Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Mercy University Hospital
Address of healthcare service:	Grenville Place Cork Co. Cork T12 WE28
Type of inspection:	Unannounced
Date(s) of inspection:	18 and 19 April 2024
Healthcare Service ID:	OSV-0001059
Fieldwork ID:	NS_0074

About the healthcare service

Mercy University Hospital is a model 3* voluntary, general acute hospital. The hospital is governed by a board of directors and is a member of the South/South West Hospital Group (SSWHG).[†] The hospital provides healthcare services for a population of over 137,000 people and has a seasonal increase of approximately 50,000 people per annum.

Services provided by the hospital include:

- emergency care
- acute general medicine
- acute and elective surgery
- intensive care
- diagnostic services
- day and outpatient care
- acute paediatric service (transferred to Cork University Hospital June 2024).

Mercy University Hospital also has governance and management responsibility for St Francis Unit, which is an 18 bedded transitional care unit located on St. Mary's Health Campus on the north side of the city, 3.2 kilometres from the hospital. The unit provides care for patients who are medically fit for discharge and require a low level of rehabilitation.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	241 inpatient beds 75 day case beds

How we inspect

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

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

† At the time of inspection, the South/South West Hospital Group comprised seven hospitals. These were Cork University Hospital, Cork University Maternity Hospital, University Hospital Kerry, Mercy University Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital and Mallow General Hospital. The hospital group's Academic Partner was University College Cork (UCC).

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, the inspectors:

- spoke with people who used the healthcare services in Mercy University Hospital to ascertain their experiences of using the services
- 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 in the hospital, interactions with people who were receiving care in the hospital and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection.

About the inspection report

A summary of the findings and a description of how Mercy University Hospital performed in relation to 11 national standards assessed during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time — before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.A full list of the 11 national

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

standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 April 2024	08.55 – 17.30hrs	Dolores Dempsey Ryan	Lead
		Nora O' Mahony	Support
19 April 2024	08.45 – 16.20hrs	Aedeen Burns	Support
		Bairbre Moynihan	Support

Background to this inspection

This inspection focused on 11 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 four clinical areas:

- Emergency Department, which included the Acute Medical Assessment Unit (AMAU)
- St Brigid's Ward
- St Catherine's Ward
- St Francis Unit located at St Mary's Health Campus, Gurranabraher, Co Cork.

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

- Representatives of the hospital's Executive Management Board
  - Chief Executive Officer
  - Director of Nursing
  - Executive Clinical Director
  - Director of Operations
  - Quality, Risk and Patient Safety Director
- A representative for the Non-Consultant Hospital Doctors (NCHDs)
- Director of Human Resources
- Complaints Manager

[§] 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.

- Representatives from each of the following hospital committees:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Care of the Deteriorating Patient (including sepsis)
  - Integrated Unscheduled Care Operational Group.

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 of receiving care in the hospital.

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

The hospital's emergency department was the point of entry for patients requiring unscheduled or emergency care. It provided undifferentiated care for adults and children 24/7. The emergency department has a total planned capacity of 26 bays. One of three single cubicles, located in the waiting area at the entrance to the hospital, was used for patients requiring transmission-based precautions. At the time of inspection, the hospital's paediatric services were being formally transferred to Cork University Hospital and following the inspection, hospital management confirmed to HIQA that this had taken place.

St Brigid's Ward was a 26-bedded general medicine and surgical ward comprising 17 single rooms, a two bedded multi-occupancy room, a three-bedded multi-occupancy room and a four-bedded multi-occupancy room. At the time of inspection, all 26 beds were occupied.

St Catherine's Ward was a 31-bedded general medicine and surgical ward comprising four six-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and four single rooms. At the time of inspection, all 31 beds were occupied.

St Francis Unit was an 18-bedded transitional care unit located on the grounds of St. Mary's Health Campus. This unit comprised nine single rooms and three, three-bedded multi-occupancy rooms.

Inspectors observed staff on the days of inspection in the clinical areas visited to be respectful, kind and caring towards patients when providing assistance with personal care, clinical assessments and treatments. Staff were also observed using privacy curtains when providing assistance to patients with their personal care needs and during assessment.

Inspectors spoke with a number of patients to ascertain their experiences of receiving care in Mercy University Hospital and St Francis Unit. Overall patients' experiences were good.

Patients were very complimentary about the staff. When asked what was good about the service or care received, patients said *'all staff are very good'*, *'nothing is a problem'*. Staff were described as *'so attentive, kind and compassionate'* and the care was *'excellent'*. Patients in the emergency department felt they were *'well looked after'* and staff in the department were described as *'very good'*. One patient said their *'experience in the emergency department was very positive'*, they had been *'triaged quickly and seen by the medical team within 30 minutes.'*

The patients who spoke with inspectors had not received leaflets on the hospital's complaints process, but all said they would talk to a nurse if they had a complaint to make. Inspectors observed that patient information leaflets about advocacy services were displayed in the clinical areas visited and patient feedback forms were located beside comment boxes on St Brigid's and St Catherine's wards. Overall, patients were very complimentary about the staff and of the care received and this was consistent with what inspectors observed over the course of the inspection.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Mercy University Hospital was found to be substantially compliant with three national standards (5.2, 5.5 and 5.8) and partially compliant with national standard 6.1 assessed. Key inspection findings informing judgments on compliance with these four 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.

Inspectors found that Mercy University Hospital had formalised integrated corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of the service. At the time of the inspection, these structures were being reviewed and updated to support the introduction of a new clinical directorate governance structure. Organisational charts setting out the hospital's current reporting structures provided to inspectors during the inspection, showed that the hospital's chief executive officer (CEO), executive clinical director and chief financial officer all reported to the hospital's board of directors. These charts also detailed the reporting arrangements of the hospital's corporate governance committees including the Clinical Quality and Safety Governance Committee (CQSGC) to the executive management board (EMB) The hospital's senior management team reported to the South/South West Hospital Group (SSWHG) each month, but this reporting arrangement was not detailed on the hospital's organisational charts.

The hospital was governed and managed by the CEO who reported to the hospital's board of directors each month and attended monthly performance meetings with the SSWHG. The executive clinical director provided clinical oversight and leadership at the hospital. The DON was responsible for organising and managing the nursing services at the hospital. The executive clinical director and DON were members of the EMB and reported to the CEO. The executive clinical director also reported to the hospital's board of directors each month.

The EMB had collective responsibility for the overall governance and executive management of Mercy University Hospital which included providing strategic and operational leadership for the hospital. Chaired by the hospital's CEO, the EMB met every two weeks and comprised the senior management team — executive clinical director, the operations director, DON and the quality, risk and patient safety director. Meetings of the EMB followed a structured format and there was evidence that hospital activity metrics, key performance indicators (KPIs), operational and escalation protocol issues including items such as workforce planning and risk strategy were discussed at these meetings. In addition, the implementation of agreed actions was reviewed and updated from meeting to meeting. Members of the EMB attended performance meetings with the SSWHG every month. Items for discussion at the performance meeting included scheduled and unscheduled care, workforce, finance, incidents rates, serious reportable incidents, complaints and the risk register. Minutes of the SSWHG performance meetings, submitted to HIQA showed meetings followed a structured format, were action orientated and that progress in implementing agreed actions was monitored.

St Francis Unit was under the governance of Mercy University Hospital. Two general practitioners (GPs) supported by a consultant geriatrician had responsibility for the medical care of the patients admitted to the unit. Medical care in the unit outside core working hours was provided by South Doc.[‡‡] The patients admitted to St Francis Unit were medically discharged from Mercy University Hospital and were waiting for long-term care placement, home care packages or rehabilitation care placement. The clinical nurse manager (CNM) for St Francis Unit reported to the Assistant Director of Nursing (ADON) in Mercy University Hospital. The ADON visited the unit each month and was available daily by phone to address any concerns or issues.

The CQSGC was accountable to the EMB and was responsible for providing assurance on the quality and safety of healthcare services provided at the Mercy University Hospital. Chaired by the executive clinical director, the committee met every month in line with its terms of reference and membership included representatives from the EMB, health and social care managers, medical and surgical quality leads and the bed management lead. The CQSGC received and reviewed quarterly and annual reports from its sub-committees that reported into it, including the Infection Prevention and Control Governance Committee (IPCC), the Drugs and Therapeutics Committee (DTC), Care of the Deteriorating Patient

[‡‡] South Doc is a service to provide you and your family with access to family doctor services for urgent medical needs. South Doc operates outside of normal surgery hours – evenings, nights, weekends and bank holidays.

