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:	University Hospital Waterford
Address of healthcare service:	Dunmore Road Waterford Co. Waterford X91 ER8E
Type of inspection:	Unannounced
Date of inspection:	5 and 6 June 2024
Healthcare Service ID:	OSV-0001105
Fieldwork ID:	NS_0075

About the healthcare service

Model of Hospital and Profile

University Hospital Waterford is a model 4* hospital, managed by the Ireland East Hospital Group (IEHG)† on behalf of the Health Service Executive (HSE). The hospital was realigned to IEHG early in 2024, having been a member of the South/South West Hospital Group previously. At the time of inspection, six new regional health areas were being established by the HSE. As part of this process, IEHG will become part of the Dublin and South East health region.

The hospital is the designated cancer centre for the southeast region of Ireland, providing rapid access assessment for breast, prostate, lung and skin cancers. It is also the regional trauma orthopaedic centre for the South/South West Hospital Group. The hospital provides the following healthcare services and care to a population of approximately 500,000 people in south Kilkenny, Waterford city and county:

- acute medical inpatient services
- elective surgery
- emergency care
- maternity care
- intensive and high-dependency care
- diagnostic services
- outpatient care.

The hospital is an academic teaching hospital affiliated with University College Dublin, the Royal College of Surgeons in Ireland and South East Technological University.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	511 inpatient and day case beds

* A model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, which is open on a continuous basis (24 hours, every day of the year) and an emergency department.

† The Ireland East Hospital Group comprises 11 hospitals – St Vincent's University Hospital, University Hospital Waterford, St Luke's General Hospital Carlow-Kilkenny, Tipperary University Hospital, Wexford General Hospital, St Columcille's Hospital - Loughlinstown, St Michael's Hospital - Dún Laoghaire, Kilcreene Regional Orthopaedic Hospital, National Maternity Hospital, National Rehabilitation Hospital and Royal Victoria Eye and Ear Hospital. The hospital group's academic partner is University College Dublin.

How we inspect

Among other functions, the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility to set and monitor standards in relation to the quality and safety of healthcare services. This inspection was carried out, as part of HIQA's role to assess compliance with the *National Standards for Safer Better Healthcare.* It was a follow-on inspection from the previous inspection of the hospital's emergency department in April 2023.

To prepare for this inspection, the inspectors[‡] reviewed relevant information, which included previous inspection findings, information submitted by the hospital and hospital group, unsolicited information[§] and other publicly available information since HIQA's last inspection in 2023.

During the inspection, the inspectors:

- spoke with people who used healthcare services in the hospital to ascertain their experiences of the care received
- spoke with staff and management to find out how they planned, delivered and monitored the healthcare services 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 the hospital performed in relation to the 11 national standards assessed during the inspection are presented in the following sections, under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time — before, during and following the 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

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

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

and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place at the hospital and how people who work in the service are managed and supported to ensure and assure the delivery of high-quality care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare services in the hospital receive on a day-to-day basis. It determines if the service is of good quality and caring that is both person-centred and safe. It also includes information about the healthcare environment where people receive care.

A full list of the 11 national 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
5 June 2024 6 June 2024	09:00hrs – 17:15hrs 09.00hrs – 15.45hrs	Denise Lawler	Lead
		Geraldine Ryan	Support
		Bairbre Moynihan	Support
		Elaine Egan	Support
		Robert McConkey	Support

Background to this inspection

HIQA carried out an inspection of the hospital's emergency department in April 2023 and the hospital was found to have a good level of compliance with the four national standards (5.5, 6.1 1.6 and 3.1) assessed from the *National Standards for Better Healthcare*. Since HIQA's last inspection, the hospital has moved to a different hospital group (from the South/South West Hospital Group to the IEHG) and Kilcreene Regional Orthopaedic Hospital has been integrated under the governance of University Hospital Waterford. During this inspection, hospital management confirmed that the realignment to the IEHG and the integration of Kilcreene Regional Orthopaedic Hospital was complete and that the realigned corporate and clinical governance arrangements were functioning well. This inspection focused on four key areas of known harm, these were:

- infection prevention and control
- medication safety

- the deteriorating patient[**] (including sepsis management)[††]
- transitions of care.[‡‡]

During this two-day unannounced inspection, the inspection team visited the following five clinical areas:

- Emergency department, which included the Emergency Assessment Unit
- Ardkeen Ward (31-bedded surgical ward)
- Medical 6 Ward (35-bedded general medical ward)
- Orthopaedic 2 Ward (31-bedded orthopaedic surgical ward)
- Medical 3 Ward (31-bedded medical ward for care of the elderly).

The inspection team also spoke with the following staff:

- Representatives of the Executive Management Board (EMB)
  - General Manager
  - Director of Nursing and Integration (DON)
  - Human Resource Manager
  - Medical Manpower Manager
  - Clinical Director for the medical directorate
  - Clinical Director for the peri-operative directorate
  - Clinical Director for the diagnostic directorate
  - Operations Manager
- Quality and Patient Safety Manager
- Risk Manager
- Bed Manager
- Discharge Coordinator
- Patient Services Manager
- Representatives for the non-consultant hospital doctors (NCHDs).
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control Committee
  - Medicines and Therapeutics Committee
  - Clinically Deteriorating Patient Committee
  - Quality and Patient Safety Committee.

Inspectors also spoke with a number of staff from different professions and disciplines, and people receiving care in the clinical areas visited.

Acknowledgements

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

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

[‡‡] Transitions of care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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 the people using the service who spoke with inspectors about their experience of receiving care in the hospital.

