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

Name of healthcare service provider:	University Hospital Kerry
Address of healthcare service:	Rathass Tralee Co. Kerry V92 NX94
Type of inspection:	Announced
Date of inspection:	20 and 21 September 2022
Healthcare Service ID:	OSV-0001036
Fieldwork ID:	NS_0014

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

University Hospital Kerry is a Model 3* acute teaching hospital. It is a member of and is managed by the South/South West Hospital Group† on behalf of the Health Service Executive (HSE). The hospital provides a range of medical and surgical services for adults and children, and maternity services to a population of approximately 150,000 in the county of Kerry and additionally to a proportion of the population from West Limerick and North Cork. The county of Kerry also has a large tourist population of approximately 2 million visitors annually.

Services provided by the hospital include:

- acute medical inpatient services
- elective surgery
- emergency care
- intensive and coronary care
- maternity care
- paediatric and neonatal care
- psychiatric care
- diagnostic services.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	254 240 inpatient beds 14 day case beds

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

† The South/South West Hospital Group comprises ten hospitals — Cork University Hospital, Cork University Maternity Hospital, University Hospital Waterford, University Hospital Kerry, Mercy University Hospital, South Tipperary General Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital, Mallow General Hospital and Lourdes Orthopaedic Hospital Kilcreene. The hospital group's academic partner is University College Cork (UCC).

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a two-day announced inspection at University Hospital Kerry to assess compliance with a number of standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, healthcare inspectors‡ reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and South/South West Hospital Group, 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 during the inspection.

A summary of the findings and a description of how the hospital performed in relation to the national standards assessed during the inspection are presented in the following sections, under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors at a particular point in time — before, during and following the on-site inspection at the hospital.

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 at the hospital

‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.
§ 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.

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 healthcare 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 University Hospital Kerry 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
20 September 2022	09.00 to 17.00hrs	Denise Lawler	Lead
21 September 2022	09.00 to 15.15hrs	Sean Egan	Support
		Dolores Dempsey-Ryan	Support
		Aoife Healy	Support

Background to this inspection

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

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

The inspection team visited the following three clinical areas:

- Emergency department
- Carrig Ward (general high-dependency medical ward)
- Rathass Ward (orthopaedic ward).

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

- Representatives of the hospital's Executive Management Team:
  - General Manager (Interim)
  - Assistant Director of Nursing
  - Clinical Director
  - Quality Manager
- Lead representatives for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Officer, University Hospital Kerry.

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

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

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

- Assistant Director of Nursing for patient flow, University Hospital Kerry
- Director Quality, Risk and Patient Safety, South/South West Hospital Group.
- A representative from each of the following hospital committees:
  - Infection Prevention and Control
  - Drug and Therapeutics
  - Deteriorating Patient.

Acknowledgements

HIQA would like to acknowledge the cooperation 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 receiving care in the service.

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

On the days of inspection, inspectors visited the emergency department, which also comprised the Acute Medical Assessment Unit. The emergency department provides undifferentiated care for adults and children with acute and an urgent illness or injuries. Attendees to the department presented by ambulance, were referred directly by their general practitioner (GP) or were self-referred. The overall attendance rate to the hospital's emergency department in 2021 was 36,719, which represents a 7% decrease on 2019 attendances (the last full year before the COVID-19 pandemic), but an 8% increase on the 2020 attendances to the department. This attendance rate for 2021 equated to an average of 3,059 attendees monthly or 101 attendees daily.

Hospital management told inspectors that the hospital was in escalation in response to overcrowding in the emergency department on both days of the inspection. However, at the time, hospital management had not formalised an escalation plan to manage the increase in demand for service and surge capacity, which is not in keeping with the HSE's policy or the operational norm found in other hospitals inspected by HIQA. This finding is discussed further discussed under standard 5.5.

The emergency department has a total planned capacity of 12 bays comprising a:

- triage room with one chair and one trolley
- three-bedded resuscitation area for the treatment of patients categorised as major
- nine single self-contained cubicles – three of these rooms were used when treating patients with respiratory conditions

- paediatric area comprising four single assessment bays and a waiting area. There was audiovisual separation between the adult area and children's area of the emergency department as recommended in the national model of care for paediatric healthcare services
- a separate eight-bedded Acute Medical Assessment Unit.

On the day of inspection, at 12.00pm, the emergency department was grossly overcrowded, relative to its intended capacity, with 11 additional patients accommodated on trolleys located on the main corridor, which was a public thoroughfare.

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

Inspectors observed staff actively engaging with patients in a respectful and kind way. Staff took the time to talk and listen to patients and encouraged patients to let them know if they felt unwell while waiting to be reviewed by nursing and medical staff. Despite this, some patients who spoke with inspectors were unhappy with the care received in the emergency department.

On the first day of inspection, inspectors spoke with a number of patients to ascertain their experiences of receiving care in the emergency department. Patients' experiences were mixed and varied. Some patients said they were happy with the care received and that staff were '*lovely, pleasant'* and *'doing a good job despite the circumstances.'* However, the majority of patients who spoke with inspectors were frustrated about the lengthy waiting times, waiting to be triaged by nursing staff, medically reviewed by medical staff, medically reviewed by a specialist medical teams and waiting for diagnostic tests and or for an inpatient bed. Patients were upset and frustrated with the undignified nature of being accommodated on trolleys on the public corridor and the impact this had on their privacy and confidentiality.

While the standard of hygiene in the emergency department during inspection was observed to be generally good, patients did comment on the how the standard of cleaning and overall hygiene levels in the department '*needed to be improved'* and the number of bathroom facilities was *'not enough for the number of people in the department and more was needed*.'

The experiences recounted by patients during inspection were consistent with the overall findings from the 2021 National Inpatient Experience Survey,[§§] where the hospital scored

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

below the national average in the following areas:

- getting answers to important questions from doctors and nurses in the emergency department — the hospital scored 7.3 (national score of 8.0)
- waiting time before being admitted to a ward — the hospital scored 6.0 (national score of 6.9).

Patients in the emergency department who spoke with inspectors did not receive information on the hospital's complaints process, but they said they would speak with the staff if they wanted to make a complaint. Inspectors did not observe patient information leaflets about the HSE's complaints process *'Your Service, Your Say'* displayed in the emergency department on the days of inspection. This is something hospital management should remedy following this inspection.

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

Carrig Ward was a large 30-bedded ward comprising six four-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and three single rooms. The clinical area did not have sufficient single rooms with en-suite bathroom facilities, but the multi-occupancy rooms had adequate communal toilet and bathroom facilities for patient use. The ward accommodated male and female medical patients. At the time of inspection, all 30 beds were occupied.

Rathass Ward was a large 30-bedded ward comprising six four-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and three single rooms. The clinical area did not have sufficient single rooms with en-suite bathroom facilities, but had adequate communal toilet and bathroom facilities for patient use. The clinical area accommodated male and female orthopaedic patients. At the time of inspection, all 30 beds were occupied.

Inspectors observed effective communication between staff and patients in both inpatient clinical areas visited. Staff were also observed actively engaging with patients in a respectful and kind way, taking time to talk and listen to patients. In each inpatient clinical area visited, staff were focused on ensuring patients' needs were responded to promptly. This was confirmed by patients who spoke who inspectors. In general, patients were satisfied with the care received as illustrated in descriptions of staff who were described as being *'friendly'*, *'nice'*, *'brilliant'*, *'attentive'* and '*would come when needed.'*

When asked what was good about the service or care received, some patients responded by saying '*you could not ask for better care'*, that '*this place [hospital] is a gift'* and they

patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

felt '*well looked after.*' Patients identified how the sharing of information with family members regarding their ongoing plan of care was an area that could be improved.

In general, patients' experiences in the two inpatient clinical areas were more positive than the hospital's overall findings from the 2021 National Inpatient Experience Survey. 48% of patients who completed this survey considered their overall experience of the hospital as 'very good', lower than the national average of 54%. The hospital also scored below the national average in the following:

- family members having the opportunity to talk to a doctor — the hospital scored 6.0, national score was 6.2
- having confidence and trust in hospital staff providing care and treatment — the hospital scored 8.4, the national score was 8.9.

Inspectors observed how staff promoted and protected the privacy and dignity of patients when providing care. This was consistent with findings from the 2021 National Inpatient Experience Survey where the hospital scored 8.5 for the question related to feeling treated with respect and dignity while in hospital, marginally lower than the national score of 9.0.

Patients in the two inpatient clinical areas visited who spoke with inspectors described how they, or a family member would speak to staff member if they wanted to make a complaint. Patients were not aware of the hospital's formal process for making a complaint. Inspectors did not observe patient information leaflets about the HSE's complaints process '*Your Service, Your Say*' displayed in either inpatient clinical area visited during inspection. This is something hospital management could improve following this inspection.

Overall, while patients were very complimentary about the staff and of the care received in the two inpatient clinical areas visited, there was a marked difference between these patients' experiences and the experiences of patients who received care in the emergency department. The majority of patients in the emergency department who spoke with inspectors were unhappy with their overall experiences in the department. Patients' experiences in the emergency department were consistent with what inspectors observed over the course of the inspection and with the findings from the 2021 National Inpatient Experience Survey. However, the experiences of patients in the two inpatient clinical areas were more positive than the survey findings.

Capacity and Capability Dimension

Inspection findings from the wider hospital and two inpatient clinical areas visited related to the capacity and capability dimension are presented under three national standards (5.2, 5.5 and 5.8) from the theme of leadership, governance and management. Key inspection

findings informing judgments on compliance with national standards are described in the following sections.

In addition, inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. Key inspection findings informing judgments on compliance with national standards are described in the following sections.

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

The hospital had some corporate and clinical governance arrangements in place. Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management, and hospital managements reporting arrangements to the Chief Executive Officer of the South/South West Hospital Group. These reporting arrangements were consistent with what inspectors found during inspection.

At the time of inspection, the hospital's senior management team were in a state of transition. The hospital was governed and managed by the general manager, appointed on an interim basis and efforts were underway to complete a recruitment campaign to fill the vacant position permanently. The general manager (interim) reported to the Chief Executive Officer of the South/South West Hospital Group. The hospital's Clinical Director was a member of the hospital's senior management team and provided clinical oversight and leadership at the hospital. The Clinical Director was appointed on a rotational basis and at the time of inspection, the current Clinical Director's term of office was due to conclude at the end of September 2022. Hospital management were seeking expressions of interest from interested medical consultants to be the next clinical director for the following three years. The Director of Nursing was also a member of the hospital's senior management team and was assigned with responsibility for the organisation and management of nursing services at the hospital. The Director of Nursing reported to the hospital's general manager (interim) and had a close working relationship with the Chief Director of Nursing and Midwifery for the South/South West Hospital Group.

Executive Management Board

The hospital's executive management board was the main corporate governance structure assigned with responsibility for the governance and oversight of the hospital's healthcare services. Chaired by the hospital's general manager, the board met every two weeks, in line with its terms of reference. The board's membership comprised of the senior management team — operation manager, director of nursing, director of midwifery, finance manager, human resource manager, risk manager and quality manager. Minutes of board

meetings, submitted to HIQA, showed that the meetings followed a structured format, were action-orientated and progress in implementing agreed actions was monitored from meeting to meeting.

The executive management board was established to oversee the hospital's compliance with defined quality and safety performance indicators, the management of identified risks, and patient-safety incidents, scheduled and unscheduled care activity and compliance with evidence-based care at the hospital. Minutes of meetings reviewed by inspectors would suggest that the board was overly involved in the day-to-day operational issues and that this severely impacted on the proactive strategic planning and development at the hospital. At operational level, there was limited evidence of devolved accountability and responsibility.

Members of the hospital's executive management board attended performance meetings between the hospital and the South/South West Hospital Group held every month, where items such as finance, workforce, quality and safety risk, scheduled and unscheduled care access and activity were reviewed and discussed. Inspectors were satisfied that the performance meetings were well attended by representatives from the hospital and hospital group, and that agreed actions were progressed from meeting to meeting.

Quality and Patient Safety Committee

The hospital's Quality and Patient Safety Committee was the main committee assigned with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. The committee, co-chaired by the hospital's clinical director and quality manager, met every month, in line with its terms of reference and meetings followed a structured agenda. Membership comprised members of the executive management board, chief pharmacist, a representative from the medical consultant staff, a health and social care representative and representatives from other departments. The committee reported and was accountable to the hospital's executive management board.

The Quality and Patient Safety Committee delegated elements of its assigned responsibility and function in the areas of infection prevention and control and medication safety to subcommittees — Infection Prevention, Control and the Drug and Therapeutics Committee. Each subcommittee had a defined and formalised accountability and reporting arrangement to the Quality and Patient Safety Committee. Minutes of meetings of the Quality and Patient Safety Committee submitted to HIQA would suggest the committee was predominantly focused on operational issues. There was limited evidence of the ongoing monitoring of the effectiveness of the hospital's risk management process and complaints process, the tracking and trending of performance against established quality and safety performance indicators, and of quality improvement initiatives implemented to improve the quality and safety of healthcare services at the hospital.

With respect to the governance of clinical elements of the service, the hospital did not have a clinical directorate structure, but instead had 12 clinical governance groups that were

assigned with responsibility for the specific governance and continuous quality improvement of their specialty. Some clinical governance committees had subcommittees who had a defined area of focus. In speaking with staff at various levels of responsibility in the hospital, HIQA was informed that the establishment of these groups represented a perceived significant improvement on arrangements prior to their development. HIQA acknowledge the efforts that have been advanced to seek to enhance clinical governance in this way. The 12 clinical governance groups reported and were operationally accountable to the hospital's Quality and Patient Safety Committee.

At operational level, HIQA was satisfied that the hospital had clear lines of accountability for two of the four areas of known harm assessed through this inspection — infection prevention and control and medication safety. The hospital had the following two committees in place, both reported and were operationally accountable to the hospital's Quality and Patient Safety Committee:

- Infection Prevention and Control Committee
- Drug and Therapeutics Committee.

At the time of inspection, the Deteriorating Patient Committee was being established and the hospital did not have a Bed Management and or Discharge Committee.

