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:	Wexford General Hospital
Address of healthcare service:	Newtown Road Carricklawn Wexford Co. Wexford Y35 Y17D
Type of inspection:	Unannounced
Date(s) of inspection:	5 and 6 March 2024
Healthcare Service ID:	OSV-0001108
Fieldwork ID:	NS_0071

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

Wexford General Hospital (incorporating Ely Hospital) is a Model 3* Health Service Executive (HSE) hospital, providing services to the population of County Wexford and the adjoining counties of Waterford, Kilkenny and Carlow. The hospital also provides maternity services and paediatric services for the population of County Wicklow. It is a member of and is managed on behalf of the HSE by the Ireland East Hospital Group (IEHG).† Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- critical care
- diagnostic services
- outpatient care
- maternity services
- paediatric care.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	222 inpatient beds 48 day case beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess

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

† The Ireland East Hospital Group comprises eleven hospitals. These are 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, Royal Victoria Eye and Ear Hospital. The Hospital Group's Academic Partner is University College Dublin (UCD).

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.

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

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

‡ 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.*

§ 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.

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

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
5 March 2024	08.50 – 17.50hrs	Danielle Bracken	Lead
6 March 2024	08.45 – 16.45hrs	Denise Lawler	Support
		Geraldine Ryan	Support
		Aedeen Burns	Support

Information about this inspection

An unannounced two-day inspection of Wexford General Hospital was conducted 5 and 6 March 2024.

During this inspection, inspectors identified that there was inadequate staff to support the delivery of safe and effective care in two areas - the nursing workforce in the special care baby unit (SCBU) and consultant anaesthesiology staffing. Immediately following this inspection, inspectors wrote to the hospital manager seeking assurance around the controls that were in place to:

- minimise the risks associated with vacant nursing positions in the SCBU
- and to address the resourcing deficit in consultant anaesthesiologist posts to provide the 2 plus 2 model of emergency care.[**]

Assurances were provided by the hospital manager in the response, and these included;

- engagement with the agreed national derogation process, seeking backfill of critical posts inclusive of SCBU nursing posts
- SCBU staff nurse recruitment campaigns
- gaps in SCBU nursing rota was an item included on the hospital risk register and escalated to IEHG
- applications were submitted for 4.0 whole-time equivalent (WTE)[††] consultant anaesthesiologist posts to the Consultant Application Screening Committee (CASC) of which the hospital were awaiting approval for at the time of inspection.

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

- infection prevention and control
- medication safety
- the deteriorating patient[‡‡] (including sepsis)[§§]

[**] The 2 plus 2 model of care requires that two consultant and two trainee anaesthesiologists are available to provide emergency cover.
[††] 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.
[‡‡] 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.[***]

The inspection team visited a number of clinical areas:

- Emergency department including the Acute Medical Assessment Unit (AMAU)
- Maternity unit
- Special care baby unit (SCBU)
- Mary's ward (general medical ward)
- Patrick's ward (general surgical and medical ward)
- Discharge lounge.

The inspection team spoke with the following staff at the hospital:

- Representatives of the hospital's Executive Management team
    - Hospital Manager
    - Operations Manager (deputy hospital manager)
    - Director of Nursing
    - Director of Midwifery
    - Clinical Director
- Quality and Patient Safety Manager
- Non-Consultant Hospital Doctors (NCHDs) representatives
- Head of Human Resources (HR)
- Staff working in the clinical areas visited
- A representative from each of the following hospital committees:
    - Infection Prevention and Control Committee (IPCC)
    - Drugs and Therapeutics Committee (DTC)
    - Deteriorating Patient Committee (DP)
    - Unscheduled Care Governance Committee.

During this inspection, inspectors reviewed documentation and data while on site in the hospital and requested additional documentation and data from the hospital which was reviewed following the inspection.

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 the service.

[***] 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 online from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

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

Patients spoke with inspectors about the care they received in the hospital, expressing that they felt "well cared for", staff were described as "very caring" and "kind" and patients "couldn't speak highly enough of staff". Additionally, patients commented that the "food is good" and "the place is clean".

At 9.30am on the first day of inspection there were three persons in the main waiting area of the emergency department which had capacity for 38 persons. The emergency department comprised: two triage rooms, two resuscitation bays, one generally used for adults and the other for paediatric patients, two assessment rooms, which were also used for review clinics, 12 adult treatment rooms, seven paediatric treatment rooms, one of which was a sensory room, one psychiatric assessment room, one family room, one procedure room and one plaster room, a minor injury area containing two treatment rooms and a surgical streaming unit with one treatment room.

The paediatric emergency department was full with all seven treatment rooms in use. The main emergency department was quiet and calm, there were 20 patients present, at various stages of treatment, with a number of treatment rooms vacant. Patients who spoke with inspectors described the emergency department as "quiet", "efficient" and "clean". When describing their experience patients told inspectors they were "looked after very well" and that they "hadn't waited long" to be seen.

The AMAU, which was located near the emergency department, had a total capacity for 20 patients and comprised 12 chair spaces, five trolley spaces and three single rooms. On the first day of inspection the AMAU was at full capacity.

Inspectors visited Mary's ward and Patrick's ward, a 31-bedded general medical ward and 32-bedded surgical and general medical ward respectively. Both wards contained multi-occupancy rooms with 5 single ensuite rooms on each ward.

The discharge lounge, located on the ground floor, received patients from clinical areas each day that were due for discharge. The discharge lounge had a total capacity for 16 patients and comprised 12 chair spaces and four bed spaces and a wheelchair accessible toilet and shower facility. On the second day of inspection at 9.30am there were no patients in this area yet but preparations were under way to receive six patients for discharge that day.

Inspectors spoke with women about their experience of care in the maternity unit. Women described their experiences as "very good" and "positive" and staff as "lovely", "very kind" and "helpful". The maternity unit had capacity for 26 women,

on the first day of inspection at 10am, 18 beds were occupied. There was a bereavement room in the unit. The delivery suite had two assessment rooms and six single rooms, on the first day of inspection at 10am all six rooms were full.

The special care baby unit had an approved capacity for five babies. On the first day of inspection at 4pm there were two babies in the unit.

Overall, there was consistency in what patients told inspectors about their experiences of the care they received and what inspectors observed in the clinical areas visited.

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. Wexford General Hospital was found to be compliant with one national standard (5.5), substantially compliant with two national standards (5.2, 5.8), and non-compliant with one 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.

Wexford General Hospital had formalised governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare, in relation to the four areas of focus. However, some areas required action, such as committees meeting at the required frequency and progressing assigned time-bound actions from meeting to meeting.

The hospital manager was the accountable officer with overall responsibility and accountability for the governance of the hospital. The hospital manager, supported by the Executive Management Team (EMT), was responsible for overseeing the quality and safety of the healthcare services provided. The hospital manager reported to the Chief Executive Officer (CEO) of IEHG. These arrangements were outlined in the organisational chart reviewed by inspectors.

The clinical director, a member of the EMT, provided clinical oversight and leadership of the clinical services provided at the hospital. The director of nursing

(DON) and director of midwifery (DOM) were members of the EMT and assigned with responsibility for the organisation and management of nursing and midwifery services at the hospital. The hospital had two operations managers; general services and clinical services managers, both were members of the EMT.

The hospital's governance of clinical services was under the remit of seven governance committees. The current reporting arrangements for these committees was to the clinical director and upwards to the hospital manager. The hospital was in the process of establishing a Clinical Governance Operational Team (CGOT) and, terms of reference were provided to inspectors.

At the time of inspection, the EMT and the Quality and Safety Committee were assigned with the responsibility for ensuring the quality and safety of healthcare services at the hospital.

The EMT, chaired by the hospital manager comprised senior managers and met every month, in line with the terms of reference. Inspectors reviewed EMT minutes and action logs. The EMT were provided with reports from a number of governance groups within the hospital and from the clinical director, director of nursing and director of midwifery. For example; reports detailed activity levels and issues that may affect the quality and safety of care provided in the hospital such as staffing shortages, and risks, such as outbreak of infection.