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

Over the course of the inspection, the inspectors observed staff and patient interactions and saw how staff actively engaged with patients in a respectful, cordial, considered and kind way. Staff were observed supporting and assisting patients with their individual needs. Staff meaningfully promoted and protected the patient's privacy and dignity when delivering care.

Patients were accommodated in multi-occupancy rooms and single rooms when their clinical condition required. Each of the clinical areas inspectors visited had a small number of single rooms with en-suite bathroom facilities (approximately four rooms in each clinical area). Staff who spoke with the inspectors confirmed it was not usual practice to accommodate patients in mixed gender wards. If needed, patients' consent was obtained before placement in a mixed gender ward and this practice was confirmed by patients who spoke to the inspectors.

Inspectors spoke with a number of patients receiving care in the five clinical areas visited. Overall, patients' experiences were very positive. Patients were highly complimentary about the staff, the care received and the food provided in the hospital. Staff were described as 'brilliant", "lovely", "very good", "wonderful", "attentive'" and "kind". Patients felt they received "great and fantastic care" and that staff were "very impressive and doing their best". Patients also felt staff were accessible and supportive and that there was 'good communication with all staff". Patients who spoke with inspectors had not received information about the hospital's complaints process and or independent advocacy services. Patients told inspectors they would speak with a member of the nursing staff if they had a complaint or concern but the majority of patients said they had no complaints about their care. The inspectors did not observe any information about the hospital's and or the HSE's complaints process displayed in the clinical areas visited. This is discussed further in national standard 1.8.

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. University Hospital Waterford was found to be compliant with two national standards (5.2 and 5.8) and substantially compliant with two national standards (5.5 and

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 the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. Decision-making, responsibility and accountability for scheduled and unscheduled care was devolved with clearly defined reporting arrangements, which were understood by staff who spoke to the inspectors. The governance arrangements outlined to the inspectors, were consistent with those detailed in the hospital's organisational charts.

The general manager was the accountable officer with overall responsibility and accountability for the quality and safety of the healthcare services delivered in the hospital. The general manager reported to and was accountable to the Interim Chief Executive Officer (CEO) of Ireland East Hospital Group (IEHG). There was a clear and defined reporting relationship between the hospital's general manager and the interim CEO of IEHG. The hospital's general manager, was supported by the Executive Management Board (EMB). The EMB led, governed and oversaw the overall quality and safety of the healthcare services provided in the hospital. The multidisciplinary Quality and Patient Safety Committee (QPSC) provided the EMB with assurances on the effectiveness of the governance arrangements in ensuring the quality and safety of healthcare services provided at the hospital. Subcommittees of the QPSC oversaw the effectiveness and quality of practice in three of the four areas of focus of this inspection – infection prevention and control, medication safety including antimicrobial stewardship and deteriorating patient. These subcommittees had formalised reporting arrangements to the QPSC. They provided the QPSC with a performance report about their areas of responsibilities every three months and a composite report on performance and compliance with best practice standards and quality metrics annually. These committees are discussed further in national standard 5.5.

On the day of inspection, there was evidence of strong executive and clinical leadership at the hospital. Responsibility for the governance and oversight of the effectiveness of clinical care lay with three clinical directorates — medical, peri-operative and diagnostic clinical directorates. Clinical leads for maternity, paediatric and cancer services, led and oversaw the quality and safety of those services. Each clinical directorate had a leadership team that comprised a clinical director, business manager, assistant director of nursing (ADON) and health and social care professional (HSCP) lead. The director of nursing (DON) and director of midwifery (DOM) oversaw the organisation and management of nursing and midwifery services at the hospital. The clinical directors from the three clinical directorates, clinical leads for the maternity, paediatric and cancer services, DON and DOM were members of the EMB. All provided an update on their respective areas of responsibilities at monthly meetings of the EMB.

It was clear from documentation reviewed by inspectors and meetings with relevant staff that the hospital's governance arrangements were robust, and the governance committees functioned in line with their terms of reference. All terms of reference for the governance committees[§§] reviewed by inspectors were in date. Committee memberships comprised relevant representation from the executive management team as well as clinical and subject matter experts. Each governance committee had a structured agenda for meetings and it was evident that the committees had oversight of the performance, quality and compliance of the service in their remit with national standards, applicable key performance indicators (KPIs) and legislation. It was clear that meetings of governance committees were action-oriented and the implementation of agreed actions to improve the quality of healthcare services was monitored by committee members. There was a formalised upward reporting structure from each governance committee to the QPSC and or the EMB, and onwards from the general manager to IEHG. It was evident to inspectors that there was a concerted focus to ensure, assure and maintain the quality and safety of healthcare services provided at the hospital.

Judgment: 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 there were defined management arrangements in place to support and promote the delivery of safe, high-quality healthcare services in University Hospital Waterford and these arrangements functioned well. The hospital's executive management team were responsive and reactive, and had good operational grip on the issues that impacted on the quality and delivery of healthcare services provided at the hospital. Several hospital committees were established by hospital management to achieve the planned objectives and ensure the effective management of infection prevention and control practices, medication safety practices, the clinically deteriorating patient and safe transitions of care. These committees included the Infection Prevention and Control Committee (IPCC), Medicines and Therapeutics Committee (MTC) and Clinically Deteriorating Patient Committee (CDPC).

