%) since July 2022 (1154 WTE).

At the time of inspection, inspectors were told that 149.07 WTE posts (10.3 %) were vacant. The areas with the largest deficits were health and social care professionals (31.83 WTE of the approved 183.1 WTE posts were vacant - 17.83 %), nursing and midwifery (85.09 WTE of the approved 600 WTE posts were vacant - 14.18 %) and patient and client care (25 WTE of the approved 165.2 WTE posts were vacant - 15.13 %). The staff turnover from January to May 2023 inclusive was reported to be 3.25 %. Exit interviews were offered both online and or in-person to leavers.

Inspectors were told that the hospital experiences challenges in recruiting candidates for some posts and that cover for maternity leave is challenging. This issue was on the hospital risk register. Hospital management told inspectors that they were actively recruiting staff to address variances. In the interim, deficits in nursing and healthcare assistant rosters were being covered through redeployment from other areas or by use of agency. The absenteeism rate for the hospital in May 2023 was reported to be 5.73 % including illness related to COVID-19. This was less than the 8 % noted on last inspection but remains above the HSE target of 4 % or less. The hospital reports its HR data to the Saolta University Healthcare Group EMT where it is reviewed at the six to eight weekly performance meetings.

Inspectors were satisfied that the hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, the deteriorating patient and transitions of care. However in relation to medication safety, the hospital like many other hospitals nationally, continues to experience challenges in the recruitment of pharmacists. The hospital had recruited some basic grade pharmacists but they need three years of experience before they can be considered senior grade pharmacists.

Inspectors were told that the hospital provides and audits attendance at induction by new staff including NCHDs at least twice a year. NCHDs are involved in audit activity and reported that they generally feel well supported on rotation. Rosters were described as acceptable. Inspectors were told that where issues arise with on-call accommodation on-site, that these are brought to the attention of the hospital and training bodies as appropriate. Inspectors were told about the resuscitation hub where the team on-call for resuscitation changes daily and so it meets daily, ensures all staff are made known to each other and are assigned roles in advance of a call. This is good practice.

Staff training and education

Monitoring of uptake of key and essential training was reported to be a line manger function. Essential and mandatory training attendance by non-consultant doctors was

recorded on the National Employment Record (NER) system.‡‡‡‡‡‡‡‡ Inspectors were told that there is currently no overall system in place to monitor compliance with uptake of training.

The hospital had training programmes for infection prevention and control, medication safety and the national early warning system. Staff who spoke with inspectors confirmed to HIQA that they had received induction training and had completed training on a variety of topics on the HSE's online learning and training portal (HSeLanD). Training for infection prevention and control included training on hand hygiene and standard and transmission based precautions.

Uptake of key and essential staff training

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The emergency department had a system in place to monitor and record staff attendance at key and essential training, and this was overseen by the Assistant Director of Nursing (while the CNM3 post was vacant). Inspectors noted that compliance could be improved overall in relation to training in infection prevention and control and in early warning systems among ED medical and nursing staff. Training for infection prevention and control included training on hand hygiene and standard and transmission based precautions. Staff uptake of mandatory training in hand hygiene in the ED in the last two years was below the HSE target of 90%.

Staff uptake of training was good overall among medical, nursing and healthcare assistant staff in St. John's ward. There is scope for improvement in the uptake of training by staff in the orthopaedic ward, for example, INEWS, sepsis, basic life support and hand hygiene training among medical staff and PEWS training among nurses.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare. There had been increases in medical staff at consultant and NCHD level for the emergency department since HIQA's last inspection and HIQA was satisfied that that medical and nurse staffing levels in the emergency department at Mayo University Hospital were maintained to support the provision of 24/7 emergency care. Although the nursing complement had been reviewed as part of Phase 1 of the Safe Staffing Framework, there was no update at the time of the inspection as to the degree of change in the recommended complement. Since the last inspection the number of pharmacists had been increased due to the filling of some posts with basic

‡‡‡‡‡‡‡‡ National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

grade pharmacists who would need to have three years of experience before being eligible to apply for senior grade posts where there were still five WTE vacancies. It is acknowledged that many hospitals have reported challenges in recruiting senior grade pharmacists. The hospital was as yet unable to provide a comprehensive clinical pharmacy service to the emergency department and most wards. As well as pharmacy, there continued to be vacancy rates above 10% in the health care assistant, nursing and health and social care professional groupings. Inspectors noted good practice where the resuscitation team met daily to ensure that all team members including NCHDs who changed over on a daily basis were introduced to each other and where roles and responsibilities of each was clarified daily in advance of any calls to assist at resuscitation. Staff attendance at key and essential training is an area that could be improved in the ED and while HIQA acknowledges one's professional responsibility to keep oneself up to date in line with national standards, it is essential that hospital management has systems in place to monitor and manage attendance at key and essential training.

In summary, there was evidence of progress in this standard bringing it from non-compliant in the last inspection to substantially compliant on this inspection noting that there is further work required as stated above to achieve full compliance with this standard.

Judgment: Substantially complaint

Inspection findings relating to the Emergency Department

Quality and Safety Dimension

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

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

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

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

Patient's privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles and multi-occupancy rooms. This was validated by patients who spoke with inspectors. While the main ED environment was largely unchanged, the allocation of the ambulatory ED with 5 additional cubicles has improved the dignity and privacy for patients who met the criteria to be seen there. It was not the same however, for the patients on trolleys placed along the corridor within the main ED. Here, despite the efforts of staff to promote and protect the privacy and dignity of patients, conversations could be overheard, patients were in close proximity with each other and there was less than a one-metre distance between the trolleys (head to foot) and they were within sight of others using the corridor. Patients talked about the impact of the noise levels within the emergency department and the repeated moving of their trolley(s) from one location in the ED to another.

Although screens had been installed in the waiting room of the ED to provide information to patients, these were not yet operational and there was no agreed date for this to happen. Inspectors noted that the 'end of life' room had been reconfigured as part of an overall review of space in the ED since the last inspection and was no longer available for use by patients and their families at this difficult time. Instead, such patients were care for in a cubicle space separated by curtains. Hospital management should consider how this need may be effectively met in the short-medium term.

Inspectors noted the findings of the 2022 National Inpatient Experience Survey where 75% of respondents considered their overall experience of the hospital as 'good' or 'very good' (overall rating of 7 to 10) which was below the national average score of 82%. In the survey questions related to the emergency department, the hospital scored significantly lower than the national average with regard to:

§§§§§§§ 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

- communication with doctors and nurses in the emergency department - 13% said they did not get the answers they could understand
- privacy when being examined or treated in the emergency department - 19% said they were not given enough privacy when being examined or treated
- 13% said they were not treated with respect and dignity in the emergency department

Findings from the National Inpatient Experience Survey were reviewed at the HMT and the directorate meetings. A quality improvement plan with the objectives of improving the patient experience times, improvements in the feedback from patients about their experience and a reduction in complaints was provided and actions were being progressed via the ED Quality Improvement Group. Inspectors noted that the proposed timeline for achievement of those was set as April 2023. Of the five objectives set,

- Increase the bed numbers at St John's ward from 28 to 33 – this had yet to happen
- Return the AMAU to function – this was not in place and the AMAU was persistently used to board admitted patients from the ED
- Reduce the length of stay for all patients - this had been achieved and a number of initiatives were underway to support continued compliance with it
- Open a discharge lounge- this had not happened but was scheduled to be in place by July 2023
- Open an acute medical ambulatory clinic- this was up and running.