Infection Prevention and Control Committee

The hospital had a well-established multidisciplinary Infection Prevention and Control Committee assigned with responsibility for the governance and oversight of the hospital's infection prevention and control plan. The committee reported and was operationally accountable to the Quality and Patient Safety Committee. Chaired by the hospital's general manager, the committee met every three months, in line with its terms of reference. Membership of the committee included members of the hospital's infection prevention and control team, representatives from the executive management board, consultant microbiologist, chief medical scientist, surveillance scientist, representatives from other infection related committees, a representative from occupational health and an antimicrobial pharmacist. The hospital also had a Decontamination Committee that was operationally accountable to the hospital's operations manager. The Infection Prevention and Control Committee submitted an infection prevention and control summary report every six months, and a report annually to the Quality and Patient Safety Committee.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA were comprehensive and showed that meetings followed a structured agenda, were well attended and that agreed actions were progressed from meeting to meeting. The committee had oversight of the hospital's compliance with key infection prevention and control-related performance indicators (including antimicrobial stewardship), audit findings, patient-safety incidents and risks, relevant infection prevention and control policies, procedures and guidelines, and staff education and training.

The Infection Prevention and Control Committee had oversight of the implementation of the hospital's infection prevention and control plan, which set out the infection prevention and control objectives and purposeful actions to be achieved at the hospital. The hospital's infection prevention and control team provided the committee with updates on the progress of implementation of the objectives and actions in the infection prevention and control plan every three months. The plan is discussed further under national standard 5.5.

Drug and Therapeutics Committee

The hospital had a well-established Drug and Therapeutics Committee assigned with responsibility for advising on medication safety practices at the hospital. The committee, chaired by a medical consultant, met every six to eight weeks, in line with its terms of reference. The committee was operationally accountable and reported to the Quality and Patient Safety Committee. Membership of the committee comprised members of the executive management board, the chief and senior pharmacists, antimicrobial pharmacist, consultant microbiologist, nurse management representative, a non-consultant hospital doctor and representatives from emergency medicine, anaesthesiologist, maternity and gynaecology services, surgery and paediatrics.

The Drug and Therapeutics Committee approved the hospital's medication safety management plan and monitored progress in implementing the plan. The committee provided an update on the progress on implementation of the objectives and purposeful actions in the plan to the Quality and Patient Safety Committee every three months. The medication safety management plan is discussed further under national standard 5.5.

Antimicrobial Stewardship Committee

The hospital had an antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship programme.[***] The Antimicrobial Stewardship Committee had oversight of the implementation of the antimicrobial stewardship programme. The committee, chaired by a medical consultant, met every three months. It reported and was operationally accountable to the Drug and Therapeutics Committee. Membership of the committee comprised members of the executive management board, members of the infection and prevention control team, antimicrobial pharmacist, consultant microbiologist, a non-consultant hospital doctor representative, a representative from the medical consultant staff and a paediatric consultant representative. The Antimicrobial Stewardship Committee submitted a report annually to the Drug and Therapeutics Committee and the Infection Prevention and Control Committee.

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

Deteriorating Patient Committee

The hospital did not have a deteriorating patient improvement programme, but at the time of inspection, hospital management were in the process of establishing a Deteriorating Patient Committee. This committee will be chaired by a consultant anaesthesiologist and will have oversight of the implementation of and the hospital's level of compliance with national guidelines on the Irish National Early Warning System (INEWS),[†††] Irish Maternity Early Warning System (IMEWS)[‡‡‡] and sepsis management.

Bed Management Committee

The hospital had no formal bed management committee with responsibility for the safe transitions of care. It was evident that data on scheduled and unscheduled care activity and inpatient bed capacity was discussed at meetings of the executive management board and reviewed at monthly performance meetings between the hospital and South/South West Hospital Group.

Operational Management Team

At operational level, the hospital's operational management team met every week to review and enable the day-to-day operational management of the hospital. Chaired by the hospital's operations manager, the team comprised the assistant director of nursing for patient flow, clinical services manager, support service manager, a maternity services representative, maintenance manager and a representative from the finance department. The team reviewed operational issues across the hospital impacting on scheduled and unscheduled care, and support services. Briefings from meetings of the operational management team were presented to the hospitals executive management board.

Effective formalised governance structures and management are fundamental to the sustainable delivery of safe, effective person-centred healthcare. While there were some corporate and clinical governance structures and processes in place at the hospital, HIQA found there were some deficits in these arrangement, which had the potential to impact on the clinical and operational effectiveness of the hospital. These governance structures were overly focused on day-to-day operational issues and there was limited evidence of devolved accountability and responsibility at operational level. There was also limited evidence of strategic planning and development as evident by the lack of a strategic plan, which is essential for the development and sustainability of healthcare services at the hospital. This would not be in keeping with the majority of hospitals inspected by HIQA under the current

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

[‡‡‡] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

monitoring programme assessing compliance with the *National Standards for Safer Better Healthcare*.

Furthermore, HIQA was not fully assured that there were adequate, robust governance arrangements at the hospital to manage the increase for service demand and that the primary focus of the service was on quality and safety outcomes. The quality assurance and improvement structures, risk management processes, clinical audit function and the complaints management process were not as integrated as found in other hospitals inspected by HIQA.

Good governance structures acknowledge the interdependencies between organisational arrangements and clinical practice, and integrate these to support the delivery of high-quality and safe healthcare. There was the potential for better integration of corporate and clinical governance structures and processes at the University Hospital Kerry. The hospital had a clinical director who provided clinical oversight and leadership and was a member of the hospital's senior management team. However, a clinical directorate structure to support and enable clinical and operational effectiveness was not in place. The 12 clinical governance groups that were in place had defined and assigned responsibility for their particular specialty. However, it was unclear to HIQA how these individual groups interfaced with each other, or supported a cohesive overall approach to clinical leadership and governance across the hospital. Furthermore, 12 clinical governance groups for a Model 3 hospital, such as University Hospital Kerry, has the potential to be overly burdensome for clinical staff, many of whom are members of a number of governance structures and also have a clinical commitment. HIQA acknowledges that the senior management team were in a state of transition and that recruitment was underway to fill the general manager's position on a permanent basis, to fill the clinical director's position for the next three years and to strengthen the quality and patient safety function at the hospital. Nonetheless, the corporate and clinical governance structures would benefit from review and restructuring, and possible rationalisation to enhance and enable integration of clinical and corporate governance arrangements, and to support and improve clinical and operational effectiveness at the hospital.

Judgment: Non-compliant

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

Findings relating to the emergency department

On the days of HIQA's inspection, inspectors identified concerns around the adequacy of management arrangements to manage the increase in demand for emergency care. An Emergency Medicine Clinical Governance Committee was established by the hospital to have oversight of the operational processes in the hospital's emergency department

including those that impact on patient flow and surge capacity in the department. The emergency department held a separate operational meeting, where the main operational aspects of the department were discussed, this meeting had a line of communication to the Emergency Medicine Clinical Governance Committee. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the on-site consultant in emergency medicine.

The emergency department was the only point of entry into the hospital for patients requiring unscheduled or emergency care. On the days of inspection, the majority of attendees (60%) to the department were self-referrals. The hospital's emergency department was grossly overcrowded and on track to have a daily attendance of over 100 people, with 53 patients in the department at 12.15pm. Over a third (34%) of these patients were admitted and awaiting an inpatient bed. Eleven patients were accommodated on trolleys on the corridor. The spacing between these trolleys was not one metre, as per national guidance on COVID-19 in place at time of inspection. This posed a cross-infection risk and hindered efforts to maintain a safe environment for patients and staff. On day two of inspection, there were 71 patients in the department at 12pm, 15 (21%) of these patients were admitted awaiting an inpatient bed.

Patients experienced long waiting times to be triaged, medically reviewed and assessed, and while waiting for an inpatient bed. This was further compounded by insufficient patient flow within and outside the hospital, and surge capacity in the hospital that resulted in the boarding of 18 patients in the emergency department on the first day of inspection and 15 patients on second day of inspection.

Other hospitals inspected by HIQA had a formalised escalation plan to support effective day-to-day operational function when experiencing an increase in demand for services. Indeed, a formalised escalation plan is imperative to facilitate optimal patient flow and increase capacity when services come under pressure such as found during this inspection. Hospital management told inspectors that an escalation plan had been developed and was due to be ratified by the executive management board in the coming weeks. The non-ratification and implementation of an escalation plan was a concern for HIQA, especially within the context of the COVID-19 pandemic, high attendance rates to the hospital's emergency department and an approaching winter season, which was expected to be characterised by high levels of influenza. Hospital management should progress the ratification and implementation of a formal escalation plan as a matter of urgency.

On arrival to the emergency department, all attendees were promptly assessed for signs and symptoms for COVID-19 and streamed to the appropriate care pathway, in line with national guidance on COVID-19 at the time of inspection. All patients were triaged and prioritised in line with the Manchester Triage System.[§§§] On the first day of inspection, the

[§§§] 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.

average waiting time from registration to triage was 38 minutes, which falls short of the 15 minutes recommended by the HSE's emergency medicine programme.

Continuous and effective flow of patients within and out of the hospital is essential for optimal service delivery in an emergency department. On the first day of inspection, all inpatient beds and clinical areas were operational. However, there were 15 delayed transfers of care from the hospital. For the year to date (2022), the hospital has lost 4,316 bed days due to delayed transfers of care, which represented an increase of 953 on the same period last year. This equates to an average of 16.4 beds subject to delayed discharge every month, which is greater than the monthly average for other Model 3 hospitals in Ireland. The availability of inpatient beds was further compounded by the delay in accessing diagnostic services at the hospital.

Collectively, the mismatch between availability and demand for inpatient beds and limited surge capacity, as evident on the days of inspection, impacted the flow of patients through the emergency department and contributed to the gross overcrowding and the boarding of admitted patients in the department. This in turn, negatively impacted on patient experience times.[****] At 11.00am on the first day of inspection, the waiting time from:

- registration to triage ranged from five minutes to two hours 23 minutes. The average waiting time was 38 minutes
- triage to medical review ranged from three minutes to eight hours 40 minutes. The average waiting time was 41 minutes
- decision to admit to actual admission in an inpatient bed ranged from 14 hours to 95 hours.

In addition, there were systems and processes in place at the hospital that were not functioning as they should be, to manage the demand in activity and to support continuous and effective patient flow through the emergency department. The hospital's eight-bedded Acute Medical Assessment Unit, was not functioning as an alternate flow pathway for patients in order to take pressure from the emergency department. In effect, it was used to accommodate admitted patients from the emergency department awaiting an inpatient bed. This indicated to HIQA that the normal processes of facilitating patient flow were simply not working at the hospital at the time of inspection. On the second day of inspection, the Acute Medical Assessment Unit was closed due to reported deficiencies in nursing staff levels in the emergency department. This further contributed to the gross overcrowding of the department.

Overall, while there were arrangements in place at the hospital to manage and oversee the delivery of care in the emergency department, HIQA was not assured that these arrangements were effective in adequately addressing issues evident in the department on the days of inspection. Operationally, the emergency department was not functioning as

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

effectively as it should be, was grossly overcrowded and had significant issues with patient flow, which collectively posed a patient safety risk and was a concern to HIQA. Other findings related to the emergency department are discussed further in the emergency department section of this report under national standards 6.1, 1.6 and 3.1.

Judgment: Non-compliant

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

Findings relating to the wider hospital and two inpatient clinical areas visited

The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and two inpatient clinical areas visited on the days of inspection, and these are discussed in more detail below.

Infection, prevention and control

The hospital had an infection prevention and control team comprising:

- one whole-time equivalent (WTE)[††††] consultant microbiologist. The hospital had approval for two WTE consultant microbiologists. At the time of inspection, only one of the two consultant microbiologist's positions was filled on a locum basis, but the consultant microbiologist was on site in the hospital. This is an improvement on findings from previous HIQA infection prevention and control inspections. Nonetheless, HIQA remains concerned that the two consultant microbiologist positions at the hospital were not filled on a permanent basis and that the hospital's microbiology laboratory remains unaccredited. This could impede the hospital's ability to operate fully and effectively as a Model 3 hospital
- 2.8 WTE clinical nurse manager grade 2 (CNM 2)
- one WTE antimicrobial pharmacist
- two WTE surveillance scientists. At the time of inspection, a 0.6 WTE surveillance scientist was employed at the hospital and was on site three days a week.

The hospital did not have an overarching infection prevention and control programme[‡‡‡‡] as per national standards.[§§§§] However, the infection prevention and control team was

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[††††] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.
[‡‡‡‡] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out a clear strategic direction for the delivery of the objectives of the programme in short-, medium- and long-term as appropriate to the needs of the service.
[§§§§] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

assigned with the responsibility to develop an infection prevention and control plan every year. The plan for 2022, submitted to HIQA was comprehensive and set out the infection prevention and control objectives and plan of work to be achieved in the year. The plan was focused on:

- increasing staff awareness and education of infection prevention and control practices
- promoting practices to reduce the rates of healthcare-acquired infections
- carrying out relevant infection prevention and control audits
- monitoring environmental hygiene
- surveillance monitoring (including central vascular catheter care bundles, peripheral vascular catheter care bundles, urinary catheter care bundles and ventilator care bundle)
- antimicrobial stewardship monitoring
- infection prevention and control screening, especially carbapenemase-producing enterobacterales screening.

The infection prevention and control team reported on progress in implementing the objectives and purposeful actions in the annual plan to the Infection Prevention and Control Committee every three months and submitted a more detailed report to the committee annually. Overall, HIQA was satisfied with the governance and oversight of infection prevention and control practices, and infection outbreaks at the hospital.

Medication safety

The hospital did not have a comprehensive clinical pharmacy service.[*****] The hospital had:

- eight WTE pharmacists, which included the chief pharmacist and three clinical pharmacists — one clinical pharmacist for oncology and one general clinical pharmacist
- six WTE pharmacy technicians.

At the time of inspection, inspectors were informed that the hospital was of the view that when compared to other Model 3 hospitals, the hospital's pharmacy department was under resourced. Hospital management had submitted business cases for an additional 10 WTE pharmacists to the South/South West Hospital Group. Staffing levels in the pharmacy department was an identified high-rated risk recorded on the hospital's corporate risk register. The lack of a comprehensive clinical pharmacy service, which includes a clinical pharmacist-led medication reconciliation service for all clinical areas, should be addressed following this inspection.