The hospital's infection prevention and control team (IPCT), together with the hospital's multidisciplinary IPCC had devised an infection prevention and control work plan for 2024, which set out the priorities for the year. The IPCC was a subcommittee of the QPSC and had a defined and formalised reporting arrangement to that committee. The IPCT was responsible for implementing the work plan. The team provided an update on the progress of the plan's implementation at IPCC meetings every three months. An annual performance

[§§] Inspectors reviewed the terms of reference, agenda and a selection of minutes for the following committees: Executive Management Board, Quality and Patient Safety Committee UHW/KROH, Infection Prevention and Control Committee, UHW/KROH Medicines and Therapeutics Committee, Clinically Deteriorating Patient Committee and Serious Incident Management Team (SIMT).

report developed by the infection prevention and control department was also submitted to the IPCC and the EMB. The 2023 annual infection prevention and control report reviewed by inspectors, detailed the work undertaken by the IPCT and the hospital's performance in relation to infection prevention and control practices, surveillance and monitoring, and compliance with national standards and applicable KPIs. The hospital's performance in these areas are discussed further in national standards 2.8 and 3.1.

The hospital's pharmacy service was led by the chief pharmacist. Measures to support medication safety practices were set out in the hospital's annual medication safety plan, which was devised by the medication safety committee and approved by the hospital's MTC. The MTC was a subcommittee of the QPSC and had a defined and formalised reporting arrangement to that committee. The medication safety committee was a subcommittee of the MTC. The medication safety committee comprised two subcommittees — medicines management working group and critical care medication safety group. Both subcommittees reported to the medication safety committee. Responsibility for the implementation of the annual medication safety plan lay with the hospital's medication safety pharmacist and medication safety committee. At the time of inspection, the medication safety pharmacist's position was unfilled (since September 2023). Consequently, the medication safety work plan for 2024 was incomplete and was not approved by the MTC. The medication safety committee submitted an annual report to the MTC that detailed the audit activity, quality improvement projects and staff training completed in the year. The hospital's antimicrobial stewardship programme[***] was implemented by the antimicrobial stewardship team with oversight by the Antimicrobial Stewardship Committee (AMSC). The AMSC was a subcommittee of the IPCC and reported on the hospital's level of compliance with antimicrobial stewardship practices to that committee.

A deteriorating patient improvement programme under the clinical leadership of a consultant in emergency medicine had been implemented across the hospital. A critical care outreach team supported staff providing care to patients discharged from the hospital's Intensive Care Unit (ICU). Oversight of the effectiveness of systems in place to recognise and manage the deteriorating patient was the responsibility of the CDPC. The CDPC had oversight of the hospital's level of compliance with national guidelines on the early warning systems,[†††] sepsis management and patient resuscitation. The CDPC was a subcommittee of the QPSC and had a defined and formalised reporting arrangement to the CDPC.

There were management arrangements in place to monitor hospital activity and issues that impacted on the demand for healthcare services and on the effective and safe transitions of care. Hospital activity, patient acuity, hospital capacity and responsiveness to meet service demand was monitored and managed daily and weekly through a number of formalised meetings. These included handover meetings, senior nurse manager meetings, patient flow

[***] An antimicrobial stewardship programme refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.
[†††] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient.

monitoring meetings, infection prevention and control meetings, visual hospital meetings clinical directorate meetings, weekly meetings with South East Community Healthcare (SECH) and daily interactions with the SECH liaison person. The hospital had a formalised escalation plan that was initiated in response to service demand. On the day of inspection, the hospital was at green escalation level, whereby there was no excess demand on bed capacity and the emergency department was functioning normally. When needed, hospital management could use the 37 designated surge beds and could scale up to 49 surge beds if the demand for healthcare services required.

Overall, on the day of inspection, it was evident that there were clear, responsive and effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services at the hospital. These arrangements supported the effective management and operational functioning of the hospital. Notwithstanding this, the hospital's medication safety plan for 2024 was not finalised or approved by the MTC.

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 monitoring arrangements in place in University Hospital Waterford to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services were systematic and functioning. Information from a range of different clinical and quality data sources was collected, collated and published in line with the HSE's reporting requirements. This information gave assurances to the EMB and relevant governance committees about the quality and safety of healthcare services provided in the hospital. The hospital's performance and compliance with quality metrics were also reviewed at the monthly performance meetings between the hospital and IEHG.

There were formalised risk management structures in place in the hospital, which aligned with the HSE's risk management framework. These structures supported the proactive identification, analysis, management, monitoring and escalation of reported clinical and non-clinical risks. The hospital's risk manager oversaw the effectiveness of the risk management processes and the management of reported patient safety incidents. The risk manager was a member of the EMB and regularly updated the EMB on the effectiveness of the risk management structures.

Clinical directorates and other governance committees, with the support of the risk manager and risk coordinators, oversaw the effectiveness of the risk management process for the clinical services within their remit. Risks identified at clinical area level were managed and monitored by the clinical nurse managers (CNMs) and ADONs. CNMs implemented corrective measures to mitigate any actual and potential risks to patients. When required, significant risks were escalated to the executive management team and recorded on the hospital's

corporate risk register. The risk manager, QSPC and EMB were responsible for overseeing and managing the risks recorded on the hospital's corporate risk register. Significant high-rated risks and the mitigating actions were reviewed at the monthly performance meetings between the hospital and IEHG.

There were systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. The QPSC and Serious Incident Management Team (SIMT) was 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. The SIMT, QPSC, EMB had oversight of the timeliness and effectiveness of the management of adverse events and patient-safety incidents reported in the hospital. The clinical directorates and clinical leads also oversaw the timely and effective management of adverse events and patient-safety incidents reported in their area of responsibility. Clinical directorates, clinical leads, the QPSC and EMB oversaw the implementation of recommendations from the review of adverse events and patient-safety incidents, and sharing lessons learned from reviews.

The hospital did not have an overarching quality and safety programme, but there were processes in place in the quality and patient safety department to ensure there was a coordinated approach to the monitoring and improvement of healthcare services. The effectiveness and outcome of the monitoring arrangements was overseen by the clinical directorates, clinical leads and QPSC, who in turn provided assurances on the quality of healthcare services to the EMB.