Inspectors were told that both a Patient Advice and Liaison Services (PALS) co-ordinator and a Patient Engagement and Partnership Coordinator had been recruited in recent months to work with patients and staff.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department as is consistent with the human rights-based approach to care supported and promoted by HIQA, and some progress was noted on inspection. Hospital management need to continue to address how patient flow and capacity may be enhanced to ensure that admitted patients have timely access to an inpatient bed and that patients attending the emergency department may be cared for in designated cubicles or rooms where privacy and dignity can be afforded to all patients including those at end of life.

Judgment: Partially compliant

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

Emergency Department

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. It 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, ambulance turnaround times and length of stay. This information and compliance with key performance indicators for the emergency department set by the HSE was reviewed at the monthly medical directorate and HMT meetings and at the 6-8 weekly Saolta University Healthcare Group Performance meetings.

In relation to the patient experience times when measured against the HSE targets during the two day inspection, inspectors found that at 11 am on the first day of inspection,

- one of the 31 registered patients (3.22%) was in the ED for more than six hours. This met the HSE target of ensuring that at least 70% of patients were either discharged or admitted to a bed within six hours of registration.
- There were no patients waiting there for more than nine hours. This met the HSE target of ensuring that at least 85% of patients were either discharged or admitted to a bed within nine hours of registration.
- There were no patients waiting there for more than 24 hours. This met the HSE target of ensuring that at least 97% of patients were either discharged or admitted to a bed within 24 hours of registration.
- No patient over the age of 75 years or more was waiting six hours or more. This met the HSE target of ensuring that 95% of patients aged 75 years or more were either discharged or admitted to a bed within six hours of registration.

At 11 am on the second day of inspection,

- 13 of the 23 registered patients (56%) including admitted patients in the ED were there for six hours or more.
- Twelve patients (52%) were there for nine hours or more.
- One patient (4.3%) was there for 24 hours or more. These statistics did not meet the HSE targets of ensuring that 70% of patients were either discharged or admitted to a bed within six hours, 85% within nine hours and 97% within 24 hours of registration.
- Seven of the 13 patients waiting six or more hours were aged at least 75 years and seven of the 12 waiting nine hours or more were at least 75 years of age. This did not meet the HSE target of ensuring that 95% of patients aged 75

years or more were either discharged or admitted to a bed within six hours, or that 99% of patients aged 75 years or more were either discharged or admitted to a bed within nine hours.
- There were no patients aged 75 years or more waiting greater than 24 hours.

These patient experience times indicate the need for more effective patient flow if patient experience times are to meet and be consistently maintained within HSE targets. All patients in 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 in the main hospital.

Published data********* relating to patient experience times in the ED for 2022 showed that:

- 53.2% of patients were either discharged or admitted to a bed within six hours of registration (HSE target: 70%)
- 72.5% of patients were either discharged or admitted to a bed within nine hours of registration (HSE target: 85%)
- 98.5% of patients were either discharged or admitted to a bed within 24 hours of registration (HSE target: 97%)

Findings from the 2022 National Inpatient Experience Survey showed that Mayo University Hospital performed less well than the national average in relation to the length of time admitted patients waited to get an inpatient bed:

- The national average for patients waiting less than 6 hours in the emergency department before being either discharged or admitted to an inpatient bed was 28.9%. The rate for the emergency department at Mayo University Hospital was 26.6%. The HSE target is 70%.
- The national average for people waiting 6-12 hours in the emergency department before being either discharged or admitted to an inpatient bed was 32.9%. The rate for the emergency department at Mayo University Hospital was 29.6%.
- The national average for people waiting 12-24 hours in the emergency department before being either discharged or admitted to an inpatient bed was 23.9%. The rate for the emergency department at Mayo University Hospital was 26%.
- The national average for people waiting more than 24 hours in the emergency department before being either discharged or admitted to an inpatient bed was

********* HSE Management Data Report 2022
https://www.hse.ie/eng/services/publications/performancereports/management-data-report-december-2022.pdf

14.4%. The rate for the emergency department at Mayo University Hospital was 17.8%.

The hospital had undertaken a bed utilisation study in October 2022 and was working on a quality improvement plan to address the deficits found. The hospital had recruited an assistant director of nursing for patient flow and both a Patient Advice and Liaison Services (PALS) co-ordinator and a Patient Engagement and Partnership Coordinator Patient Engagement officer to liaise with patients across the service. While there was evidence of action and some improvements in patient experience times, further work is required to achieve and sustain patient experience and patient experience times in line with national targets.

Risk management

Emergency department related risks were managed at department level with oversight of the process assigned to the CNM2 and ADON in the absence of the CNM3. These were reviewed at Directorate meetings attended by the QPS staff. Serious high-rated risks were escalated to the medical directorate's Serious Incident Management Team (SIMT) and were, along with mitigation actions, recorded on the directorate's risk register and escalated to the hospital's corporate risk register which was reviewed by the HMT and medical directorate at their monthly meetings where the effectiveness of actions and controls implemented to manage and mitigate risks were reviewed and updated. Risks not managed at hospital level were escalated to the Saolta University Healthcare Group.

Infection prevention and control

The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to single cubicles and isolation rooms in line with the HSE guidance[††††††††]. Staff confirmed that terminal cleaning[‡‡‡‡‡‡‡‡] was carried out following suspected or confirmed cases of infection.

Minimum physical spacing of one metre was maintained in the waiting area but not within the emergency department, where trolleys lined up along the corridor were less than one metre from each other head to foot. Although the emergency department was overcrowded and clearly lacked space, it was generally clean. At the time of inspection, reconfiguration of room space was in progress in the main ED

[††††††††] Guidance on Balancing Competing Demands in Relation to Restrictions on Bed Use Related to Infection Prevention and Control in Acute Hospital Settings (HSE Dec 2022). https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/guidelines/Guidance%20on%20Balancing%20Competing%20Demands%20Re%20Restrictions%20on%20Bed%20Use%20Related%20to%20IPC.pdf

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

department and it appeared generally untidy in some areas. The storage areas in the ED-B area were congested and there was over a dozen boxes of filing stored in the main office of the ED-B. This was brought to the attention of the nurse in charge and to the hospital management.

Audit summary reports submitted to HIQA showed that the ED had achieved averages of 87% compliance (target of 85%) with environmental and patient equipment infection prevention and control practices over the last 2 years. Inspectors noted follow-up correspondence from the auditor to the ADON regarding the need to improve attendance by ED staff at hand hygiene training. HIQA noted that time-bound action plans to support the implementation of corrective actions to address findings from the audits of clinical practice in the emergency department were not always developed. Action plans provide a framework to ensure that identified changes are made to improve healthcare services, this is an area for improvement that can be readily addressed following HIQA's inspection.

Staff had 24/7 access to a consultant microbiologist and access to an infection prevention and control nurse during core hours.

Medication safety

The emergency department did not have a dedicated comprehensive pharmacy service. Medicine reconciliation was undertaken on patients aged 75 years and older by the pharmacist on the Home First§§§§§§§§§ team. Inspectors viewed the medicine reconciliation policy dated May 2023 which included a prioritisation tool for clinical pharmacy review. A pharmacy technician visited the department daily to replace pharmacy stock. Inspectors were informed that a pharmacist could be contacted if required. Inspectors observed a high-risk medication list and a SALAD********** list displayed in the medicine room in the emergency department. Staff in the department had access to an antimicrobial pharmacist. Inspectors noted that the drug fridge temperature was monitored by the pharmacy department and the duty manager (clinical operations team) out of hours. Staff were knowledgeable on the alert system if the temperature was outside of the recommended range.