Committee (including sepsis) (CDPC) and the Integrated Unscheduled Care Operational Group.

The hospital's multidisciplinary IPCC was responsible for the governance and oversight of infection prevention and control and antimicrobial stewardship practices at the hospital and in St Francis Unit. This committee was operationally accountable to the CQSGC who reported to EMB. Minutes of meetings of the IPCC from 2023 to 2024 submitted to HIQA showed that this committee had not met quarterly in line with its terms of reference. Hospital management told inspectors that this was due to staffing shortfalls and committee member's clinical requirements. Membership of the IPCC included members of the hospital's infection prevention and control team (IPCT), representatives from the EMB and consultant microbiologists. It was clear from minutes of meetings reviewed by inspectors and meetings with relevant staff that the IPCC had governance and oversight of infection prevention and control practices in the hospital and St Francis Unit, which included oversight of surveillance and outbreak reports and audit reports. It was evident that meetings of the IPCC followed a structured agenda and the implementation of agreed actions to improve infection prevention and control were monitored from meeting to meeting.

The hospital had an Antimicrobial Stewardship Committee (AMSC), which had responsibility for monitoring antibiotic use and implementing the antimicrobial stewardship programme in the hospital and in St Francis Unit. Chaired by a consultant microbiologist, the committee met quarterly and reported to the IPCC in line with its terms of reference. Minutes of meetings reviewed by inspectors showed that items discussed included antibiotic consumption, audit findings and education initiatives. Antibiotic consumption in St Francis Unit was not formally recorded because the information was not collected in the hospital in-patient enquiry (HIPE) system. An estimation of antibiotic use in St Francis Unit was included in local antibiotic consumption reports. Meetings of the AMSC followed a structured agenda and the implementation of agreed actions to improve antimicrobial stewardship in the hospital was monitored from meeting to meeting.

The hospital had a well-established multidisciplinary DTC that had responsible for the governance and oversight of medication safety practices in the hospital. The committee reported to CQSGC twice a year and provided an annual report to the EMB on the committee's activities. Chaired by a medical consultant, the DTC met every two months, in line with its terms of reference. Membership included members of the EMB, the chief pharmacist, the medication safety pharmacist and the quality, risk and patient safety director and the risk manager. Meetings of the DTC followed a structured agenda and there was evidence that agreed actions to improve medication safety were progressed from meeting to meeting.

The hospital had recently set up a Care of the Deteriorating Patient Committee (including sepsis) (CDPC), to provide governance and oversight of the hospital's level of compliance

with national guidelines on the early warning systems[§§] and sepsis management. The committee's terms of reference was not ratified, but there was a plan to meet quarterly. The committee was chaired by the clinical lead for emergency medicine and had met once in March 2024 and hospital management reported that the ADON for St Francis Unit will be a member of the committee.

Mercy University Hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled care. The hospital had an Integrated Unscheduled Care Operational Group, which reported to the CQSGC. This group met monthly and the meetings were chaired by the hospital's operations director. Membership included representatives for medical and nursing staff, the patient flow team and the integrated operational lead for Cork Kerry Community Healthcare, Community Health Organisation four (CHO4). Minutes of meetings of the Integrated Unscheduled Care Operational Group, EMB, board of directors and SSWHG, viewed by inspectors showed that performance data on scheduled and unscheduled care activities, and inpatient bed capacity was reviewed at these meetings.

Overall, there was evidence that Mercy University Hospital had formalised corporate and clinical governance arrangements in place, which were being reviewed to facilitate the introduction of a clinical directorate structure. The Care of the Deteriorating Patient Committee (including sepsis) was recently set up, but the:

- CDPC's terms of reference was not ratified
- EMB's reporting arrangement to the SSWHG was not detailed on the hospital's organisational charts.

Judgment: Substantially compliant

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

The inspectors found that Mercy University Hospital had management arrangements in place in relation to the four key areas of know harm. The IPCT had developed an infection prevention and control annual plan for 2024 based on the infection prevention and control strategic programme (2024-2029), which was endorsed by IPCC. The IPCC submitted quarterly reports and an annual report to the CQSGC on the progress made with implementing the infection prevention and control plan. The draft infection prevention and control annual report of 2023, reviewed by inspectors detailed the hospital's performance in relation to infection prevention and control practices, surveillance and monitoring, and

[§§] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient.

compliance with national standards and key performance indicators. This is discussed more in national standard 2.8.

The hospital's antimicrobial stewardship service plan for 2024 was developed and implemented by the antimicrobial team. The team reported to the AMSC, who provided quarterly updates and an annual report (2023) on progress made with implementing the plan to the IPCC. The annual report for 2023 outlined the hospital's compliance with national key performance indicators and targets related to antimicrobial stewardship, antimicrobial consumption, antimicrobial guidelines development and uptake of education and training.

The hospital's clinical pharmacy service,[***] was led by the hospital's chief pharmacist, but the services was limited due to staffing resource issues in the pharmacy department. Measures to support medication safety were set out in the hospital's medication safety strategy (2022-2026) and plan for 2024. The medication safety working group (MSWG), along with the medication safety pharmacist had responsibility for implementing the strategy and plan. The MSWG reported on the progress in the implementing the medication safety strategy and plan to the DTC.

The hospital had appointed a clinical lead at consultant level to oversee the implementation of the hospital's deteriorating patient programme.[†††] However, there was no designated co-ordinator appointed to support staff using the Irish National Early Warning System (INEWS). This is discussed in more detail under standard 3.1.

The hospital had management arrangement in place to monitor and manage transitions of care within the hospital, St Francis Unit and into the community. Unscheduled care activity including patient experience times, delayed discharges and capacity issues were monitored at hospital's governance meetings including the Integrated Unscheduled Care Operational Group meetings, meetings with the Cork, Kerry Community Healthcare, (CHO4) and the SSWHG. Consistent with the hospital's compliance plan (2023), inspectors found that there was evidence from minutes of meetings and through discussion with representatives from bed management that the hospital was engaging weekly with the integration operation lead for Cork, Kerry Community Healthcare to access community beds to optimised discharges and improve patient flow in the hospital and bed capacity.

Inspectors found that Mercy University Hospital had improved the management arrangement in place to support patient flow since the last inspection (March 2023) which included the re-opening of the acute medical assessment unit (AMAU) in the emergency

[***] 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.

[†††] Deteriorating Patient Programme is a standardised, high quality systematic approach to the recognition, response and management of the deteriorating patient through the implementation of National Early Warning Systems (EWS). Access online from: https://www2.healthservice.hse.ie/organisation/qps-improvement/deteriorating-patient-improvement-programme/

department. On the day of inspection, the hospital was in amber escalation with ten admitted patients waiting in the emergency department for an inpatient bed. It was evident to inspectors that actions taken to manage patient flow on the days of inspection aligned with the actions for amber escalation level in the hospital's escalation plan. These actions included convening hospital huddle meetings, holding escalation meetings, sending web-text to consultants and medical teams to discharge patients, putting extra trolleys in the wards and using surge capacity beds. Hospital management had re-instated the AMAU, which was operating four days a week and on the first day of inspection the AMAU was functioning reasonably well. The operational management of patient flow is discussed in more detail in national standard 3.1.

Overall, Mercy University Hospital had management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services. The emergency department and the AMAU were functioning reasonably well on the days of inspection. However,

- there were admitted patients receiving care in the emergency department on the first day of inspection, which indicated an issue with patient flow across the hospital
- the hospital would benefit from a designated co-ordinator to support staff using the Irish National Early Warning System (INEWS).

Judgment: Substantially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services, but did not have an audit committee in place. Information on a range of different clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with the HSE's reporting requirements. Collated performance data was reviewed at the two weekly meetings of the EMB, monthly board of director meetings and monthly performance meetings between the hospital and the SSWHG.