Findings from the National Inpatient Experience Surveys and related quality improvement measures were reviewed at meetings of the QPSC and relevant clinical directorates, with updates provided to the EMB. The inspectors found evidence that the quality improvement plans developed following the most recent National Inpatient Experience Surveys, were being implemented to improve patients' experiences. Quality improvement initiatives, such as continence promotion in elderly patients, were also being implemented at the time of inspection.

Judgment: Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.
The workforce arrangements in University Hospital Waterford were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. At the time of inspection, the hospital had a small (3%) shortfall in the overall staff (across all categories)

[‡‡‡] 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).

numbers. Staffing deficits and challenges across all staff grades and categories were risks recorded on the hospital's corporate risk register.

Twelve whole-time equivalent (WTE) [§§§] (7%) of the 168 WTE funded medical consultant positions across a range of specialties were unfilled. The majority of permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Hospital management confirmed there were arrangements in place, in accordance with HSE requirements to support medical consultants who were not on a specialist division of the register with the IMC. Medical consultants at the hospital were supported by a total of 323 WTE NCHDs at registrar and senior house officer (SHO) grades providing medical cover across the hospital 24/7. Three WTE (1%) NCHD positions were unfilled at the time of inspection –1 WTE at registrar grade and 2 WTE at SHO grade.

The hospital was funded for a total of 29.09 WTE pharmacists and 24.31 WTE pharmacy technicians. All the pharmacy technician positions were filled and 5 WTE (17%) pharmacist's positions were unfilled at the time of inspection. The shortfall in pharmacists did impact on the ability to provide a comprehensive clinical pharmacy service[****] and on the surveillance and promotion of medication safety practices across the hospital. The MTC were aware of the risks associated with the pharmacist's staffing shortfall. Accordingly, staff resources was a risk recorded on the hospital's corporate risk register.

All IPCT positions were filled at the time of inspection. The core IPCT comprised 1 WTE consultant microbiologist, 1.5 WTE surveillance scientist, 2 WTE antimicrobial pharmacists, 5 WTE clinical nurse specialists (rotating the remit for surgical site infection and also providing cover for Kilcreene Regional Orthopaedic Hospital), 4 WTE NCHDs at specialist registrar grade, 1 WTE ADON and 1 WTE CNM 3. The IPCT also comprised the wider microbiology and antimicrobial stewardship teams, which comprised 4 WTE consultant microbiologists (1 WTE had responsibility for infection prevention and control).

The hospital was funded for a total of 1,200 WTE nurses (inclusive of management and other grades). This total was inclusive of the additional uplift of 93 WTE nursing staff approved as a result of the Department of Health's staffing frameworks.[††††] Thirty (2.5%) WTE nursing positions were unfilled at the time of inspection. While the five clinical areas had their rostered complement of nursing staff over the two days of inspection, nursing staff shortfalls arising from short-term absenteeism or statutory leave were reported. The reported nursing staff shortfall was 6.5 WTE (18%) in Medical 3 Ward, 5.67 WTE (13%) in Medical 6 Ward, 3 WTE (7%) in Ardkeen Ward and 2 WTE (4%) in Orthopaedic 2 Ward. No nursing staff shortfalls was reported in the emergency department.

[§§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.
[****] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[††††] 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.

The delivery of patient care was supported by healthcare care assistants. At the time of inspection, 58.5 WTE (39%) of the total funded 150.5 WTE healthcare assistant's positions were unfilled. Hospital management told inspectors that a panel of healthcare assistants was in place. However, hospital management did not have a derogation from the HSE's recruitment embargo introduced in quarter four of 2023, and therefore could not fill the vacant healthcare assistants' positions. Hospital management did not measure the proportion of care delayed, unfinished or omitted as a consequence of the reported shortfall in nurses and healthcare assistants. Therefore, it was not possible for hospital management to quantify the specific impact that the reported staffing shortfalls had on care delivered.

There was no centralised mechanism in the hospital to record and monitor the uptake of staff attendance at mandatory and essential training. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system. Attendance at mandatory and essential training by nurses and healthcare assistants was monitored at clinical area level by the CNMs and clinical skills facilitators with oversight by the ADON and DON. Staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in the hospital. Nursing staff had access to and were required to complete essential and mandatory training in infection prevention and control, medication safety and the early warning systems on the HSE's online learning and training portal (HSELanD). Training records reviewed by inspectors showed that the uptake of essential and mandatory training for nurses in hand hygiene and the Irish National Early Warning System (INEWS) was good, with levels generally above 90%. However, there were gaps in the uptake of essential and mandatory training in standard and transmission-based precautions, basic life support and the Irish Maternity Early Warning System. There were also gaps in the uptake of essential and mandatory training for healthcare assistants and medical staff.

The reported staff absenteeism rate at the hospital was 5.28% in April 2024, which was above the HSE's target of 4% or less. The human resources department was tracking absenteeism rates and back-to-work interviews were conducted. Occupational health supports were available to staff. In addition, there was a proactive focus on promoting the health and wellbeing of staff. Activities such as yoga, pilates and mindfulness sessions were available to all staff. Succession, recruitment and retention planning were ongoing areas of focus overseen by the EMB. Staff performance development planning was being implemented at the time of inspection. Overall, staffing shortfalls across the different staff groups were relatively small, but in four of the five clinical areas visited by inspectors, there were nursing staff shortfalls in the range of 4% to 18%. This, together with unfilled healthcare assistant's positions, had the potential to impact on care delivery. In addition, there were gaps in staff attendance at and uptake of mandatory and essential training.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. University Hospital Waterford was found to be compliant with two national standards (1.7 and 3.3) and substantially compliant with five national standards (1.6, 1.8, 2.7, 2.8 and 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 that all staff 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 were committed and dedicated to promoting a person-centred approach to care. Staff were observed being kind and caring and assisting patients in a timely manner when needed. Staff listened to patients and were responsive to their individual needs. The patients who spoke with inspectors were familiar with their immediate surroundings and used a call bell for assistance. Privacy curtains were used to support privacy when patients received care. Arrangements were made to find a private area or room when patients wanted privacy with family members. Staff told inspectors that patients receiving end-of-life care were prioritised for a single room. The inspectors observed patients' healthcare records and patients' personal information stored in line with relevant legislation and standards. Inspectors observed information about the 'Just A Minute (JAM)' initiative introduced at the hospital to support people with disabilities and or communication difficulties to communicate with staff. Patients requiring transmission-based precautions cohorting in a multi-occupancy room were required to use commodes at the bedside, which did impact on their privacy and dignity.