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

The Drug and Therapeutics Committee developed a medication management plan, which comprised short-, medium- and long-term objectives to support medication safety practices at the hospital. The areas of focus identified for 2022 included:

- recruiting and filling the shortfall of pharmacists at the hospital
- appointing a medication safety officer
- implementing bi-annual reporting to the Drug and Therapeutics Committee and Quality and Patient Safety Committee
- ensuring induction of new staff in medication safety practices relevant to their area of responsibility and scope of practice
- increasing patient involvement in improving medication safety practices
- developing policies, procedures, protocols and guidelines that ensure standardised, evidence-based medication practices across the hospital
- regular auditing of medication practices at the hospital to facilitate the identification of areas requiring improvement
- coordinating and providing staff with training and resources on safe medication practices.

Deteriorating patient

The hospital did not have a deteriorating patient improvement programme. At the time of inspection, the hospital was establishing a Deteriorating Patient Committee and had recruited a clinical nurse specialist[†††††] to focus on the deteriorating patient. Hospital management were progressing with the recruitment of two WTE Advanced Nurse Practitioners[‡‡‡‡‡] who, along with a consultant anaesthesiolgist as clinical lead, will roll out the deteriorating patient improvement programme at the hospital. The hospital had a critical care outreach team comprising two Advanced Nurse Practitioners who worked as part of the multidisciplinary team to identify patients at risk of clinical deterioration and patients with high early warning system scores. The hospital was using the appropriate national early warning systems for the various cohorts of patients — the INEWS, the IMEWS and the Irish Paediatric Early Warning System (IPEWS). However, the hospital had not implemented the INEWS version 2 guideline and observation chart at time of inspection. This is discussed further under national standard 3.1.

[†††††] A clinical nurse specialist is a registered nurse that is engaged in specialist practice – a particular area of focus. The clinical nurse specialist works as part of the multidisciplinary team providing specialist care to patients in hospital, community and outpatient settings.
[‡‡‡‡‡] Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

Transitions of care

Transitions of care incorporates internal transfers, shift and interdepartmental handover, external transfer of patients and patient discharge. The hospital had a patient flow manager at assistant director of nursing grade, who had oversight of the issues contributing to and impacting on patient flow, transitions of care and delayed discharges at the hospital. The hospital also had a discharge coordinator. The hospital had implemented a number of hospital admission avoidance pathways and measures to improve patient flow, and the safe transfers of patients within and from the hospital. These included:

- An alternative pre-hospital care pathway — comprising an emergency medicine non-consultant hospital doctor and emergency medicine technician from the national ambulance service who attend patients wherever they are located. The aim is to reduce emergency department overcrowding and enhance national ambulance service capacity.
- Community Intervention Team pathway — a nurse-led team, supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.
- Early Supported Discharge pathway — a multidisciplinary team that facilitates eligible patients to return home from hospital as soon as possible, while continuing to receive rehabilitative services in their home.
- Discharge to Assess pathway — eligible patients who require a medical review that cannot be carried out in another setting are reviewed and decisions regarding their care and treatment are made by the non-consultant hospital doctor at registrar grade assigned to the hospital's Acute Medical Assessment Unit and the referring consultant physicians, if necessary.
- Home Support Service for Older People — this pathway provides help and support to older persons living at home. The supports are provided by the HSE or external providers that have a service level agreement with the HSE.
- Kerry Integrated Care Programme for Older Persons — this is a national initiative that integrates primary and secondary care services for older people, especially those with more complex needs.[§§§§§] In this pathway, care is provided by a multidisciplinary team under the clinical governance of a consultant geriatrician.
- Accessing and transferring eligible patients for transitional, rehabilitation and step down care in five community hospitals[******] in the hospital's catchment area.

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§§§§§ Health Service Executive. *Integrated Care Programme for Older Persons*. Dublin, Health Service Executive. 2022. Available online from: https://www.hse.ie/eng/about/who/cspd/icp/older-persons/.
****** These five hospitals are Killarney Community Hospital, Listowel Community Hospital, Kenmare Community Hospital, Cahersiveen Community Hospital and Dingle Community Hospital.

- Using the 'daily dynamic discharge approach' to plan and ensure the timely discharge of patients. This approach involved:
  - multidisciplinary discharge planning
  - predicating a patient's discharge date early
  - effective ward rounding by medical teams
  - daily whiteboard meetings to identify patients suitable for discharge and issues impacting on delayed discharges
  - using the SAFER[††††††] patient flow bundle in all clinical areas
  - reviewing inpatient bed capacity, patient discharge and transfers into and out of the hospital at daily multidisciplinary meeting.

In 2021, hospital management, the hospital group and national HSE commissioned an external review of clinical requirements and activity at University Hospital Kerry to inform the hospital's 10 year development control plan. The review report sets out the challenges faced by the hospital in meeting forecasted demand for services at the hospital over the next 15 years. The review team recommended a phased replacement of the hospital's current facilities to ensure an environment that supports patient and staff wellbeing.

HIQA was not fully assured that the hospital had effective, robust management arrangements in place to monitor issues that impact effective, safe transitions of care. Inspectors were unclear about the governance arrangements in place at the hospital to monitor and oversee the effectiveness of the various hospital avoidance pathways and measures, and the effective and safe transitions of care within and from the hospital. As evident from findings set out in this report, the various initiatives and measures introduced to date, to improve patient flow and increase surge capacity at the hospital were not fully effective in managing the many challenges encountered. Inspectors heard how there were capacity challenges with step-down facilities, dementia-specific beds in the community and homecare support packages. However, it was not clear where and at what governance meeting these challenges were discussed by senior management, where decisions were made, and agreed actions to support continuous patient flow at and egress from the hospital.

[††††††] 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.

Nursing, medical and support staff workforce arrangements

The human resource department was responsible for workforce management in the hospital. The department tracked and trended staffing levels and absenteeism rates, which were reported at monthly performance meetings with the South/South West Hospital Group. Absenteeism rates at the hospital over the six months prior to HIQA's inspection averaged 9%, which was significantly above the HSE's target of 4% or less.

The hospital's total approved complement of nursing staff was 483 WTE. At the time of inspection, 409 WTE nursing positions were filled, which represented a variance of 74 WTE (15%) between the approved and actual nursing staff complement.

The hospital's total approved complement of midwifery staff was 98.93 WTE. At the time of inspection, 77.26 WTE midwifery positions were filled, which represented a variance of 11.59 WTE (22%) between the approved and actual midwifery staff complement.

The hospital had a total approved complement of 60 WTE medical consultant staff and had recently successfully recruited a number of consultants to a range of specialties. Notwithstanding this, at the time inspection, 48 WTE (80%) consultant positions were filled, which represented a variance of 12 WTE (20%). HIQA remained concerned about the radiologist consultant staffing compliment at the hospital. The hospital had been approved for five WTE consultant radiologists but at the time of inspection, three WTE positions were filled — one permanently, two by locum staff and two remains unfilled. The hospital was reliant on additional outsourcing to external providers for certain reporting and on call services to meet the deficits in consultant staff. During inspection, there was a reported emerging backlog (450 X-ray reports and 120 computerized tomography (CT)[‡‡‡‡‡‡] scan reports) in the clinical reporting of certain radiological examinations. This was a concern to HIQA, especially when considered in the context of prior issues and concerns around the functioning of the radiology services, which had prompted managerial intervention to seek to place the service on a more sustainable footing. This concern was escalated to the Chief Executive Officer of the South/South West Hospital Group after the on-site inspection.

The hospital had a total approved complement of 160.5 WTE non-consultant hospital doctors. At the time of inspection, 149.5 WTE (93%) positions were filled.

The hospital's inability to recruit and retain suitably qualified medical, nursing and midwifery staff was a high-rated risk recorded on the hospital's corporate risk register. Hospital management had enacted controls and actions to mitigate this risk and these controls were reviewed and updated at meetings of the executive management board. The South/South West Hospital Group had developed a nursing and midwifery workforce

[‡‡‡‡‡‡] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles of the body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside the body. CT scan images provide more detailed information than plain X-rays.

planning strategy for 2020 – 2025, but there was no evidence that a time-bound action plan was developed to facilitate the implementation of the strategy.

Staff training and education

The hospital did not have a central process to monitor the uptake of mandatory and essential training at the wider hospital level. Attendance at essential and mandatory training by non-consultant doctors was recorded on the National Employment Record (NER) system.[§§§§§§] Attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at clinical area level by clinical nurse managers. A greater level of oversight of staff uptake of mandatory and essential training is needed by the senior management team. Staff uptake of mandatory and essential training is discussed further under national standard 3.1.

There were occupational and other support systems in place at the hospital to support staff in the delivery of high-quality, safe healthcare, but hospital management could do more to ensure information about these services are available and accessible to all staff.

In summary, the hospital had functioning management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the areas of infection prevention and control, and medication safety. However, this was not the case for the deteriorating patient and the safe transitions of care. Furthermore, HIQA was not assured that there were effective governance arrangements to manage any increase in service demand, especially in emergency care and that the primary focus of the service was on quality and safety outcomes. Hospital management had implemented a number of hospital admission avoidance pathways, but more innovative measures and collaboration with community services is needed to further support these pathways and improve the experiences of people who use the services, especially older persons. HIQA acknowledges hospital management's efforts to recruit medical, nursing and midwifery staff. Nevertheless, there were substantive deficits in the hospital's approved and actual rostered complement of medical, nursing and midwifery staff, which significantly impacts on the delivery of high-quality, safe care and is a risk to patient safety, especially in the radiology department. A greater level of oversight of staff attendance at and uptake of mandatory and essential training is needed at a senior management team level.

Judgment: Non-compliant

[§§§§§§] The 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.

Inspection findings relating to the Emergency Department

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

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.
Medical staffing levels in the emergency department were not maintained at levels to support the provision of 24/7 emergency care. The emergency department had four WTE consultants in emergency medicine — three WTE appointed on a permanent and one WTE on a locum basis. The hospital had recently received approval to appoint a fifth WTE permanent consultant in emergency medicine and were progressing with the recruitment campaign to fill the position. One of the four consultants in emergency medicine was the assigned clinical lead for the department and was responsible for the day-to-day functioning of the department. Consultants in the emergency department were operationally accountable and reported to the hospital's Clinical Director. All three permanent consultants in emergency medicine were on the specialist register with the Irish Medical Council. At the time of inspection, formalised arrangements were not in place to ensure consultant cover in the emergency department 24/7. A senior clinical decision-maker[*******] at consultant level was on site in the emergency department each day during core working hours. However, HIQA was concerned about the clinical governance and supervision of non-consultant hospital doctors working in the emergency department outside core working hours. Specifically, HIQA found that there was no agreed or formalised mechanism for more junior medical staff to seek advice or support from their consultant colleagues outside of core working hours. The issue of consultant oversight and supervision of more junior staff in the emergency department outside core working hours was a high-rated risk recorded on the hospital's corporate risk register. Notwithstanding same, HIQA identified that this risk remained at the time of this inspection and it prompted HIQA to request that this issue be adequately addressed following the inspection. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

[*******] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who has undergone appropriate training to make independent decisions around patient admission and discharge.

The hospital was not an approved training site for non-consultant hospital doctors on the basic and higher specialist training schemes in emergency medicine. Consultants in the emergency department were supported by 18 WTE non-consultant hospital doctors at registrar, senior house officer and intern grades — 12 registrars and six senior house officers. Four WTE (22%) of the 18 non-consultant hospital doctor positions at registrar grade were unfilled at the time of inspection.

The emergency department's approved nursing staff (including management grades) complement was 55.2 WTE. The hospital's Acute Medical Assessment Unit was staffed from the emergency department's nursing staff rostered complement. At the time of inspection, the department's actual nursing staff complement was 42.2 WTE, which represented a variance of 13 WTE (24%). Hospital management were managing the deficit in nurse staffing levels through an ongoing recruitment campaign, the use of agency nurses and existing staff working additional hours (relief staff), which is not sustainable in the long-term. In addition, the rostering of staff was dependent on manual processes at local clinical area level, the hospital did not have a centralised or computerised rostering system to support nurse managers.

Inspectors reviewed nursing staff rosters from the emergency department for the preceding three-week period to HIQA's inspection and these showed short-term absenteeism did impact on the department's rostered nursing staff levels, both on day and night duty. The rostered complement of nursing staff was only maintained through the use of relief or agency staff. During this period, the department was short in the range of one to five staff nurses (11%-45%) during the day and one to three staff nurses (13%-33%) at night. While, the shortfall in nurse staffing levels over the three-week period was generally 11%-27% during the day and 13%-22% at night, inspectors noted that on one occasion it was 45% during the day and on another occasion it was 33% at night.

A CNM 3 had overall nursing responsibility for the emergency department and was rostered on duty Monday to Friday during core working hours. A CNM 2 was rostered on each shift (day and night). Nursing staff were supported by eight WTE healthcare assistants. However, due to short-term absenteeism, the department was short of two WTE (25%) on the rostered complement of healthcare assistants. Other members of the multidisciplinary team in the emergency department included a 2.8 WTE Advanced Nurse Practitioners and a clinical skills facilitator.

The *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*, launched by the Minister of Health in June 2022[†††††††] will help determine if an uplift in nursing and support staff is required for the emergency department. Until then, it is imperative that hospital management identify more sustainable measures to ensure the

[†††††††] 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.

department has the rostered complement of nursing staff to provide safe, high-quality care.

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. Essential training relevant to the four areas of harm was overseen by the clinical nurse manager and clinical skills facilitator assigned to the emergency department. HIQA found that the percentage of staff attendance and uptake at mandatory and essential training was sub-optimal and could be significantly improved. Training records in the emergency department showed that:

- 89% of nurses were up to date in training on transmission-based precautions
- 60% of nurses were compliant with hand hygiene practices – significantly below the HSE's target of 90%
- 86% of nurses were up to date in basic life support training
- no nurses had attended training on INEWS and IMEWS in the 24 months previous to HIQA's inspection
- 96% of nurses were up to date with training on medication safety
- no nurses had attended training on national guidance in clinical handover and Introduction, Situation, Background, Assessment, Recommendation (ISBAR)[‡‡‡‡‡‡‡] communication tool in the 24 months previous to HIQA's inspection
- 65% of nurses were up to date in training on the Manchester Triage System.