There were formalised risk management structures and processes in place in the hospital to proactively identify, analyse, manage, monitor and escalate identified risks. Hospital management were implementing the HSE's enterprise risk management policy and procedures (2023) and had drafted a risk management strategy and improvement plan (2024-2026) at the time of inspection. The hospital's corporate risk register was reviewed at the quarterly meetings of the EMB and CQSGC meetings, at monthly performance meetings with the SSWHG and at the six monthly board of directors meetings. Responsibility for implementing and overseeing the effectiveness of the control measures

on the corporate risk register lay with the risk co-ordinators. Risk coordinators reviewed the risk register at quarterly meetings with individual members of EMB.

There was no formalised audit plan or clinical audit committee to coordinate clinical and non-clinical audit activity in the hospital. The executive clinical director and the quality, risk and patient safety director approved requests to carry out clinical and non-clinical audits, although this process was informal. The IPPC, Hygiene Committee, DTC and Integrated Unscheduled Care Operational Group had oversight of the audit findings and the implementation of related quality improvement plans for their area of responsibility.

The hospital had systems and processes in place to proactively identify and manage patient-safety incidents in line with national guidelines. The Serious Incident Management Team (SIMT), EMB, CQSGC, board of directors and SSWHG had oversight of the effectiveness of the management of patient-safety incidents, including serious reportable events reported in the hospital. Patient safety incidents are discussed in more detail under national standard 3.3.

Staff who spoke with inspectors in the clinical area visited were not aware of any quality improvement initiatives being implemented in response to the National Inpatient Experience Survey 2022. In addition, inspectors found little evidence in minutes of governance committees that findings from National Inpatient Experience Surveys were reviewed at meetings of these committees.

Overall, the hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services, and improvements could be progressed to

- ensure a co-ordinated approach to auditing compliance with best practice standards and guidance across the hospital
- ensure that there are sufficient awareness among staff of quality improvement initiatives being implemented in response to the National Inpatient Experience Survey findings of 2022.

Judgment: Substantially compliant

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

Inspectors found that the workforce arrangements in place in Mercy University Hospital were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare services in the hospital.

The emergency department was funded for 5 whole-time equivalent (WTE) consultants in emergency medicine, with 2.5 (50%) WTE posts filled at the time of the inspection, which was the same as the previous inspection findings. Hospital management had advertised

and interviewed to fill the 2.5 WTE consultants in emergency medicine, but recruitment was unsuccessful.

As a result, arrangements were not in place to ensure comprehensive consultant cover in the emergency department 24/7. Consultants in emergency medicine were on site in the emergency department during core working hours (8am-5pm), Monday to Friday. Additional cover was provided by a consultant in emergency medicine up to 8pm three evenings a week. Outside core working hours, inspectors were told that three out of five weekends (60%) were covered by the consultants in emergency medicine. However, this was not always supported, based on a review of the on-call roster for the month of April 2024. Hospital management had contingency plans in place to address the gaps in the emergency medicine consultant's on-call roster. These contingency plans were clearly set out in a standing operating procedure and were as follows:

- NCHDs in the emergency department could refer and seek advice from the specialist consultants on call for the hospital.
- Staff could phone an emergency medicine consultant.
- When the emergency medicine consultant was not available, staff had access to the consultant lead for the emergency department or the executive clinical director.

Consultants in emergency medicine reported to the lead consultant for the emergency department, who in turned reported to the executive clinical director for the hospital. The consultants in emergency medicine were supported by 19 WTE NCHDs – 14 WTE registrars and 5 WTE senior house officers (SHOs), all these posts were filled at time of inspection. Senior clinical decision-makers,[‡‡‡] at registrar grade were onsite in the emergency department 24/7.

The executive clinical director confirmed to inspectors that all permanent medical and surgical consultants employed in the hospital were on the relevant specialist division of the register with the Irish Medical Council (IMC). At the time of the inspection, the hospital had 57.56 WTE medical consultants in position, supported by 141.80 WTE NCHDs.

The hospital was approved for 16.29 WTE pharmacists and 14.82 WTE pharmacy technicians. At the time of inspection, all the pharmacy technician's positions were filled, but 24% of clinical pharmacist's positions were unfilled, this included the antimicrobial pharmacist position. This impacted on the ability to provide a comprehensive clinical pharmacy service across the hospital. A daily clinical pharmacist service was provided to the emergency department and the intensive care unit (ICU), and twice a week to the other inpatient wards.

Mercy University Hospital had approval for funding for 43 hours of consultant microbiologist cover per week to be provided by 2 WTE consultant microbiologists with shared

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

responsibility for the South Infirmary Victoria Hospital, community care and Cork University Hospital. At the time of the inspection, these two post were progressing through the recruitment phase. At the time of inspection, 1.6 WTE consultant microbiologists' positions were filled and 0.4 WTE consultant microbiologist position was unfilled. Of the 1.6 WTE positions filled, 1 WTE consultant microbiologist was on statutory leave until September 2024, but the 0.6 WTE position was filled on a locum basis. To mitigate any risk associated with the shortfall in consultant microbiologists, hospital management had appointed a microbiology specialist registrar (in their last three months of training) to an acting consultant microbiologist position from April to July 2024. Hospital management confirmed to inspectors that staff had access to clinical microbiology advice 24/7. The advice was provided by a consultant microbiologist in Mercy University Hospital and supported by consultant microbiologist staff in Cork University Hospital.

The number of consultant microbiologists was a risk recorded on the hospital's corporate risk register. Hospital management had developed and submitted a business case for an additional 2 WTE consultant microbiologists which were shared positions with other hospitals and the community services, to the SSWHG.

The IPCT comprised 1 WTE ADON and 2 WTE clinical nurse specialists (CNS). One WTE CNS position was vacant at the time of inspection and a recruitment campaign was underway to fill the position.

The patient flow team comprised 1 WTE ADON with responsibility for unscheduled care, 2 WTE patient flow CNM 2s and 1 WTE admission CNM 2. There were 3.39 WTE discharge co-ordinators, which included a 0.5 WTE discharge co-ordinator allocated to St Francis Unit.

The hospital's overall approved complement of nursing staffing was 623.79 WTE with 564.93 WTE positions filled at time of inspection, which represented a 9% variance. Nursing staffing levels had increased in three of the four clinical areas visited as a result of the Department of Health's safe staffing frameworks.[§§§]

Inspectors found that the emergency department had increased its complement of nursing staff by 9% and healthcare assistants (HCAs) since the last inspection. At the time of this inspection, the emergency department's was approved for 65.40 WTE nursing staff (included nurse manager and other grades), with 65.61 WTE filled. A CNM 2 was assigned to care for admitted patients in the emergency department during core working hours Monday to Friday. Nursing staff shortfalls, when they occurred were filled by agency staff and or staff were redeployed from other clinical areas to the emergency department. The emergency department had its approved complement (14 WTE) of HCAs.

St Bridget's Ward had approval for 28.92 WTE nursing staff (including managers and other grades), with 30 WTE positions filled which represented an increase of 3.6%.

[§§§] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

St Catherine's Ward had approval for 33.50 WTE nursing staff (including managers and other grades) and 27.69 WTE of these positions were filled, which represented a variance of 17%. On the second day of inspection, inspectors visited St Catherine's Ward and it had its rostered complement of staff.

St Francis Unit had approval for 12.10 WTE nursing staff (including managers and other grades), with 11.68 WTE nursing positions filled, which represented a discrepancy of 3.5%. The unit had approval for 6 WTE HCAs with 5.70 WTE of these posts filled at time of inspection.

The human resource department tracked and reported on staff absenteeism rates in the hospital and St Francis Unit. Staff absenteeism rates were reviewed at meetings of the board of directors, EMB and monthly performance meetings with the SSWHG. The hospital's reported absenteeism rate for February 2024 was 5.05%, which was above the HSE target of 4%. To improve staff absenteeism rates, hospital management were focusing on reducing short-term absenteeism rates. Back to work interviews were completed by CNMs and staff in the clinical areas visited had access to support services, including occupational service and the employee assistance programme.

There was no centralised mechanism in the hospital to record and monitor staff attendance at and uptake of mandatory and essential training. The human resource department had responsibility for monitoring staff compliance with mandatory training and compliance rates were reported to EMB. Subcommittees who reported to the CQSGC reported on the uptake of mandatory staff training for their areas of responsibility. CNMs had oversight of staff training records in the clinical areas visited during inspection.