Judgment: Substantially 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 patients receiving care at the hospital. Inspectors observed staff to be respectful, kind and caring towards patients in the clinical areas they visited. This was confirmed by patients who spoke positively and were highly complimentary about their interactions with staff. Patients described staff as "lovely, caring and kind". Staff listened to patients and used a number of validated assessment tools to assess patients' needs and to determine the individual supports needed in relation to nutrition and hydration, falls and dementia. Nurse specialists in areas such as dementia, diabetes and tissue viability were available to staff to ensure a person-

centred, individual approach was taken when assessing and planning patient care. Patients who spoke with the inspectors were aware of their care plan and felt included in the decision-making process about their care. The hospital was implementing a hospice-friendly hospital programme to support end-of-life care. Patient information leaflets which provided information on a range of health topics were available and accessible to patients. There was no Patient Advice and Liaison Service (PALS) in the hospital, but patients were provided with an information booklet that contained information about independent advocacy services. The hospital also had a hairdresser available on site for patients and staff.

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 inspectors found there was a clear, transparent, open and accessible complaints procedure in place in University Hospital Waterford. The procedure enabled and supported a coordinated approach to the management of complaints from patients and families. The HSE's complaints management policy *Your Service Your Say* was used. Hospital management promoted and supported point-of-contact complaint resolution in line with national guidance, and formal and informal complaints were recorded. The patient services manager was the hospital's designated complaints coordinator for the receipt and effective handling of complaints. The name and contact details of the patient services manager was available on the HSE's website. The Patient Service Office (PSO) supported the patient services manager to manage and resolve complaints. Complaints management training was not mandatory but encouraged for all staff. The patient services manager oversaw how many staff completed complaints management training. All complaints received in 2023 were acknowledged within five days. A quarter (24%) of these complaints were investigated and resolved within 30-days, so the hospital was not compliant with the HSE's target of 75%. Hospital management attributed the staffing resource in the PSO as a factor contributing to the non-compliance with the HSE's 30-days resolution target. Hospital management confirmed that complainants were informed and kept updated about any delays in resolving their complaint. A grade 3 administrative support was appointed to the PSO in September 2023 as a replacement for the previous post-holder who was promoted to deputy patient services manager and whose responsibility it was to address the complaint backlog.

The PSO tracked and trended complaints to identify emerging themes, categories and departments involved. Information on the tracking and trending process was shared with CNMs for their areas of responsibility. CNMs shared this information with staff at ward meetings, safety huddles and 'intentional rounds' that were carried out by CNMs and members of the executive management team. The patient services manager submitted reports on the number and types of complaints received, the timeliness and outcomes of the complaints management process to the QSPC and EMB every three months and in a more

comprehensive report annually. There was evidence that quality improvement plans were devised to implement recommendations from the complaints resolution process. The patient services manager, QPSC and EMB monitored the implementation of the quality improvement plans.

Overall, there were systems and processes in place to ensure and support a coordinated approach to the management of complaints and concerns. However, the hospital was not meeting the HSE's target to investigate and resolve 75% of complaint received within 30-days.

Judgment: Substantially compliant

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

During the inspection, the inspectors observed that the clinical areas were secure, generally well maintained, and clean, with few exceptions. There was evidence of some general wear and tear, woodwork and paintwork was chipped, and in some areas flooring needed repair. This did not always facilitate effective cleaning and posed an infection prevention and control risk. Cleaning staff who spoke with the inspectors confirmed they had received relevant training including training on discharge and terminal cleaning.[‡‡‡‡] Cleaning staff were knowledgeable about their role and clearly described the cleaning processes in place. Cleaning supervisors and CNMs had oversight of the standard of cleaning in their areas of responsibility. CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place and the timely response of the maintenance service 24/7. Cleaning of patient equipment was assigned to healthcare assistants, but it was unclear to inspectors if there was a system to identify cleaned equipment. Patient equipment was observed to be generally clean, with some exceptions in all the clinical areas visited. Environmental and patient equipment audits were carried out monthly, these are discussed further in national standard 2.8. Hazardous material and waste was observed to be safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms in the clinical areas visited. Supplies and equipment were stored adequately and appropriately. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas inspectors visited. Hand hygiene sinks in these clinical areas conformed to required specifications.[§§§§] There was a formalised process in place to

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

ensure appropriate placement of patients requiring transmission-based precautions and this process was overseen by the IPCT. The IPCT also generated a daily 'isolation report' that detailed the number of in-patients requiring transmission-based precautions who were not isolated. These patients were risk-assessed and their placement prioritised based on that assessment's outcome. This information was presented and discussed at the daily meetings with bed management and senior nurse management. Signage in relation to the correct and appropriate use of transmission-based precautions was displayed but it was difficult to read some of the signage. Personal protective equipment (PPE) was available outside single, isolation rooms and multi-occupancy rooms where patients requiring transmission-based precautions were accommodated. However, some staff did not wear the most appropriate and correct PPE for different multi-drug resistant organisms (MDROs), in line with national guidance. Transmission-based precautions signage and PPE use was raised with and remedied by the CNM during the inspection. The inspectors also observed that the doors of some rooms accommodating patients requiring transmission-based precautions were open, which did not follow national guidance. When discussed with the CNM, the inspectors were told the doors were open because the patients required a higher level of observation by the nursing staff.