There was evidence of regular monitoring and evaluation of medication safety practices carried out by pharmacy staff, for example audits carried out in the ED included controlled drugs, medication administration process, medication

§§§§§§§§§ Home First Team is a specialist team supporting patients aged 75 years or more (who have presented to either the emergency department or the acute medical assessment unit), to identify any needs that would delay them from leaving hospital after treatment, in order to minimise any delays. This team comprises a physiotherapist, an occupational therapist, a medical social worker, a clinical pharmacist and a clinical nurse manager.

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

prescriptions and medication storage and custody. Findings, recommendations and action plans were documented and shared with ward staff and reviewed at the medication safety committee. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1 for the wider hospital.

Deteriorating patient

The hospital was using the relevant observation charts from the Irish National Early Warning System (INEWS), the Irish Maternity Early Warning Score (IMEWS), the Paediatric Early Warning System (PEWS) and the Sepsis bundle[††††††††††] for the relevant cohorts of patients to support the recognition and response to a deteriorating patient in the emergency department in line with national guidance. These were used for both the admitted and non-admitted patients in the emergency department. Inspectors were told that training on the emergency medicine early warning score was ongoing but that it had yet to be rolled out at Mayo University Hospital and was dependent on staffing levels.

HIQA viewed evidence of quarterly audits of compliance with the INEWS using the NOCA[‡‡‡‡‡‡‡‡‡‡] INEWS Escalation and Response Protocol audit tool. According to the minutes of the DPMC, findings were fed back to the ADON for the relevant areas however there were no action plans included. Inspectors were told that the $ISBAR_3$ communication tool was used for interdepartmental transfer of patients and when escalating early warning scores or other concerns and that the Clinical Handover Committee were reviewing how ISBAR may be integrated in the clinical handover. A multidisciplinary safety huddle, was held daily at 9 am to discuss the status of all patients in the emergency department and identify patients that were of concern. Inspectors viewed records of same for each day of the inspection. The hospital also collated performance data through monthly test your care metrics relating to the escalation and response (including use of ISBAR3) of the acutely deteriorating patient in the ED, achieving scores of between 95-100% compliance in the three months prior to this inspection. An external audit against national guidance on INEWS and sepsis had been undertaken by the Group nurse lead for sepsis and follow up actions were being progressed by the DPMC.

Transitions of care

The nursing clinical handover took place at 7.30 am and at 8 pm daily. There was also a minimum of two and up to four safety pauses held per 24 hours depending upon the activity levels within the department. Inspectors were told that the $ISBAR_3$

[††††††††††] Sepsis bundle is used to refer to a number of tasks and tests to be undertaken on a potent with suspected sepsis. Also referred to as the 'sepsis 6 - take 3 (blood cultures, urine output and serum lactate) and give 3 (antibiotics, fluid and oxygen)'.

[‡‡‡‡‡‡‡‡‡‡] National Office for Clinical Audit (NOCA) National Office for Clinical Audit (NOCA) manages a suite of national clinical audits including hip fracture, major trauma, hospital mortality, ICU care and joint replacements. https://www.noca.ie/

communication tool was being used for handover of a patient when being admitted to a ward and the multidisciplinary Clinical Handover committee was examining a more efficient method of handover for up to 60 patients at a time in the ED. Delayed transfers of care compounded the issue of availability of inpatient beds at the hospital and impacted on waiting times in the emergency department. On the day of inspection, the hospital had 16 delayed discharges. Hospital management attributed the delay in transferring patients mainly to capacity issues, access to step-down beds and access to cardiac investigations. Inspectors note that the bed utilisation study conducted in October 22 also highlighted those and other issues including non-compliance with meaningful predicted dates of discharge (with the exception of the orthopaedic ward) and standardised use of the whiteboards at ward level. A quality improvement plan had been devised and was being progressed through the Length of Stay committee.

Management of patient-safety incidents

The quality and patient safety department had been enhanced within the last year with the appointments of a Quality and Patient Safety Manager and a Quality and Patient Safety Co-ordinator who was the complaints manager. Although the Hospital were not yet using the National Incident Management System (NIMS) §§§§§§§§§ directly, HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported to the NIMS in line with the HSE's incident management framework. The hospital managed and monitored these through use of the hospital's own computerised system. Feedback on patient-safety incidents was provided by the QPS manager to the HMT on a weekly basis and to each directorate on a monthly basis. Directorate ADONs shared the learning with staff at the daily safety pauses and at staff meetings.

In relation to medication safety, there is a need to ensure that clinical staff are supported in the area of medication safety by ensuring that up to date information on drug prescribing and administration via the online GUH guidelines which are available at ward level but not at the point of preparation in the appropriate clinical treatment area in all wards. Inspectors note the work in progress to implement the Emergency Medicine Early Warning Score in the ED setting. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address these areas.

In summary, some improvements were noted, for example, patient experience times and management of complaints, bringing the judgement of this standard from non-

§§§§§§§§§ The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

compliant in the last inspection to partially compliant on this inspection. Further work however, is required in the areas set out above to achieve full compliance.

Judgment: Partially compliant

Inspection findings relating to the wider hospital and clinical areas

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

Capacity and Capability Dimension

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

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.

Monitoring service's performance

HIQA was satisfied that the hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). The hospital collated performance data for unscheduled and scheduled care, including data on emergency department attendances and patient experience times, bed occupancy rate, average length of stay, scheduled admissions and delayed transfers of care. The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant monthly directorate meetings, the monthly HMT meetings and the 6-8 weekly performance meetings between the hospital and hospital group.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospital's corporate risk

register was reviewed at the monthly directorate and weekly HMT meetings. Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to mitigate the risks, in relation to the four key areas of known harm were recorded on the hospital's corporate risk register. These risks are outlined further in national standard 3.1- wider hospital. Inspectors viewed the corporate risk register and noted that of the 37 risks recorded, all had been risk rated and had controls documented however 31 of the 37 had past their review dates which ranged from January – May 2023. Most risks on the register related to infection prevention and control, lack of isolation rooms, suboptimal infrastructure and inadequate capacity. Five risks related to deficits in consultant cover in specific specialties, whether consultants were on the specialist register, lack of pharmacists and lack of nurses. Risks not managed at hospital level were escalated to the Saolta University Healthcare Group. Hospital management need to ensure that the corporate risk register is inclusive of risks not manageable at department level and is reviewed and updated in a timely manner.

Audit activity

The hospital had a multidisciplinary Clinical Audit Assurance Committee and an annual audit plan. The hospital submitted agendas and minutes of meetings. It was chaired by a consultant physician and had a multidisciplinary membership including representatives from management, nursing and midwifery, pharmacy, radiology and the health and social care professional groupings. Attendance was satisfactory at the three meetings held year to date in February, April and June. Actions were identified and allocated to named attendees. While inspectors found an increased level of audit activity in place at the hospital, there was scope for improvement in the development and implementation of action plans in order to complete the audit circle and improve practice. This is discussed further under national standard 2.8.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System, in line with the HSE's Incident Management Framework. The hospital's quality and risk manager tracked and trended patient-safety incidents and provided reports to the relevant directorates and the HMT. Incidents were rated by severity, category and location. Inspectors noted that slips, trips and falls, pressure ulcers and medication incidents were the most frequently occurring incidents in the medical directorate in 2022. Feedback on patient-safety incidents was provided to clinical nurse managers by the quality and risk manager. Patient-safety incidents were discussed at performance meetings with the Saolta University Healthcare Group. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3- wider hospital.