The hospital's overall compliance rates with infection prevention and control training for standard based precautions and transmission-based precautions was low for both nursing and medical staff. The hospital's overall compliance rates for hand hygiene training varied from 60% to 100%, so was not always compliant with the HSE's target of 90%. Hand hygiene training was identified as an areas for improvement in the emergency department during the last inspection (March 2023). At the time of this inspection, the majority of staff in the emergency department were up-to-date with training in hand hygiene. Compliance with hand hygiene training for HCAs required improvement. Over 77% of nurses and medical had completed basic life support training, including staff in St Francis Unit. Medication safety education training records were available to inspectors for only two of the four clinical areas visited and were not available for the wider hospital. The hospital's overall compliance with INEWS training ranged from 65% to 82%. Compliance rates for the Irish Maternity Early Warning System (IMEWS) was 70% for staff in clinical areas where IMEWS was used — St Catherine's and St Patrick's Wards. The emergency department had introduced the Emergency Medicine Early Warning System (EMEWS) and the uptake of training for nursing and medical staff ranged from 80% to 100%. All nurses who triaged

patients in the emergency department were up to date with training on the Manchester Triage System.[****]

In summary, there was no further improvement with compliance with this standard since the last inspection. While nursing and healthcare staffing levels have improved,

- there was no improvement in the medical workforce arrangements in the emergency department since HIQA's last inspection
- there were shortfalls in the WTE consultant microbiologists and the infection prevention and control team
- 24% of pharmacist positions were unfilled, which impacted on the ability to provide a comprehensive clinical pharmacy service across the hospital
- there was little improvement in staff attendance at mandatory and essential training in relation to infection prevention and control, medication safety and clinical handover.

Judgment: Partially Compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Mercy University Hospital was found to be compliant with three national standards (1.6, 1.7 and 1.8), substantially compliant with two national standards (2.8 and 3.3) and partially compliant with two national standards (2.7, 3.1) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

It was evident to the inspectors through communication and observation that staff in the clinical areas visited were aware of the need to respect and promote the dignity, privacy and autonomy of patients and this was consistent with the human rights-based approach to care promoted by HIQA. Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients when providing assistance with personal care, clinical assessments and treatments. Staff were observed in

[****] 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.

all of the clinical areas visited using privacy curtains when providing assistance to patients with their personal care needs and during assessment. Call bells were observed located on a wall beside the trolley in cubicles in emergency department within easily reach for patients. Patient's personal information in the clinical areas visited, was observed to be protected and stored appropriately in line with legislation and best available evidence. St Brigid's ward had a room for patients requiring end of life care, which was being refurbished with input from the end of life coordinator at the time of inspection.

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

Judgment: Compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. Staff were observed to be kind and considered when interacting with patients and when providing assistance when offering drinks and with mobilisation. Staff were also observed communicating with patients in a kind and sensitive manner when providing care to patients.

To maintain confidentially and respect the right to privacy, patients in St Catherine's and St Brigid's wards were taken to an office or room when receiving bad news and in St Francis Unit when speaking with a social worker. Inspectors were told by the CNM that they could request enhanced supervision for vulnerable patients and this process was supported by hospital management. Patients were assessed using a validated form and if were deemed high risk of confusion or violent behaviour, they were prioritised for enhanced supervision.

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

Judgment: Compliant

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

The hospital had a designated complaints officer who reported directly to the quality, risk and patient safety director and had responsibility for managing complaints. The hospital also had a patient liaison officer.

The CQSGC and the SSWHG had oversight of the effectiveness and timeliness of the complaints management process. The complaints officer provided a report every six months to the CQSGC and a monthly report to the SSWHG.

Complaints were recorded on the complaints management system and the SSWHG had access to this system. In quarter one of 2024, 92% of written complaints received by the complaints officer were resolved within 30 working days, exceeding the national HSE target of 75%.

The hospital's complaints policy (2021-2024) was based on the HSE's complaints management policy 'Your Service Your Say'.[††††] Complaints were tracked and trended and emerging themes identified. Patient's feedback on their experience of care received was sought and inspectors observed comment boxes on St Brigid's Ward. In addition, inspectors were told by staff and reviewed documents which showed that the hospital was planning to introduce a QR[‡‡‡‡] code system which would allow patients to easily access a complaints platform about their experience of the service.

Informal complaints were managed locally at point of care by the CNM and staff were not required to record them. CNMs linked with the complaints officer and with the patient liaison service if they required support to resolve a complaint. For example, complaints about the showers in St Catherine's were escalated to the complaints officer and hospital management and feedback was provided by the complaints officer to the CNM. The complaints officer provided feedback on complaints which was shared with staff at ward huddle meetings. Feedback on complaints related to the emergency department was shared with staff at the emergency medicine critical review meetings.

Overall, at the time of inspection, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

On the days of inspection, inspectors observed that overall the hospital's physical environment was clean with few exceptions. There was evidence of general wear and tear observed, with paint work and wood finishes chipped. In St Catherine's Ward, the surface

[††††] 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.

[‡‡‡‡] A Quick response (QR) code is a type of barcode that can be scanned by a digital device and can be used to direct the user to a website or other quick reference material

on the patient's bed tables was chipped and the floors in St Brigid's Ward was in need of significant repair, this did not facilitate effective cleaning.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical areas visited. Personal protective equipment (PPE) was available outside single and isolation rooms. Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. The hospital had implemented processes to ensure appropriate placement of patients and the process was underpinned by a formalised policy. Inspectors observed that not all of the hand hygiene sinks in the clinical areas visited conformed to national guidance requirements,[§§§§] but documentation viewed by inspectors showed that the hospital had a sink replacement programme in place to address this.

Inspectors observed a number of infrastructural issues on St Brigid's Ward, St Catherine's Ward and the emergency department, which staff had raised with hospital management during quality and safety walk-rounds, but any potential or actual risks to patient safety had not being formally assessment using a risk assessment tool. Hospital management documented the actions to be taken to address the issues raised during the quality and safety walk-rounds in action plans. Each clinical area visited had an action plan, with a named person identified to implement the actions. The majority of the actions in the action plans for St Brigid's Ward and St Catherine's Ward, reviewed by inspectors were completed. Controls were in place to mitigate any risks to patients arising from longer term actions such as a new building.

Inspectors raised concerns with hospital management about the physical infrastructure of St Brigid's Ward, these concerns aligned with the risks recorded on the hospital's corporate risk register. Controls in place to address the risks included a new build, which will increase the hospital's complement of beds by 105 beds, this is due to commence in 2026.The new build when completed will include a provision for the beds in the 17 single rooms in St Brigid's Ward.

In St Brigid's Ward, inspectors observed:

- One of the corridors was very narrow and impeded access and egress for a patient bed down the corridor. In addition, the beds could not be moved out of the rooms on this corridor as they could not fit through the door way. As a risk mitigation measure, hospital management requested that mobile patients be allocated to these single rooms while the new build was progressed. In the event of a patient's condition deteriorating in these rooms, staff described the process to utilise a patient trolley to transfer the deteriorating patient to another ward area.

[§§§§] National Clinical Guidance No. 30-Infection Prevention and Control (IPC). Available online from https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-full-report-volume-1. This includes reference to 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

- Additional issues observed in St Brigid's Ward related to the general corridor area being cluttered with equipment due to the lack of storage facilities. There was no glass on the doors of two of the single rooms to observe patients unless the door was kept opened. In addition, not all of the single rooms had ensuite bathroom facilities. The main corridor was a thoroughfare as it provided direct access to the endoscopy unit during core working hours which impacted the security of the environment as the ward entrance doors were opened. As outlined above, hospital management were progressing with an action plan to address all these risks and had controls in place to mitigate the risks.
- In the emergency department, inspectors found that there were infrastructural issues with the clean utility room which meant that staff had very limited space to prepare medications. Staff had raised this risk with hospital management and there was a plan to address it as part of the capital improvement plan in quarter three of 2024.
- In St Catherine's Ward, there was a negative pressure room with an ante room and pressure was maintained in the room when the doors were kept closed, however there was no pressure gauge monitor outside the doors to advise when pressure was achieved. Inspectors brought this risk to the attention of the CNM to request the infection prevention and control team to review.
- Patients in St Catherine's ward, St Brigid's Ward and St Francis Unit did not have adequate access to shower facilities. Patients in St Francis Unit had limited access to shower and bathroom facilities due to a legionella water outlet risk.
- In St Catherine's Ward, inspectors observed that pulp bedpans and urinal were used, however the ward did not have a macerator. Following inspection, a risk assessment was provided (25 April) to HIQA which outlined the controls and additional controls in place to mitigate the risk. Controls in place included the repossessing of reusable patient care equipment and a plan to provide education to staff on the ward on the use of the washer disinfector. Inspectors noted that there was no action owner or time-bound action plan to address this risk.
- Infection prevention and control signage observed at the entrance to single rooms in the two clinical areas visited by inspectors did not specify what type of precautions were being taken which was brought to the attention of the CNM.
- Cleaning of equipment was assigned to HCAs. In the clinical areas a colour tagging system was used to identify clean patient equipment, but inspectors found that the green tag date was not used consistently in the clinical areas visited. This was escalated to the CNM.