Training records for healthcare assistants in the emergency department showed that:

- all were up to date in training on transmission-based precautions
- 75% were compliant with hand hygiene practices
- 88% were up to date in basic life support training.

Records of the uptake of mandatory training for medical staff in the emergency department were not submitted to HIQA.

Overall, HIQA found that the emergency department had a significant shortfall in medical and nursing staff. At the time of inspection, there were no formalised arrangements in place to ensure consultant oversight in the emergency department 24/7. Consequently, HIQA was concerned about the clinical governance and supervision of non-consultant hospital doctors working in the emergency department outside core working hours. The emergency department also had a significant shortfall on the rostered complement of

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

nursing staff. Immediate risks to patients posed by this deficit were being prevented by the use of agency staff and relief staff working overtime, but this is not sustainable in the long-term. HIQA was concerned about the potential patient safety risk as a result of the nurse staffing shortfall. Hospital management need to plan, organise and manage their workforce to ensure the service is responsive to changes in workload or resources to ensure the delivery of high-quality, safe services. Furthermore, staff attendance at and uptake of mandatory and essential training is an area that needs significant improvement. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should be readily fixable, and should represent a key focus for hospital management following this inspection.

Judgment: Non-compliant

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[§§§§§§§] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs. Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department. In general, staff in the emergency department were observed actively engaging and communicating with patients in a respectful, kind and sensitive way.

Privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles and multi-occupancy rooms. This was confirmed by patients accommodated in single cubicles and was consistent with the hospital's findings from the 2021 National Inpatient Experience Survey, where with regard to:

- privacy when being examined or treated in the emergency department, the hospital's score was consistent with the national score of 8.3
- treated with respect and dignity while in the emergency department, the hospital scored 8.3, below the national score of 8.8.

Notwithstanding this, during the inspection, inspectors observed the severe difficulty caused by the gross overcrowding and trolley congestion in the emergency department. It

[§§§§§§§] 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.](https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services)

was clear that the privacy, dignity and confidentiality of patients accommodated on trolleys in the corridor was severely compromised. For these patients, clinical consultations and assessment were carried out on the corridor. Therefore, it was impossible to maintain the patient's privacy and confidentiality. Others (patients, visitors and staff) could overhear patient-clinician conversations and the exchange of personal information between patients, medical and nursing staff. This was not consistent with a human rights-based approach to healthcare promoted and supported by HIQA. In addition, there was limited evidence of person-centred initiatives to improve the patient experience times for older persons attending the emergency department. HIQA acknowledges that initiatives had been introduced to reduce or avoid hospital admission, but at the time of inspection, there was limited evidence of any innovative initiatives to improve and support effective care for older people attending the department.

Overall, the environment in the emergency department posed a significant risk to the health and welfare of patients attending the department. The situation in the department at the time of inspection, significantly impacted on the meaningful promotion of the patient's human rights. HIQA did not find sufficient evidence that actions taken by hospital management were effective in respecting, promoting and protecting the dignity, privacy and autonomy of patients using the service. Hospital management's inadequate efforts to address the issue of gross overcrowding in the department compromised patients' dignity, privacy and confidentiality, especially patients accommodated on the corridor. In addition, there was limited evidence of innovative dedicated pathways for older persons attending for emergency care at the hospital.

Judgment: Non-compliant

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

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

Data on patient experience times collected on the first day of inspection, showed that at 12.15pm, the hospital was non-compliant with the national key performance indicators for the emergency department. At that time:

- 24 (45%) attendees to the emergency department were in the department for more than six hours after registration — not in line with the national target that 70% of

attendees are admitted to a hospital bed or discharged within six hours of registration.

- 23 (43%) attendees to the emergency department were in the department for more than nine hours after registration ─ not in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- Eight (15%) attendees to the emergency department were in the department for more than 24 hours after registration ─ not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- Five (9%) attendees to the emergency department were aged 75 years and over. 60% (three) of these patients were admitted or discharged within nine hours of registration ─ not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.
- All attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration.

Findings on patient experience times were consistent with the findings from the 2021 National Inpatient Experience Survey where, 60% of patients waited in the emergency department between six and 24 hours before being admitted to an inpatient ward, above the national average of 56%. The hospital did not have a formalised escalation plan to respond to emergency care demand. Hospital management should progress the ratification and implementation of an escalation plan to ensure the effective management of demand for emergency care, patient flow and sufficient surge capacity within and outside the hospital.

Risk management

Emergency department-related risks were managed at department level with oversight of the process assigned to the CNM 3. Risks that could not be managed at department level were escalated to and recorded on the hospital's corporate risk register. At the time of inspection, there were two high-rated risks related to the emergency department recorded on the hospital's corporate risk register ─ capacity and consultant emergency physician cover outside core working hours. During inspection, there was limited evidence that the actions and controls applied to reduce the identified risks were effective.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were screened for signs and symptoms of COVID-19 and assigned to the appropriate pathway. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic

operating system. A prioritisation system was used to allocate patients to the single cubicles. Staff confirmed that terminal cleaning******** was carried out following suspected or confirmed cases of COVID-19. The emergency department was generally observed to be clean and well maintained on both days of inspection. Environmental hygiene was audited in the emergency department and quality improvement plans were developed to improve any areas of non-compliance. This is discussed further under national standard 2.8.

Medication safety

A comprehensive clinical pharmacist service was not in place in the hospital. Pharmacy technicians provided top-up services to the clinical areas visited during the inspection. There was evidence that some medication safety practices were audited in the department and quality improvement plans were developed to improve areas of non-compliance. This is discussed further under national standard 2.8.

Deteriorating patient

The INEWS, version 1 observation chart was used to support the recognition of and response to clinical deterioration of patients in the emergency department. However, there was limited evidence that compliance with the use and completion of the INEWS observation chart, and use of the INEWS escalation protocol in the department was audited. Hospital management were planning to introduce staff training on the emergency medicine early warning system in December 2022. The ISBAR communication tool was used when requesting patient reviews. However, there was limited evidence that compliance with national guidance on ISBAR use in the department was audited.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers to and from the emergency department. An interdepartmental transfer form was used to share relevant clinical information when transferring patients within the hospital and a referral form was used when transferring patients to community services.

Management of patient-safety incidents and serious reportable events

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported in line with the HSE's Incident Management Framework. The hospital's Serious Incident Management Team (SIMT) and executive management board had oversight of the management of serious reportable events and serious incidents that occurred in the emergency department. Patient-safety incidents and serious reportable events related to the department were tracked and trended by the quality and patient safety department. Feedback on emerging trends and themes from patient-safety and serious reportable events was not shared with staff in the emergency

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

department. Hospital management should implement a formal standardised system to facilitate the sharing of learning from patient-safety and serious reportable events.

Management of complaints

HIQA was not assured that complaints related to the emergency department were managed in line with the hospital's complaints policy. Complaints relating to the emergency department were managed locally by the CNM 3. Complaints were tracked and trended by the quality and patient safety department. Feedback on emerging trends and themes was not shared with staff in the emergency department. This is discussed further under national standard 1.8.

Overall, on the days of inspection, the number of patients boarding in the emergency department was symptomatic of increased demand for the service, ineffective patient flow and limited surge capacity. The situation was further compounded by the fact that there was no formalised escalation plan in place on the days of inspection to manage the increased demand for the service and improve operational capacity and capability. Considering the increase in morbidity and mortality associated with prolonged waiting times in the emergency department, this was a concern for HIQA. Hospital management need to introduce sustainable improvements to protect patients receiving care in the emergency department from harm and hospital management need to be supported to do this from hospital group and national HSE levels.

Judgment: Partially compliant

Inspection findings relating to the wider hospital and two inpatient clinical areas visited

This section of the report describes findings relating to the wider hospital and two inpatient clinical areas visited during the inspection. It sets out the 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).

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

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

Monitoring of service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting

requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report.

Risk management

HIQA was assured that the hospital had formalised structures and processes in place to proactively identify, analyse, manage, monitor and escalate identified risks. Risks were identified, managed and monitored locally at clinical area level and by senior hospital management. Risks identified at local clinical area level were recorded on a local risk register. Clinical nurse managers were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential patient safety risks. Risks not managed at clinical area level were escalated to senior hospital management and recorded on the hospital's corporate risk register. The executive management board had oversight of the management of risks recorded on the hospital's corporate risk register. High-rated risks not managed at hospital level were escalated to the South/South West Hospital Group. The management of risks related to the four areas of known harm is discussed further under national standard 3.1.

Audit activity

The hospital did not have a clinical audit committee that had oversight of all clinical audit activity and or the implementation of quality improvement plans arising from audit findings across the hospital. This resulted in an uncoordinated and a fragmented approach to the management of clinical auditing at the hospital. This was a high-rated risk recorded on the hospital's corporate risk register. In recognition of this, the hospital had introduced measures to mitigate the risk to patient safety, including providing staff with training in the practice of clinical audit and the recruitment of a person that will have a dedicated clinical audit support function.

Management of serious reportable events

The hospital's SIMT were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. The team had been established to ensure oversight of the reporting, reviewing and management of category one serious reportable events and serious incidents that occurred in the hospital. Serious reportable events and serious incidents were reviewed, tracked and trended by the quality and patient safety department each month. The executive management board had governance and oversight of all serious reportable events and serious incidents that occurred at the hospital. The Quality and Patient Safety Committee had recently approved a policy to standardise the approach to implementing report recommendations across the hospital. Notwithstanding this, HIQA was concerned with the delay in implementing the learning and recommendations from previous serious reportable events and serious incidents, such as the look-back of the hospital's radiology services carried out in 2018, and the potential patient safety risk associated with such delay. HIQA escalated concerns related to the apparent lack of progress in implementing the

recommendations of the look-back of radiology services to hospital management and the South/South West Hospital Group immediately following inspection.

Management of patient-safety incidents

There were systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System (NIMS),[††††††††] in line with the HSE's Incident Management Framework. The executive management board and Quality and Patient Safety Committee had governance and oversight of reported patient-safety incidents. Patient-safety incidents were also discussed at performance meetings with the South/South West Hospital Group. The hospital's rate of reporting clinical incidents to the NIMS within 30 days of date of notification was significantly less than the national target of 70%. Patient-safety incidents related to the four areas of known harm are discussed further under national standard 3.3.

Feedback from people using the service

Findings from National Inpatient Experience Surveys were reviewed at meetings of the Quality and Patient Safety Committee and updates were provided to the executive management board. The hospital was working with the HSE to implement quality improvement initiatives, in response to the 2021 National Inpatient Experience Survey findings. The quality improvement plans focused on:

- improving waiting times in the emergency department
- improving food and nutrition
- supporting patients to communicate concerns, worries and fears
- providing patient information on the side effects of medication
- early discharge processes at the hospital.

Overall, while the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. HIQA was concerned about the resources in place to support the monitoring and reporting of hospital performance. It was evident from findings of this inspection that the staffing deficits in the quality and patient safety department impacted on the operational ability to proactively promote, monitor and improve the quality and safety of services at the hospital. In addition, the hospital's rate of reporting clinical incidents to the National Incident Management System within 30 days of date of notification was significantly less than the national target of 70%. This is an area that needs to be improved following this inspection. Hospital management should also ensure and enable a proactive approach to the learning

[††††††††] 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).

from findings of serious reportable events and patient-safety incidents, and the timely implementation of recommendations to support patient safety at the hospital.

HIQA was also concerned with the apparent delay in implementing the learning and recommendations from the look-back of radiology services at the hospital and the potential patient safety risk with this delay. The emerging backlog in the clinical reporting of certain radiological examinations at the hospital was concerning in terms of the potential clinical risk this presented, and also the identified problems with the service, which resulted in the commissioning of an external review in 2018.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings related to the two inpatient clinical areas visited and wider hospital 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 informing judgments on compliance with national standards are described in the following sections.

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

Inspectors observed staff in the clinical areas visited promoting a person-centred approach to care. Inspectors observed staff in the two inpatient clinical areas visited orientating and familiarising patients with their surroundings. Staff sought patient's consent for procedures. Staff were also observed being responsive to patient's individual needs in a dignified and respectful manner. Staff were observed offering assistance at meal times, helping patients to mobilise, and providing assistance with personal cares when required.

In general, the physical environment in the two inpatient clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. Privacy curtains were used when patients were being assessed and receiving care. These findings were consistent with the overall findings from the 2021 National Inpatient Experience Survey, where most participants felt that they were always treated with respect and dignity, and had enough privacy while in the hospital. However, findings from the emergency department reported in this report showed that this was not the case in all the clinical areas visited during inspection.

The limited number of single rooms in the two inpatient clinical areas visited meant that some patents with an infection risk were cohorted together in a multi-occupancy room with

no en-suite bathroom facilities. Patients were therefore required to use commodes in the multi-occupancy room, which had the potential to impact on their privacy and dignity. The limited en-suite bathroom facilities also meant that these patients with an infective status did not have ready access to shower facilities. If a patient requested a shower, a work around was implemented – whereby they would use shower facilities in another multi-occupancy room, where patients with no infection risk were accommodated. While these showers would then be decontaminated, this approach is far from ideal from the perspective of the patient using the shower and was a potential infection prevention and control risk for other patients.

Inspectors observed whiteboards being used to record activity in the clinical areas visited and key information about patient care. On the days of inspection, no personal identifiable information was recorded on these whiteboards. However, in one inpatient clinical area, inspectors observed that patients' healthcare records and patients' personal information was not stored in line with general data protection and regulation standards. This was brought to the attention of the clinical nurse manager at the time and inspectors requested that immediate action be taken to remedy and mitigate any potential risk associated with the non-compliance.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. However, the limited number of rooms with en-suite bathroom facilities did result in some cohorted patients with a known infection having to use commodes in a multi-occupancy room, which had the potential to impact on their privacy and dignity. Patients' personal information should be protected at all times and hospital management needs to ensure that systems and processes are in place to achieve this and ensure compliance with relevant data protection legislation.