Management of serious reportable events

The Saolta University Healthcare Group Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents occurring and reported by the hospital. Hospital management were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT was a multidisciplinary group which was chaired by the Group's clinical director for patient safety and included representation from medical, nursing, QPS and pharmacy staff as well as hospital management from all of its six acute hospitals. The terms of reference stipulated monthly meetings or more often if required. In addition, serious incidents and serious reportable events were also discussed at the HMT and relevant directorate meetings.

Feedback from people using the service

Findings from the National Inpatient Experience Survey were reviewed at the HMT and the directorate meetings. A quality improvement plan was provided and actions were being progressed via the ED Quality Improvement Group.

In summary, at wider hospital level, the hospital were monitoring performance against key performance indicators in the four areas of known harm and there was evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvement initiatives were implemented in response to audit findings although there was room for further improvement in the risk management processes and in the completion of audit activity. Overall, inspectors were satisfied that hospital management were identifying and acting on opportunities to continually improve the quality and safety of healthcare services at the hospital.

Judgment: **Substantially Compliant**

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

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

Staff demonstrated a person-centred approach to care and made every effort to maintain their patient's dignity, privacy and autonomy. For the most part, the physical environment in the clinical areas visited, provided support for privacy, dignity and confidentiality of patients receiving care through the use of single and multi-occupancy rooms plus adequate toilet and shower facilities. However, there were also patients on trolleys in one of the wards inspected where this proved more challenging. Patients reported that it was not ideal but that staff brought them to the treatment room for examinations to ensure privacy and dignity. Inspectors viewed the risk assessment pertaining to this situation which was associated with the rollout of the hospital's escalation plan. Inspectors were satisfied that the risk assessment detailed controls to mitigate risk to the patient in such a scenario.

Staff promoted independence among patients, for example by encouraging and supporting patients in the 'Get Up, Get Dressed, Get Moving' campaign and to mobilise independently using the hospital's approved 'Wellness walkway'. Patient's personal information in the clinical areas visited, during the inspection, was observed to be protected and stored appropriately. Inspectors note the overall findings from the 2022 National Inpatient Experience Survey, where with the exception of a score higher than the national average score for choice of food, the hospital scored similar to or below the national average for most survey questions resulting in an overall score which was lower than the national average.

In response, the hospital had developed an improvement plan to include:

- introduction of purposeful visiting as a component for protected mealtimes to enhance and improve nutrition and hydration and continence care,
- timely access to staff by patients and carers for improved communication
- to provide consistent high-quality information to patients throughout their stay up to and including their discharge.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA.

Judgment: Substantially compliant

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

Inspectors observed staff to be respectful, kind and caring towards patients. They were actively listening and communicating effectively with patients in an open and sensitive

manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors who described staff in the clinical areas as *'very nice, looking after me well', 'staff lovely', 'very professional'*.

Inspectors observed that care was being taken by staff to protect and promote the privacy and dignity of patients when providing care. This included the use of privacy screens for the patients on trolleys on the orthopaedic ward and the practice of moving those patients into the treatment room for examinations. Inspectors were told by one patient that it was *'not ideal to be on the corridor but I would rather it be me on the corridor than an older person'*. Patients in St John's ward spoke positively about the ward environment, *'fabulous, airy, clean, quiet, pleasant'*. However others described some delay in responses to meeting their needs but added, *'you wait for things…… but it will come '*.

HIQA found evidence of a person-centred approach to care, especially for vulnerable patients receiving care. For example inspectors were told of an initiative in use in both of the inspected wards to screen for signs of possible delirium and cognitive impairment to ensure appropriate referral and provide patient-focussed care. Inspectors also noted separate discrete signage used to communicate if a patient was demonstrating confusion or had dementia. The hospital had also employed both a Patient Advice and Liaison Service (PALS) coordinator and a Patient Engagement and Partnership Coordinator to work with staff and patients and improve communication and experience.

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

Judgment: Compliant

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

Since HIQA's last inspection in August 2022, Mayo General hospital had recruited a Quality and Patient Safety Manager and Quality and Patient Safety Co-ordinator who was the designated complaints manager, a Patient Advice and Liaison Service (PALS) coordinator and a Patient Engagement and Partnership Coordinator. HIQA was assured that complaints were being managed locally by CNMs with oversight from their CNM3 or ADON, in line with the hospital's complaints policy and the HSE's 'Your Service You Say'.

The hospital had a complaints management system and used the HSE's complaints management policy 'Your Service Your Say'. Verbal and written complaints were tracked and trended to identify the emerging themes, categories and departments involved. Updates on the volume, nature and trends were shared along with status updates on the KPIs relating to complaints management. Feedback on emerging trends and themes was provided to the directorate teams including the emergency medicine consultants and the ADON for ED. The ADON shared the learning with staff at staff huddles and meetings. Collated data and information on the hospital's compliance with national guidance and standards on complaint management was submitted to the relevant monthly directorate meetings and the weekly HMT meetings and to the 6-8 weekly performance meeting with the Saolta University Healthcare Group.

Inspectors were told that the PALS coordinator dealt with stage 1 and verbal complaints which were logged and presented at directorate meetings by the PALS coordinator. HIQA was satisfied that written complaints were managed locally, in line with the hospital's complaints policy by the complaints manager. The hospital was not yet using the national complaints management system but they were using a computerised system to manage and monitor complaints.

HIQA noted the progress made within the last year in terms of resolution and closing of a backlog of complaints together with management of new complaints within the recommended timeframes. Inspectors were told that 65% of complaints were closed out within 30 days during 2022 and 56% of complaints were closed out within 30 days during 2023 up to the time of inspection which was still below the national HSE target of 75% for investigating complaints within that timeframe.

Inspectors were told about training in communication which had been undertaken in the maternity unit and was then provided to staff in the emergency department. Inspectors were told of plans to roll it out hospital-wide by twelve staff who were receiving additional in-person and online training in facilitating communication training.

Inspectors noted the presence of either the HSE *'Your Service Your Say'* leaflets or the Mayo Hospital information booklet on display in the clinic areas visited. Of note, on the day of inspection, some of the patients who spoke with inspectors said that they did not know how to make a complaint although they did say they would ask a staff member. Inspectors were told that the Patient Engagement and Partnership Coordinator was undertaking a patient satisfaction survey to measure and monitor what needs attention.

Overall, HIQA were satisfied that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and noted good practice in relation to in-house patient satisfaction surveys.

Judgment: Compliant

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

On the day of inspection, inspectors visited the orthopaedic ward on the main hospital building and St John's ward located in the Sacred Heart Hospital, Castlebar. Access to the wards was via fob access however inspectors found that there was no door release function at the nurses' station in St John's ward to facilitate easier door release for those wishing to gain access which if present, would support adherence to the secure system in place. It was instead close to the entrance of the ward but on the day of inspection, it was not activated and inspectors noted that it was possible to enter and leave the ward without intervention by staff. This was raised with staff on the ward and with hospital management while on inspection who assured HIQA that they would ensure that the system in place was used as intended immediately. Although the admission criteria for the ward required patients to have good cognitive skills, surveillance of egress from a ward is important in the context of the risk of absconsion of patients who may become confused during their stay. Overall the hospital's physical environment was well maintained and clean with a few exceptions which were brought to the attention of the CMN2.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) displayed throughout the clinical areas. Inspectors noted that not all of the hand hygiene sinks throughout the unit conformed to standard requirements[**********]. Although designated as a hand hygiene sink, there was no hand wash soap at one sink. Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Staff were observed wearing appropriate personal protective equipment in line with current public health guidelines.

Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited however one room being used for isolation did not have signage and the door was open. This was brought to the attention of the CNM2.