Environmental cleaning was carried out by external contract cleaning company. Inspectors were told that there were sufficient cleaning staff in the clinical areas visited and staff had access to maintenance staff.

There were risks associated with the layout of the aged physical infrastructure of St Brigid's Ward, which impacted patient movement on the ward. In addition, staff were using pulp

bedpans in the absence of a macerator in one of the wards visited. Infection prevention and control signage did not specify what type of precautions were to be taken.

In summary, notwithstanding the difficulties identified in providing care in an aged infrastructure, further work is required to ensure that the physical environment fully supports the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients.

Judgment: Partially compliant

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

Inspectors found that the hospital had systems and processes in place to systematically monitor, analyse, evaluate and respond to information to improve the quality of the service. Data was collated from a variety of sources to measure the effectiveness of systems and processes in place to improve the service. Data collated included key performance indicators (KPIs), findings from audit activity, risk assessments, patient-safety incident reviews and complaints.

Infection prevention and control monitoring

The IPCT and the surveillance scientist collated infection prevention and control surveillance data and the IPCC submitted this information in its quarterly reports to the CQSGC who reported to EMB. Every month, as per the HSE's reporting requirements, the IPCT submit a monthly report on rates of *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections and hospital-acquired COVID-19. The hospital patient safety incident report for March 2024 showed a decrease in the incidents rates for *Staphylococcus aureus* blood stream infections rates (zero) and *Clostridioides difficile* infection rates (1.50) in March 2024 which was an improvement on the patient safety incident rates reported in March 2023 (3.0) and reported throughout 2023.

A national point prevalence preliminary audit report (May 2023) showed that the percentage of healthcare-associated infection rate was 9.7%, higher than the national rate of 7.5%. The IPCC told inspectors that they plan to set up three sub-groups to address high infection rates which was part of the IPCT's annual plan objectives for 2024. The antimicrobial stewardship team plan to continue to monitor key performance indicators and targets for healthcare associated infections and antimicrobial usage and provide feedback to prescribers on antibiotic consumption as part of their service plan for 2024. Antimicrobial stewardship ward rounds were limited due to reduced staffing resources and the antimicrobial pharmacist position was vacant. The IPCC was using the World Health Organisation guidelines on antibiotic classification for evaluation and monitoring of use.

The hospital's overall environmental hygiene score for February 2024 was 95.2%. Environmental audits compliance rates for January to April (2024) for the four clinical areas visited ranged from 86.3% to 99%. While there was a quality improvement plan for the emergency department who scored 97.6%, there were no quality improvement plans provided to inspectors for the other clinical areas visited where compliance rates fell below acceptable standards (100%). The average environmental hygiene compliance rate for January to April 2024 for St Francis Unit was 98.9%.

Mercy University Hospital's national hand hygiene audit for 2023 was compliant with the HSE's target of 90%. However, the IPCC representatives who spoke with inspectors reported that the hand hygiene compliance rate at time of inspection was 81%. The low hand hygiene compliance rates were attributed to the lack of trained auditors and staff resources.

Patient equipment hygiene audits were completed by the hygiene control team as part of the environment hygiene audits. The hospital's overall score for patient equipment hygiene from January to March 2024 was 97%. The patient equipment hygiene audit score for two of the four clinical areas visited ranged from 66.7% to 80%. Where standards fell below acceptable levels (100%) there were no quality improvement plans provided with the audit reports to inspectors. Inspectors observed that patient equipment in the clinical areas visited was clean on the day of inspection.

There was evidence that a number of medication safety audits were completed in 2023 and early 2024. Medication safety audits completed included laser wrist band use, insulin use, safe storage of medicines and potassium prescribing. Inspectors noted that there was evidence of quality improvement plans in place to address practices that fell below expected standards identified in the medication audit reports. The medication safety working group provided reports on audit findings to the DTC. Due to limited resources, pharmacist-led medication reconciliation on admission was carried out for approximately 60% to 70% patients.

Compliance with the early warning system escalation and response protocol was audited monthly as part of the nursing and midwifery quality care metrics and compliance rates in the months (January-March 2024) preceding the inspection varied from 86% to 100%. There was no action plans provided to inspectors where standards fell below acceptable levels. Inspectors were told by staff in the clinical areas visited that the DON and the ADON had oversight of the nursing and midwifery quality care metrics and the results in relation to non-compliance were fed back to the CNM and staff at safety huddle meetings. The emergency department had introduced the EMEWS and audits on the escalation and response protocol were completed each week to identify areas for improvement. The inspectors did not find any evidence of auditing of compliance with the national guidance

on clinical handover and the use of the Identify, Situation, Background, Assessment, Recommendation/Read Back/ Risk communication tool ($ISBAR_{3)}$[*****].

The number of new attendances to the hospital's emergency department, patient experience times (PETs), average length of stay (ALOS) of medical and surgical patients and DTOC were tracked at the hospital in line with the HSE's requirements. Predicted date of discharges (PDD) were determined by the patient's consultant and recorded by the CNM. The unscheduled care team audited performance in relation to the recording of patient's PDD. Audit findings showed an improvement of 7% in the recording of patient's PPD from in March 2023 to March 2024.

In summary, the hospital had systems and processes in place to monitor, analyse and evaluate information from multiple sources to inform continuous improvement of services. However,

- quality improvements plans were not always developed when areas for improvement were identified
- compliance with the national guidance on clinical handover and the use of $ISBAR_3$ was not audited.

Judgment: Substantially compliant

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

Mercy University Hospital had systems in place to proactively identify, evaluate and manage immediate and potential risks to people using the service, including ensuring that the necessary actions were taken to eliminate or minimise these risks. The hospital's corporate risk register was reviewed quarterly at the EMB and CQSGC meetings, at monthly performance meetings with the SSWHG and every six months at board of directors meetings. Risks on the corporate risk register included risks associated with paediatric services, hospital acquired infections, lack of single rooms and shower facilities, no refurbishment of the old hospital structure and patients boarding in the emergency department. In the clinical areas visited, the CNMs escalated risks to their ADON who managed and monitored risks with support from the risk manager. There were no local risk registers. The emergency department had a register and all risks were discussed at the monthly emergency department clinical risk meetings.

The IPCC maintained a local risk register of infection risks. One risk recorded on the IPCC's risk register related to a legionella risk found in the outlets water system in St Francis Unit. A risk assessment for legionella completed in February 2024 outlined the

[*****] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

control measures in place to mitigate the risk. There was evidence on the day of inspection that these controls were in place in St Francis Unit. Hospital management confirmed to inspectors that they plan to set up a water safety group in line with national standards[†††††] to monitor the hospital's water systems. Members of the IPCT did not attend St Francis Unit to monitor infection prevention and control practices, they provided support remotely via the telephone to staff in the unit.

The hospital's information patient management system (iPMS) supported the identification and appropriate management of patients with MDROs by alerting staff to patients who were previously inpatients in the hospital with MDROs. All patients were screened for *Methicillin-Resistant Staphylococcus Aureus* (MRSA) and CPE on admission in line with national guidelines. Due to high incident rates of *Vancomycin-Resistant Enterococcus* (VRE), patients in three of the clinical areas visited were screened for VRE on admission. Patients in St Francis Unit were screened in the Mercy University Hospital prior to transfer to the unit and if they were transferred from the emergency department, they were screened for CPE on admission to the unit.