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 in the two inpatient clinical areas visited. In general, staff were observed actively listening to and effectively communicating with patients in an open and sensitive manner, in line with the patient's expressed needs and preferences. Staff were also observed responding in a timely manner to patient call bells and were attentive to patient's individual needs. This was confirmed by patients in the two inpatient clinical areas visited who spoke positively about their interactions with staff. However, some patients in the emergency department were concerned and frustrated that staff were not listening to or considering their experiences of receiving care in the department.

A culture of kindness, consideration and respect was promoted at the hospital through the development of a number of quality improvement initiatives. For example:

- the hospital had introduced a blue plate initiative to identify patients who require assistance with meals
- vulnerable patients who required assistance with care were identified at clinical handover
- translation services were used to support the effective communication with non-English speaking patients
- vulnerable and older patients at risk of falls were risk assessed. A colour coded system was used to identify those at high risk of falls and who needed assistance and support when mobilising.

Overall, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. However, listening to and acting on patient experiences is an area identified for improvement following this inspection.

Judgment: Substantially compliant

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

There were systems and processes in place at the hospital to respond to complaints and concerns. The hospital's general manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was oversight and monitoring of the timeliness of responses and the management of complaints by the relevant governance structures — Quality and Patient Safety Committee and the executive management board. The Quality and Patient Safety Committee had recently approved a policy to standardise the approach to implementing complaint recommendations across the hospital.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*'.[‡‡‡‡‡‡‡‡‡] There was limited evidence that hospital management supported and encouraged point of contact complaint resolution in line with national guidance, whereby complaints would be managed at local clinical area level by the clinical nurse manager. Informal and formal complaints were managed by the general

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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.

manager, which given the person's scope of responsibility may not be sustainable in the long-term. Verbal complaints were not recorded at the hospital, this is a missed opportunity for shared learning and quality improvement.

The hospital formally reported on the number and type of complaints received annually. Hospital management received a total of 100 complaints in 2021. Only 23% of these complaints were resolved within a 30-day timeframe, which was significantly lower than the HSE's target of 75%. Hospital management told inspectors that the delay in responding to complaints was as a result of staffing deficits in the quality and patient safety department. A complaints manager (interim) was recently appointed to the department and this person was initially assigned with the responsibility to manage the backlog in complaints that has since progressed to the management of new complaints.

There was evidence of some improvement in the complaints resolution process year to date in 2022. Eighty-five (85) written complaints were received in 2022 up until the date of inspection. Forty-eight (56%) were closed at time of inspection. The majority (71%) of the complaints were managed within the recommended timeframe of 30 days. While this demonstrates how the compliance in the management of complaints within the recommended timeframe has improved at the hospital, the percentage of complaints managed within 30 days remains lower than the HSE's target of 75%. The progress made in this area should be supported and sustained to ensure compliance with the national target.

Complaints were tracked and trended by the hospital's quality and patient safety department to identify the emerging themes, categories and departments involved. Safe and effective care, communication and information were two key themes arising from the tracking and trending of complaints in 2021. Staff outlined how a recent complaint about medical staff not communicating effectively with families was managed and successfully resolved.

There was some evidence that quality improvement initiatives were implemented to improve compliance with the complaints management process. However, hospital management need to have greater oversight of the effectiveness of these initiatives.

Staff who spoke with inspectors reported that they did not get feedback from the tracking and trending of complaints for their clinical areas and that learning from complaints or the complaints resolution process was not shared with staff or across the wider hospital, which is an opportunity missed.

Inspectors did not observe information about the HSE's '*Your Service Your Say*' displayed in the clinical areas visited on the days of inspection. Furthermore, the majority of patients who spoke with inspectors did not know how to make a complaint and had not been provided with information on the complaints process.

The hospital did not have a dedicated patient advice and liaison service. In hospitals that have such service, the service supports patients, their families and carers to provide feedback or make a compliant about the care patients received at the hospital. They ensure

that the patient voice is heard either through the patient directly or through a nominated representative. Patients and staff who spoke with inspectors were not aware of any independent advocacy services available to patients. Inspectors did not observe information about independent advocacy services displayed in any of the clinical areas visited on the days of inspection.

Overall, while there were systems and processes in place at the hospital to respond to complaints and concerns raised by people who use their services, HIQA was not satisfied that these were fully effective in resolving complaints and concerns promptly and effectively. Hospital management should continue to implement measures to support the prompt, open and effective resolution of complaints within HSE targets so as to improve the experience of people using the service. Hospital management should also support and encourage point of contact complaint resolution, in line with national guidance. Patients receiving care at the hospital should be provided with information on the hospital's complaints process and on any independent advocacy services available to them. A formal standardised system should also be implemented at the hospital to facilitate the sharing of learning from complaints and the complaints resolution process to help reduce reoccurrence of the same issues for people using their services.

Judgment: Partially compliant

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

During inspection, inspectors observed that overall, in the clinical areas visited, the hospital's physical environment was generally well maintained and clean with few exceptions. There was evidence of general wear and tear of woodwork and floor surfaces, with paintwork and wood finishes chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk.

Environmental cleaning was carried out by an external contract cleaning company and the process was underpinned by a formal policy approved by the chair of the Hygiene Services Committee and the hospital's deputy general manager. Cleaning supervisors and clinical nurse managers had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal cleaning was carried out by designated cleaning staff. Clinical nurse managers who spoke with inspectors said they were satisfied with the level of cleaning resources in place during and outside core working hours.

Cleaning of equipment was assigned to healthcare assistants and a tagging system was used to identify clean equipment. In all clinical areas visited, the equipment was observed to be generally clean. Hazardous material and waste was safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Hand hygiene sinks throughout the hospital conformed to requirements.[§§§§§§§§] Infection prevention and control signage in relation to transmission-based precautions was observed. Where transmission-based precautions were in place, the patient's chart was stored appropriately outside the patient's room.

PPE was available outside isolation rooms and multi-occupancy rooms where patients with confirmed or suspected infections were accommodated. Staff were also observed wearing appropriate PPE, in line with public health guidelines at the time of inspection. Physical spacing of one metre was observed to be maintained between beds in multi-occupancy rooms in the inpatient clinical areas visited. However, this was not the case for trolleys on the corridor in the emergency department. Supplies and equipment were stored adequately and appropriately in all clinical areas visited.

There were processes in place to prioritise and ensure appropriate placement and management of patients with suspected or confirmed communicable disease, which was underpinned by a formalised prioritisation criteria. There were isolation facilities in both inpatient clinical areas visited. Notwithstanding this, the number of isolation rooms with adequate en-suite bathroom facilities was insufficient. This was a high-rated risk recorded on the hospital's corporate risk register.

On the first day of inspection, inspectors identified the following number of issues that had the potential to impact on patient safety:

- patients with an infection risk were cohorted in a multi-occupancy room, but inspectors observed that the door to the room was open, which is not in line with effective infection prevention and control practices. Inspectors brought this to the attention of the clinical nurse manager during inspection for immediate remedy
- the bed pan washer and disinfector in one clinical area visited was out of service for a number of weeks prior to HIQA's inspection. A risk assessment had been completed and it was evident relevant controls put in place to mitigate the potential risk to patients. The issue had been escalated to hospital management.

In summary, the physical environment and patient equipment was observed to be generally clean and well maintained at the time of inspection. However, 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 therein. The number of isolation rooms with en-suite bathroom facilities in both inpatient clinical areas visited was inadequate, which increased the risk of cross-infection. A bed pan washer was out of service for several weeks and while a work around was implemented, the measure was not ideal.

[§§§§§§§§] 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.

Doors of isolation rooms were left open, which is not consistent with effective infection prevention and control practices. Collectively, these issues presented a potential risk to patient safety.

Judgment: Partially compliant

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

Hospital management monitored and reviewed information from multiple sources, including:

- quality and safety performance metrics
- findings from audit activity
- risk assessments
- quality nursing and midwifery metrics
- patient-safety incident reviews
- complaints
- national inpatient experience surveys.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee had oversight of the monitoring of infection prevention and control practices at the hospital. Monthly environment, equipment and hand hygiene audits were undertaken at the hospital using a standardised approach.

Environmental hygiene audits were carried out by clinical nurse managers and the hospital's quality coordinator for hygiene services. Recent compliance rates for the three clinical areas visited during inspection showed that the clinical areas were not compliant with the national HSE target of 90% for environmental hygiene. Compliance rate with environmental hygiene practices ranged from 72.9% (emergency department) to 86.8% (Rathass). The hospital's overall environmental audit score, based on audits findings from four clinical areas, for quarter one and two of 2022 was 89.5%, marginally lower than the HSE's target of 90%.

Findings from environmental hygiene audits were shared with clinical staff and there was some evidence that time-bound action plans were developed when hygiene standards fell below expected standards. The infection prevention control team and clinical nurse managers were responsible for and had oversight of the implementation of these action plans. However, this is an area that could be improved, action plans should be developed for

all incidences of non-compliance to ensure the hospital comes into compliance with effective environmental hygiene standards.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection.[*********]

Every month the hospital monitored and publically reported on rates of:

- *Clostridioides difficile* infection
- carbapenemase-producing enterobacterales
- hospital-acquired *Staphylococcus aureus* blood stream infections
- hospital-acquired COVID-19 and outbreaks.

Year to date in 2022, the hospital's rate of new cases of:

- hospital-acquired *Clostridioides difficile* ranged from 2.90 (April) to 6.90 (January), which were above the HSE's target of less than 2 per 10,000 bed days. Inspectors were unclear what action or actions had been introduced at the hospital in response to high rates of *Clostridioides difficile*.
- hospital-acquired *Staphylococcus aureus* blood stream infection ranged from 1.50 (April) to 1.70 (June), which was significantly above the HSE's target of less than 0.8 per 10,000 bed days.

The hospital had two cases of carbapenemase-producing enterobacterales for the year to date in 2022. HIQA was satisfied that these two cases were appropriately investigated, with recommendations made and learning shared with staff to reduce the incidence of reoccurrence. Notwithstanding this, there was no evidence that a time-bound action plan was developed to implement the various recommendations from the outbreak management review, to mitigate the risk to patient safety in the medium- and longer-term and to sustain safe, high-quality healthcare services.

Regular hand hygiene audits were conducted across the hospital, but findings from audits carried out in 2021 showed that the hospital was not compliant with the HSE's target of 90%. To bring the hospital into compliance, the infection prevention and control team provided staff with additional training on effective hand hygiene practices. Compliance with peripheral vascular catheter and urinary catheter care bundles was also monitored monthly and documentation submitted to HIQA showed a high level of compliance with these care bundles.

[*********] 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.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication audits were carried out in the following areas:

- medical reconciliation
- venous thromboembolism prophylaxis[†††††††††]
- custody and storage of controlled drugs
- prescribing, dispensing, storage and administration of insulin
- dosing and monitoring the use of gentamicin
- dosing and monitoring the use of gentamicin and vancomycin in obstetrics and gynaecology.

Quality improvement initiatives were identified at the end of each medication audit report, but there was limited evidence that time-bound action plans were developed to implement these initiatives. Notwithstanding this, there was evidence that some initiatives were introduced to improve medication safety practices at the hospital. Inspectors observed initiatives in use to improve the custody and storage of controlled drugs and the storage, labelling and use of insulin. There was limited evidence that the new initiatives were re-audited to determine the effectiveness of improvements on medication safety practices.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. An audit into antimicrobial use was carried out in May and June 2022, which found that the hospital was non-compliant with the majority of the HSE's metrics for the prescribing of antimicrobial therapy. There was limited evidence that time-bound action plans were developed and implemented to improve compliance in this area.

The hospital participated in the HSE's national antimicrobial point prevalence study. The findings of the August 2022 point prevalence survey showed that the hospital had an antimicrobial prevalence rate of 67%, which was significantly higher than the expected rate of 30-35%. While the majority (71%) of the antimicrobial agents prescribed were in line with local guidelines or approved by the consultant microbiologist, the rate was significantly lower than the 87% reported in quarter 2 of 2022. Quality improvement initiatives were identified at the end of antimicrobial audit reports, but there was no evidence that time-bound action plans were developed to improve antimicrobial use at the hospital. The high

[†††††††††] Venous thromboembolism (VTE) prophylaxis consists of pharmacologic and non-pharmacologic measures to diminish the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE).

rate of antimicrobial use does need to be further explored and measures implemented to bring the hospital in line with the expected rate of 30-35%.

Deteriorating patient monitoring

Performance data relating to the escalation and response of the deteriorating patient was collated monthly through HSE's 'Test Your Care'[‡‡‡‡‡‡‡‡‡] metrics. Compliance with these metrics varied across the clinical areas visited, with a high level of compliance noted in some clinical areas. However, the auditing of compliance with national guidance on INEWS and sepsis management, and the ISBAR communication tool could be improved across the hospital.

Transitions of care monitoring

The number of new attendances to the emergency department, patient experience times, the average length of stay of a medical and surgical patient and the rate of delayed transfer or discharge were tracked at the hospital every month. At the time of inspection, 15 patient transfers were delayed.

There was limited evidence of auditing compliance with national guidance on clinical handover. National guidelines recommend that clinical handover be monitored and audited regularly to assure senior managers that any necessary continuous quality improvements are put in place to ensure compliance with national guidance.

Staff in all three clinical areas visited were not aware of the hospital's findings from the National Inpatient Experience Survey and could not provide examples of quality improvement plans in place to improve the experience for people using the service.

Overall, the hospital had some systems in place to monitor and evaluate healthcare services provided at the hospital. However, the hospital was not auditing compliance with national guidance on clinical handover, the use of the ISBAR communication tool, INEWS and sepsis management. Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with standards and guidance, they identify areas for improvement and provides hospital management and people who use the service with assurances on the quality and safety of services provided at the hospital. HIQA was not fully assured that all information from monitoring activities was being used to improve practices in relation to the four areas of known harm and the effectiveness of any improvements were being re-audited.