Environmental cleaning and terminal cleaning was carried out by the external contract cleaning company. The clinical areas visited did not have a dedicated cleaner. Cleaning supervisors and clinical nurse managers had oversight of the cleaning schedules and

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

the quality of cleaning in the clinical areas visited. Inspectors were told that the cleaning supervisor visited the ward however inspectors noted an absence of supervisor sign-off on the cleaner's sign-off sheets. Inspectors note that if this documentation is in use, it should be completed. Inspectors were told that staff were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe.

Cleaning of equipment was largely assigned to multi-task attendants in the ED and to healthcare assistants in the wider hospital clinical areas. In clinical areas visited, the equipment was observed to be clean and there was a green tag 'I am clean' system in use to identity equipment that had been cleaned however inspectors noted that this was not being used for all equipment. Hospital management need to ensure that there are systems in place and being used to safely identify clean equipment. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

The hospital had implemented processes to ensure appropriate placement of patients — the infection prevention and control nurse liaised with bed management on the placement of patients daily. The hospital used the 'Guidance on Balancing Competing Demands in Relation to Restrictions on Bed Use Related to Infection Prevention and Control in Acute Hospital Settings (HSE Dec 2022)'. The lack of isolation rooms at the hospital was identified on the hospital's risk register and inspectors were told that a procurement process was dependant on funding.

In summary, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. Hospital management need to ensure that the systems in place to support the intended access and egress from St. John's ward area adhered to, that hand hygiene sinks conform to HBN requirements, that use of signage and closed doors is in place when rooms are used for isolation purposes, that there is documented oversight of cleaning standards in line with the system in use in the hospital and that there is a standardised system in use to identify clean equipment.

Judgment: Partially compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management,

and to the hospital group on the quality and safety of the services provided at wider hospital level. HIQA found that the hospital had monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments and patient experience surveys.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Audit summary reports submitted to HIQA showed that the clinical areas visited on the day of inspection had achieved averages of 95% and 85.6% compliance respectively on St John's ward and the orthopaedic ward (target of 85%) with environmental and patient equipment infection prevention and control practices over the last 2 years. Audit findings were shared with clinical staff and time-bound action plans developed to address areas requiring improvement. Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices.

The antimicrobial stewardship committee which met every two months reported into the IPC committee. Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.[††††††††††] The infection prevention and control team submitted a monthly healthcare-associated infection surveillance report to the Infection Prevention and Control Committee. These reports were also shared with consultants and staff in clinical areas.

In line with HSE's national reporting requirements, the hospital reported on rates of:

- clostridium difficile. The rate of clostridium difficile[‡‡‡‡‡‡‡‡‡‡] at Mayo University Hospital from January – May 2023 was 0.53 cases per 10,000 beds days. The rate among the other three model-3 hospitals in the Saolta University Healthcare Group ranged between 0.86-3.28 for the same period. The rate at Mayo University Hospital was 0.5 in 2022 while the rate among the other three model -3 hospitals in Saolta was 1.07-2.79. It was also the lowest rate when compared to all model-3 hospitals. The hospital's clostridium difficile rate was within the national target of 2.

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

[‡‡‡‡‡‡‡‡‡‡] Clostridium difficile is a bacterium that can affect the bowel and cause diarrhoea.

- carbapenemase-producing enterobacterales[§§§§§§§§§§] (CPE). Mayo University Hospital conducts universal screening for CPE. From January – May 2023 inclusive, the incidence of new cases was averaging at 2.25 cases per month (down from a total of 36 cases in 2022). This compared well with the three other model 3 hospitals in the Saolta hospital group who conduct criteria-based screening and where the range of incidence was found to average 0-4 cases per month from January – May 2023 inclusive (range of 0.58-1.17 cases per month in 2022). There is no HSE target for new cases of CPE.
- hospital acquired staphylococcus aureus blood stream infections. The rate of hospital acquired Staphylococcus aureus[**********] blood stream infection per 10,000 bed days at Mayo University Hospital from January – May 2023 was 0.5. The rate among the other three model-3 hospitals in Saolta was ranged between 0.6-1.14 for the same period. The rate at Mayo University Hospital was 0.2 in 2022 while the rate among the other three model-3 hospitals in Saolta ranged from 0.46-1.21. It was also among the lowest of all model-3 hospitals in the country. The hospital's staphylococcus aureus blood stream infection rate although increased since last year remained within the national target of 0.8.
- hospital acquired COVID-19
- and outbreaks.

For hospital acquired cases, HIQA was satisfied that the hospital investigates those appropriately and shares the learning with staff to reduce the incidence of recurrence.

As discussed under NS 5.5, inspectors were told of the audit report received in May 2023 from the ADON, Group Sepsis/Deteriorating Patient Lead, for the Saolta University Health Care Group who audited compliance with medical and surgical sepsis at the hospital. It was noted that there needed to be improvements and inspectors were told that the IPC team were developing a quality improvement plan to address the deficits.

Medication safety monitoring

There was good evidence of regular monitoring and evaluation of medication safety practices at the hospital being carried out by pharmacy staff, for example audits carried out in the clinical areas visited included controlled drugs, medication administration process, medication prescriptions and medication storage and custody.

§§§§§§§§§§ 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.

********** Staphylococcus aureus is a type of bacteria often found on human skin, nose, armpit, groin and other areas. While it does not always cause harm, it is the leading cause of skin and soft tissue infections such as abscesses, boils and cellulitis. It can also cause more serious illnesses such as bloodstream infection, pneumonia, endocarditis and bone and joint infections

Findings, recommendations and action plans were documented and shared with ward CNMs and ADONs and reviewed at the medication safety committee. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital collated performance data through monthly test your care metrics relating to the escalation and response (including use of ISBAR$_3$) of the acutely deteriorating patient in the clinical areas visited achieving an average score of 81.6% compliance in the three months prior to this inspection. HIQA also viewed evidence of quarterly audits of compliance with the INEWS using the NOCA INEWS Escalation and Response Protocol audit tool. Results of quarterly audits on PEWS were also viewed by inspectors. According to the minutes of the DPMC, findings were fed back to the ADON for the relevant areas however there were no action plans included. Inspectors were told that the ISBAR$_3$ communication tool was used for interdepartmental transfer of patients and when escalating early warning scores or other concerns but not yet for the clinical handover at ward level. Inspectors found that there was room for improvement in the development and follow-through of action plans in response to non-compliances of audit activity.

Transitions of care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's hospital patient safety indicators. The hospital reported on the number of inpatient discharges, number of beds subjected to delayed transfer of care and the number of new attendances to the emergency department every month. Performance data in relation to patient transfers and discharges was reported and discussed at 'Length of Stay' meetings, Mayo Egress Group meetings, directorate and HMT meetings. Patient flow and hospital activity were also discussed at Patient Safety huddles. There was no evidence of specific audit activity related to transitions of care including discharge or external transfers. This is an area for the hospital to act upon to ensure quality and safety of such discharges and transfers. This will be discussed further under national standard 3.1.

Overall, HIQA was broadly satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital. However, following this inspection, the hospital should ensure that non-compliances with audit findings are used to develop action plans to bring activity back into compliance and provide assurance on the quality and safety of clinical practice and the services provided at the hospital.

Judgment: Substantially compliant

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

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people availing of healthcare services at the hospital. Risks were managed at department level by the CNM2 with support and oversight from the CNM3 or assistant director of nursing for the directorate. For example, inspectors viewed the risk assessment conducted in relation to the placement of patients on trolleys in ward corridors as part of the hospital's escalation plan and noted the controls which were put in place to mitigate risk during such situations.