In summary, at the time of inspection, the physical environment and patient equipment were observed to be generally clean and well maintained. The physical environment supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care in the hospital. However, there were issues with signage in relation to the correct and appropriate use of transmission-based precautions. In addition, the most appropriate and correct PPE for different MDROs was not always used.

Judgment: Substantially compliant

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

The inspectors found that there were assurance systems in place at University Hospital Waterford to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management used information from a variety of sources to compare and benchmark the quality of their healthcare services with other similar hospitals in and outside the IEHG, and to support the continual improvement of healthcare services. Some sources included KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, complaints and patient experience surveys and their families.

As per the HSE's reporting requirements, hospital management reported on a monthly basis on rates of *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections, hospital-acquired COVID-19 and outbreaks. The IPCT generated and submitted a summary report on organism surveillance (*Methicillin-resistant Staphylococcus aureus* (MRSA), *Vancomycin-Resistant*

Enterococci (VRE), *Clostridioides difficile,* CPE) to the IPCC every three months and a more comprehensive report on the hospital's performance was submitted annually to the IPCC and EMB. Patients were screened for CPE in line with national guidance, and compliance with this guidance was audited. Audit findings on CPE screening reviewed by the inspectors showed a good level of compliance (ranging from 96% to 100%). Surgical site surveillance (SSI) for orthopaedic surgery (neck of femur fracture) was also audited in the hospital and findings were reported to the IPCC every three months.

Monthly environment, patient equipment and hand hygiene audits were undertaken by the IPCT using a standardised approach and audit findings were reported to the IPCC. There was evidence of good compliance with environmental hygiene standards in the clinical areas visited in the months preceding the inspection. Compliance rates ranged from 87% to 95% in the emergency department, 85% to 86% in Ardkeen Ward, 90% to 97% in Orthopaedic 2 Ward, 82% to 96% in Medical 6 Ward and 86% to 88% in Medical 3 Ward.

There was also evidence of good compliance with patient equipment hygiene standards. In the months preceding the inspection, compliance rates with patient equipment hygiene standards ranged from 90% to 94% in Ardkeen Ward, 89% to 94% in Orthopaedic 2 Ward, 66% to 69% in Medical 6 Ward and 63% to 71% in Medical 3 Ward. Time-bound action plans were not always developed when environmental and patient equipment hygiene standards fell below the 85% standard set by hospital management. This finding was similar to previous inspection findings in April 2023. Hand hygiene audits were carried out by the ICPT and audit findings for the months preceding this inspection showed that all five clinical areas visited were compliant with the HSE's target of 90%. It was clear that when hand hygiene standards fell below expected standards, additional hand hygiene education was provided by the IPCT and the practice was re-audited.

Medication audits were carried out and audit findings were reported to the medication safety committee and the MTC. Medication audits carried out in the months preceding the inspection, showed a variation in compliance with six of the hospital's medication policies in the clinical areas visited. Quality improvement plans were developed when medication safety standards fell below the expected standards. The plans reviewed by inspectors did not have a named person assigned to oversee the implementation of actions and they were not time-bound. Medication practices (storage and custody) were also monitored on a monthly basis as part of the nursing and midwifery quality care metrics, with good levels of compliance noted by the inspectors.

Antimicrobial stewardship practices at the hospital were monitored and evaluated. In quarter two of 2023, the hospital participated in the European Centre for Disease Prevention and Control point prevalence survey of hospital-acquired infections and antimicrobial use and the resulting report was being reviewed by the IPCC at the time of inspection. The hospital was also involved in the National Clinical Surveillance Infection Control System Project, which will enable enhanced surveillance of healthcare-associated infections in real time.

Compliance with the early warning system escalation and response protocol was audited on a monthly basis as part of the nursing and midwifery quality care metrics. Compliance rates with the protocol in the months preceding the inspection varied. In Orthopaedic 2 Ward the overall compliance rate was 95.8%, in Medical 3 Ward compliance rates ranged from 64% to 89% and in Medical 6 Ward compliance rates ranged from 89% to 100%. The inspectors did not find any evidence of monitoring for compliance with the national guidance on clinical handover and the use of Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool.[*****] National guidelines recommend that compliance with guidance should be audited regularly to ensure continuous quality improvements. Audit findings were shared with CNMs for circulation to staff in their areas of responsibility, heads of departments, clinical directors and the EMB.

Data in relation to hospital activity and capacity, numbers of new attendances to the hospital's emergency department, patient experience times (PETs), medical and surgical patients' average length of stay (ALOS) and delayed transfer of care (DTOC) were tracked in line with the HSE's reporting requirements. Collated data was submitted as part of the daily situational report and reviewed at the EMB's monthly meetings. Data on quality metrics relating to unscheduled and scheduled care was also reported on and reviewed at the monthly performance meetings between the hospital and IEHG. Staff in the clinical areas visited were not aware of the findings from the National Inpatient Experience Survey. Overall, there were assurance systems in place to monitor and evaluate healthcare services. However, auditing of compliance with clinical handover and $ISBAR_3$ use was not in line with national guidance. In addition, when practices fell below expected standards, quality improvement plans were not always developed to improve healthcare services and care provided. Quality improvement plans should be time-bound with named persons assigned to enable implementation of actions detailed in the plan.