In 2023, the hospital had 26 outbreaks of COVID-19, nine norovirus outbreaks, one outbreak of VRE and one outbreak of sapovirus. In March 2024, there were three outbreaks (two influenza A cases and one norovirus case). A multidisciplinary outbreak teams was convened to advise and oversee the management of these outbreaks and develop action plans that aligned with best practice standards and guidance. Inspectors viewed two outbreaks reports and noted that the reports outlined the outbreak control measures implemented, but there was no record of lessons learned from the outbreaks in the reports. The IPCC told inspectors that learnings from the review of infection outbreaks were shared at the hospital daily huddle meeting at 08.45 hours. Inspectors attended the hospital huddle meeting on day two of the inspection and observed members of the infection prevention and control team providing feedback on infection outbreaks.

A limited clinical pharmacy service was provided to the wards twice a week and a daily pharmacy service was provided to the emergency department. While a clinical pharmacist does not formally visit St Francis Unit, advice was available to staff via email or telephone. Due to the lack of clinical pharmacists, medication reconciliation on admission was completed for about 60% to 70% of patients. Outside core working hours, the site ADON had access to the pharmacy department to provided wards, including St Francis Unit with medications when requested by clinical staff. Inspectors observed the use of risk reduction strategies to support the safe use of medicines in relation to anticoagulants, insulin and opioids. The hospital had a sound-alike-look-alike drug (SALAD) list, but there was no list of high-risk medications. Prescribing guidelines, including antimicrobial guidelines and

[†††††] HIQA National Standards for the prevention and control of healthcare-associated infections in acute healthcare services (2017). Accessed on line: https://www.hiqa.ie/sites/default/files/2017-05/2017-HIQA-National-Standards-Healthcare-Association-Infections.pdf

medication information were available and accessible to staff at the point of care in hard copy format and on the hospital intranet.

Inspectors found that staff in two of the clinical areas visited used different versions of INEWS observation charts which was raised by inspectors with hospital management. Hospital management told inspectors that they plan to appoint a designated nurse lead to support the implementation of the deteriorating patient programme and had advertised the position a number of times, but recruitment was unsuccessful. Clinical facilitators provided staff in the clinical areas with training on early warning systems which included INEWS.

The hospital had introduced the $ISBAR_3$ communication tool. Staff who spoke with inspectors were clear about the escalation protocol for the deteriorating patient. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition had or was deteriorating. Staff used the $ISBAR_3$ communication tool for shift handover and the internal and external patient transfers within the hospital, but the ISBAR sticker was not always placed in the patient's healthcare record. An intra-hospital transfer checklist viewed by inspectors was used to record information on the patient's early warning score when transferring care. Hospital management told inspectors that the hospital had no deteriorating patient guidance for patients in St Francis Unit and INEWS was not used in the unit. However, inspectors were informed that patients that deteriorate in St Francis Unit, were transferred back to Mercy University Hospital in line with the unit's transfer criteria.

Mercy University Hospital did not have a high dependency unit (HDU). Patients requiring closer observations were cared for in designated observation beds located in medical and surgical wards. The nurse to patient ratio for these patients was 1:4, 24/7 to ensure a closer level of monitoring. Clinical oversight of patients in the observation beds lay with the medical or surgical consultant and their registrars. Staff were provided with informal training on specific medical equipment used to support patients in the observation ward, such as continuous positive air pressure (CPAP).

The hospital's policies, procedures and guidelines were approved through the CQSGC. The hospital had a range of infection prevention and control, medication safety policies, procedures, protocols and guidelines, some of which required updating. The hospital also had a range of policies, procedures, protocols and guidelines related to the clinical deteriorating of patients which required review. Staff had access to policies, procedures, protocols and guidelines on the hospital intranet

The hospital had systems and processes in place to support the discharge planning and safe transfer of patients within and from the hospital. On the day of inspection, the hospital had ten delayed discharges. Hospital management attributed the delay in transferring patients mainly to the lack of access to rehabilitation beds in the community. Weekly meetings were held with representation from the hospital and the Cork Kerry Community Healthcare team (CHO4) to review delayed and complex discharges. The hospital had access to external beds in St Francis Unit, St Finbarr's Hospital, Mallow General Hospital,

the South Infirmary Victoria Hospital, the Mater Private Network, the Bon Secours Hospital, and access to beds in private nursing homes. To support the safe transfer of patients back to the community, the hospital had a number of referral templates to refer patients to rehabilitations services, rehabilitations services, community intervention teams and complex cases management teams. In addition, an intra-hospital transfer checklist was used to record information when transferring patients.

On the first day of inspection, the emergency department and the AMAU were functioning reasonably well. All patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. At 11.00am on the first day of inspection, ten of the 22 patients registered in the emergency department were admitted patients waiting for an inpatient bed. There were no patients on trolleys on the corridor which was an improvement on the last inspection where patients were accommodated on trolleys along a narrow corridor.

Of the 10 admitted patients, one was waiting in the department for more than 24 hours while waiting for an inpatient bed. This was an improvement on the last inspection where ten patient were waiting in the emergency department for more than 24 hours for an inpatient bed.

- The average waiting time from registration to triage was 9.5 minutes. This was an improvement on the last inspection and met the HSE target of 15 minutes.
- The average time from triage to medical assessment was 43.5 minutes, which had disimproved since the last inspection.
- The average time from medical assessment to decision to admit was 5 hours 6 minutes.
- The average time from decision to admit to admission to an inpatient bed in the main hospital was 10 hours 12minutes.

Data on the hospital's emergency department PETs collected at 11.00am on the first day of inspection, showed that the hospital was compliant with two of the five HSE's targets and non-compliant with three which was an improvement on the last inspection. At 11.00am:

- 45% of 22 patients were waiting in the emergency department for more than six hours following registration. This represented an improvement on the 74.3 % found waiting during the previous inspection, but was not in line with HSE's target of 70%.
- 45% of 22 patients were waiting in the emergency department for more than nine hours of registration, but was not in line with HSE's target that 85%
- One patient (4.5% of attendees) was in the emergency department for more than 24 hours after registration. This represented an improvement on the 25.6 % (10 patients) found waiting in the previous inspection and slightly below (95.5%) the HSE target of 97%.
- One patient who was over 75 years was in the emergency department greater than nine hours of registration — which was an improvement on the 10 patients (76.9%) found during the previous inspection, but not in line with the HSE's target of 99%.

- The hospital was compliant with the HSE target of 99% that all attendees to the emergency department aged 75 years and over be discharged or admitted within 24 hours of registration. This represented an improvement on the 23% found during HIQA's previous inspection. The hospital was focussing on admitting patients over 75 years of age as part of the zero to trolleys quality improvement initiative. This initiative had resulted in 50% less people over 75 years of age breaching the 24 hour patient experience time target.

On the day of inspection, there were ten delayed transfers of care (DTOC) and eight of these patients were delayed as they required access to rehabilitation care beds. The average length of stay (ALOS) for medical patients was 8.7 days and for surgical patients was 6.45 days in 2024, remained higher than the corresponding HSE's targets of ≤7.0 for medical patients and ≤5.0 days for surgical patients. Collectively, the data showed that delayed discharges, the increase in the average length of stay for patients and non-compliance with the majority of the PETs targets impacted patient flow and the availability of inpatient beds in the hospital.

To support patient flow in the wider hospital, the hospital had increased its bed capacity by 30 beds and had 11 surge beds. Staff in the emergency department confirmed that the increase in bed capacity and surge beds had improved patient flow. The hospital had implemented a number of hospital admission avoidance pathways and measures to support efficient patient flow. These included:

- Minor injuries pathway to the Local Injury Unit located off site in St Mary's campus.
- AMAU pathway in the emergency department.
- Frailty Intervention Therapy Team (FITT) pathway.
- Pathway for the management of deep vein thrombosis (DVT)
- Integrated care programme for older people (ICPOP).
- Mercy Home Care.[‡‡‡‡‡]
- An ambulatory care pathway.
- Trauma bypass protocol pathway.
- Mercy Home Care service team.