Judgment: Partially compliant

[‡‡‡‡‡‡‡‡‡] Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

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

The hospital had systems and processes in place, which were intended to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. Risks were identified and managed at clinical area level and risks not managed at that level, were escalated to senior management and recorded on the hospital's corporate risk register. The Quality and Patient Safety Committee and executive management board had oversight of the risks on the hospital's corporate risk register and the effectiveness or not of corrective actions or controls in place to mitigate the risks to patient safety.

At the time of inspection, 21 high-rated risks related to the four areas of known harm were recorded on the hospital's corporate risk register. These included risks related to: infrastructure and physical environment, medical, nursing and midwifery staffing levels, auditing systems and clinical governance arrangements.

Infection outbreak preparation and management

Patients were screened for multi-drug resistant organisms and patients who were suspected or symptomatic for COVID-19 were screened at point of entry to the hospital. However, not all patients were screened on admission for carbapenemase-producing enterobacterales, as per national guidance. Due to the limited numbers of single isolation rooms at the hospital, all patients with an infective status were not isolated within 24 hours of admission or diagnosis as per national guidance. In addition, the patient's infection status was not recorded on a sample of healthcare records reviewed by inspectors. HIQA acknowledges that it will take time to address the infrastructural issues at the hospital. Potential risks were mitigated by the cohorting of patients suspected or confirmed with infection in multi-occupancy rooms or the boarding of patients in the emergency department, if patients had accessed care there.

For the year to date (2022), the hospital has had outbreaks of COVID-19 and carbapenemase-producing enterobacterales. The process of managing an infection outbreak was underpinned by a formalised up-to-date policy. Multidisciplinary outbreak teams were convened to advise and oversee the management of the COVID-19 and carbapenemase-producing enterobacterales outbreaks. The summary reports from both outbreaks, submitted to HIQA were comprehensive and outlined control measures to mitigate the risk to patient safety in the short-term, potential contributing factors and recommendations to reduce reoccurrence of outbreaks. However, time-bound action plans were not developed to implement the recommendations made from the outbreak reports, which comprised the implementation of medium to longer-term actions to mitigate the risk to patient safety and sustain safe, high-quality healthcare services.

Medication safety

There were only limited clinical pharmacy services at the hospital and pharmacy-led medication reconciliation was not undertaken on all patients. Medication stock control was carried out by pharmacy technicians every week. HIQA was satisfied that risk-reduction strategies for high-risk medicines were used in the hospital. The hospital had a list of high-risk medications that included the core high-risk medications represented by the acronym 'A PINCH'.[§§§§§§§§§] The use of high-risk medications was underpinned by a formalised policy approved by the Drugs and Therapeutic Committee that was due to be updated in 2021. The hospital had a list of sound-alike look-alike medications (SALADs). Inspectors observed the use of risk-reduction strategies to support the safe use of anticoagulant, insulin and opioid medicines. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care in hard copy format, and through an application for smart phones.

Deteriorating patient

The hospital had implemented the INEWS version 1 guideline and observation chart. The INEWS version 2 guideline and observation chart were published by the Department of Health in July 2020. The INEWS version 2 guideline was developed by the National Clinical Effectiveness Committee (NCEC), a committee set up by the Minister for Health in September 2010. The committee have published a number of national clinical guidelines providing guidance and standards for improving the quality, and to support the provision of evidence-based and consistent services across the Irish healthcare system. The guidelines are mandated from the Minister of Health and should be implemented across the healthcare system. The national mandated guideline and observation chart for INEWS version 2 were implemented in the other hospitals inspected by HIQA to date.

Staff in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient. There were systems in place to manage patients with a triggering early warning system. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. The ISBAR communication tool was used when requesting a patient review. The hospital also had an outreach critical care team who were available to review patients with a triggering early warning score. Inspectors reviewed a sample of healthcare records and found that INEWS charts were not always completed correctly, INEWS scores were not always calculated correctly and documentation was not compliant with acceptable standards of recording clinical practice. Inspectors escalated and discussed these issues with the clinical nurse managers during inspection.

[§§§§§§§§§] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

Safe transitions of care

The hospital had some systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services, and to support safe and effective discharge planning. The hospital had a discharge coordinator and staff used a number of transfer and discharge forms to support the exchange of information, which is imperative to the safe transition of care. Notwithstanding this, HIQA found evidence of a delay in the issuing of discharge summaries to primary healthcare services. Timely discharge summaries to primary care healthcare professionals is essential to enable and support improved quality and continuity of care after discharge from acute services.

Policies, procedures and guidelines

The hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, managements of patients in isolation and equipment decontamination.

The hospital also had a suite of up-to-date medication policies, procedures, protocols and guidelines.

All policies, procedures, protocols and guidelines were accessible to staff via the hospital's Intranet. The hospital had no computerised document management system in place, but would benefit from such a system to assist document control and ensure clinical staff have access to up-to-date versions of policies, procedures, protocols and guidelines.

Uptake of mandatory and essential training

There was evidence that clinical nurse managers and clinical skills facilitators were responsible for maintaining a record and had oversight of the uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and INEWS on the HSE's online learning and training portal (HSELanD). Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training.

Staff uptake of mandatory and essential training was sub-optimal and requires significant improvement.

- Nursing and midwifery staff uptake of mandatory training in hand hygiene in the last two years was 71%, significantly below the HSE target of 90%.
- Nursing and midwifery staff uptake of mandatory training in standard and transmission-based precautions in the last two years was 69%.
- Nursing staff uptake of mandatory training in donning and doffing PPE in the last two years was 80%.

- Nursing and midwifery staff uptake of mandatory training in medication safety in the last two years was 49%.

Nursing and midwifery staff uptake of mandatory training in early warning systems in the last two years was also sub-optimal. The rates of uptake for:

- INEWS and sepsis management was 10% - significantly lower than the HSE's target of 85%.
- IMEWS was 8%
- IPEWS was 9%.

Training records detailing the uptake of training in hand hygiene, transmission-based precautions, donning and doffing PPE and early warning systems for medical staff were not submitted to HIQA.

In summary, there were some systems in place at the hospital to identify and manage the potential risks associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. A comprehensive clinical pharmacy service should be developed and implemented across all clinical areas to support safe medication practices at the hospital. Hospital management must also ensure and support the implementation of the latest version of the early warning systems. Notwithstanding the impact the COVID-19 pandemic has had on the delivery, attendance at and uptake of essential and mandatory training over the last two years, staff attendance at and uptake of training was sub-optimal, and is an area in need of significant improved. It is essential that hospital management ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice, and at the required frequency, in line with national standards.

Judgment: Partially compliant

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

There were systems in place at the hospital to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital's rate of reporting of clinical incidents to NIMS for 2021 was lower (8.20 to 19.10 per month), when compared to other similar sized hospitals.[**********] Higher reporting rates of clinical incidents generally mean there is a good reporting culture and greater visibility of risk at the hospital, which are key determinants for safer healthcare services.

[**********] Compared to Mercy University Hospital, Midland Regional Hospital Tullamore, Regional Hospital Mullingar, St. Luke's General Hospital, Kilkenny and Wexford General Hospital.

In 2021, 42% of the clinical incidents that occurred in the hospital were reported within 30 days of date of notification, this is significantly lower than the HSE's target of 70%. On average, it took 79 days for clinical incidents and 50 days for serious incidents and serious reportable events to be reported to NIMS. Hospital management, identified that the under resourcing of the quality and patient safety department was a major contributor to the hospital's non-compliance with the rate of reporting to NIMS.

Staff who spoke with HIQA were knowledgeable about what and how to report, and manage a patient-safety incident and were aware of the most common patient-safety incidents reported ─ falls. The quality and patient safety department tracked and trended patient-safety incidents in relation to the four key areas of known harm. The Quality and Patient Safety Committee, SIMT, executive management board and South/South West Hospital Group had oversight of the numbers and categories of reported patient-safety incidents. Information relating to and feedback on patient-safety incidents was shared with staff in clinical areas informally by clinical nurse managers. There was no evidence that safety huddles were held in the inpatient clinical areas visited. Safety huddles is a process to share learning from patient-safety incidents and discuss operational issues that could impact on patient safety. A formal standardised system should be implemented at the hospital to facilitate the sharing of learning from patient-safety incidents.

The implementation of recommendations from reviews of patient-safety incidents was monitored by the hospital's quality and patient safety department. Updates on the progress of implementation of recommendations were provided to relevant governance committees. Despite these arrangements, HIQA found that the implementation of recommendations from reviews of patient-safety incidents were not always progressed in a timely way. Consequently, there was a further risk to patient safety associated with this delay. HIQA was concerned with the apparent delay in implementing the learning and recommendations from the look-back of radiology services carried out in 2018 and the potential patient safety risk associated with this delay.

Infection prevention and control patient-safety incidents

The infection prevention and control team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective action or preventative measures. Infection prevention and control related patient-safety incidents were reported to the Infection Prevention and Control Committee who had oversight of the effectiveness of any actions and measures introduced to mitigate any patient safety risk.

Medication patient-safety incidents

Medication patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Medication related patient-safety incidents were reported to the Medication Safety Committee. In 2021, 170 medication patient-safety

incidents were reported in the hospital, with omitted or delayed dose being the most commonly reported incident.

Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not tracked or trended at the hospital.

Overall, HIQA was satisfied there was a system in place at the hospital to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm. Infection prevention and control patient-safety incidents and medication incidents, were tracked and trended and it was evident that some initiatives were implemented to improve clinical practices and patient safety in these areas. Notwithstanding this, hospital management should ensure compliance with timelines for data entry into NIMS. HIQA was concerned with the apparent delay in implementing the learning and recommendations from serious reportable events and patient-safety incidents and the possible impact this may have on the continual improvement of practice and services for people using the service.

Judgment: Partially compliant

Conclusion

HIQA carried out an announced inspection of University Hospital Kerry to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on a selection of the national standards, and as part of same HIQA placed a particular focus on measures the hospital had put in place to manage four areas of known potential patient safety risk — infection prevention and control, medication safety, deteriorating patient and transitions of care. The inspection also assessed levels of compliance against a number of national standards in the emergency department. Overall, HIQA found evidence of significant non-compliance with the national standards assessed during inspection (see Appendix 1). HIQA escalated the findings from the inspection to hospital management and the hospital group and sought that immediate actions be identified and implemented to address them.

Capacity and Capability

The hospital had defined corporate and clinical governance arrangements in place. However, these structures were overly operational and there was limited evidence of devolved accountability and responsibility. There was also limited evidence of the integration of corporate and clinical governance structures and processes at the hospital. The hospital's senior management team were in a state of transition and efforts were underway to improve and strengthen the quality and patient safety function at the hospital. Moreover, HIQA acknowledge significant recent efforts to seek to enhance clinical governance at the hospital. Notwithstanding this, the clinical governance structures would benefit from further review

and restructuring, and possible rationalisation to enhance and enable integration of clinical and corporate governance arrangements, to support and improve clinical and operational effectiveness.

There were management arrangements at the hospital to manage and oversee the delivery of high-quality, safe and reliable healthcare services in the areas of infection prevention and control, and medication safety. However, this was not the case for the deteriorating patient and transitions of care. HIQA was not fully assured that there was adequate governance arrangements to manage any increase in service demand and that the primary focus of the service was on quality and safety outcomes. Moreover, HIQA was not assured that the management arrangements in the emergency department were effective in managing issues evident in the department on the days of inspection. Operationally, the emergency department was not functioning as effectively as it should be, was grossly overcrowded and had significant issues with patient flow and inadequate surge capacity, which collectively posed a patient safety risk and was a concern to HIQA. This was further compounded by the fact that there was no formalised escalation plan in place, which is not the operational norm found in other the hospitals inspected by HIQA. HIQA acknowledges that following this inspection, it is intended that an escalation plan is to be ratified by the relevant governance structure and introduced imminently.

Hospital management were working to recruit medical, nursing and midwifery staff to fill vacant positions. Nevertheless there were substantive deficits in the hospital's approved and actual rostered complement of medical, nursing and midwifery staff. This is a substantial risk to patient safety. The senior management team also need to have a greater level of oversight of staff attendance at and uptake of mandatory and essential training. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice, and at the required frequency, in line with national standards.

The hospital had monitoring arrangements in place for identifying and acting on opportunities to improve the quality and safety of all services. However, the hospital was not systematically monitoring compliance with all national standards and guidance. Quality improvement plans were not always developed to improve practices and standards in the hospital. HIQA was concerned about the effect that staffing deficits in the quality and patient safety department was having on the operational ability to proactively promote, monitor and improve the quality and safety of services at the hospital.

The hospital had occupational and other support systems in place to support staff, but hospital management could do more to ensure information about these services are available and accessible to all staff.

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 promote 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 had varied experiences of receiving care at the hospital. Those who received care in inpatient clinical areas tended to have a more positive experience than people who received care in the emergency department. Patient's privacy, dignity and confidentiality was severely compromised in the emergency department, especially for patients accommodated on trolleys on the corridor.

HIQA was not satisfied that the systems and processes in place at the hospital to respond to complaints and concerns raised by people who received care at the hospital was fully effective in resolving complaints and concerns promptly and effectively. Hospital management should continue to implement measures to support the prompt, open and effective resolution of complaints. Hospital management should also further support and encourage point of contact complaint resolution where possible. A formal standardised system should also be implemented to facilitate the sharing of learning from compliments and complaints and the complaints resolution process, serious reportable events and patient-safety incidents.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of en-suite bathroom facilities, which increases the risk of cross-infection.

There were systems in place at the hospital to monitor and improve healthcare services. However, there was no auditing of compliance with national guidance on clinical handover and the use of the ISBAR communication tool or escalation and response in relation to acute clinical deterioration. Furthermore, time-bound action plans were not always developed to action findings from audit activity so evidence of continual improvement was limited. Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with best practice standards and guidance. Audits identify areas for improvement and provides hospital management and people who use the service with assurances on the quality and safety of the care and services provided at the hospital.