Judgment: Substantially compliant

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

There were arrangements in University Hospital Waterford to ensure the proactive identification, evaluation, analysis and management of significant information and risks to the delivery of safe healthcare services. There were systems in place to proactively identify, assess and manage immediate and potential risks to patients, including ensuring the necessary actions were taken to eliminate or minimise any risks to patients. The evaluation of the effectiveness of any mitigating actions applied was monitored through the relevant governance structures. The hospital's risk manager was a member of the QPSC and EMB. The risk manager provided these committees with updates about the management of any

[*****] 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.

potential and actual risks to patient safety. Staff were trained to identify risks or potential risks to the safety and effectiveness of care, relevant to their roles and remit. However, staff had not received training on the HSE's most recent risk management framework, but there were plans to roll out that training to relevant staff across the hospital later in the year.

In the clinical areas visited, the CNMs with the ADON assessed and analysed any immediate and potential risks to patients. Risk coordinators supported and advised CNMs in this process. Mitigating actions were applied and responsibility for implementing and overseeing the effectiveness of these actions lay with the CNMs. Significant risks were escalated to the EMB. The EMB managed the risks and had oversight of the effectiveness of mitigating actions recorded on the hospital's corporate risk register. Risks were also reviewed at the monthly performance meetings between the hospital and the IEHG. At time of inspection, there were three high-rated risks related to HIQA's monitoring programme recorded on the corporate risk register — two risks related to infection prevention and control, one risk related to discharge pathways.

Patients admitted to the hospital were screened for MDROs — *Clostridioides difficile* infection, *Staphylococcus aureus* blood stream infections, CPE, VRE, MRSA and COVID-19. The hospital's information patient management system (iPMS) alerted staff to patients who were previously in-patients with confirmed MDROs. Compliance with MDRO screening was audited by the IPCT with oversight by the IPCC. Patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. If isolation facilities were not available, a risk assessment was carried out and suitable patients were cohorted in multi-occupancy rooms. At the time of inspection, there were four infection outbreaks — CPE, MRSA, VRE and COVID-19 in the hospital. Hospital management had convened multidisciplinary outbreak teams to advise and ensure that the management of the outbreaks aligned with best practice standards and guidance. Every three months, the IPCT submitted a report to the IPCC on the location(s), control measures implemented and status of the outbreak(s).

A limited clinical pharmacy service was provided at the hospital and pharmacy-led medication reconciliation was not undertaken for all patients. Medication reconciliation was carried out for prioritised patients, but the prioritisation criteria was not clearly indicated in any standard operating procedure or policy reviewed by the inspectors. Medication stock control was carried out by pharmacy technicians. Staff applied risk-reduction strategies with high-risk medicines and this practice was underpinned by a formalised policy. The hospital's list of high-risk medications aligned with the acronym 'A PINCH'[†††††] and there was a list of sound alike look alike drugs (SALADs). Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care and the majority of these were up-to-date.

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

Staff used the most recent version of the national early warning systems for the various cohorts of patients — the INEWS. THE 'Sepsis 6' care bundle and ISBAR$_3$ communication tool were also used. Hospital management had planned to implement the Emergency Medicine Early Warning System (EMEWS) clinical guideline and observation chart but there was no definitive date for its implementation. Staff were knowledgeable about the INEWS escalation and response protocol and there were processes in place to ensure the timely management of patients with a triggering early warning system. The hospital's critical care outreach team also supported staff caring for patients discharged from ICU.

There were systems and processes in place to support discharge planning and the safe transfer of patients within and from the hospital. Each patient had a planned date of discharge and there was cohorting of medical specialty, which supported the efficient ward rounding by medical teams. Daily and weekly bed management meetings were held with representation from the hospital and community services. Issues impacting on the discharge process, complex discharge cases and actions required to enable the safe discharge of patients were discussed at these meetings. The hospital's liaison public health nurse acted as the community link for the home care support services and attended weekly meetings with community services. Hospital management contracted 15-17 step down beds for patients requiring convalescence or transitional care in a private hospital located in Waterford city and several egress beds were available in community hospitals and private nursing homes in counties Waterford and Wexford. Hospital admission avoidance initiatives such as the Community Intervention Team (CIT), Integrated Care Programme for Older People (ICPOP) community specialist teams and Home First and Outpatient Parenteral Antibiotic Therapy (OPAT) were used. The timely issuing of discharge summaries to general practitioners (GPs) and primary healthcare services further supported the safe transition of care.

Over the course of the inspection, the hospital's emergency department functioned well. On the first day of inspection, at 11.00am there was a total of 37 patients registered in the emergency department. No patients were admitted and lodging in the department while awaiting an in-patient bed in the main hospital. All patients in the emergency department were triaged and prioritised in line with the Manchester Triage System and all were accommodated in designated treatment areas.

The average waiting time from:

- registration to triage ranged from 7 to 49 minutes. The average was 22 minutes. The average time was slightly higher than the 15 minutes recommended by the HSE's emergency medicine programme, but was similar to the waiting time found during HIQA's previous inspection
- triage to medical assessment ranged from 4 minutes to 1 hour 29 minutes for non-urgent patients. The average was 40 minutes, which was a significant improvement on the 2 hours 46 minutes found in HIQA's previous inspection.

The hospital was compliant with all the HSE's emergency department's PETs. Over the course of the inspection, the hospital's ALOS for medical patients was 9.2, which was higher the HSE's target of ≤7.0, but the ALOS for elective (3.9) and emergency (6.7) surgical patients was lower than the HSE's targets of ≤5.0 and ≤6.0 respectively. The number of DTOC was 11. There was no evidence that the ALOS for medical patients and the DTOC numbers had impacted on the flow of patients through the hospital during the inspection. Staff had access to a range of up-to-date infection prevention and control and medication policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff through the hospital's document management system.