In summary, areas requiring attention included:

- The IPCT provided remote support to staff in St Francis Unit via telephone which may need to be reviewed in light of the outbreaks of infection.
- The hospital had no water safety group in place to monitor the hospital's water systems particularly in light of the legionella outlet risk and the age of the hospital infrastructure.
- The IPCT completed outbreak reports, but there was no record of lessons learned in the reports to mitigate the risk of another outbreak.

[‡‡‡‡‡] Mercy Home Care: This was a new service introduced with the support of a clinical nurse manager and two healthcare assistants to provide support to patients who were discharged home and waiting for a home care package).

- The hospital was compliant with two of the five HSE's targets for patient experience times (PETs) on the day of inspection.
- The average time from triage to medical assessment had increased since the last inspection and needs to be reviewed
- The hospitals average length of stay for medical and surgical patients remains higher than the HSE targets.

Judgment: Partially compliant

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

Mercy University Hospital had effective patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The CQSGC, EMB, SIMT, board of directors and SSWHG had oversight of the management of patient-safety incidents and serious reportable events reported at the hospital.

The quality and risk management department provided a quarterly clinical incident report and an end of year clinical incident report to CQSGC. A clinical incident report on each ward was also provided to the DON each quarter. The clinical incident reports provided details on the number of incidents reported by location, hazard type, clinical care, and case management, outcome of staff affected by incidents, and outcome at time of incident reporting. Inspectors noted that the incident reporting rates were high, which suggested that there was a good culture of incident reporting across the hospital including St Francis Unit. There was ample evidence that infection prevention and control incidents were reported to the quality and risk management department, this included incidents from St Francis Unit. Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not tracked or trended at the hospital.

Staff who spoke with inspectors 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 in their clinical area. Staff provided inspectors with examples of medication incidents reported and the education provided to staff following a specific medication incident. Feedback on learnings from patient-safety incidents was provided by CNMs to staff and staff could describe quality improvements initiatives implemented after patient-safety incidents. Staff in St Francis Unit also received feedback on patient-safety incidents and complaints reported via telephone. In the emergency department, there was evidence that their clinical incident quarterly reports were discussed at their departmental monthly critical review meetings.

The SIMT and CQSGC were responsible for ensuring that all serious reportable events and serious incidents were reported to the National Incident Management System (NIMS) §§§§§ and managed in line with the HSE's Incident Management Framework. In 2023, the hospital was compliant with the HSE's target of 75% for reporting of patient-safety incidents to NIMS within 30 days from the date the incident occurred. However, in 2024 the rate of reporting to NIMS was 35 days and this delay was related to the increase in the volume of incidents to be entered onto NIMS.

The hospital's SIMT was chaired by the CEO and the team met when required. Minutes of SIMT meetings provided to HIQA showed that the team had met in June and August 2023 and in January 2024. The meetings followed a structured agenda and there was evidence that the implementation of agreed actions were followed up from meeting to meeting. Hospital management acknowledged that they were not meeting the 125 day target for completing reviews.

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

- the hospital's rate of reporting of clinical incidents to NIMS for year to date 2024 was not within the HSE's 30 day timeframe.

Judgment: Substantially compliant

Conclusion

HIQA carried out an unannounced inspection of Mercy University Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Health*.

Capacity and Capability

Mercy University Hospital had formalised integrated corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare, but at the time of the inspection, these structures were being reviewed and updated by the executive management board. In addition, the hospital had recently set up the Care of the Deteriorating Patient Committee (including sepsis), but the terms of reference was not ratified.

Inspectors found that the workforce arrangements in place in Mercy University Hospital were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare in the emergency department. Inspectors found that the emergency

§§§§§ 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).

department had approval for five whole-time equivalent (WTE) consultants in emergency medicine and 2.5 of these posts were filled. This contributed to significant gaps in the consultant in emergency medicine's on-call roster to provide oversight to non-consultant hospital doctors. Inspectors found there was no improvement in compliance with the National Standard 6.1 since the last inspection, but acknowledged that hospital management had tried to fill the consultants in emergency medicine positions and were unsuccessful.

Similarly, the hospital had a deficit in relation to consultant microbiologists. The hospital had approval for 43 hours of consultant microbiologist cover per week to be provided by 2 WTE consultant microbiologists with shared responsibility for the South Infirmary Victoria Hospital, community care and Cork University Hospital. At the time of the inspection, these two post were progressing through the recruitment phase. At the time of inspection, 1.6 WTE consultant microbiologists' positions were filled and 0.4 WTE consultant microbiologist position was unfilled. Of the 1.6 WTE positions filled, 1 WTE consultant microbiologist was on statutory leave until September 2024, but the 0.6 WTE position was filled on a locum basis. To mitigate any risk associated with the shortfall in consultant microbiologists, hospital management had appointed a microbiology specialist registrar (in their last three months of training) to an acting consultant microbiologist position from April to July 2024. In addition, staff also had access to clinical microbiology advice 24/7 provided by the Mercy University Hospital consultant microbiologist and supported by consultant microbiologist staff in in Cork University Hospital.

Nursing staffing arrangements across the hospital had improved significantly since the last inspection. Three of the four clinical areas visited had increased their overall nursing complement. However, 24% of pharmacist positions were unfilled, which included the antimicrobial pharmacist position and this impacted on the ability to provide a comprehensive clinical pharmacy service in all clinical areas. The attendance at mandatory and essential training required improvement across most disciplines.

Mercy University Hospital did not have a clinical audit committee and the approach to auditing the hospital's compliance with best practice standards was not coordinated, but individual governance committees had oversight of audit findings related to areas they have responsibility for. Staff in the clinical areas visited had no awareness of quality improvement initiatives developed in response to the National Inpatient Experience Survey findings of 2022.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their

experience of receiving care in the emergency department and wider hospital, including St Francis Unit and were very complimentary of staff.

The hospital's physical environment and ageing infrastructure did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of shower facilities in the clinical areas visited. Inspectors found evidence of inappropriate use of disposable bedpans, inadequate infection prevention and control signage and ineffective system to identify clean patient equipment.

The hospital had systems and processes in place to monitor, evaluate and improve services at the hospital. However, quality improvements initiatives were not always implemented when standards fell below acceptable levels. In addition compliance with the national guidance on clinical handover and the use of $ISBAR_3$ communication tool was not monitored.

On the day of inspection, the hospital's emergency department and the AMAU were functioning reasonable well, relative to its intended capacity which was an improvement on the findings from the last inspection. The average waiting time from registration to triage had improved, but the average time from triage to medical assessment was higher than the findings on the previous inspection. The hospital was compliant with two of the five HSE's targets for PET on the day of inspection which was an improvement on compliance since the last inspection.

Outbreak reports were completed outlining the outbreak control measures implemented to manage outbreaks, but there was no record of lessons learned from the outbreak to mitigate the risk of another outbreak. The IPCT did not have an onsite presence in St Francis Unit, remote support was provided to the staff via the telephone. There were systems and processes in place to support the discharge planning and safe transfer of patients within and from the hospital. The hospital had systems in place to report and monitor patient safety incidents and serious reportable incidents and the data indicated that there was a good culture of incident reporting in the hospital and in St Francis Unit.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension

Overall Governance	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially-compliant

quality, safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Appendix 2 – Compliance Plan submitted to HIQA

Compliance Plan for Mercy University Hospital

OSV- 0001059

Inspection ID: NS_0074

Date of inspection: 18 and 19 April 2024

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
Outline how you are going to improve compliance with this standard. This should clearly outline: (a) details of interim actions and measures to mitigate risks associated with non-compliance with standards. (b) where applicable, long-term plans requiring investment to come into compliance with the standard Following a successful recruitment campaign, 2.0 ED consultants will commence December 2024/January 2025. This will bring our ED Consultant number to 5. As one ED Consultant is also Clinical Director for Medicine we have requested funding for 0.5 WTE additionality for "on the floor " presence. At which point recruitment can commence. A submission was	

made to the SSWHG of priority posts under the Pay and Numbers 2024 Strategy which included these vacant ED consultant posts. Recruitment underway for 2.0 Consultant Microbiologist posts, interviews scheduled for September 2024. A submission was made to the SSWHG of priority posts under the Pay and Numbers 2024 Strategy which included these vacant Microbiologist posts. Recruitment currently underway with open campaigns for both Staff Grade and Senior Grade Pharmacists. A business case has been developed for the introduction of a Learning Management System (LMS) as a central database to accurately monitor and collate mandatory training compliance records and brought to the EMB for approval. This is currently in the procurement stage. It is hoped that we will commence installation in Q1 2025. A clinical strategy has been completed and the Consultant Workforce and pan hospital workforce plan to accompany this is in development.
Timescale: April 2025