Risks not manageable at ward or department level were escalated and recorded on the hospital's corporate risk register. The HMT had oversight of the risks recorded on this register. Inspectors viewed the corporate risk register and noted that of the 37 risks recorded, all had been risk rated and had controls documented however 31 of the 37 had past their review dates which ranged from January – May 2023. Most risks on the register related to infection prevention and control, lack of isolation rooms, suboptimal infrastructure and inadequate capacity. Five risks related to deficits in consultant cover in specific specialties, whether consultants were on the specialist register, lack of pharmacists and lack of nurses. Risks not managed at hospital level were escalated to the Saolta University Healthcare Group.

There is room for improvement in the area of maintenance of the hospital risk register, for example, inspectors were told of a risk associated with the use of a clinical information system with a potential impact for medication safety. Inspectors were told that a risk assessment was completed by the ICU pharmacist and lead anaesthetist on 7/6/23 for escalation to the Saolta Group for Project Board for the ICU CIS. This is under regular review as it is a live project. Inspectors were told that there were controls in place to mitigate risk including ensuring that a specific pharmacist was allocated and prioritised for the particular clinical area to monitor the situation however the risk was not on the risk register. Hospital management need to ensure that the hospital risk register captures all current risks not manageable at ward or departmental level including those escalated to the hospital group and record regular review of the risk register.

Infection prevention and control

HIQA was satisfied that the hospital screened patients for multi-drug resistant organisms at point of entry to the hospital and that patients with a confirmed infection were isolated within 24 hours of admission or diagnosis as per national guidance. The infection status of each patient was recorded on the hospital's electronic operating system. The hospital carried out universal CPE screening with the exception of children and maternity patients. Compliance with this was over 90% and was closely monitored

by the IPC team. Inspectors viewed documentation relating to the follow-up of non-compliances. Due to the lack of isolation rooms, a prioritisation system was used to allocate patients to the single and or isolation rooms. Staff confirmed that terminal cleaning was carried out following suspected or confirmed cases of infection. A multidisciplinary outbreak team was convened to advise and oversee the management of each outbreak. Inspectors viewed outbreak report management reports and were satisfied that it was in line with national guidance. Inspectors also viewed evidence of monthly auditing of hand hygiene, environmental hygiene and equipment hygiene at ward level and noted that there was room for improvement in the development of action plans to manage non-compliances. Inspectors noted some broken and faulty hand gel dispensers on ward drug trolleys and this was brought to the attention of the CNM2.

The infection prevention and control team maintained a local risk register of potential infection risks. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register. This included the lack of single isolation rooms.

Medication safety

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication safety, storage and custody was monitored both as part of the Nursing and Midwifery Quality Care Metrics and by regular audits by pharmacy.

The hospital did not have a comprehensive pharmacy service due to the shortfall of five WTE pharmacists. Instead pharmacists were allocated to priority areas and cohorts of patients for example, a comprehensive clinical pharmacy review and medication reconciliation is provided for high risk patients on a number of wards which have pharmacist cover and at request on those that do not have designated cover and the pharmacist on the Home First team which worked across the ED and AMAU carried out medicine reconciliation for patients aged 75 years or more. Pharmacy technicians supported medication stock control at ward level. The hospital had recruited basic grade pharmacists to fill some vacancies and they would need three years of experience before they would be considered as senior grade pharmacists. The hospital was supporting two of its senior pharmacy technicians to undertake additional training to enable them to support some protocol-guided medication reconciliation in specific cohorts of patients.

The hospital was using the online Galway University Hospital intravenous drugs guide and although this was accessible at the nurse's station in each ward, it was not accessible in all medication treatment rooms as it should be, due to lack of data points. This was a documented area for improvement by the Medication Safety Committee. Hospital management need to ensure that this is resolved to support medication safety.

HIQA was satisfied that the hospital had a list of high-risk medications aligned with the acronym 'A PINCH'[††††††††††††]and a list of sound-alike look-alike medications (SALADs) however, inspectors noted an adjacency in storage of two medications which looked similar and this was brought to the attention of the CNM2. Inspectors observed the use of risk-reduction strategies to support the safe use of high-risk medicines in the clinical areas visited. The hospital did not have a formulary. Inspectors noted the presence of copies of the British National Formulary being available at ward level.

Inspectors viewed the medication safety committee's list of short, medium and long-term priorities set out for 2023 with actions and assigned responsibilities to owner. However there was no recorded status update on the list.

Deteriorating patient

The hospital were using observation charts from the Irish National Early Warning System (INEWS), the Irish Maternity Early Warning Score (IMEWS), the Paediatric Early Warning System (PEWS) and the sepsis bundle for the relevant cohorts of patients to support the recognition and response to a deteriorating patient in the hospital in line with national guidance. Inspectors were told that training on the emergency medicine early warning score was ongoing but that it had yet to be rolled out at Mayo University Hospital and was dependent on staffing levels. There was no agreed implementation date.

The hospital had systems in place to manage patients whose early warning system triggered. This included the INEWS version 2 observation chart and an ISBAR communication tool which was placed in the patient's chart when escalation of care occurred. The hospital also provided high dependency and intensive care facilities. Inspectors were satisfied that the early warning systems in place at the hospital were being audited regularly however there was no evidence of documented quality improvement plans associated with audit findings. The DPMC did not have a risk register and there were no issues on the hospital risk register related to the DPIP.

The hospital had been audited by the Saolta University Healthcare Group Nurse lead for sepsis in respect of compliance with INEWS and the Sepsis bundle and had recently received a list of recommendations regarding ongoing training due to lack of compliance associated with documentation. A preliminary action plan subject to agreement at the upcoming DPMC meeting was viewed by inspectors.

Transitions of care

The nursing clinical handover took place at 07.30 and at 20.00 hours daily. Inspectors were told that the ISBAR communication tool was used for handover of a patient when being admitted to a ward but not for clinical handover. Inspectors noted that the

[††††††††††††] APINCH is an acronym for medications including anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

whiteboards were not complete and up to date for all patients on the day on inspection in relation to early warning scores, length of stay and predicted day of discharge.

Delayed transfers of care compounded the issue of availability of inpatient beds at the hospital. On the day of inspection, the hospital had 16 delayed discharges. In 2022, 4038 bed days were lost through delayed transfers of care. Hospital management attributed the delay in transferring patients to deficits in available bed capacity and other factors as found during the bed utilisation study conducted in October 2022. An assistant director for patient flow had recently been appointed in line with recommendations from that study.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. A hospital-wide multidisciplinary safety huddle was held daily at 9 am to discuss the status of hospital activity and included all patients in the emergency department and identify patients that were of concern in the ED and throughout the hospital. Inspectors viewed records of same for each day of the inspection. Inspectors also viewed a sample of transfer and discharge policies and discharge templates to facilitate safe transitions of care. The patient's infection status was recorded on the discharge and transfer templates. However, as inspectors also found on the last inspection, there was a delay in issuing some discharge letters on the day of discharge. Hospital management had included resolution of this on its previous action plan however more work is needed to ensure compliance with this standard given the risk associated with transitions of care. Published data showed that in 2022, 12.3% of patients had emergency readmissions to Mayo University Hospital for acute medical conditions. This was higher than the HSE target of 11.1% or less. Hospital management should explore the reasons associated with this and seek to reduce in line with national targets.

Policies, procedures and guidelines

The hospital had a local suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines which included policies on standard and transmission based precautions, outbreak management, management of patients in isolation, environmental cleaning and equipment decontamination. One of these was overdue for review. The hospital also had a local suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of medication, medicine reconciliation, high-alert medicines and sound alike look alike drugs. Three of medication safety related policies and procedures were overdue for review. Inspectors viewed the policy and procedure dated January 2020 on missing in-patients. This had been due for review in January 2023.

National policies, procedures and guidelines relating to the deteriorating patient, transitions of care, risk and incident management, complaints and healthcare records management were also in use at the hospital. Policies, procedures, protocols and

guidelines were accessible to staff via the hospital's document management system on a shared hard drive of the computers.

Staff training and education

Compliance with uptake of infection prevention and control training (including hand hygiene, standard-based precautions, transmission-based precautions, and donning and doffing of personal protective equipment) by staff groups as presented for the whole hospital could be improved among health care assistants, housekeeping and cleaning staff, and health and social care professionals. The compliance level among these groups ranged from 70-84%. The hospital should have a system in place to monitor overall compliance of uptake of key and essential training at an individual, department and discipline groupings as well as overall attendance.

In summary, HIQA was not fully satisfied that the hospital had systems in place to identify and manage potential risk of harm associated with medication safety, the deteriorating patient and transitions of care. Hospital management need to ensure that the hospital risk register reflects all of the risks at the hospital which have been identified but are not manageable at department level and that the hospital risk register needs to be kept up to date. Hospital management need to ensure that access to wards is in line with hospital policy. In relation to medication safety, there was evidence of improvements since the last inspection however the hospital does not yet have its full complement of approved and funded pharmacists. It does not provide a hospital wide comprehensive clinical pharmacy service and medicine reconciliation and although prioritised for certain groups of patients, remains limited. Inspectors noted the limited access to the use of online GUH IV prescribing guidelines at the point of drug preparation and some storage issues of drugs that had similar appearances. In relation to transitions of care, there continues to be a delay in issuing some discharge letters on the day of discharge and there was a high re-admission rate at the hospital according to 2022 data. Some policies and procedures viewed were overdue for review. The hospital did not have an overall system to capture and monitor attendance by staff at key and essential training and the levels of attendance at training such as hand hygiene requires improvement in some areas. These represent areas for improvement to achieve a higher rating in this standard.

Judgment: Partially compliant

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

The quality and patient safety department had been enhanced within the last year with the appointments of a Quality and Patient Safety Manager and a Quality and Patient Safety Co-ordinator (who was also the complaints manager). HIQA was satisfied that

patient-safety incidents and serious reportable events, initially reported to the QPS department using the hospital's own computerised system were reported to the NIMS and managed at local level or through the Group SIMT in line with the HSE's incident management framework.

Inspectors were told of an increase in the number of patients presenting to the hospital with pressure ulcers within the last year. This was brought to the attention of the Director of Public Health Nursing, the person(s) in charge of the individual nursing homes and the tissue viability clinical nurse specialist within the hospital and remains under close review. Quality and patient safety staff attended the two serious incident management meetings held per month (one for the general hospital and one for the women and children's managed clinical academic network.

The hospital's rate of reporting of clinical incidents into the NIMS was 13.89 per 1000 bed days in 2022 which was the second lowest level of reporting by model 3 hospitals (HSE target 14.8 per 1000 bed days). Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported — slips, trips and falls, pressure ulcers and medication errors. The hospital tracked and trended patient-safety incidents in relation to the four key areas of harm and an incident summary report was submitted to each monthly directorate and monthly HMT meeting and to the Saolta University Healthcare Group every month. Directorate ADONs shared the learning with staff at the front line through staff meetings and safety pauses.

By the end of quarter 2, 2023, the hospital had reported a total of nine serious reportable events (SREs) and these had been reviewed and were managed in line with national guidance. The range of serious reportable events by the 17 model 3 hospitals for that period ranged from 0-27 with Mayo University Hospital eighth highest.

Inspectors were told of support systems‡‡‡‡‡‡‡‡‡‡‡‡ in place for staff following adverse events.

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

Judgment: Compliant

‡‡‡‡‡‡‡‡‡‡‡‡ Supporting Staff following an Adverse Event, the 'ASSIST ME' model (HSE 2021) https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/assist-me-a-model-of-staff-support-following-patient-safety-incidents-in-healthcare-january-2021-.pdf

Conclusion

HIQA carried out an unannounced inspection of Mayo University Hospital on 21 and 22 June 2023 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. The inspection included follow-up of the compliance plan submitted by the hospital in respect of partial and non-compliances as found during the announced two-day inspection in 2022.

On this inspection, inspectors found that the hospital was found to be compliant or substantially complaint in eight standards and partially or non-compliant in five of the 13 national standards it was measured against. This reflects an increase in compliance against 5 national standards and where NS 6.1 increased two levels from non-compliant to substantially compliant. Improvements were noted in several areas since the last inspection as discussed throughout the report however, more work is required to achieve overall higher ratings.

Capacity and Capability

HIQA inspectors found that Mayo University Hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. Several improvements were noted since the last inspection namely the progression of the anaesthesiology staffing situation, reconfiguration of the quality and safety department and recruitment of QPS and PALS staff. An update on progress of the compliance plan was submitted to HIQA and while there was evidence of progress in relation to this standard, the hospital had yet to achieve its objective in issuing discharge letters for all patients at the point of discharge and filling all pharmacy positions.

On the day of inspection, the hospital's emergency department was busy, relative to its intended capacity. The overall patient experience times - while improved since the last inspection and the ambulance turn-around times remained outside of HSE targets. While HIQA notes and commends the improvements made since its last inspection, further improvements such as access to a functioning AMAU, access to the electronic dashboard system enabling effective triage and provision of an overview of the status of ED patients at a glance, improved access to cardiac investigations for primary care, and improved timeliness of out-of-hours referrals for diagnostics all require further .attention to support and enhance effective patient flow throughout.

Inspectors were satisfied that hospital management were identifying and acting on opportunities to continually improve the quality and safety of healthcare services at the hospital while noting that there was room for further improvement in the risk

management processes and in the completion of audit activity. Following this inspection, the hospital should ensure that non-compliances with audit findings are used to develop action plans to bring activity back into compliance and provide assurance on the quality and safety of clinical practice and the services provided at the hospital.

HIQA was satisfied that that medical and nurse staffing levels in the emergency department at Mayo University Hospital were maintained to support the provision of 24/7 emergency care. There had been a significant improvement in medical staffing at NCHD level and an increase in the number of permanent consultants from locum contracts for the emergency department since HIQA's last inspection. Although the nursing complement had been reviewed as part of Phase 1 of the Safe Staffing Framework there was no update at the time of the inspection as to the degree of change in the recommended complement. Since the last inspection the number of pharmacists had been increased due to the filling of some posts with basic grade pharmacists however there were still five WTE vacancies including that of the Medication Safety pharmacist. While the hospital was unable to provide a comprehensive clinical pharmacy service, patients admitted to the ED who were 75 years old or more and patients on three other wards were seen by designated pharmacist for clinical review. As well as pharmacy, there continued to be vacancy rates above 10% in the health care assistant, nursing and health and social care professional groupings. Inspectors noted the good practice where the resuscitation team met daily to ensure that all team members including NCHDs who changed daily were introduced to each other and where roles and responsibilities of each was clarified daily in advance of any calls to assist at resuscitation.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were generally positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff. The hospital was aware of the need to support and protect more vulnerable patients and had developed a plan to act on findings from the National Inpatient Experience Surveys. HIQA were satisfied that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and noted good practice in relation to in-house patient satisfaction surveys.

Inspectors found that patient's privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles and multi-occupancy rooms and this was validated by patients who spoke with inspectors. The hospital had increased access to ED by use of five additional cubicles in an adjacent facility ED-B. It

was not the same however for patients on trolleys placed along the corridor. Here, despite the efforts of staff to promote and protect the privacy and dignity of patients, conversations could be overheard, there was less than a one-metre distance between the trolleys (head to foot) and patients were within sight of other people using the corridor. Due to the loss of the designated 'End of Life' room as part of an overall reconfiguration of space in the ED, patients at this stage of life were cared for instead in cubicles separated by curtains. Patients talked about the impact of the noise levels within the emergency department and the repeated moving of their trolley (s) from one location in the ED to another.

HIQA found that the physical environment did not fully support the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. Hospital management need to ensure that hand hygiene sinks conform to HBN requirements, that there is compliance with the use of signage and closed doors for rooms being used for isolation, that there is documented oversight of cleaning standards in line with the system in use in the hospital, that there is a standardised system in place to identify clean equipment and that there is a system in place to support adherence to hospital policy in relation to access and egress from St John's ward.

Improvements were noted in relation management of complaints and there was a slight improvement in patient experience times. Staff attendance at key and essential training is an area that needs to be improved hospital-wide and it is also essential that hospital management has systems in place to monitor and manage attendance at key and essential training.

In relation to the wider hospital, HIQA was not fully satisfied that the hospital had systems in place to identify and manage potential risk of harm associated with medication safety, the deteriorating patient and transitions of care. Hospital management need to ensure that the hospital risk register reflects all of the risks at the hospital which have been identified but are not manageable at department level and that the hospital risk register needs to be kept up to date. In relation to medication safety, there was evidence of improvements since the last inspection however the hospital does not yet have its full complement of approved and funded pharmacists. It does not provide a comprehensive clinical pharmacy service and medicine reconciliation although prioritised for certain groups of patients, remains limited. Inspectors noted the limited access to use of the online GUH IV prescribing guidelines at the point of drug preparation and some storage issues of drugs that had similar appearances. In relation to transitions of care, there continues to be a delay in issuing some discharge letters on the day of discharge. Some policies and procedures viewed were overdue for review. The hospital did not have an overall system to capture and monitor attendance by staff at key and essential training and the levels of attendance at training such as hand hygiene require improvement in some areas.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the seven national standards identified above as being partially or non-compliant with national standards.

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

Compliance classifications

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

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

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

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

Capacity and Capability Dimension
Judgments relating to wider hospital and clinical areas findings only

Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	**Substantially Compliant**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Substantially compliant**
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	**Compliant**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Compliant**
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	**Partially compliant**
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	**Substantially compliant**
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Partially compliant**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	**Compliant**

Compliance Plan Submitted by the Hospital

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

Issues NS 5.5	Action	Position October 2023
Increase compliance with Ambulance Turnaround times	a. Implement secondary triage room. b. Work with Ambulance control to ensure compliant c. Ambulance arrival screen available to all management team, as well as in ED for awareness. d. Clear escalation process in place if compliance is breaching.	Meeting schedule with ambulance control
Reduction of number of patient waiting admission on Trolleys in ED and the wards Reduction in the number of inpatients waiting for beds, this will be done with the following actions. 1. Reduce LOS for all patient >48 hour. - (bed utilisation survey carried out weekly) - Share daily LOS picture with safety huddle, wards, specialities and consultants.	Weekly/Monthly reporting on MUH 1. First focus on >75 years 2. PET 6hrs and 9hrs all patients 3. LOS Medical and Surgical 4. National AMP KPI	LOS working group in place improvement noted in all KPI as listed *First focus on >75 years* *PET 6hrs and 9hrs all patients* *LOS Medical and Surgical* *National AMP KPI* Discharge lounge Monday- Friday opened July Open acute medical Ambulatory clinic to promote early discharge Criteria being developed by AMP.
AMAU fully functioning.	Full QI project in place on this with	

	-committee being formed reporting into medical Directorate -AMAU tracker to monitor KPI - update referral process and criteria ED and GP - operation plan to be finalised and supported by Medical department	Partially completed.
Ensure full use of ED tracker Ensure all staff have access to the HPVP situation review	Transition any staff not already on Health IRL	Now in place in ED
Clinical communication and handover committee and DPMC will ensure there is aligned actions.	1. Full use of ISBAR for formal handover 2. The deteriorating patient policy is being updated and will be fully aligned to the clinical communication and handover guidance. 3. The inter-hospital and intra-hospital policy in final draft for critical and non-critical patient child and adult.	Partially completed
Implementation of the electronic discharge letter with discharge prescription for specialties.	This is part of the clinical communication and handover committee.	Partially completed

National Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objective for high quality, safe and reliable healthcare.		
Issues NS 6.1	**Actions**	**Position October 2023**
Ensure compliance with national Safer Staffing in ED once final allocations are agreed and funded.	Waiting funding allocation.	Stages 1 and stage 2 is complete.
Ensure 100% compliance with all relevant mandatory training for ED and wards	Monthly report on performance via line management and to directorate.	All clinical currently >90% compliant.
Implement the ED EWS. In MUH this will be managed via the deteriorating patient management committee (DPMC)	100% training for Medical and Nursing staff. Audit plan in place for compliance with the policy as part of the Hospital audit plan 2023 and 2024.	Implementation is initiated Target Q1 2024

National Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. Relates to ED		
Issues NS 1.6	**Actions**	**Progress Oct 23**
Open 2 extra beds in Elderly medicine Get AMAU fully functioning		AMAU QI team in place LOS QI team in place 6hr, 9hr and 24hr KPI have all improved. ED QI team continue to look at priority areas. LOS
ED QIP team in place with external support		Working with HSE and HPVP to progress this QI. Meeting set Dec QI project has been ongoing over the last year. Feedback provided to HM and QI group at ED QI Meeting March 8th Feedback to be provided to full ED team March 22nd and 29th Multiple QI projects identified
New ED AMAU Capital project at stage one waiting for planning permission approval		This will be a 2025 / 2026 target.

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services - relates to ED.		
Issues NS 3.1 ED	**Actions**	**Position October 2023**
Implement the ED EWS in MUH. This will be managed via the management of deteriorating patient committee.	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.	Target compliance Q4 2023
Clinical communication and handover committee and DPMC will ensure there is aligned actions.	Full use of ISBAR for formal handover The deteriorating patient policy is being updated and will be fully aligned to the clinical communication and handover guidance. The inter-hospital and intra-hospital policy in final draft for critical and non-critical patient child and adult.	Partially completed
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 and increase standards of care for AMP.	Capital plan long term plan	

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.		
Issues NS 2.7	**Actions**	**Position October 2023**
Ensure there is strong supervision of cleaning compliance and audits.	.	Compliance in place for supervision assurance now.
Ensure all hand hygiene sinks comply with recommended standard.	Request for the replacement of all sinks in St John's.	Compliance Q1 2024
IPC audits to focus on signage across all wards.		This is now compliant
Long Term Action Progress with national approval for a 75-bedded ward block with 50 new and 25 replacement beds.	Capital plan approval.	

National Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. Wider Hospital		
Issues NS 3.1 wider hospital	**Actions**	**Position October 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 2024.	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 department and ward.	Committee in place report to be submitted Q1 2024
Ensure online intravenous guideline are available in all treatment rooms.	Wall mounted computers have been installed in all drug rooms on the wards to support electronic access.	This is now in place.
Ensure all SALAD alerts and risk are well managed	A number of audits are planned on the high risk and risk management plan is in place for the drugs identified on the day of the visit.	Now compliant.
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.		Plan for completion in Q1 2024

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