There were systems in place at the hospital to proactively identify, manage and minimise unnecessary or potential risk of harm to people receiving care at the hospital. However, hospital management should work to ensure that a comprehensive clinical pharmacy service is developed and implemented across all clinical areas to support safe medication practices at the hospital. In addition, staff attendance at and uptake of mandatory and essential training was sub-optimal and needs significant improvement. It is essential that hospital management ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

HIQA was satisfied that there was a system in place at the hospital to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm. Notwithstanding this, the hospital's timeliness of reporting patient-safety incidents to

the National Information Management System should be improved. HIQA was also concerned with the apparent delay in implementing the learning and recommendations from the look-back of radiology services carried out in 2018 and the potential patient safety risk associated with this delay. At the time of the inspection, HIQA identified that there was an emerging backlog in the clinical reporting of certain radiological examinations. This was concerning both in terms of the potential clinical risk this presented, and also given previously identified problems with the service which prompted external interventions.

Immediately following this inspection, HIQA escalated a number of risks to patient safety identified during the course of the inspection to senior management at the hospital and the Chief Executive Officer of the South/South West Hospital Group. HIQA was particularly concerned about the lengthy waiting times in the emergency department, nursing staff levels at the hospital, the absence of formalised consultant cover in the emergency department outside core working hours, the lack of clarity regarding the appointment of a new clinical director and the apparent lack of progress in implementing many of the recommendations from the look-back review report of the hospital's radiology services carried out in 2018. HIQA also met with the Chief Executive Officer and other members of the management team from the South/South West Hospital Group shortly after the inspection to specifically discuss these concerns in further detail and ensure clarity in relation to the issues HIQA identified in the interest of them being rapidly addressed. At this meeting, the hospital group committed to supporting hospital management to implement actions and measures to manage and mitigate the patient safety risks identified during the course of the inspection.

The *National Standards for Safer Better Healthcare* were mandated for implementation in public acute hospitals by the Minister for Health in 2012. Since that time, HIQA has identified through its monitoring, a general pattern of progress in many hospitals in their efforts to enhance governance arrangements and other mechanisms to ensure service quality and safety, and compliance with the standards. However, this most recent inspection at University Hospital Kerry identified a number of significant deficits, with respect to levels of compliance against the national standards. Indeed, HIQA found significant deficits in governance and management arrangements to promptly manage risks at a time when the hospital management team were in transition. Notwithstanding that, inspectors were able to identify that a number of important and positive developments had been progressed at the hospital by highly committed staff to improve the quality and safety of services in recent times. However, the hospital remains substantially behind many of its peers in relation to the proper functioning of many of the arrangements that ensure service quality and safety that are well embedded elsewhere.

Consequently, significant further work – underpinned by effective leadership and support external to the hospital in the delivery of a clear improvement plan – are required to further progress service quality and safety at the hospital and address many of the findings HIQA has identified through this inspection. Moreover, it is imperative that when issues are identified within the hospital such as those previously found in the radiology services,

management oversight ensures that the risk issues that have previously led to the issuance of recommendations to improve services are fully and sustainably addressed.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management and the South/South West Hospital Group (see Appendix 2), as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to properly address HIQA's findings at the hospital, in the best interest of the patients that the hospital serves.

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

Compliance classifications

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

Capacity and Capability Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Non-compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Substantially complaint
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant

Quality and Safety Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for University Hospital Kerry

Compliance Plan for University Hospital Kerry OSV-0001036

Inspection ID: NS_0014

Date of inspection: 20 and 21 September 2022

Introduction: This document sets out a compliance plan for healthcare providers to outline intended action(s) following an inspection by the Health Information and Quality Authority (HIQA) whereby the service was not in compliance with the National Standards for Safer Better Healthcare. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

This compliance plan only relates to:

- National standards that were deemed partially or non-compliant by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

It is the service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). The compliance plan should detail how and when the service provider will comply with the standard(s) that the organisation had failed to meet.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Instructions for use

The service provider must complete this plan by;

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

The service provider's compliance plan should be SMART in nature;

- Specific to the standard
- Measurable so that it can monitor progress
- Achievable

- Realistic
- Time bound.

Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems they have in place to ensure compliance with a particular standard, under which a partial or non-compliance has been identified.
- Service providers should change their systems as necessary to bring them back into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame(s) as set out in this compliance plan.
- Subsequent action(s) and plans for improvement related to high risks already identified to service providers should be incorporated into this compliance plan.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate measures to address the areas of risk previously identified by HIQA inspectors may result in escalation to the relevant accountable person in line with HIQA policy and continued monitoring.

Long-term and medium-term work to meet compliance with the standards

HIQA recognise that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the service plans to improve the level of compliance with the relevant national standard.

In addition to detailing longer term solutions, HIQA requires assurance and details of;

- how mitigation of risk within the existing situation will be addressed
- information on short and medium-term mitigation measures to manage risks and improve the level of compliance with standards should be included in the compliance plan
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance Plan Service Provider's Response

The following compliance plan below is aligned to the External Review conducted in University Hospital Kerry (UHK) in 2022.

The following timescale is used for structuring the actions to be taken to bring the hospital in to compliance with the relevant standards:

Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to overall inspection findings	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. National Acute Operations, SSWHG and UHK to agree the development and implementation of a robust action plan with clear owners and time bound deliverables as detailed in the UHK Review 9th-11th Match 2022
2. The Executive Management Board to develop and implement a hospital strategy for UHK, informed by the UHK Review commissioned by National Director for Acute Operations and the Ingenium Culture Survey and other relevant national strategies e.g. Sláintecare
3. In conjunction with National Acute Operations Office and as per the UHK Review 9th-11th Match 2022 establish a transformation team to support the development of business units or a clinical directorate structure with business support, processes and functions to enable effective operation.
4. Address issues with patient flow through the full implementation of the five fundamentals project including (a) the acute floor (b) SAFER (c) Egress pathways. These will be EMB mandated projects with EMB sponsors for agreed priority work programmes. Clinical Programme leads to be identified and appointed working to EMB.
5. Full implementation of the Deteriorating Patient Improvement Programme overseen by the Deteriorating Patient Committee

Medium Term

1. Governance review and restructure the Executive Management Board committee to ensure the focus is on strategic planning and development.
2. Review and restructure the Quality and Patient Safety Committee to ensure monitoring and oversight of quality & patient safety processes
3. Integrate the quality, risk, complaints and clinical audit structures and processes within the hospital under the leadership of a Grade 8 Quality, Risk and Patient Safety Manager (recruitment in progress)

Short Term

1. EMB now has additional clinical representation to ensure the integration of corporate and clinical governance **Complete**
2. Deteriorating patient programme to be overseen by the Deteriorating Patient Committee:
   (a) INEWS ongoing education and training sub group in place. **Complete**
   (b) cANP's Outreach Critical Care and CNM II for deteriorating patient appointed. **Complete**
   (c) Clinical lead for Deteriorating Patient in place. **Complete**
   (d) Deteriorating Patient Committee Terms of Reference agreed. Committee will Be established
3. Bed Management/Discharge Committee will oversee:
   (a) Agreement to review the joint working arrangements across acute and community services with initial weekly meetings during winter period to support effective patient flow and egress Terms of reference to be agreed
   (b) Revise terms of reference of Acute Egress Group with designated escalation contact in the acute and community sectors
4. Development of the daily EDAMU safety huddles at 08.15 to include representation from General Management. Actions will be documented in a time bound action plan. ED/Paediatric daily 16.00 huddle. **Complete**

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to Emergency Department findings	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. Development of capital restructuring of University Hospital Kerry to be informed by the Archus Report
2. Development of Minor Injury Unit to be progressed by the Business Manager for Capital projects and Estates in conjunction with Cork/Kerry Community Healthcare
3. Out Patient Antimicrobial Treatment service to be fully established
4. Address issues with patient flow through the full implementation of the five fundamentals project including (a) the acute floor (b) SAFER (c) Egress pathways. These will be EMB mandated projects with EMB sponsors for agreed priority work programmes. Clinical Programme leads to be identified and appointed working to EMB.

Medium Term

1. Governance review and restructure of the Executive Management Board committee to ensure the focus is on strategic planning and development to include emergency care services provided by the hospital.
2. Implementation of Framework for Safe Nurse staffing and skill mix in Adult Emergency Care settings.
3. Full implementation of Health Performance Visualisation Platform to support patient flow to be overseen by Operations Manager
4. UHK escalation policy in place. **Complete**. Review of effectiveness to be undertaken by General Manager
5. Review and understand performance data for unscheduled care both acute and community.
6. Improved flow in transitions of care will lead to a reduced PET time for ED patients. Performance will be measured by the Egress group using the Health Performance Visualisation Platform

7. To work with CHO colleagues to address the reduction in GP referrals.

Short Term

1. Local implementation group for Safe Staffing to oversee implementation of Framework for Safe Nurse staffing and skill mix in Adult Emergency Care settings commencing 12/01/2023 in conjunction with National Lead for Safe Nursing Staffing ONMSD
2. Daily EDAMU safety huddles at 08.15 to include representation from General Management. Actions will be documented in a time bound action plan. ED/Paediatric daily 16.00 huddle. **Complete**
3. Weekly AMU steering group meetings (chaired by the Director of Nursing/scheduled care lead) to maximise AMU, discharge to assess productivity including issues relating to access to diagnostics **Complete**
4. Model of frailty at the front door as supported by Enhanced Community Care project to be reviewed, recruitment commenced, implementation group to be established and oversight by the integrated unscheduled care group
5. Agreement to re-establish the local integrated unscheduled care group with initial weekly meetings during winter period. Terms of reference to be agreed
6. Revise terms of reference of Acute Egress Group with designated escalation contact in the acute and community sectors to oversee delayed transfers of care and complex discharges
7. Implementation of Pathfinder, recruitment commenced, local implementation group commencing 15/12/2022 comprising of local and national representation to report to the local unscheduled care group
8. Hospital Ambulance Liaison Person has commenced in ED UHK, effectiveness to be overseen by Regional Unscheduled Care Group in conjunction with National Ambulance Service. **Complete**
9. ED Triage escalation plan in place, daily Senior Management oversight of triage KPI**. Complete**

Timescale:

Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to Emergency Department findings	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Long Term

1. In conjunction with SSWHG seek approval for additional Emergency Department Consultant cover to ensure continuous senior oversight and supervision of more junior staff.
2. Implement centralised Electronic Rostering, business case submitted to SSWHG.
3. Implement centralised electronic system to capture mandatory training which will be overseen by the Training & Development Officer.
4. Full implementation of the Framework for Safe Nurse Staffing and Skill Mix in Adults Emergency Care Settings in Ireland. Implementation group commencing.
5. Development of the Human Resource department UHK to support recruitment and workforce development.

Medium Term

1. UHK escalation policy in place to ensure workforce is responsive to changes in service demands. **Complete.** Review of effectiveness to be undertaken by General Manager.
2. In accordance with the UHK Review 9th-11th Match 2022 the hospital is working from a low staffing base in comparison with other Model 3 hospitals. A review will be undertaken of current resources within UHK in conjunction with the SSWHG to support operational effectiveness.

Short Term

1. Emergency Consultant cover - 80% 24/7. **Complete**
2. Awaiting start date for 5th ED Consultant. Locum ED Consultant position has been offered out.

3. Ongoing ED nurse recruitment, seven nurses recruited to reduce the deficit in ED since inspection. Baseline ED WTE will be in place
4. Recruitment will be ongoing to implement the Safe Nurse Staffing. Local Implementation group commencing
5. Mandatory Training needs identified are being addressed, schedule agreed. Attendance monitored by Nurse Practice Development department.
6. Medical Manpower team to explore options for enhanced oversight of the NER system to track mandatory training done by NCHDs
7. Model of frailty at the front door as supported by Enhanced Community Care project to be reviewed, recruitment commenced, implementation group to be established and oversight by the integrated unscheduled care group

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard **Judgments relating to Emergency Department findings**	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Long Term

1. Development of capital restructuring of University Hospital Kerry to be informed by Archus Report which will seek to address the need to protect the privacy and dignity in the design of the physical environment
2. Establishment of a Patient Advocacy Liaison Service (PALS) to maintain throughout the Hospital awareness of the primacy of the patient in relation to all hospital activities.

Medium Term

1. Patient Advocate Liaison Officer business case to be submitted to SSWHG
2. Develop >75 year old assessment area in the ED
3. Development of individual pathways of care to improve streaming and reduced wait times in ED
4. To work with CHO colleagues to address the reduction in GP referrals.
5. Trainers to be identified to sustain National Healthcare Communication Programme training within UHK
6. Reinstate volunteer project to be overseen by HR department

Short Term

1. Model of frailty at the front door as supported by Enhanced Community Care project to be reviewed, recruitment commenced for addition positions, implementation group to be established, to be overseen at integrated unscheduled care group
2. Implementation of Pathfinder, recruitment commenced, local implementation group commencing 15/12/2022 comprising of local and national representation to report to the local unscheduled care group

3. Patient Support & Communications Officer in ED to liaise between Patients and their families/carers.
4. Provision of comfort packs for ED patients
5. Acute floor navigation hub to be augmented by CNM II to facilitate streaming
6. Training in National Healthcare Communication Programme commencing
7. Operational procedure for Volunteers in UHK to be developed.

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to Emergency Department findings	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(c) long-term plans to come into compliance with the standard

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

Long Term

1. Establishment of Minor Injury Unit to be progressed by the Business Manager for Capital Projects and estates in conjunction with Cork Kerry Community Healthcare
2. Address issues with patient flow through the full implementation of the five fundamentals project including (a) the acute floor (b) SAFER (c) Egress pathways. These will be EMB mandated projects with EMB sponsors for agreed priority work programmes. Clinical Programme leads to be identified and appointed working to EMB.
3. Development of capital restructuring of University Hospital Kerry to be informed by Archus Report

Medium Term

1. Review of all scheduled care processes to ensure compliance with access to care targets to include:
   (a) OPD utilisation (b) Theatre utilisation/ Transforming Theatre Project (c) Day ward utilisation (d) Endoscopy utilisation. To be overseen by Scheduled Care Committee
2. Full implementation of INEWS 2 to be overseen and audited by the deteriorating patient committee.
3. Review of Corporate Risk Register to include risks specific to ED
4. Quality & Safety walk rounds to include the Emergency department

Short Term

1. UHK escalation plan in place to respond to emergency care demand to align with the national key performance indicators for emergency departments. **Complete**. Effectiveness to be overseen by General Manager
2. Model of frailty at the front door as supported by Enhanced Community Care project to be reviewed, recruitment commenced for addition positions, implementation group to be established, effectiveness to be overseen by integrated unscheduled care group

3. Implementation of Pathfinder, recruitment commenced, local implementation group commencing 15/12/2022 comprising of local and national representation to report to the local unscheduled care group
4. Hospital Ambulance Liaison Person has commenced in ED UHK, effectiveness to be overseen by Regional Unscheduled Care in conjunction with National Ambulance Service. **Complete**
5. Process implemented to ensure ongoing review of effectiveness of control actions on identified risks in the Emergency Department listed on the Corporate Risk Register. **Complete**
6. Daily EDAMU safety huddles at 08.15 to include representation from General Management. Actions will be documented in a time bound action plan. ED/Paediatric daily 16.00 huddle. **Complete**
7. Hospital wide audit on INEWS and ISBAR completed. **Complete.** Oversight of audits by the Deteriorating Patient committee
8. Quality, Risk & Patient Safety departments now provide Incident analysis/SREs data at ED Clinical Governance Committee meetings. **Complete**
9. Quality Risk & Patient Safety department in conjunction with ED clinical governance to oversee implementation of complaints feedback and review of trends. **Complete**

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Long Term

1. Pursue accreditation of the microbiology lab
2. Chief Pharmacist and Operations Manager to prioritise and implement staffing deficits as per gap analysis in Medication Safety Plan 2022
3. Full implementation of the Deteriorating Patient Improvement Programme overseen by the Deteriorating Patient Committee
4. To reduce the reliance on outsourcing, with SSWHG further develop an on-site Diagnostic and Radiology reporting service to ensure the availability of a 24/7 model
5. SSWHG develop a time bound action plan for implementation of nursing and midwifery workforce planning strategy in line with Safer Staffing Framework
6. Implement centralised electronic system to capture mandatory training to be overseen by the Training & Development Officer

Medium Term

1. Governance review and restructure of the Executive Management Board committee to ensure the focus is on strategic planning and development provided by the hospital.
2. UHK escalation policy in place to improve patient flow and increases in surge. **Complete** General Manager to oversee effectiveness of implementation and report to the Executive Management Board
3. Full implementation of INEWS 2 to be overseen and audited by the Deteriorating Patient Committee
4. Full implementation of Health Performance Visualisation Platform to support patient flow and waiting list data to be overseen by the Scheduled Care Group
5. Review of the hospitals absenteeism rate to assess impact of implementation of absenteeism policy and nursing QIP on short term sick leave.

Short Term

1. One WTE locum Consultant Microbiologist in place. Two permanent position for readvertisement in Dec 2022
2. Gap analysis on the HIQA IPC standards to inform the Infection Prevention and Control programme for 2023 to be coordinated by Infection Prevention & Control CNMs and overseen by the Infection Prevention and Control Committee.
3. Business case for ED Clinical Pharmacist submitted to UHK pay bill, to provide a clinical pharmacist led medication reconciliation service, for submission to SSWHG.
4. Deteriorating Patient Improvement programme to be overseen by the Deteriorating Patient Safety committee:
    (a) INEWS ongoing audit, education and training sub group in place. **Complete**
    (b) cANP's and CNM II for deteriorating patient appointed. **Complete**
    (c) Clinical lead for Deteriorating Patient in place. **Complete**
    (d) Deteriorating Patient Committee Terms of Reference agreed. Committee will be established in Dec 2022
5. Agreement to re-establish the local integrated unscheduled care group with initial weekly meetings during winter period. Terms of reference to be agreed
6. Revise terms of reference of Acute Egress Group with designated escalation contact in the acute and community sectors and to include review of Delayed Transfers Of Care and/or complex discharges
7. Local and International nurse recruitment in place, nursing deficit reduced since time of inspection. On-going nurse recruitment is ongoing to implement the Safe Nurse Staffing. Local Implementation group commencing early 2023.
8. Nursing QIP in place to address short term sick leave overseen by Director of Nursing.
9. External support for radiological reporting is provided by two Radiologists within SSWHG and are reporting remotely. Radiological reporting is accessed through agency and further supported by local overtime agreements to address backlog in reporting. **Complete** rates of reporting overseen by Operations Manager
10. Tender developed to provide an on-site Diagnostic Service and a Radiology reporting Service with the provision of 2 Radiologist. The service will be provided during normal working hours (Monday to Friday from 9am to 5pm) to support the normal operation of the Radiology Department. **Complete**
11. Training & Development Officer business case has been approved, they will provide reports to the Senior Management Team with regards to attendance and uptake of mandatory training. Due for advert Dec 2022.

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	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.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. Establish a hospital wide clinical audit programme supported by a clinical audit committee and strategy, this will be overseen by the Quality & Patient Safety Committee chaired by the Clinical Director
2. To reduce the reliance on outsourcing, with SSWHG develop an on-site Diagnostic and Radiology reporting service to ensure the availability of a 24/7 model

Medium Term

1. Development of a hospital wide clinical audit schedule by Clinical Director & Quality Manager supported by the SSWHG Patient Safety Strategy team
2. Review of National Incident Management System KPI compliance

Short Term

1. Business case for Clinical Audit facilitator approved at UHK pay bill submitted to SSWHG. **Complete**
2. Quality, Risk & Patient Safety department implemented process for recommendations and learning from SREs and incidents. Clinical Governance quality & patient safety dashboard developed. **Complete**
3. Review of non-compliance with National Incident Management System KPI undertaken, actions identified and implemented, and oversight provided on Quality & Patient Safety dashboard report. Individual Clinical Governance Committees will oversee self compliance. **Complete**
4. General Manager and SSWHG to review and develop time bound QIP to address any outstanding recommendations for the Radiology review
5. External support for radiological reporting is provided by two Radiologists within SSWHG are reporting remotely. Radiological reporting is accessed through agency and further supported by overtime agreements. **Complete**

6. Tender developed to provide an on-site Diagnostic Service and a Radiology reporting Service with the provision of 2 Radiologist. The service will be provided during normal working hours (Monday to Friday from 9am to 5pm) to support the normal operation of the Radiology Department. **Complete**
Timescale: Short Term – within 3 months Medium Term – within 6 months Long Term – within 3 years.

National Standard **Judgments relating to wider hospital and inpatient clinical areas findings**	**Judgment**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. Establishment of a Patient Advocacy Liaison Service (PALS) to maintain throughout the Hospital awareness of the primacy of the patient in relation to all hospital activities.

Medium Term

1. Quality, Risk & Patient Safety Manager (Grade VIII) to oversee complaints management process and compliance with Your Service Your Say Policy once in place.
2. Trainers to be identified to sustain National Healthcare Communication Programme training within UHK
3. Patient Advocate Liaison Officer business to be developed and submitted to SSWHG
4. Quality, Risk and Patient Safety Department will implement process to feedback on complaints to clinical governance committees

Short Term

1. Complaints Management QIP which includes reporting on KPIs in place with oversight by Executive Management Board. **Complete**
2. Training in National Healthcare Communication Programme commencing
3. Patient Support & Communications Officer in ED to liaise between Patients and their families/carers to improve patient experience in the ED which in turn should improve resolution of verbal complaints.
4. All patients for admission to UHK receive written information on how to make a complaint. **Complete.** Effectiveness of process to be overseen by Quality, Risk and Patient Safety department
5. Complaints tracking and trending process implemented for oversight at clinical governance committees. **Complete**

6. Contact details for Patient Advocacy Services on new Patient Information folder given to all admitted Complaints tracking and trending process implemented for oversight at clinical governance committees. **Complete**
Timescale: Short Term – within 3 months Medium Term – within 6 months Long Term – within 3 years.

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) **long-term plans to come into compliance with the standard**
(b) **details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.**

Long Term

1. Capital restructuring of University Hospital Kerry as per Archus Report
2. Laboratory expansion in development due for completion June 2023
3. Plans for additional (6th) theatre is at pre tender stage

Medium Term

1. A capital submission for the provision of a new ward block including single room and single isolation room facilities is currently being worked up by Estates on behalf of UHK.
2. Review of workflow in Radiology department
3. Development of new clinical area for Oncology patients as an interim whilst Estates are progressing permanent build
4. Increase in availability of clinical areas due to movement of administrative functions off site
5. Upgrade of CSSD as part of enabling works to allow for additional theatre

Short Term

1. Maintenance to finalise a schedule of works for all wards in UHK, plan to be overseen at Maintenance Committee chaired by General Manager
2. Successful submission to SARI for one ready room. **Complete**
   Second submission to be submitted early 2023
3. A capital plan has been submitted for 24 isolations beds within grounds of UHK
   Complete

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	Judgment
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. Implement centralised electronic system to capture mandatory training to be overseen by Training & Development Officer
2. Establish a hospital wide clinical audit programme supported by a clinical audit committee and strategy
3. Full implementation of the Deteriorating Patient Improvement Programme to be overseen by the Deteriorating Patient Committee

Medium Term

1. Development of a hospital wide clinical audit schedule by Clinical Director & Quality Manager supported by the SSWHG Patient Safety Strategy team
2. Evaluation of effectiveness of Quality & Safety walk rounds
3. Quality & Patient Safety local performance dashboard in development to provide oversight of national performance indicators to evaluate quality and safety of care.

Short Term

1. Environmental Hygiene QIPs will be closed out in a timely manner and overseen at the Infection Prevention & Control Steering Committee.
2. Implementation of SMART QIPs from IPC outbreaks to be standing agenda item at the Infection Prevention & Control Steering Committee
3. Medical Manpower team to explore options for enhanced oversight of the NER system to track mandatory training done by NCHDs
4. Implementation of SMART QIPs from Medication safety quality initiatives and reaudits
5. Implementation of SMART QIPs to address rates of high antimicrobial use to be overseen by the Antimicrobial Stewardship committee
6. Auditing of compliance with Sepsis, INEWS & ISBAR communication tool complete, education plan in place. **Complete** continuous oversight to be maintained by the Deteriorating Patient Committee

7. Clinical handover audit and quality improvement projects commenced for**:**

(a) Medical teams daily and weekend handover(to be overseen at Medical Clinical Governance)

(b) Paediatric MDT daily handover (to be overseen at Paediatric Clinical Governance)

(c) ED internal handover and transitions of care.(to be overseen at ED Clinical Governance)

8. National Inpatient Experience Survey: quality improvement plans to be displayed on quality boards in each clinical area.

9. Implementation of Quality & Safety walk rounds, oversight provided by the General Managers office

10. Quality, Risk & Patient Safety department implemented process for recommendations and learning from SREs and incidents. Clinical Governance quality & patient safety dashboard developed. **Complete**

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Long Term

1. Development of capital restructuring of University Hospital Kerry to be informed by Archus Report
2. A capital submission for the provision of a new ward block including single room and single isolation room facilities is currently being worked up by Estates on behalf of UHK. A capital plan has been submitted for 24 isolations beds.
3. CPE universal screening capacity to be reviewed on completion of laboratory capital works
4. Chief Pharmacist and Operations Manager to prioritise and implement staffing deficits as per gap analysis in Medication Safety Plan 2022
5. Full implementation of the Deteriorating Patient Improvement Programme overseen by the Deteriorating Patient Committee
6. Implement centralised electronic system to capture mandatory training.
7. Complete QIPS from Clinical handover gap analysis

Medium Term

1. Full implementation of INEWS 2 to be overseen and audited by the Deteriorating Patient Committee
2. Review of Corporate Risk Register by Executive Management Board

Short Term

1. Implementation of SMART QIPs from hospital outbreaks to be standing agenda item at the IPC Steering Committee
2. Business case for Critical Care Clinical Pharmacist to be submitted to SSWHG
3. Business case for document management system (to include mandatory training module) developed, to be submitted to SSWHG. Oversight for implementation to be provided by the Quality Department

4. Hospital wide audit on INEWS and ISBAR completed. **Complete** ongoing audits to be overseen by the Deteriorating Committee
5. Gap Analysis performed on National Clinical Communication (Clinical Handover) Guideline. Clinical handover audit and quality improvement projects commenced for:
   (a) Medical teams daily and weekend handover (to be overseen at Medical Clinical Governance)
   (b) Paediatric MDT daily handover (to be overseen at Paediatric Clinical Governance)
   (c) ED internal handover and transitions of care.(to be overseen at ED Clinical Governance)
6. UHK in conjunction with ICT Network Manager have agreed increased staffing complement to support and enhance ICT function in order to facilitate more timely discharge summaries.
7. Medical Manpower team to explore options for enhanced oversight of the NER system to track mandatory training done by NCHDs

Timescale:
Short Term – within 3 months
Medium Term – within 6 months
Long Term – within 3 years.

National Standard Judgments relating to wider hospital and inpatient clinical areas findings	Judgment
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Long Term

1. Bring reporting rates for incidents in line with national rates for similar sized hospitals.
2. Implementation of Electronic Point of Entry (EPoE) reporting of incidents to the NIMS system in line with National Quality and Patient Safety Directorate roll out of EPoE.
3. Review ward assessment pilot project with a view to further roll out

Medium Term

1. Roll out of hospital-wide training for incident reporting and completion of NIRF forms.
2. General Manager and SSWHG to review and develop time bound QIP to address any outstanding recommendations from the Radiology review
3. Ward Assessment process in development to include safety huddles

Short Term

1. Implementation of Quality & Safety walk rounds. **Commenced** Oversight provided by the General Managers office
2. Quality, Risk & Patient Safety department developed implementation process via Clinical Governance Committees for implementation of recommendations and learning from SREs. **Complete**
3. Incidents relating to deteriorating patient transitions of care will be tracked and trended by the Quality, Risk & Patient Safety Departments.
4. Review of non-compliance with National Incident Management System KPI undertaken, actions identified and implemented, and oversight provided on QPS dashboard report at individual Clinical Governance Committees and Quality & Patient Safety Committee. **Complete**

5.	Quality, Risk & Patient Safety department implemented process for recommendations and learning from SREs and incidents. Clinical Governance quality & patient safety dashboard developed. Complete
Timescale: Short Term – within 3 months Medium Term – within 6 months Long Term – within 3 years.	