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

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

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

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

Item No:	Description:	Interim Measure	Long Term Measure
1.	Bed tables chipped in St. Catherine's ward	Full audit of all bed tables in the hospital completed in August 2024. Full list of requirements sent to Procurement and a phased replacement has been put in place.	N/A
2.	Flooring repairs – St. Brigid's	Sections of damaged corridor flooring being repaired in Q4 2024.	
3.	Hand hygiene sinks not meeting national guidance requirements	MUH has an ongoing sink replacement programme and will continue this rollout into 2025 subject to funding.	
4.	Review site quality walk action plan	These are being reviewed and updated locally for each area.	
5.	Not all single rooms had ensuite facility	No update.	Lee View Block 2 is in at feasibility stage and this development will provide single ensuite bedrooms to current healthcare standards.
6.	The main corridor was a thoroughfare as it provided direct access to the endoscopy unit during core working hours which impacted	There is access control installed on a set of cross corridor doors to cordon off the ward from Endoscopy unit and the operational use needs to be managed by the ward.	

	the security of the environment as the ward entrance doors were opened. As outlined above, hospital management were progressing with an action plan to address all these risks and had controls in place to mitigate the risks – St. Brigid's.		
7.	Drug Prep area - ED	This is being refurbished commencing 23rd September 2024.	
8.	No negative pressure gauge	This is under review with consulting mechanical engineer.	
9.	Limited access to shower facilities – St. Francis Unit due to local Legionella outbreak.	This is now addressed and all shower facilities available again.	
10.	Pulp bedpans and urinal were used however ward did not have a macerator. Inspectors noted that there was no action owner or time-bound plan to address this risk.	Following inspection, a risk assessment was provided (25 April) to HIQA which outlined the controls and additional controls in place to mitigate the risk. Controls in place included the repossessing of reusable patient care equipment and a plan to provide education to staff on the ward on the use of the washer disinfector.	Staff educated on correct disposal practice
11.	IPC signage and control signage observed at the entrance to single rooms in two clinical areas visited by inspectors did not specify what type of	We are using the National AMRIC posters and all of these are in line with our local policy and NCG IPC guidance - we intend to await the national system.	

	precautions were being taken and was brought to the attention of the CNM.	We use the alert system to identify the level of precautions and have completed some education in relation to this and have issued one of our IPC safety bulletins on alerts and their management to support this. This is further supported with daily IPC ward visits and review of patients with alerts and isolation requirements.	
12.	Cleaning of equipment was assigned to HCAs. In the clinical areas a colour tagging system was used to identify clean patient equipment, but inspectors found that the green tag date was not used consistently in the clinical areas visited. This was escalated to the CNM.	Ongoing recruitment for housekeepers for areas without one as they play a vital role in the management of hygiene for near patient equipment.	

Timescale:

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

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

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

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

The IPCT provided remote support to staff in St Francis Unit via telephone which may need to be reviewed in light of the outbreaks of infection.
Interim Actions

The IPCT provide a remote resource to staff in St Francis Unit as required and requested basis e.g. in relation to the management of alerts for patients with MDROs, routine queries etc.
In addition to this in the event of an outbreak of infection – daily IPCT phone contact is made to update the outbreak line list and provide advice and support.
Since the HIQA inspection IPC have completed two site visits.
Long Term Plans
Going forward during an outbreak of infection a member of the IPC nursing team will complete a site visit.

The hospital had no water safety group in place to monitor the hospital's water systems particularly in light of the legionella outlet risk and the age of the hospital infrastructure.

Interim Actions
A subgroup on water safety which reports directly to the Infection Prevention and Control Committee (IPCC) has been established.
The water safety subgroup has met on two occasions (14th May 2024 and 30th July 2024).
Next meeting scheduled for quarter 4 of 2024.
Long Term Actions
The water safety subgroup of the IPCC will meet on a quarterly basis.

The IPCT completed outbreak reports, but there was no record of lessons learned in the reports to mitigate the risk of another outbreak.

Interim Actions
The IPC outbreak report template has been revised to allow for the development of a local quality improvement plan (QIP) with the lessons learned from the outbreak. This QIP is completed by the CNM for the affected area.
The QIP must be signed off by the CNM and ADON for the area to allow for accountability and local ownership of the lessons learned.
The IPCT will support the area with any resources required e.g. training etc.
Outbreaks are discussed at the quarterly IPCC lessons learned will be discussed at this forum.
The IPCC now issue a email to all relevant staff in relation to shared learning from the IPCC this will include any lessons learned from outbreaks.

The hospital was compliant with two of the five HSE's targets for patient experience times (PETs) on the day of inspection.

PET targets (within six hours following registration, PET within nine hours of registration, PET over 75 years within nine hours of registration) the following actions have been put in place:

- ADON Patient flow is constantly monitoring PET times and training has also been provided to NCHD's and nursing.
- ED Consultants and ADON Patient flow assess every patient at 6Hours and 9Hours following their registration in ED.
- Emergency Department and AMAU team continually review patient suitability to be followed up as outpatients.

- Ambulance triage and arrivals are supported by a triage nurse.
- MUH utilise Community services for admission avoidance.
- Ambulance TAT running concurrently – show improvement over (April to August 2024, see chart below).

	APRIL	MAY	JUNE	JULY	AUG
ED Attendances	2846	3016	2796	2705	2545
ED Admissions	614	670	577	590	584
UCC Attendances	1704	1853	1641	1579	1662
Total Attendances	4550	4869	4437	4284	4207
UCC Paediatric Presentations	391	455	276	227	9
UCC >75 Presentations	107	138	141	113	145
Overall ED Conversion %	22%	22%	21%	22%	23%
>75 year old ED Presentations	449 (16%)	414(14%)	410(15%)	424(16%)	418(16%)
>75 year old ED Admissions	208 (34%)	210(33%)	186(33%)	207(36%)	212(37%)
>75 year old ED Conversion %	46%	50%	45%	49%	51%
> 75year 24hr trolley breach	33	13	41	33	11

	APRIL	MAY	JUNE	JULY	AUG
Non Admitted 6 Hour PET ED YTD	51%	52%	53%	58%	61%
Non Admitted 9 hour PET ED YTD	71%	74%	73%	72%	79%
Admitted 6 Hour PET ED YTD	14%	15%	9%	7%	16%
Admitted 9 hour PET ED YTD	32%	35%	24%	15%	44%
PET ED > 24 hours	168 (6%)	99(3%)	164(6%)	147(5%)	78 (3%)
ED last 30 days Moving Average Trolley GAR	12.6	7	12	11	7.7
Ambulance Turnaround Times <20 mins	49%	60%	57%	65%	74%
Amb TAT < 60 mins	92%	96%	95%	96.00%	98%
AMAU Attendances	135(5%)	131(4%)	121(4%)	152(6%)	120(5%)
% Left Before Treatment Completion		216 (7%)	264 (9%)	190(7%)	167(7%)

Status: Complete

The average time from triage to medical assessment had increased since the last inspection and needs to be reviewed

- Successful recruitment process completed.
- Presently on boarding two additional Emergency Medicine consultants with a panel formed.
- An additional Senior House Officer has been recruited and is in post since July 2024.

Status: MUH are presently on boarding

The hospitals average length of stay for medical and surgical patients remains higher than the HSE targets.

- MUH have added an additional Patient flow (CNM2) to provide a 7-day service.
- The Patient flow (CNM2) person alternates with MUH discharge coordinator working 7 over 7.
- MUH have implemented the HSE SAFER discharge stamp process for the weekends starting Thursdays each week.
- MUH continually communicate discharge numbers and actions required when the Hospital moves from Green status.
- Ongoing Journey to Zero trolleys meetings to communicate required actions on a daily basis.

Status: Complete