The multidisciplinary Quality and Safety Committee, chaired by the clinical director, met quarterly and was responsible for providing assurances of the quality and safety of services within the hospital to the EMT. Minutes of meetings reviewed showed evidence of discussion and oversight in relation to quality and patient-safety activity including infection prevention and control, medication safety and the deteriorating patient. However, actions were not time-bound and there was no documented evidence that actions were consistently completed from meeting to meeting.

Committees reporting to the Quality and Safety Committee related to known areas of harm included:

- Infection Prevention and Control Committee (IPCC)
- Drugs and Therapeutics Committee (DTC)
- Deteriorating Patient Improvement Committee (DP)

The hospital's multidisciplinary Infection Prevention and Control Committee (IPCC) was responsible for the oversight of the quality and safety of infection prevention and control practices. Inspectors reviewed documentation in relation to the IPCC and noted that the terms of reference had last been updated in 2020, and the committee were not meeting quarterly as per the terms of reference, having met twice in 2023. A quarterly infection prevention and control report was discussed,

this included infection prevention and control issues, rates and outbreaks of healthcare-associated infections.

From a review of meeting minutes there was some evidence of discussion at committee meetings related to audit findings such as hand hygiene compliance rates and some actions arising out of these meetings, for example, provision of additional training in relation to infection prevention and control practices. However, actions were not always time-bound. Infection prevention and control was a standing item on the Quality and Safety Committee's agenda and an infection prevention and control report was submitted to the EMT on a monthly basis. These reports provided a summary of activity and data relevant to infection prevention and control practices throughout the hospital. Recommendations made in these reports included enhanced environmental cleaning and monitoring of infection rates in clinical areas that had experienced outbreaks of infection.

The hospital's Drugs and Therapeutics Committee (DTC), a multidisciplinary committee, was responsible for governance and oversight in relation to medication practices. Inspectors reviewed documentation in relation to the DTC and noted that the committee did not meet four times a year as per the terms of reference, having met twice in 2023. The DTC committee have oversight of audit activity, metrics and risks associated with medication safety. Follow up on actions from meeting to meeting was not documented in meeting minutes reviewed by inspectors.

The Medication Safety Team (MST) which was a subcommittee of the DTC provided an update to the DTC at each DTC meeting. Inspectors reviewed documentation in relation to the MST and noted that the committee did not meet quarterly as per the terms of reference, having met twice in 2023. Medication safety incidents and issues affecting medication safety in the hospital were discussed at this meeting, and there was evidence of assigned actions arising out of meetings, however, these were not always time-bound. The MST provided reports on the progress of the committee twice a year to the Quality and Safety Committee. Oversight in relation to antimicrobial stewardship activity in the hospital was the responsibility of both the IPCC and the DTC committee.

The multidisciplinary Deteriorating Patient Improvement Committee (DP) was responsible for governance and oversight of the hospital's compliance with national guidelines on early warning systems. This committee was newly formed and had incorporated pre-existing committees in relation to the deteriorating patient such as the sepsis, early warning score and resuscitation committees. The committee held its first meeting in August 2023 and met twice in 2023. Representatives from the committee who met with inspectors, described oversight by the committee in relation to relevant training, audits and quality improvements, which was confirmed by meeting minutes reviewed by inspectors. However, actions arising

from the committee were not always time-bound. It was clear from documentation reviewed by inspectors and meetings with relevant staff that there was governance and oversight of the hospital's level of compliance with national guidelines on the early warning systems,[†††] sepsis management and resuscitation.

The Unscheduled Care Governance Committee reported through the hospital's clinical governance structure. The committee chaired by the hospital manager met every second month in line with the terms of reference. This committee had oversight of current performance levels in relation to unscheduled care activity and the issues impacting safe transitions of care. This committee was action orientated with progress of assigned actions being monitored through the use of an action log which was updated at each meeting. A monthly unscheduled care operations and activity report was produced and forwarded to the EMT for review.

The emergency medicine department management meeting, as per the terms of reference, was attended by representatives from the emergency department and AMAU. The group was responsible for optimising the capacity and capability of the emergency department and AMAU to provide safe effective care. The terms of reference did not include membership from AMAU who had joined the group in late 2023. This group chaired by the emergency medicine consultant lead, as per meeting minutes reviewed by inspectors, discussed issues that had the potential to impact on the quality of care provided in the emergency department and AMAU, such as, access to psychiatric services, point of care testing and security requirements. These issues were also discussed by the consultant clinical lead for emergency medicine with inspectors. There was evidence of assigned actions arising from the group that were actioned from meeting to meeting.

In summary, there were formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare in place in Wexford General Hospital, in relation to the four areas of focus. However, the following areas for action were identified:

- A number of committees were not meeting at the frequency required by their terms of reference.
- Assigned time-bound actions were not progressed by some committees.

Judgment: Substantially compliant

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

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

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

The senior management team, chaired by the hospital manager, met fortnightly. Minutes reviewed documented updates from various departments, including the maternity unit. There was some evidence of assigned time-bound actions arising from this meeting. The terms of reference of this meeting were last updated in 2020 and senior management told inspectors that this group was due to be replaced by the General Management Operational Team (GMOT) in the weeks following inspection. Terms of reference for the GMOT were provided to inspectors.

The hospital had an infection prevention and control (IPC) team in place. The team comprised a consultant microbiologist based in Wexford General Hospital, an IPC assistant director of nursing (ADON) and two WTE IPC clinical nurse managers, grade two (CNM2). The hospital had no microbiology laboratory onsite. Laboratory and microbiology services were provided by University Hospital Waterford with a 0.6 WTE consultant microbiologist based in University Hospital Waterford providing microbiology advice over the telephone. There was access to a consultant microbiologist for advice over the telephone 24/7. Antimicrobial stewardship is discussed in more detail under national standards 2.8 and 3.1.

The hospital's pharmacy service was led by the chief pharmacist. There were arrangements in place to provide a clinical pharmacy service and a pharmacy technician service for stock control to ward areas.

A deteriorating patient improvement programme, had been implemented across the hospital. The programme was under the clinical leadership of a consultant geriatrician and consultant anaesthesiologist, supported by nursing colleagues in quality and safety and nurse practice development departments, and clinical skills facilitators.

There were management arrangements in place in the hospital to monitor issues that impacted on the effective and safe transitions of care. There was a formalised patient flow and escalation policy in place at the hospital outlining steps to take at times of increased demand. On the days of inspection, the hospital was at green escalation level, which meant that the emergency department was not over capacity and there was bed availability in the hospital. On those occasions when the hospital was in escalation the various steps to take to address this were clearly outlined in the policy, this included the use of additional 'surge' capacity, which was being utilised by the hospital when required. The patient flow team, led by an

ADON, had oversight of patient flow and discharge processes seven days a week and supported clinical areas with safe discharge.

Day-to-day management for the emergency department was the responsibility of the lead emergency medicine consultant supported by consultant colleagues and NCHDs and the CNM 3 supported by nursing colleagues. The AMAU was managed by a medical physician and a CNM 2 and operated five days a week Monday to Friday and saw patients referred to them by the emergency department, general practitioners, the national ambulance service, and patients for review. The emergency department had minor injuries and surgical streaming pathways in place, both of which had strict criteria in place for the types of patients that they could cater for. Patients with minor injuries were reviewed by advanced nurse practitioners (ANPs), there are 2.6 WTE emergency department ANPs and one candidate paediatric emergency department ANP in place.

The hospital were monitoring activity in relation to the emergency department and AMAU. All patients in the emergency department were triaged and prioritised in line with the Manchester Triage System.[‡‡‡] Inspectors identified improvements in the waiting times since the inspection in February 2023. For example; on the first day of inspection the average waiting time from registration to triage was four minutes, this was an improvement from a median waiting time of 22 minutes in February 2023. Average waiting time from triage to medical assessment was 15 minutes, and in 2023 these were ranging from 36 minutes to seven hours and 50 minutes. The range of waiting times from decision to admit to admission to an inpatient bed was one hour to 12 hours, which was previously one hour and seven minutes to 17 hours and one minute. Assurances were provided in the compliance plan submitted after the inspection in February 2023 that point of care testing for COVID-19 and influenza would be implemented and inspectors identified that this had been actioned. Staff informed inspectors that one of the factors that influenced timely patient flow from the emergency department was access to point of care testing for COVID-19 and influenza testing. In 2023, one fifth (20%) of patients were admitted to an inpatient bed from the emergency department, and 32% of patients were admitted from the AMAU.

Inspectors visited the AMAU on both days of inspection and found that it had no patients accommodated in the area overnight. Activity data for the AMAU was reviewed by inspectors for January and February 2024 and on average 105 patients were seen a week, with a daily range of 13-36 patients, approximately 19 patients (18%) were admitted to the hospital per week. The surgical streaming unit

[‡‡‡] 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.

saw approximately 8-10 patients a day and these were normally discharged with a low amount of patients requiring admission.

Hospital management had implemented a number of hospital admission avoidance pathways and measures to support efficient patient flow. These included:

- An AMAU
- Minor injuries and surgical streaming pathways in the emergency department
- An Early Pregnancy Assessment Unit (EPAU)
- A Fetal Assessment Unit (FAU)
- Frailty Intervention Team (FIT)
- Community Intervention Team (CIT)
- Outpatient parenteral antimicrobial therapy (OPAT)
- Home Support Service for Older People
- Discharge lounge

Patients in Wexford General Hospital could be referred to the CIT and outpatient parenteral antimicrobial therapy (OPAT) services to support early discharge. CIT referrals to nurses, occupational therapists and physiotherapists had increased in 2023 by 15% to 889 referrals when compared to 2022, where there were 759 referrals to this team. OPAT activity up to the time of inspection had saved a total of 95 bed days in 2024. The frailty intervention team at the time of inspection consisted of a CNM and occupational therapist. The team facilitated referrals to the Integrated Care Programme for Older Persons (ICPOP) and Community Intervention Team (CIT) and assessed if patients were fit for discharge.

The discharge lounge which had been re-opened in quarter four of 2023, was facilitating the discharge of between 25-55 patients per week year to date 2024. On the first day of inspection, there were eight beds subject to delayed discharge in the hospital. In 2023, the average length of stay (ALOS) for medical patients, 5.0 days, and surgical patients, 4.0 days, were lower than the figures for 2022 (6.7 days for medical patients, 4.6 days for surgical patients) and lower than the corresponding HSE targets of ≤7.0 and ≤5.0 days. Measures to improve patient flow which affected length of stay, such as predicted date of discharge being in place and multidisciplinary team huddles are discussed in more detail under national standard 3.1.

In summary, the hospital had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Judgment: 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 for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital required some improvement. For example; audit in relation to maternity services.

Information on a range of performance indicators and data related to the quality and safety of healthcare services was published, in line with the HSE's reporting requirements. Performance data was reviewed by the EMT. Performance data was discussed at performance meetings between the hospital and IEHG with a standing agenda item for quality and patient safety.

There were formalised risk management structures and processes in the hospital. From a review of meeting minutes, and discussions with management and lead representatives, the EMT and clinical governance committees had oversight over risk management processes for clinical services within their remit. Relevant high rated risks were escalated to the EMT, recorded on the hospital's corporate risk register and discussed at the risk register committee. Inspectors viewed a copy of the risk register in relation to the four areas of focus and noted that it had recently been updated in February 2024 with action owners and action due dates assigned to help manage risks. For example; the risk associated with hospital infrastructure such as 'limited single rooms' had been updated to note that planning permission for a new ward block with 97 single rooms had been approved in January 2024.

A clinical audit committee was in place in the hospital. The clinical audit committee reported to the Quality and Safety Committee regarding the number of audits that had taken place per quarter and the number of quality improvement plans returned. Audits included antimicrobial prescribing. The audit committee did not oversee all audit activity within the hospital, with relevant governance committees overseeing clinical audit activity relevant to their role and remit such as infection prevention and control, medication safety and the deteriorating patient. Audit activity was also discussed with lead representatives that met with inspectors in relation to infection prevention and control, medication safety and the deteriorating patient. However, there were no local audits being carried out in relation to sepsis or clinical handover at the time of inspection.

There was oversight by the EMT in the hospital in relation to patient-safety incidents. The Serious Incident Management Team (SIMT), chaired by the hospital manager, in line with the terms of reference, met every second month and also met when a serious incident occurred. Serious incidents and serious reportable events were discussed in detail at this meeting. A review of minutes of this meeting provided evidence to inspectors that this committee was action orientated with a

focus on shared learning such as discussing serious incidents at morbidity and mortality meetings. The Maternity Services SIMT, chaired by the hospital manager, met every second month in line with the terms of reference. Similar to the SIMT, minutes of this meeting reviewed by inspectors provided evidence that the committee was action orientated. Inspectors found evidence of discussion of patient-safety incidents and actions required to address these in minutes of clinical governance committees. For example, additional training in relation to medication errors. Staff who spoke with inspectors in clinical areas told them that feedback on patient-safety incidents was provided at safety huddles.

Data for the Maternity Safety Statement (MSS) and Irish Maternity Indicator System (IMIS) was reported monthly to the HSE. Meeting minutes reviewed by inspectors noted discussion of this data at EMT and Quality and Safety Committee meetings. Hospital management told inspectors that this data provided them with assurances of the quality and safety of the maternity services. Irish Maternity Early Warning System (IMEWS) use was audited using the nursing and midwifery quality care metrics. There were no local sepsis audits or clinical handover audits taking place in the maternity unit. Hospital management told inspectors that the shortfalls in the quality and safety department, as discussed under national standard 6.1, had impacted on audit activity in the maternity unit.

In summary, there were systems in place in the hospital to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services, however, an area for action was identified:

- There were no local sepsis audits or clinical handover audits taking place in the wider hospital or maternity unit at the time of inspection.

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.

The workforce arrangements did not fully support and promote the delivery of high-quality, safe and reliable healthcare. Inspectors found that there were significant staffing deficits in a number of areas, some of which were due to difficulties in recruitment. The hospital had noted these risks on the hospital's risk register and escalated to the corporate risk register and IEHG where relevant.

During this inspection, inspectors identified a deficit in relation to inadequate staffing to support the delivery of safe and effective care in two areas in particular

— staffing of the nursing roster in the special care baby unit (SCBU) and consultant anaesthesiologist staffing to support the minimum acceptable cover of '2 plus 2' model of anaesthesiology outside core working hours promoted by the HSE for model 3 hospitals with a co-located maternity unit.

The SCBU had a significant percentage of unfilled nursing posts, 5.0 WTE (33%) of the funded 15.0 WTE nursing posts (inclusive of management grades) were unfilled. The staffing levels in SCBU on the first day of inspection did not meet those recommended by the British Association of Perinatal Medicine (BAPM)[§§§] in relation to nurse: infant ratio at all times.

On the first day of inspection, inspectors requested a copy of the hospital's risk assessment in relation to SCBU staffing. From a review of this risk assessment inspectors noted a number of controls were in place to reduce this risk which included the use of an acuity tool to assess staff to infant ratio, daily huddles between the SCBU, maternity unit and line management to discuss potential issues and staff recruitment campaigns. On the second day of inspection, inspectors requested an update on SCBU staffing from hospital management, which was provided, with a safe ratio of staff to infants in place on that day.

Based on the staffing complement, the SCBU were approved to take five babies with various levels of need at any one time. However, the unit was regularly over capacity. The nurse: infant ratio in SCBU was further compounded by short-term absenteeism and presented a risk when one of the nurses had to attend for a birth in the delivery suite or operating theatre and when transferring a baby from the SCBU to another hospital. To counteract this, staff from other areas were deployed and or agency staff were used to fill absences. However, deployed staff were not always SCBU trained. The unit using an acuity tool was recording all of the occasions when the unit was over capacity and did not have the required ratio of staff to infants. Inspectors reviewed acuity tools over a three week period from 7 February to 29 February 2024 and found that there were seven occasions during which the unit was over capacity in relation to the number of babies in the unit, short-staffed in terms of staff to infant ratio, or a combination of both. This presented a risk in relation to the ability to provide safe and effective care within the unit.

On the day following the inspection, HIQA sent correspondence to the hospital manager seeking assurance in relation to how the nurse staffing deficits in the SCBU was being managed. The response from the hospital manager outlined that the national HSE recruitment pause in 2023 was impacting on the ability to fill SCBU nursing posts. Hospital management had sought to backfill SCBU nursing posts through the national derogation process but had been unsuccessful. This risk

§§§ *The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK,* 2022.

had been escalated to the IEHG. As an interim measure the hospital was supplementing the staffing levels in the unit with staff midwives and paediatric nurses when available and with agency staff. An escalation process was also in place in the maternity unit to manage situations when there were shortfalls in staffing in SCBU. Staff who spoke with inspectors were aware of this escalation process.

The hospital had an approved complement of four anaesthesiologists, however, in order to provide the '2 plus 2' model of emergency cover**** recommended for hospitals with maternity units, a total of eight anaesthesiologists was required. As documented on the hospital's risk register, this risk had been escalated to IEHG. Inspectors discussed the risks associated with non-compliance with the '2 plus 2' model of care with hospital management during inspection and the day following inspection HIQA sent correspondence to the hospital manager seeking assurance in relation to how this risk was being managed. In response, the hospital manager outlined that applications for four additional consultant anaesthesiology posts had been submitted. Control measures to reduce the risk included the provision of a 1 plus 2 model of emergency cover rota — one consultant and two trainee anaesthesiologists.

At the time of inspection, 40.5 (WTE) (84%) of the 48 WTE funded medical consultant positions across a range of specialties were permanently filled. All permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Medical consultants were supported by 137 WTE NCHDs at registrar, senior house officer and intern grades providing medical cover across the hospital 24/7, fourteen of these posts (10%) were unfilled at the time of inspection. Recruitment of these posts was being impacted by the HSE recruitment pause.

The emergency department had an approved total of eight WTE emergency medicine consultants, which was an uplift compared to HIQA's inspection in February 2023 when there were six WTE emergency consultant posts approved. At the time of inspection, four of these posts (50%) were vacant. One of these posts was filled on a temporary basis by a locum consultant and two posts were due to be filled in April 2024. There was 24/7 cover in the emergency department by a senior decision-maker.

The hospital did not have any approved consultant psychiatrist posts. Access to psychiatry services was through the Waterford, Wexford mental health services with a department of psychiatry located on the University Hospital Waterford campus. These services included a clinical nurse specialist liaison psychiatry

**** *Model of Care for Anaesthesiology*, National Clinical Programme for Anaesthesia. Available online: https://www.hse.ie/eng/about/who/cspd/ncps/anaesthesia/moc/model-of-care-for-anaesthesiology.pdf

service, which was provided in Wexford General Hospital, seven days a week, during core working hours. A non-consultant hospital doctor was on site Monday to Friday. There was access to a psychiatrist by telephone outside core working hours. Inspectors found that access to psychiatry services had impacted on patient flow on the first day of inspection. This was a finding on a previous inspection of the emergency department in February 2023.

At the time of inspection, 76.4 WTE (15%) of the funded 504.65 WTE nurses (inclusive of management and other grades) positions for the hospital were unfilled. Inspectors were informed and documentation confirmed that there were no shortfalls in unfilled nursing positions in the emergency department, Mary's ward, Patrick's ward or AMAU. At the time of inspection, 22.5 WTE (28.5%) of the funded 79.0 WTE midwives (inclusive of management and other grades) positions for Wexford General Hospital were unfilled. Inspectors were told that shortfalls in midwifery staffing impacted on the ability to provide one to one care in the delivery suite. Shortfalls included a vacant clinical skills facilitator post, which impacted on staff training in the area of the deteriorating patient.

The delivery of patient care was supported by healthcare and maternity care assistants. At the time of inspection, all the maternity care assistant posts were filled, however, 11.3 (19%) WTE of the approved 59.21 WTE healthcare assistant (HCA) positions were unfilled. Two of the clinical areas visited, the emergency department and Patrick's ward had vacant HCA positions. However, on the first day of inspection, inspectors were informed that there were no unfilled HCA shifts.

The hospital was approved for 6.0 WTE pharmacists and 9.6 WTE pharmacy technicians. At the time of inspection all technician posts were filled, however, 25% of pharmacist positions were unfilled, one of which was an antimicrobial stewardship (AMS) pharmacist post. These vacancies impacted on the ability to provide a comprehensive clinical pharmacy service[††††] across the hospital. The antimicrobial stewardship service was impacted by the vacant post. This is discussed under national standard 2.8 and 3.1.

At the time of inspection there were unfilled positions in the quality and patient safety department, these included a 0.5 WTE quality and patient safety manager position and 1.0 WTE quality and clinical risk (maternity services) officer. Inspectors were told that the impacts of these unfilled posts included the inability to fully implement a quality and patient safety strategy and the timely implementation of quality improvement plans in the maternity unit and wider hospital. A complaints coordinator post in the hospital was vacant at the time of inspection, this is discussed in more detail under national standard 1.8.

[††††] 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.

In addition to vacant posts the hospital was challenged by absenteeism. The human resource department reported on staff absenteeism rates and the rates were reviewed at meetings of the EMT and performance meetings with the IEHG. The hospital's most recent reported absenteeism rate was 7% in February 2024 which was above the HSE's target of 4% or less. Inspectors were informed that support was offered to staff via occupational health.

It was identified during a previous HIQA inspection of the hospital in 2023 that a greater level of oversight of mandatory and essential training was required by management. On this inspection, inspectors observed, and minutes of meetings confirmed that oversight had improved. However, oversight was not in the format of monthly key performance indicators as outlined in the hospital's compliance plan to address findings of the previous inspection. Training records from the clinical areas inspected reviewed by inspectors showed that most areas inspected required focussed improvement to achieve compliance with mandatory training. Areas of training that required improvement included standard and transmission based precautions, hand hygiene, basic life support, IMEWS, CTG and fetal monitoring and training related to obstetric emergencies.

Inspectors identified the following areas where the hospital did not meet national standard 6.1:

- There were (33%) unfilled SCBU trained nurse posts, impacting on the ability to staff the special care baby unit to the required recommended level.
- In order to provide the 2 plus 2 model of emergency care, the hospital required an additional four WTE (50% uplift) consultant anaesthesiologist posts.
- The hospital's AMS pharmacist post was vacant at the time of inspection.
- There were unfilled vacancies in the quality and patient safety department.
- Access to psychiatry services was impacting on patient flow.
- Significant gaps were identified in mandatory training.
- Staff absenteeism rates were not within the national target.

Judgment: Non-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. Wexford General Hospital was found to be compliant with two national standards (1.6, 1.7),

substantially compliant with three national standards (1.8, 2.7, 3.3) and partially compliant with two national standards (2.8, 3.1) assessed on inspection. 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.

From discussions with staff it was clear that they were aware of the need to respect and promote the dignity, privacy and autonomy of patients, with some areas for improvement noted, for example, protecting patient names from view. Staff were observed providing a person-centred approach to care, interactions with patients observed by inspectors were respectful. Staff were observed responding to patient needs and providing assistance.

Privacy curtains were used in clinical areas to support privacy while patients received care. In the emergency department care was carried out in individual treatment rooms, mobile privacy screens were used when there were patients on trolleys in corridors to afford more privacy. There was a family room available in the emergency department to afford a private space in which to have difficult conversations with families and carers at times such as end of life.

Multi-occupancy rooms in clinical ward areas afforded less privacy, although private conversations with family could take place in the offices of clinical nurse and midwife managers. In addition to privacy curtains around bed spaces there were mobile privacy screens available at ward level. Inspectors observed patient names above bed spaces and patient names visible on whiteboards in clinical areas visited, which did not promote privacy and confidentiality. This was brought to the attention of local management. Healthcare records were observed to be stored appropriately.

In the maternity unit, inspectors observed that autonomy was promoted through the use of birth plans and lactation advice was available to support breastfeeding. Dignity and privacy around bereavement was supported by the use of a bereavement room, there was also a bereavement service in place in the maternity unit. Women who spoke with inspectors about their experience of maternity services expressed that they felt well informed and involved in decision-making in relation to what to expect when discharged home and how to care for themselves and baby.

Overall, the dignity, privacy and autonomy of those using services in the hospital were maintained.

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. Inspectors observed staff to be respectful, kind and caring towards patients in the clinical areas visited. This was confirmed by patients who spoke positively about their interactions with staff.

Inspectors observed that one of the treatment rooms in the paediatric emergency department was a sensory room. This provided a safe space where paediatric patients could be comforted and supported in times of anxiety.

It was evident the hospital supported patients and their families at end of life. Patients at end of life were prioritised for a single room and there were family rooms available in some areas. There was an end-of-life room in the emergency department.

There was support and assistance for women in the maternity unit during and following labour, there was a birthing pool in place, a homebirth service, lactation support and an early transfer home service. The maternity unit provided supports to women using maternity services in times of stress, there was a birth reflection service in place and perinatal mental health supports available. The pregnancy loss symbol was in use, there was a bereavement room and a bereavement clinical nurse specialist in place.

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.

There were systems and processes in place in the hospital to respond to complaints and concerns. An operations manager was the designated complaints officer and had been supported by a complaints coordinator, however this post was vacant since January 2024. As a result, inspectors were informed that there was a delay in entering complaints in to the national complaints management system (CMS).

The HSE's '*Your Service Your Say*' (YSYS) policy was implemented throughout the hospital. Staff in clinical areas who spoke with inspectors were knowledgeable about the complaints management process and focussed on local resolution of complaints. Local complaints were not always recorded in clinical areas visited which is a missed opportunity for staff learning. Staff who spoke with inspectors told them that there was discussion of complaints at local level at huddles and safety pauses. Staff were aware of common themes of complaints, with communication being the most common theme.

In line with the hospital's compliance plan to address previous inspection findings, there had been a focussed effort to increase communication training, with staff completing National Healthcare Communication Programme training. Other quality improvement plans related to complaints included a process for lost property, the 'hello my name is' campaign was rolled out in the hospital, a birth reflection group for maternity patients was in place and the HSE's values in action initiative had commenced at the hospital.

Inspectors observed evidence of YSYS posters, information leaflets and comment boxes in most clinical areas visited. Some patients who spoke with inspectors were aware of how to make a complaint and had seen YSYS posters displayed, while others expressed to inspectors that they would speak with staff if they had any complaints or concerns. A Patient Advocacy Liaison Service (PALS) was not available in the hospital, although information on independent advocacy services was observed by inspectors in some clinical areas visited. Inspectors were told by the designated complaint's officer that a patient advocacy group had visited the hospital to provide information, posters and leaflets in relation to the advocacy services they provided.

Formal complaints were logged on a local database according to theme and also logged in to the national complaints management system (CMS). Hospital management formally reported on the number and type of complaints received to the HSE annually. In 2023, 54% of complaints were resolved within 30 working days, year to date, 2024, this percentage had risen to 63%. However, this still falls short of the HSE's target of 75%. Inspectors were informed that complaints were escalated to hospital group level in line with YSYS policy.

Complaints were discussed as a standing item on the agenda of the Quality and Safety Committee. In addition, a complaints report was submitted to EMT and the Quality and Safety Committee. The designated complaints officer told inspectors that they were part of a patient feedback forum at group level which met every second month to present complaints data and share learning.

The following areas require action:

- Complaints were not responded to in line with HSE timelines.
- There was a delay in entering complaints in to the CMS system.

Judgment: Substantially compliant

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

Inspectors visited a number of clinical areas during this inspection — the emergency department, the AMAU, Mary's ward, Patrick's ward, the discharge lounge, the maternity unit and SCBU.

Mary's ward and Patrick's ward were 31-bedded general medical ward and 32-bedded surgical and general medical ward respectively. Both wards had five single rooms and a number of multi-occupancy rooms with ensuite toilet and shower facilities.

The maternity unit comprised an antenatal and postnatal ward and a delivery suite. The antenatal and postnatal ward visited was newly refurbished, there was physical distancing of one metre between beds and ease of access to rooms. The antenatal and postnatal ward comprised 26 beds with four single rooms and a number of multi-occupancy rooms. The delivery suite comprised six single rooms. There were adequate toilet and shower facilities in the unit.

The special care baby unit had six cot spaces one of which was in an isolation room and had an approved capacity for five babies.

A number of areas including the emergency department and maternity unit had recently undergone repainting and refurbishment following a fire in the hospital which had occurred in March 2023. Although all clinical ward areas were operational, some services within the hospital were in temporary accommodation such as the AMAU. Building works, which were continuing at the time of inspection were being overseen by the HSE estates team. In general, inspectors observed that the clinical areas visited were clean and well maintained. Some patients who spoke with inspectors also commented on the cleanliness of the clinical areas.

Clinical nurse and midwife managers stated that they were satisfied with the level of cleaning resources in clinical areas. Inspectors were told by clinical nurse and midwife managers that there was a responsive maintenance service in place. Patient equipment in clinical areas was observed to be clean. Clinical areas had different systems for indicating that equipment was clean with some areas operating a sticker system and other areas operating a checklist system. Environmental and equipment audits were carried out in clinical areas and these are discussed in more detail under national standard 2.8.

Inspectors noted that there were issues in some clinical areas in relation to a lack of storage, particularly for large pieces of equipment. For example, inspectors observed equipment stored in the ambulance entrance corridor in the emergency department. Storage of equipment in corridors was a risk recorded on the hospital's risk register. The AMAU was challenged with space due to the layout. Inappropriate items such as staff files, which were in a locked cupboard, were stored in a clinical room due to a lack of office space. This was brought to management's attention on the day. Hazardous material and waste was observed to be securely stored. Additionally, linen was observed to be appropriately segregated and stored.

Personal protective equipment and alcohol-based hand sanitiser were readily available for use in clinical areas visited. Clinical hand wash sinks observed by inspectors throughout clinical areas conformed to requirements.[‡‡‡‡] It was noted by inspectors that handwashing technique posters had not been replaced in all areas following painting and refurbishment. This was brought to management's attention on the day of inspection.

There was a process in place to ensure appropriate placement of patients requiring transmission based precautions under the direction of the infection prevention and control team although prioritisation of patients for a single room was not formalised through a local policy. The hospital was challenged due to an insufficient number of isolation rooms that had both ensuite and clinical hand wash facilities. This was on the hospital risk register and was a contributory factor in outbreaks of infection which is discussed in more detail under national standard 3.1. The AMAU had three isolation rooms with ensuite toilet and shower facilities. The emergency department had two treatments rooms that were used for isolation purposes both of which had ensuite toilet and shower facilities, additionally one was a negative pressure room[§§§§] with anteroom. The hospital had two additional negative pressure rooms at ward level. There were 12 rooms in the hospital which

[‡‡‡‡] Clinical hand wash basins should conform to *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

[§§§§] Negative pressure rooms are rooms where the air pressure inside the room is lower than the air pressure outside the room. This means that when the door is opened, potentially contaminated air or other dangerous particles from inside the room will not flow outside into non-contaminated areas.

were adequate for isolation purposes. The hospital had 10 single rooms with ensuite facilities but no clinical hand wash facilities, and 24 isolation pods, without ensuite or clinical hand wash facilities. The lack of isolation facilities was discussed with the infection prevention and control team and with the EMT who outlined that a capital investment project was required to remedy the lack of adequate isolation facilities. Inspectors were told that planning permission for a new ward block with 97 single rooms had been granted, the start date for works was awaited with completion of works due in 2027.

Clinical areas visited by inspectors appeared to be safe and secure in general, however inspectors were informed that adequate provision of security was a challenge for the emergency department in particular. This was identified as a risk on the hospital's risk register.

The physical environment did not fully support the delivery of high quality, safe, reliable care and protect the health and welfare of service users:

- There was an inadequate amount of suitable isolation facilities in the hospital.
- Adequate provision of security arrangements for the emergency department were a challenge.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from a variety of sources with some areas for action noted by inspectors, for example, AMS reporting, and the development of time-bound action plans to improve services.

Sources of information to measure the care provided included performance indicators, metrics, audit findings, findings from risk assessment and patient-safety incidents and feedback from service users, including complaints. Hospital management were publically reporting data required for Hospital Patient Safety Indicator Reports (HPSIR), Irish Maternity Indicator System (IMIS), Maternity Safety Statement (MSS), National Perinatal Epidemiology Centre (NPEC) and HSE performance assurance reports. This information was used to assess the quality and safety of services provided and to benchmark performance.

The infection prevention and control team collated infection prevention and control surveillance data and submitted a quarterly report to the IPCC and reported

publically on this data as per HSE requirements. Environment, equipment and hand hygiene audits were being carried out in the clinical areas visited using a standard audit tool. Inspectors reviewed quarter four 2023 results for environment and equipment audits of clinical areas visited and noted high compliance levels of 93-100%. This was in line with the observations of inspectors on the days of inspection. Examples of actions to address findings of equipment audits described by staff included the introduction of a cleaning checklist for healthcare assistants, a sample of which was provided to inspectors. In general, results of hand hygiene audits reviewed by inspectors were high, with the exception of one score of 85% for the emergency department which fell below the national target of 90%. Opportunities for improvement included hand hygiene before and after patient contact. There was no accompanying quality improvement plan to address the findings of this hand hygiene audit provided to inspectors as requested.

Samples of nursing quality care metrics measuring medication safety practices for January and February 2024 provided to inspectors for Mary's ward and Patrick's ward showed high compliance and there was evidence that quality improvement plans were put in place to address non-compliances, for example, recording of patient weights on medication prescribing and administration records. Inspectors reviewed medication prescribing and administration records and observed that patient weights were being recorded. Similarly, the results of a medication management audit for AMAU from January 2024 was 100%. There were examples of medication audits with a focus on transitions of care which were carried out in the emergency department and critical care areas in February 2023. These audits included compliance with opioid prescribing guidelines and 'timeliness and correctness' of antimicrobial prescribing during transitions of care. Inspectors noted recommendations arising out of these audits but they did not include a time-bound action plan with assigned actions.

The antimicrobial stewardship pharmacist, when in post, had been producing quarterly AMS reports. This report included guideline development and review, consumption reporting, audit activity and education in relation to antimicrobials and details on quality improvements in relation to antimicrobial stewardship. The last available report was quarter two of 2023 due to the AMS pharmacist post becoming vacant.

Performance in relation to recognition and response of the deteriorating patient was being measured by nurse practice development and clinical facilitators on a quarterly basis in relation to the Irish National Early Warning System (INEWS). Inspectors reviewed INEWS audit reports for quarter four 2023 for Mary's and Patrick's wards, the reports were detailed and a time-bound quality improvement plan with assigned actions produced for each area. It was noted by inspectors that compliance in the area of escalation and response ranged from 60-70%, which was an improvement on the previous quarter where compliance ranged from 46-48%.

Performance in relation to patient flow and transitions of care was being measured in a number of ways, this included patient experience time and patient flow data such as delayed transfers of care and average length of stay.

The maternity services measured a number of quality indicators and metrics. The hospital were publically reporting on and benchmarking the quality of the maternity services provided through Maternity Safety Statements (MSS), Irish Maternity Indicator System (IMIS) and National Perinatal Epidemiology Centre (NPEC) reports. Local measurement of performance of the quality and safety of services provided in the maternity unit was limited to midwifery metrics and IMEWS audits. Midwifery metrics were measured monthly and these were observed to be displayed on a quality board. There was some evidence of IMEWS metrics in place and IMEWS observations audits being carried out in the maternity unit although evidence of quality improvement plans were not evident despite results indicating a number of areas which required attention. Inspectors requested quality improvement plans onsite and following inspection, however, none were submitted. Other audits in relation to the deteriorating patient were not being carried out in the maternity unit, these included audits of maternal and neonatal emergencies, fetal monitoring and fetal heart/ CTG interpretation.

Quality improvement plans had been produced in response to patient experience surveys such as the National Inpatient Experience Survey, the most recent National Maternity Experience Survey and National Maternity Bereavement Experience Survey. However, staff who spoke with inspectors were unaware of these quality improvement plans.

Overall, while the hospital had some systems and processes in place to monitor, analyse, evaluate and respond to information in relation to the quality and safety of care provided in the hospital, additional areas for action were identified:

- AMS reporting had not taken place since Q2 2023.
- Quality improvement plans with time-bound assigned actions were not always developed in relation to audit findings.
- There was no evidence of quality improvement plans in response to audit findings in the maternity unit.

Judgment: Partially Compliant

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

The hospital's systems and processes to identify, evaluate and manage immediate and potential risks to patients required strengthening in relation to infection

prevention and control, medication safety, and ensuring policies, procedures, protocols and guidelines are kept up-to-date.

The EMT had oversight of the risks and effectiveness of control measures recorded on the hospital's risk register. This was discussed under national standard 5.8. There were local risk registers in place in a number of clinical areas visited including the emergency department and maternity unit. Inspectors were told that local level risks were discussed with line management. In general there was a good understanding of risk in clinical areas visited, for example, risks and mitigating controls associated with wandering patients and patients with behaviour that challenge were described by staff in detail to inspectors. Inspectors were told that there were safety pauses in place in all clinical areas visited, which provided an opportunity for staff to discuss risks, issues and concerns in relation to patient care.

The hospital did not have a documented overarching infection prevention and control programme[*****] as per national standards.[†††††] The IPC team carried out surveillance in relation to healthcare associated infection, oversaw the placement of patients requiring transmission based precautions and oversaw infection outbreaks. The IPC team offered an advisory service to staff in the hospital, visited clinical areas as required and were available by phone during core working hours. The infection prevention and control team had a number of risk assessments relating to infection prevention and control. Although this document detailed risks, existing and additional control measures, these were not time-bound. There had been an antimicrobial stewardship programme in place in the hospital in 2023, however, there was no documented antimicrobial stewardship programme developed for 2024. At the time of inspection antimicrobial stewardship rounds were not taking place. This is discussed in further detail in standard 6.1.

The hospital had two alert systems in place to identify patients who may have been infected with multi-drug resistant organisms (MDROs). These included the information patient management system and the microbiology laboratory system. As discussed earlier in the report, point of care testing for COVID-19 and influenza was established in the emergency department and this contributed to the timely identification of patients with these infections prior to transfer to wards. Patients were screened for MDROs in line with national guidance in clinical areas visited. For example; Methicillin Resistant *Staphylococcus Aureus* (MRSA) and Carbapenemase

[*****] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short-, medium- and long-term, as appropriate to the needs of the service.

[†††††] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

Producing *Enterobacterales* (CPE). Patients requiring transmission-based precautions were isolated as per the advice of the infection prevention and control team. As discussed under national standard 2.7, there were an insufficient number of isolation rooms in the hospital and this resulted in patients being cohorted in multi-occupancy rooms. Inspectors observed appropriate signage on doors where patients were isolated, the doors of which were all closed, in line with national guidance.

At the time of inspection there was an active outbreak of norovirus infection, resulting in restrictions to visitors in a number of medical wards. Inspectors noted that there had been several outbreaks of COVID-19 with three in November and December of 2023 and three in January 2024. Outbreak reports reviewed by inspectors identified that the lack of isolation capacity within the hospital contributed to the outbreaks. Inspectors observed that staff in patient areas were wearing masks as advised by the infection prevention and control team in order to minimise outbreaks of COVID-19.

'Risk reviews' were completed on the use of a number high risk medicines including opioids, potassium and chemotherapy. Inspectors found that the risk reviews had detailed control measures outlined, some of which were observed by inspectors. For example; inspectors observed that opioids were stored in locked controlled drugs cabinets and a medication management and administration policy was in place.

There was a medication safety programme for 2024 in place in the hospital, overseen by the Medication Safety Team (MST). A limited clinical pharmacy service was provided at the hospital and pharmacy-led medication reconciliation was not undertaken in all clinical areas. Medication stock control was carried out by pharmacy technicians every week. An automatic dispenser for medicines was observed by inspectors in the emergency department and outside Patrick's ward for use outside core hours. The automatic dispensers reduced the risks associated with sound-alike look-alike medications (SALADs). The chief pharmacist provided examples of medication safety alert memos that had been sent out to staff in relation to SALADS and high risk medicines. This included a memo using the acronym 'A PINCH'[ǂǂǂǂǂ] in general clinical areas to help staff identify high-risk medicines. However, information in relation to SALADS and high risk medicines was not observed in all clinical areas visited. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care.

[ǂǂǂǂǂ] 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, for example, INEWS and IMEWS. The Identify, Situation, Background, Assessment, Recommendation (ISBAR) tool was in use to escalate concerns in relation to deteriorating patients. In the SCBU staff were using the neonatal alert, trigger and track tool. Staff in the clinical areas visited were knowledgeable about the use of the early warning tools in use and the escalation and response processes related to them. Inspectors observed accessible resuscitation trolleys in clinical areas visited. Checks on the resuscitation trolley were not up-to-date in Patrick's ward which was highlighted to local management. There were systems and processes in place to respond to obstetric emergencies and access to the operating theatre and critical care.

There were procedures in place in the hospital to support discharge planning and safe transfer of patients within and from the hospital, for example, women with high-risk pregnancies. Each patient had a planned date of discharge and discharge plan. Staff who spoke with inspectors were knowledgeable about factors affecting a safe discharge.

Daily operational structures in relation to patient flow included a situation report at 7am where the hospital's situation in relation to bed capacity was discussed. An operational huddle took place daily at 10.15am, where unscheduled and scheduled care activity, access to diagnostics and issues that may affect the safe and efficient flow of patients into and out of the hospital were discussed. Inspectors attended multidisciplinary huddles in Patrick's ward, Mary's ward and in the maternity unit and observed that these functioned well in relation to sharing of relevant information regarding the plan of care for patients in clinical areas and women and babies in the maternity unit. Requirements to facilitate safe discharges were also discussed at these meetings.

The overall attendance rate to the hospital's emergency department in 2023 was 37,274 attendances, this represented seven months of attendance as the department had been closed between 1 March and 25 July 2023 as a result of a fire in the hospital. The Unscheduled Care Governance Committee was tracking emergency department and AMAU attendances with an average increased attendance of 10% noted for August to December of 2023 when compared to 2022.

Data on the emergency department patient experience times (PETs) collected at 11.00am on the first day of this inspection, showed that the hospital was compliant with four out of six of the HSE's targets. At 11.00am:

- 86% of attendees to the emergency department were admitted or discharged within six hours of registration (HSE target 70%).
- 91% of attendees to the emergency department were admitted or discharged from within nine hours of registration (HSE target 85%).

- 100% of attendees to the emergency department were admitted or discharged within 24 hours of registration (HSE target of 97%).
- 80% of attendees aged 75 years and over were admitted or discharged within six hours of registration (HSE target of 95%).
- 80% of attendees aged 75 years and over were admitted or discharged within nine hours of registration (HSE target of 99%).
- 100% of attendees aged 75 years and over were admitted or discharged within 24 hours of registration (HSE target of 99%).

The hospital did not have an electronic document management system in place, and this was on the hospital risk register. Policies, procedures, protocols and guidelines (PPPGs) were accessible to staff via the hospital's intranet. There was a PPPG committee in place at the hospital to review and sign-off policies, procedures, protocols and guidelines. However, inspectors noted that a number of PPPGs related to infection prevention and control required updating. For example, the outbreak management policy was due for review in May 2020 and, this was a finding on a previous inspection in November 2020. The hospital also had a range of medication PPPGs, the majority of which were up-to-date. There were a number of PPPGs in place in relation to the deteriorating patient including transfer of critically ill patients, most of these required updating.

Areas for action following this inspection include:

- There was no documented infection prevention and control programme.
- Antimicrobial stewardship rounds were not taking place.
- A fully comprehensive clinical pharmacy service was not provided.
- A number of policies, procedures, protocols and guidelines (PPPGs) required updating.
- Information in relation to sound-alike, look-alike drugs and information on high risk medications was not available in all clinical areas visited.

Judgment: Partially compliant

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

The hospital had oversight arrangements in place in relation to identifying, reporting, managing and responding to patient-safety incidents. There were a number of structures within the hospital that facilitated this, with discussion of patient-safety incidents and serious reportable events (SREs) taking place at SIMT and Maternity Services SIMT. Inspectors noted that discussion of relevant patient-

safety incidents took place at governance committees and at the Quality and Safety Committee and EMT.

Patient-safety incidents were reported to the National Incident Management System (NIMS).§§§§§ Hospital management reported monthly on the number of clinical incidents per 1,000 bed days used (BDU) for general clinical areas and on the total number of clinical incidents reported to NIMS for the maternity service. In relation to timely recording of incidents in NIMS within 30 days of notification the HSE's target of 70% had not been achieved in quarter one of 2023, however, this target was achieved subsequently throughout 2023. Inspectors were informed and documentation confirmed that systems analysis reviews of patient-safety incidents were not being completed within the required 125 day timeline. In a rolling 12-month period from October 2022 to September 2023, 14% of review reports were completed on time. Inspectors were told that the timeliness of completion of review reports was being impacted by a 0.5 WTE deficit in the quality and patient safety manager position, as discussed under national standard 6.1. Staff who spoke with inspectors were knowledgeable about how to report and manage a patient-safety incident and described the more common patient-safety incidents reported, for example, medication errors. Medication related patient-safety incidents were discussed at Medication Safety meetings, with recommendations made to address these, for example, education of staff.

The hospital's quality and patient safety department collated information on the number and types of reported clinical incidents, dangerous occurrences and serious reportable events (SRE), submitting monthly reports to EMT. Additionally, an annual incident overview report was produced, tracking and trending the number and rate of incidents, type of incident, type of injury and location where the incident occurred.

The implementation of recommendations from reviews of patient-safety incidents was monitored by the quality and patient safety department, the SIMT, Maternity Services SIMT and relevant governance committees. There were forums for shared learning in place, such as Morbidity and Mortality meetings and safety pauses in clinical areas. Relevant patient-safety incidents were reviewed through formalised after action review processes. Inspectors were told in the clinical areas visited that feedback on patient-safety incidents was also shared informally by managers.

§§§§§ 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).
§§§§§ HSE –Incident Management Framework and Guidance. 2020. Available online from: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

While the hospital had some good practices in place in relation to identifying, reporting, managing and responding to patient-safety incidents, the following area for action was identified:

- Systems analysis reviews of patient-safety incidents were not being completed within 125 days in line with national guidance.

Judgment: Substantially compliant

Conclusion

An unannounced inspection of Wexford General Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better* Healthcare.

Capacity and Capability

Inspectors found evidence of good levels of compliance in some areas, with other areas requiring attention, one of these related to the effective organisation and management of the workforce to achieve the service objectives for high quality, safe and reliable healthcare. Following the inspection, concerns were escalated to hospital management in relation to insufficient numbers of nursing staff in the special care baby unit (SCBU), especially at times of high acuity, and an insufficient number of consultant anaesthesiology posts to provide emergency cover in line with the 2 plus 2 model of care. Hospital management were aware of and actively working to minimise the associated risks, however, these issues will persist until an uplift in the required staffing levels is achieved.

Inspectors found that the hospital manager along with the EMT were updating the governance structures within the hospital. Some structures within the hospital were working well. These included the EMT and the Unscheduled Care Committee. Clinical governance arrangements were clear, however a number of committees were not meeting at the frequency required in their terms of reference and actions arising from committees were not always time-bound and progressed from meeting to meeting. There were effective management arrangements in place in the hospital. On the days of inspection the emergency department and AMAU were functioning well as were patient flow processes throughout the hospital. Overall, the governance structures in Wexford General Hospital supported opportunities to identify and act on areas of the service requiring improvement.

Quality and Safety

Overall, inspectors found that there was a person-centred approach to care provided in Wexford General Hospital, with a culture of kindness, consideration and respect evident in inspected areas. Inspectors found evidence that feedback from patients including complaints was managed appropriately, although complaints response timelines were not being met. It was clear to inspectors that staff in the hospital sought to learn from feedback and complaints in order to improve patient experiences. There was a focussed effort within the hospital on ensuring that staff were trained in effective communication skills.

The hospital were challenged by a lack of adequate isolation facilities with outbreaks of infection occurring throughout the hospital. Management stated that an approved new ward block of 97 single rooms, due to open in 2027 would address the lack of isolation facilities in the hospital. However, management did not have a date for the commencement of building works.

Inspectors found evidence that performance in relation to the quality and safety of services provided at the hospital was being measured in a number of ways, although findings in relation to performance did not always result in time-bound assigned action plans. There was considerable scope for improvement within the hospital in relation to ensuring that policies, procedures, protocols and guidelines were kept up to date. It was evident to inspectors that Wexford General Hospital had oversight arrangements in place in relation to identifying, reporting, managing and responding to patient-safety incidents. However, improvements were required in the timely completion of systems analysis reviews of patient-safety incidents in line with national targets.

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 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.	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	Non-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.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Substantially 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.	Partially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2 – Compliance Plan Service Provider's Response

Compliance Plan for Wexford General Hospital

OSV-0001108

Inspection ID: NA_0071

Date of inspection: 05 and 06 March 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	Non-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.

1. Derogation received from IEHG to recruit 4 WTE special care baby unit (SCBU) Staff Nurses following HIQA visit and subsequent correspondence following inspection.

All vacant posts have been offered to successful candidates and preclearance is ongoing with the view to commencement dates in August and September 2024. These start dates are dependent on work permit for one individual and current restrictions under 2024 Pay and Numbers Strategy.

Controls in place to reduce risk in the interim of recruitment:

- the use of an acuity tool to assess staff to infant ratio,
- transfer out to alternative maternity units for high risk deliveries when occupancy levels are high and staffing deficits exist in SCBU,
- assessment and transfer of stable babies to the Paediatric Ward when capacity allows,
- daily huddles between SCBU, maternity unit and line management,
- attendance at general hospital ops huddle daily. Opportunities to establish levels of paediatric staff support available.
- additional hours, overtime available to all staff at nationally agreed rates,
- agency staff engaged to cover shift deficits.

2. Since the HIQA visit, approval has been granted to recruit 4 WTE Consultant Anaesthesiologists to ensure compliance with the 2 plus 2 Model of Care. These posts are currently with the Public Appointments Service (PAS) for permanent campaign to be advertised.

WGH has progressed with a temporary campaign to fill these posts pending permanent appointments. 3 candidates are in pre-clearance with the expectation of commencement of employment in August 2024. 4th post has been re-advertised; applicants are currently being shortlisted for interview.

3. Vacant Clinical Skills Facilitator post in Maternity has been offered and successful candidate to scheduled to commence duty on 12th August, 2024.

4. Pharmacist vacancies currently at 1.6 WTE including an antimicrobial stewardship (AMS) Pharmacy post. Awaiting clarification regarding Pay and Numbers Strategy as to how WGH can progress these posts.

Controls in place to reduce risk in the interim of recruitment:

- some elements of the AMS role covered by all pharmacists where resources allow
- Representation by a nominated senior pharmacist from WGH at the AMS groups continues to continue engagement and awareness of updates etc.
- Safety memos for antimicrobial medications when required continue
- Antimicrobial medication updates continue at D&T and IPC committee
- Oversight and updates to Antimicrobial guidelines continue by Pharmacy Executive Manager
- Submission of antimicrobial consumption reports to the HSCP continue.
- Medication reconciliation continues to be provided to some ward areas where resources allow

5. 9 WTE HCA posts are being progressed to fill (under Safe Staffing funding/WTE approvals).

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

Under 2024 Pay and Numbers Strategy, prioritisation of critical posts will need to be managed as there are restrictions to WTE ceiling imposed for the remainder of 2024. Clarity is awaited as to how this will effect/impact Wexford General Hospital. This impacts all vacant posts at WGH.

<u>Access to Psychiatry Services:</u>

Engagement is ongoing with General Manager and Head of Services for Mental Health in CHO5 regarding details of service available and locum arrangements to ensure timely and equitable access to services.

Mandatory Training:

Engagement with Department Heads to highlight the requirement to release staff to complete mandatory training. Plan in place to prioritise and promote one area of mandatory training each month from September to December with promotional stands in areas frequented by staff such as canteen, coffee shop and communal rest areas such as medical res/on call accommodation.

Reminder email sent to all Heads of Departments regarding maintenance of up to date training databases.

A new database has been developed for line managers to utilise and report into the DHM/HM office on a quarterly basis. The database will be fully operationally by September 2024.

Staff Absenteeism Rates:

Staff absenteeism rates remain above the national average. Managing Attendance Policy distributed to Heads of Departments and Absenteeism Committee meeting regularly. Engagement with Occupational Health Department to provide assistance to staff on long term sick leave.

Timescale:

- August/September, 2024 to fill SCBU and Consultant Anaesthesiologist posts (pending approval to progress to appointment stage).
- The overall number of vacancies at WGH is a concern and Detail of Pay & Numbers Strategy will be provided at meeting scheduled to take place week commencing 29th July 2024. This will outline approval pathways for recruitment.
- Access to Psychiatry Services: Discussions ongoing.
- Mandatory Training Database: September 2024.
- Managing Attendance: Committee meeting on a bimonthly basis.

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

Outline how you are going to improve compliance with this standard. 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 hospital acknowledges that AMS reporting has not taken place since Q2, 2023. This is as a direct consequence of the vacancies that currently exist in the Pharmacy Department. The hospital has been unable to proceed to fill AMS Pharmacist post due to the Recruitment Moratorium. Detail of the Pay and Numbers Strategy and mechanism/pathways for filling of posts is awaited and once clarified this post will progress to recruitment if approved. It is anticipated that clarity will be provided by end July 2024.
    - See Standard 6.1 above re interim actions and measures to mitigate the risk
- The requirement to ensure that time bound quality improvement plans are developed following all audits and to address findings will be discussed at all committee and governance group meetings within this quarter: Q3, 2024.
- It is acknowledged that there was no evidence of Quality Improvement plans in response to audit findings in the maternity Unit. The vacant VI Quality & Clinical Risk Officer- Maternity Services, Vacant Clinical skills Facilitator and the deficit in midwifery staffing requiring the Clinical Managers to replace clinical staff has compounded the lapse of timely development and implementation of improvement plans. Detail of the Pay and Numbers Strategy and mechanisms/pathways for filling of posts is awaited and once clarified these posts will progress to recruitment if approved.
- A group has been established in the Maternity Unit to begin the development of Quality Improvement plans in response to the audit findings. This group will meet in first week August 2024.
- Patient experience surveys: Communication and responses to patient experience surveys will be coordinated through the Consumer Affairs Department who will set up working groups to support the survey process, results and QIP. Part of this promotion will be a 'you said we did' poster campaign. Currently there is a group working on the 2024 NPES who will providing a QIP and communication campaign by end of Sept 2024.

Timescale:

- Development of time bound quality improvement plans – immediate.
- Filling of vacant posts: Detail of the Pay and Numbers Strategy and mechanism/pathways for filling of posts is awaiting and once clarified recruitment will progress if approvals received. It is anticipated that clarity will be provided by end July 2024.
- You Said, We Did poster campaign – September 2024.

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

- A detailed infection prevention and control programme will be developed and documented by the end of Q3, 2024 (30th September 2024).
- Antimicrobial Stewardship rounds will recommence with the recruitment of an antimicrobial stewardship pharmacist. This recruitment, similar to other posts is dependent on the Pay & Numbers Strategy and approval to recruit for this post.
- A full clinical pharmacy service is not provided due to the number of vacant posts in the department.
- The hospital does not have an electronic document management system in place. A review of out of date IPC and Deteriorating Patient PPPGs will commence via the PPPG committee. The PPPG committee will formulate an action plan with identified action owners and associated timeframes to update the PPPGs in line with current best evidence-based practice. Time frame to complete action plan 30th August 2024. Timeframe to complete the update of PPPGs to be decided once scope of work to be undertaken identified by PPPG committee.
- The requirement to have information in relation to SALADs and high risk medicines available in all clinical areas is noted. This will be brought to the attention of the Medication Safety Committee immediately.

Timescale:

- IPC Programme will be developed by 30th September 2024.
- Work on PPPG reviews will commence and action plan will be available by 30th August 2024. The absence of a Document Management Systems is on the hospital's risk register.
- Information in relation to SALADS and high risk medicines will be available in all Clinical areas with immediate effect.
- Clarity on Pay & Numbers Strategy anticipated week commencing 29th July.