In summary, as evident by the findings presented above, there were arrangements in place in the hospital to ensure there was proactive monitoring, analysis and response to information significant to the demand for and delivery of safe healthcare services. The hospital was compliant with all the HSE's emergency department's PETs and good patient flow was evident across the hospital site.

Nonetheless, a clinical pharmacy service was not provided in all clinical areas and pharmacy-led medication reconciliation was not undertaken on all patients. The EMEWS clinical guideline and observation chart were not implemented at the time of inspection and there was no definitive date for their implementation. Clinical staff had not received training on the updated HSE risk management framework.

Judgment: Substantially compliant

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

There was a system in place in University Hospital Waterford to identify, manage, respond to and report patient-safety incidents, in line with national legislation, standards, policy and guidelines. Hospital management included on the number of clinical incidents reported to NIMS in the monthly hospital patient safety indicator report. Staff who spoke with the inspectors knew what and how to report patient-safety incidents. Staff outlined the most common patient-safety incidents reported in their clinical areas. The IPCT reviewed all relevant patient-safety incidents, made recommendations for mitigating actions and these were reported to the IPCC. Medication related patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) and were reported to the medication safety committee and MTC.

Clinical directorates and governance committees ensured the timely and effective management of patient-safety incidents and adverse events reported in their areas of responsibility. The QPSC and SIMT were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Patient-safety incident reporting to NIMS was timely and in line with national

targets. However, inspectors were told that sometimes it was a challenge to complete concise and comprehensive reviews of adverse events within the national target of 125 days. The complexity of the case and or availability of subject matter experts were the main reasons cited by hospital management for the non-compliance with this timeline. Information on the number and types of reported patient-safety incidents, serious reportable events and serious incidents were collated by the risk manager. This information was included in the risk management report submitted every three months to the clinical directorates and QPSC, and a composite report was generated annually for the QPSC and EMB. The implementation of recommendations from reviews of patient-safety incidents serious reportable events and serious incidents was monitored by the risk manager, the SIMT, clinical directorates, relevant governance committees and QPSC. There was evidence that there was a structured approach to sharing feedback and the learning from reviews of patient-safety incidents serious reportable events and serious incidents. Feedback on patient-safety incidents and review reports was disseminated at clinical directorate meetings, governance committee meetings and shared with CNMs who circulated to staff in the clinical areas.

In summary, there was an effective and robust system in place to ensure the timely reporting and management of patient-safety incidents. There was evidence that recommendations from the review of patient-safety incidents and serious reportable events were implemented and learning was shared with staff to support service improvement and enable the delivery of safe, quality care.

Judgment: Compliant

Conclusion

An unannounced inspection of University Hospital Waterford was carried to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. Overall, the inspectors found good levels compliance with the national standards assessed.

Capacity and Capability

There was evidence of integrated corporate and clinical governance structures and that these structures functioned according to their terms of reference. The hospital's executive management team were cohesive and worked collaboratively to ensure there was a concerted focus on the quality and safety of healthcare services provided at the hospital. There was evidence of good operational grip by the executive management team and devolved accountability and responsibility for the four areas of focus — infection prevention and control, medication safety, deteriorating patient and transitions of care. The management arrangements supported the operational functioning of the hospital and promoted the delivery of safe, high-quality healthcare services. Ratification of the hospital's medication safety plan will ensure a concerted focus on medication safety practices at the hospital for this year. The monitoring arrangements in place in the hospital enabled the systematic identification of opportunities to continually improve the quality, safety and reliability of healthcare services. Implementation of quality improvement initiatives ensured that improvement of clinical practice and services were realised but all quality improvement initiatives should be time-bound. The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. Notwithstanding this, the reported nursing staff shortfalls in the range of 4% to 18% in four of the five clinical areas visited during this inspection, together with the reported shortfall in healthcare assistants had the potential to impact on care delivery. Although, there was no evidence of delayed or omitted care over the course of the inspection. There were gaps in staff attendance at and uptake of essential and mandatory training.

Quality and Safety

Staff promoted a person-centred approach to care and the inspectors observed staff being respectful, kind and caring towards patients. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients, which was consistent with the human rights-based approach to care, promoted by HIQA. Patients also spoke positively about their experiences of receiving care in the hospital. There were systems and processes in place to ensure and support a coordinated approach to the management of complaints and concerns. However, the investigation of complaints could be more efficient and prompt. The hospital's physical environment mostly supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care in the hospital. There were assurance systems in place to monitor, evaluate and continuously improve the healthcare services. However, compliance with national guidance on clinical handover and the $ISBAR_3$ communication tool was not audited. Time-bound quality improvement plans developed when practices fall below expected standards will support and enable the improvement of

healthcare services at the hospital. Hospital management were planning to implement the EMEWS clinical guideline and observation chart and to roll out staff training on the HSE's most recent risk management framework to relevant staff across the hospital. There was a management system to identify, manage, respond to and report patient-safety incidents, in line with national legislation, standards, policy and guidelines. Recommendations from the review of patient-safety incidents and serious reportable events were implemented and learning was shared with staff to support service improvement and enable the delivery of safe, quality care. Complexity of the case and or availability of subject matter experts contributed to delays in completing concise and comprehensive reviews of adverse events within the national target.

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

Compliance classifications

An assessment of compliance with the 11 national standards assessed during this inspection of University Hospital Waterford was made following a review of the evidence gathered 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 national standards was identified, HIQA issued a compliance plan to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant