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:	Letterkenny University Hospital
Address of healthcare service:	Kilmacrennan Rd, Ballyboe Glencar, Letterkenny, Co. Donegal. F92 AE81
Type of inspection:	Unannounced
Date(s) of inspection:	07 and 08 November 2023
Healthcare Service ID:	OSV-0001039
Fieldwork ID:	NS_0064

The following information describes the services the hospital provides.

Model of hospital and profile

Letterkenny University Hospital (LUH) is a model 3* public acute general hospital and is one of the seven acute hospitals within the Saolta† University Health Care Group. Letterkenny University Hospital serves the population of most of County Donegal with a catchment area of over 140,000 people.

The hospital provides a range of acute services on an outpatient, day case and in-patient basis. Services include emergency department, intensive care, coronary care, general medicine, geriatric care, renal dialysis, general surgery, urology, obstetrics and gynaecology, paediatrics and neonatology, orthopaedics, oncology and haematology.

The following information outlines some additional data on the hospital.

Model of hospital	3
Number of beds	378 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 compliance with the National Standards for Safer Better Healthcare as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors‡ reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service

* The model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care.
† The Saolta University Health Care Group comprises six hospitals: University Hospital Galway and Merlin Park University Hospital, Sligo University Hospital, Letterkenny University Hospital, Mayo University Hospital, Portiuncula University Hospital, Roscommon University Hospital. The Hospital Group's Academic Partner is the National University of Ireland Galway (NUI Galway).
‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

- 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

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 it is a good quality, caring service, that is 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. The hospital's compliance plan is included in Appendix 2.

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector and Role
07 November 2023	09.15. – 17.25 hours	Patricia Hughes, Lead Nora O'Mahony, Support Aoife O'Brien, Support John Tuffy, Support
08 November 2023	09.00 – 16.15 hours	

Information about this inspection
An unannounced inspection of Letterkenny University Hospital was conducted on 07 and 08 November 2023. The inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. It was also used to assess progress on implementation of the hospital's compliance plan relating to the HIQA two-day announced inspection, conducted in November 2022. The inspection focused in particular, on four key areas of known harm, these being: ▪ infection prevention and control ▪ medication safety

- the deteriorating patient§ (including sepsis)**
- transitions of care.††

The inspection team visited three clinical areas:

- Emergency department (ED) including a short visit to the acute medical assessment unit (AMAU)
- Surgical 2
- Medical 3.

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

- Representatives of the Hospital's Executive Board (HEB)
  - General Manager
  - Director of Nursing (DON)
  - Director of Midwifery (DOM)
  - Associate Clinical Directors (Medical Directorate, Women's and Children's MCAN and Pathology and Cancer MCAN)
  - Lead Consultant in Emergency Department
- Quality and Patient Safety Manager
- Representative for the non-consultant hospital doctors (NCHDs)
- Human Resource Manager
- Medical Manpower Manager
- lead representatives from each of the following:
  - Infection Prevention and Control
  - Medication Safety
  - Deteriorating Patient
  - Transitions of Care
- staff from a range of disciplines in the various clinical areas inspected.

Acknowledgements

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

§ The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
** Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
†† Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover: World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

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

On the day of inspection, inspectors visited the emergency department, which operates 24 hours a day, 365 days a year and is supported by an acute medical assessment unit.

The emergency department provided care for undifferentiated adult, maternity and paediatric patients with acute and urgent illness or injuries. Attendees to the emergency department at Letterkenny University Hospital presented by ambulance, were referred directly by their general practitioner (GP) or self-referred.

The emergency department comprised:

- a waiting area which including a separate paediatric area and an area for patients presenting with signs and symptoms of transmissible infections.
- two triage rooms
- eight cubicles
- a minor injuries area and designated plaster room with capacity for one patient each
- two single rooms with en-suite toilets used for isolation.
- an audio-visually separated paediatric area comprising a waiting area and a consulting room
- one resuscitation room.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment.

Inspectors spoke with a number of patients in the emergency department to hear their experience of the care received in the emergency department on the day of inspection. Staff were described as '*kind*' and '*helpful*' although '*they were very busy*'. Patients described being seen relatively quickly in triage but then waiting for long periods of up to 12 hours to see a doctor or wait for an x-ray or scan.

Inspectors observed staff in the emergency department actively engaging with patients in a respectful and friendly manner. Inspectors observed staff promoting and protecting patients' privacy and dignity. For example, curtains or blinds were pulled to ensure privacy and dignity when patients were being clinically assessed or having treatments. Staff spoke clearly and quietly to patients in shared areas. Children and their parents were being cared for in an audio-visually separated area of the emergency department, which had been established since the previous HIQA inspection. Patients who had been present in the emergency department overnight said that they had been offered drinks and a snack.

Medical 3 ward was a 24-bedded ward consisting of two four-bedded rooms and 16 single en-suite rooms. The ward had adequate toilet and shower facilities for patients. The ward

was used to facilitate care of medical patients. At the time of inspection, all 24 beds were occupied and there was an additional patient being cared for on a bed in the treatment room in response to the hospitals' escalation plan.

Surgical 2 ward was a 29-bedded ward consisting of two six-bedded rooms, one three-bedded room, two two-bedded rooms and 10 single en-suite rooms. The ward had adequate toilet and shower facilities for patients. In addition, there was also a four-bedded high-dependency unit (HDU) on the ward. Surgical 2 ward was used to facilitate care for surgical patients, but also catered for the needs of a number of medical patients in line with demands on hospital beds. At the time of inspection, all 29 beds on the ward and the four HDU beds were occupied. In addition to this, two patients were being cared for on beds in the ward corridor in response to the hospital's escalation plan. Mobile screens were observed around the beds on the corridor.

Inspectors observed kind interactions between staff and patients on these clinical ward areas. This was validated by patients who described staff in these areas as '*fantastic*', '*pleasant*', '*very hard working*', '*very obliging*'. Inspectors observed that the privacy and dignity of patients was promoted and protected by staff when providing care. Patients told inspectors that they '*get very good care*' and '*nurses are powerful*".

Patients who spoke with inspectors were not aware of the formal complaints process in the hospital, but would ask a member of their family to support them to complain if they had an issue. One patient said they would take up any issue with ward staff, or the hospital management, depending on what the complaint was. The HSE's complaints management policy 'Your Service Your Say' leaflets were observed available and accessible in the emergency department and on the other clinical areas visited.

Overall, there was consistency with what inspectors observed in the emergency department and the other clinical ward areas visited and what patients told inspectors about their experience of receiving care in those areas.

Capacity and Capability Dimension

Findings from national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital. Inspection findings from the theme of workforce are presented under national standard 6.1.

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

Inspectors found that the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring

the quality and safety of healthcare services. The hospital was governed and managed by the Hospital Manager who reported to Chief Executive Officer of Saolta University Health Care Group.

The Hospital had a directorate structure and it also had two managed clinical and academic networks (MCAN).[‡‡] The directorates were medicine, perioperative, radiology and pathology. The two MCANS were and cancer and women's and children's MCANs. The Directorates and MCANs were led by associate clinical directors who reported operationally to the Hospital Manager and clinically to the relevant clinical director of the Saolta University Health Care Group.

The Director of Nursing was responsible for the organisation and management of nursing services at the hospital, and reported locally to the Hospital Manager and to Chief Director of Nursing at group level.

Hospital Executive Board

The Hospital Executive Board (HEB) was the main governance structure at the hospital. Chaired by the Hospital Manager, the HEB met twice a month and had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. The HEB membership comprised of the Hospital Manager and Assistant Hospital Manager the Directors of Nursing and Midwifery and representative from - the directorates and MCANS, quality and patient safety, human resources, finance and facilities. Minutes of HEB meetings, submitted to HIQA, showed that the meetings followed a structured format, and progress in implementing actions was monitored from meeting to meeting. However, there was opportunity for discussion and actions related to issues raised at meetings in minutes reviewed.

Quality and Patient Safety Committee

The Quality and Patient Safety (QPS) Committee was the main committee assigned with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. This Committee, chaired by the Director of Nursing Quality and Safety, met every month and had appropriate multidisciplinary membership.

The QPS Committee reviewed and considered reports from the various committees that reported into it such as, the Drugs and Therapeutics Committee, the Infection Prevention Control and Antimicrobial Stewardship Committee and the Deteriorating Patient Operations Steering Committee. The hospital's Risk Register Committee reviewed and updated the hospital's risk register monthly, and reported to the QPS committee.

The Quality and Patient Safety Committee also reviewed the hospital's patient-safety incidents and complaints, reviewed feedback from patient experience surveys, audits and

[‡‡]A MCAN is a group-wide management structure under which clinical services are organised across Saolta Hospitals.

monitoring of metrics and key performance indicators and provided oversight of the implementation of recommendations and quality improvements from the data collated.

Infection Prevention Control and Antimicrobial Stewardship Committee

The hospital's Infection Prevention Control and Antimicrobial Stewardship Committee was responsible for the governance and oversight of infection prevention and control at the hospital. Meetings followed a standardised agenda with actions progressed through an action log. However, meeting attendance was low, based on the membership outlined in the terms of reference. The last meeting minutes submitted to HIQA were dated June 2023, so no evidence of meetings held since June was seen by inspectors.

The Infection Prevention Control and Antimicrobial Stewardship Committee was accountable and reported to the QPS Committee. The hospital had recently appointed a second consultant microbiologist and 1.8 whole-time equivalent (WTE)[§§] antimicrobial pharmacists were now in post. An antimicrobial stewardship programme was now in place at the hospital, which was an improvement on the previous inspection. HIQA was satisfied with the governance and oversight of infection prevention and control practices at the hospital.

Drugs and Therapeutics Committee

The hospital's Drugs and Therapeutics Committee was assigned responsibility for the governance and oversight of medication safety practices at the hospital. The Committee was chaired by a consultant anaesthetist and met at least every two months with multidisciplinary membership. However, attendance at meetings was low relative to membership outlined in committee's terms of reference. The Committee was operationally accountable and reported to the QPS Committee. Meetings followed a structured format and were action orientated with actions monitored from meeting to meeting.

LUH Deteriorating Patient Operational Steering Committee

The hospital had formalised governance arrangements in place for the oversight and management of the deteriorating patient and the management of a patient with sepsis. The LUH Deteriorating Patient Operational Steering Committee had oversight of the implementation of national early warning systems (EWS)[***] and the National Clinical Guideline on Sepsis Management at the hospital. This Committee reported to the QPS Committee. This Committee was chaired by a consultant physician, met monthly and had appropriate multidisciplinary membership with good attendance at meetings. This Committee had a standardised structured agenda and was action orientated, with actions monitored from meeting to meeting. EWS and sepsis audits were discussed by the

[§§] [§§] Whole-time equivalent (WTE) - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

[***] Irish National Early warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Pediatric Early Warning System (PEWS), Emergency Medicine Early warning System (EMEWS) and National Clinical Guideline on Sepsis Management at Letterkenny University Hospital.

Committee with implementation of recommendations monitored**.** Incidents related to the deteriorating patient were discussed and reviewed by the committee.

Transitions of care

The Unscheduled Care Governance Group (USCGG) was responsible for reviewing and improving the flow and experience of patients attending for emergency care at the hospital and onward into the community. The Committee met monthly, was chaired by the Hospital Manager or Assistant Hospital Manager and reported to the HEB. The Committee had multidisciplinary membership with representation from the hospital and the community. Minutes of the meetings were action focused and there was evidence of monitoring of progress. However, not all disciplines were represented at minutes of meeting seen by inspectors. This should be reviewed, to ensure ownership from all disciplines of initiatives and activities to improve patient flow and the patient's experience.

Overall, the hospital had formalised corporate and clinical governance arrangements in place, attendance at meetings remains low relative to the membership outlined in terms of reference of some committees.

Judgment: Substantially compliant

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

Findings relating to the emergency department

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. There was evidence of strong clinical and nursing leadership in the emergency department. Operational governance and oversight of day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine supported by non-consultant hospital doctors. Outside core working hours,[†††] medical oversight of the emergency department was provided by on call consultants.

In 2022, the overall attendance rate at the hospital's emergency department was 52,685, which equated to an average attendance rate of 4,390 each month or 142 attendances every day. In 2023 year to date, attendance was 44,530 which was the second highest of all model 3 hospitals and a 7% increase on same time period in 2022, and a 19% increase on same timeframe in 2019 pre pandemic.

[†††] Core working hours is consider Monday to Friday 9.00am to 5.00pm.

On the day of inspection, the emergency department was busy with patients waiting on average up to 6 hours for medical assessment post triage. At 11am, on the first day of inspection there were 64 patients in the emergency department, however, only two of these patients were admitted awaiting an inpatient bed. Of these 64 patients, 30% had arrived via ambulance, 47% had been referred by their GP and 23% had self-referred. Fourteen of the 64 attendees were over 75 years of age (32%).

The average waiting time from registration to triage at 11am was 36 minutes, which was not in line with the 15 minutes triage time recommended by the HSE's emergency medicine programme and longer than that observed during the previous inspection. The average time from triage to medical assessment was 400 minutes (6.6 hours). The average waiting time from medical assessment to admission was 418 minutes (6.9 hours).Two patients who spoke with inspectors were in the ED for 17 and 19 hours respectively, one patient was admitted awaiting an inpatient bed and the other patient was awaiting diagnostics.

The conversion rate (rate of admission of patients to an inpatient ward) for the emergency department over a 12-month time frame was 36% which was higher than all hospital's inspected by HIQA.

Medical patients average length of stay (ALOS) from January to August 2023 was 7.4 days which was marginally above the national target of less than or equal to 7.0 days. The surgical patients ALOS for the same time period was 5.7 days, above the national target of less than or equal to 5.0 days. On the day of inspection, the ALOS for medical patients reported by the hospital was 18 days, which was a significant higher than the January to August average of 7.3, and the national target. The ALOS for surgical patients of 9.36 reported by the hospital on the day of inspection was also higher than the 2023 national target and the hospital average from January to September 2023.

At the time of inspection, there were 24 patients in the hospital who had completed their acute episode of care and were experiencing delayed transfers of care (DTOC)[‡‡‡] to the community. This was among the highest number of DTOC when compared to other model 3 hospitals. Hospital management outlined that patients complex discharge needs and shortage of community carers posed challenges to transferring patients to safe appropriate care in the community

The hospital was not compliant with all the HSE's key performance indicators for patient experience times (PETs)[§§§] reported in published data for January to September 2023 as outlined in Table 1. The hospital's PETs were lower than the national average for six and nine hours PETs, but above the national average for 24 hour PETs.

[‡‡‡] Delayed transfers of care (DTOC): A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred.

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

Table 2: Average patient experience times when compared to HSE targets and national average of all hospitals in published data January to September 2023.

	Average % of all patients admitted or discharged within:			Average % of patients aged 75 or over admitted or discharged within:	
	6 hours	9 hours	24 hours	9 hours	24 hours
HSE Target	70%	85%	97%	99%	99%
National average Jan-Sept 2023	56.9%	73.5%	95.4%	54.3%	90.7%
LUH Jan-Sept 2023	50%	68.2%	96.5%	44.2%	92.8%

For the week prior to the inspection the percentage of patients admitted or discharged from the ED within six hours was 42%, well below the national target of 70%, within nine hours was 78.5%, still below target of 85%. The percentage of patients admitted or discharged from the ED within 24 hours was 99.7%, compliant with the national target of 97%.

The hospital had systems and processes in place to support patient flow through the emergency department. These included:

- Twice daily safety flow huddles meetings at 9.15 and 2.15 pm, attended by patient flow and discharge liaison representatives, nurse managers from all wards, assistant directors of nursing (ADONs), the Director of Nursing and Midwifery (DON/DOM), the Hospital Manager and representatives from infection prevention and control, radiology and cardiology investigations. This forum facilitated staff to look back over the previous 24 hours and address any relevant issues or concern. The forum then planned for the next 24 hours based on: the number of patients attending the hospital, the predicted discharges and the staff available, with the aim to predict and plan for safe, quality patient flow.
- CDLMS[****]and LUH integrated forum for Delayed Transitions of Care (DTOC) met weekly and monitored all patients with delayed and complex discharges. The aim of this forum was to support any actions to advance safe and appropriate patient discharge from the acute hospital to the community. Progress and actions to support discharges were monitored for each patient on a tracker, which was reviewed and updated weekly.
- Integrated discharge rounds were held weekly with community partners to review and progress actions to facilitate discharge. Challenges to discharge were discussed and actioned.

[****] CDLMS : Cavan, Donegal, Leitrim, Monaghan and Sligo (Community Area)

The hospital had some alternative pathways and admission avoidance initiatives in place. However, at the time of inspection some of these pathways were not functioning as intended to support patient flow:

- Frailty Intervention Team (FIT) - a multidisciplinary team who carried out a comprehensive assessment for people over 75 years of age reviewing alternative pathways to avoid admission or to facilitate early discharge. The FIT team comprised of a clinical nurse specialist, a physiotherapist, an occupational therapist and a healthcare assistant. However, inspectors were informed that the physiotherapist and occupational therapist were on leave and not replaced at the time of inspection. Therefore the team was not functioning as intended to support patient care for the frail elderly attendee and to support patient flow through the ED.
- The Hospital Ambulance Liaison Person (HALP) was in place in the ED Monday to Saturday to improve communication and assist with ambulance off-loading.
- A rapid access zone (RAZ) was recently opened. This service was consultant led, and patients meeting set criteria were referred to the RAZ for assessment and management following ED triage. Inspectors were informed that the service only operated when staffing allowed and had not been opened the previous day as an alternative pathways from triage due to staff shortages.
- Minor injury unit (purple pathway) was run by advanced nurse practitioners and reviewed patients based on set criteria.
- The acute medical assessment unit (AMAU) was consultant led and operated from 9am to 5pm Monday to Friday with dedicated nursing and medical staff. There was no direct GP referrals, and all GP referred patients were triaged in ED and if within the AMAU criteria were accepted by the AMAU during opening hours. The AMAU criteria had recently been updated by the hospital. However, staff who spoke with inspectors, outlined that there was an opportunity to increase AMAU referrals in line with the Operational Policy of the AMAU to increase the unit's activity and improve patient flow. This should be reviewed by the hospital following this inspection.
- Pathfinders had commenced in the hospital in April 2023. Pathfinders is a collaborative service staffed by health and social care professionals and the HSE's National Ambulance Service. The aim of this services is to avoid transfer to the emergency department following a 999 call for patients over 65 years of age with low acuity, by providing treatment at the scene if appropriate, and or referral to community health and social care service. From April to the time of inspection, the pathfinder service had reviewed 216 patients in total. 76% of these patients had been managed in their own home, avoiding hospital attendance.
- The hospital had some pathways in place in the ED for example: chest pain pathway, cellulitis pathway and a deep vein thrombosis pathway. Work was ongoing as part of

the Emergency Department Quality Improvement Plan (QIP) to review and update admission avoidance ED pathways and ambulatory pathways as outlined below.

The hospital had set up an Emergency Department Quality Improvement Plan (QIP) to identify areas for improvement within the ED such as admission avoidance strategies and pathways to assist with patient flow in the department. The QIP had six specific areas of focus:

- AMAU resources and processes
- Allocations roles and responsibilities
- Pathways
- Over 75 years of age 24 hour PETs
- Ambulance turnaround times
- Electronic triage

Evidence of process against some of these QIPs was viewed by inspectors. For example, a draft Zero Tolerance Framework for 24 hour PETs for patients 75 years of age and over was provided to inspectors, with triggers and actions to be implemented outlined. The ambulance turnaround time (TAT) QIP was progressed through an Ambulance Turnaround Time Project meetings, with examples of initiatives to improve the ambulance TAT outlined, such as 'fit to sit.'[††††] A draft Ambulance Turnaround Times Escalation Framework viewed by inspectors was to be rolled out over three stages, each stage covering a consecutive three month period. The final stage 3 was a zero tolerance of ambulances being delayed for over one hour and actions to be taken were outlined, based on the time the ambulance was delayed in the department. The timeframe for completion was November 2023. The average ambulance TAT for the week prior to the inspection was 55.4 minutes. Although still outside the national target, this was a notable improvement for the hospital.

Inspectors were informed that a HSE Support Team had been commissioned by the Chief Operations Officer in response to overcrowding of the Emergency Department at the hospital. The draft terms of reference provided to inspectors, outlined that the support team would review the day to day functioning of LUH and the community services within a leadership, management, operational and clinical context to consider how improvements in LUH could be enabled in the short term. Most importantly, it will seek to identify what local, regional and national supports are needed to ensure operational and clinical effectiveness on a sustained basis across LUH and the community services**.** The duration of the team's engagement was to be over seven weeks between November and December 2023.

A Bed Utilisation Study carried out in December 2022 identified many areas that could be improved with focus and actions. A draft Standard Operating Procedure Statement (dated April 2023) submitted to HIQA outlining a plan to set up a Working Group to complete the associated actions required to lead to better bed utilisation within the hospital. However,

[††††] [††††] Fit to Sit is the term assigned to an assessment by ambulance personnel of a patient's suitability to sit on a chair rather than require a stretcher.

recommendations, action plans or progress reports relating to this study, although requested, were not submitted to HIQA. Considering the currently high average length of stay and delayed transfer of care identified on the day of inspection, it would be imperative that the recommendations of this report are implemented as a matter of priority.

Findings related to the wider hospital and other clinical wards areas visited

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

Infection, prevention and control

The hospital had an overarching infection prevention and control (IPC) programme as per national standards.[‡‡‡‡] The hospital's antimicrobial stewardship (AMS) team had recently been re-established following an increase in consultant microbiologists and antimicrobial pharmacists at the hospital. This team were now responsible for implementing the hospital's antimicrobial stewardship programme.[§§§§] The IPC and AMS teams worked closely together, held joint meetings and developed a joint annual plan and annual report.

Medication safety

The hospital's pharmacy service was led by the hospital's chief pharmacist. Documentation submitted to HIQA relating to pharmacy staffing levels outlined that all 32.7 approved and funded pharmacy staff posts were filled at the time of inspection. This was an improvement on the previous inspection when there was a shortfall of 28% in the 32 WTE approved and funded posts at that time. Inspectors were informed that the approved pharmacy staffing complement did not include funding for pharmacists to provide a clinical pharmacy service[*****] for the peri-operative services including the surgical 2 ward, orthopaedics, surgical high-dependency unit, medical 7 ward and the theatre. Inspectors were informed that a business case was submitted by the hospital for additional posts to cover the peri-operative areas, but approval was not received. Hospitals should be resourced to ensure consistency in baseline clinical pharmacy service across all clinical areas to support the safe use of medicines

Deteriorating patient

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. The hospital had the following early warning systems in place to support the recognition and response to a deteriorating patient: the Irish National Early Warning System (INEWS), Irish Maternity Early Warning System

[‡‡‡‡] National Clinical Effectiveness Committee. National Clinical Guidelines. Draft Guidance on Infection Prevention and Control. 2022. Available on line from: ncec-ipc-guideline-2022-for-consultation.pdf (hse.ie)

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

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

(IMEWS) the Paediatric Early Warning System (PEWS) and the Emergency Medicine Early Warning system (EMEWS).The HSE Adult Sepsis Form was in use at the hospital. Escalation protocols in place were in line with national guidance.

There was an assigned consultant lead for the deteriorating patient improvement programme which included sepsis. A digital INEWS system had been introduced as a pilot on one ward visited by inspectors. The pilot was reported to be working well and the hospital planned to extend the digital INEWS to other areas on the hospital. The hospital had a system in place to communicate critical results from the laboratory.

Transitions of care

The hospital had a number of personnel and committees to support the transitions of care for people on admission, transfer or discharge from the hospital. The patient flow team were operationally responsible for transitions of care within the hospital. The discharge liaison teams were operationally responsible for the coordination of safe transitions of care between the hospital and the community.

The hospital provided HIQA with an update of the quality improvement plan for gynaecology services developed from the recommendation arising from the HIQA's targeted assurance review of gynaecology services in 2021. An external clinical director had been working with the hospital for a six month period from September 2022 to provide support for the gynaecology services in the implementation of these recommendations. Of the 26 recommendations in the report, the majority of associated actions were in progress or completed. The actions that were not in progress were outside the scope of the hospital, or required additional staff to implement.

At the time of this inspection, there were five funded consultant obstetrician and gynaecologists' posts, which was an increase of one since the previous inspection. Three posts were filled on a permanents basis, which was an improvement on the previous inspection, and two on a long-term locum basic. Inspectors were informed that a sixth consultant post was currently going through the Consultant Application Advisory Committee.

The hospital appointed a change plan implementation manager to implement the recommendations from the Phase 3 Change Programme developed with support from an external consultancy team in 2022. In February 2023, the Change Plan Implementation Manager commenced a two year post to lead, co-ordinate, monitor and oversee the Change Plan at the hospital. This Manager was based at the hospital for at least 50% of the time and was responsible for co-ordinating and supporting five work streams to deliver agreed strategic priorities. The five work streams outlined below had both group and local leads and each had sub-working groups. The groups reported to the monthly LUH Change Plan Steering Committee Group. Each stream had set three main priorities, and updates on progress on these priorities was provided to inspectors during the inspection. Inspectors

were informed that there had been very good engagement with staff about the Change Plan, and that hospital staff were very positive about the change plan process.

Work streams implementation groups and associated working groups:

- Patient Safety and Quality Improvement Implementation Group
  - Clinical handover working group
  - Clinical recording documentation working group
  - Bi-directional flow and inter hospital transfer working group
- Communication, Engagement and Relationships and Culture Implementation Group
  - Staff engagement working group
- Leadership, Accountability, and Governance structures Implementation Group
  - Model 3 service profile working group
- Knowledge and Skill
  - Knowledge and skill working group Implementation Group
- Information Implementation Group
  - ED department

Through HIQA's monitoring of LUH, issues such as listening to and responding to staff feedback have been highlighted. As part of the Change Plan, the Communication, Engagement and Relationships and Culture Implementation Group were reviewing the hospital mission, value, purpose and vision, which would be implemented and evaluated with the support of the Staff Engagement Forum. It is imperative that Letterkenny University Hospital supports and promotes a culture that values, respects, actively listens to and responds to the views and feedback from staff members. The Change Plan process, with which staff were actively engaging, is a very positive action in moving towards this goal and needs to be progressed in accordance with the plan and associated timelines.

Overall, the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department. As mentioned previously, the hospital needs to implement the recommendations from the Bed Utilisation Study. There were still long waits in ED for reviews and inpatient beds and conversion rates were high in comparisons to other hospitals. Targets such as PETs and ambulance turnaround time require more improvements, and more communication and clarity around ED pathways is required. The ED Quality Improvement Plan had highlighted areas for improvements and this work needs to be supported to make meaningful and sustainable improvements within the ED.

At the time of inspection, the hospital continued to have additional supports in place. The Change Plan Implementation Manager was on site and a Support Team were due to commence in the hospital. The benefits and the gains from the input of these supports would take time to be realised. Ultimately, the impact of these supports would only be fully measurable when the hospital management were functioning effectively without such supports and the planned changes were embedded within the organisation with local ownership. It is essential that strong oversight arrangements are put in place to ensure the

timely implementation of quality improvements plans arising from any recommendation from the HSE support Team, with support as required at local, regional and national level.

Judgment: Partially compliant

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

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

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospitals Risk Register Committee reviewed and updated the hospital's risk register monthly and reported to the Quality and Patient Safety Committee. Patient-safety incidents were also discussed at performance meetings with the Saolta University Health Care Group. Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to mitigate the risks, in relation to the four key areas of known harm were recorded on the hospital's corporate risk register. These risks are outlined further under national standard 3.1.

Management of patient-safety incidents

Patient-safety incidents were reported directly to the National Incident Management System, in line with the HSE's Incident Management Framework. The hospital's quality and patient safety manager tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the Quality and Patient Safety Committee. Incidents were rated by number, category and severity. Feedback on patient-safety incidents was provided to clinical nurse managers by the areas ADON, who attended the QPS Committee meetings and received QPS reports. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). The data was reviewed at the monthly Quality and Patient Safety Committee.

The hospital collated performance data for unscheduled and scheduled care, including data on emergency department attendances and patient experience times, bed occupancy rate, average length of stay, scheduled admissions and delayed transfers of care.

The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governance committees, the Quality Patient Safety Committee and at Group Performance meetings.

Audit activity

The hospital had monitoring arrangements in place to monitor some areas of the services performance. For example, evidence of monitoring of the ambulatory gynaecology services and infection prevention and control against set targets was viewed by inspectors. There was opportunity for improvement in the monitoring and evaluation of healthcare services provided at the hospital, especially in relation to medication safety and transitions of care.

Service user feedback

Findings from the National Inpatient Experience Survey were reviewed at meetings of the Quality and Patient Safety Committee. The Quality and Patient Safety Manager provided quarterly updates of progress against the National Patient Experience Survey 2022 quality improvement plan.

In summary, the hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. There were risk management structures in place and monitoring and analyses of patient-safety incidents, complaints and performance data. Examples were provided where this information was used to improve the quality and safety of services. Quality improvement initiatives were implemented in response to audit findings, patient safety incidents and feedback from people using the service

The hospital were monitoring performance against key performance indicators in relation to the infection prevention and control and the deteriorating patient, but there was opportunity for improvement in the monitoring and evaluation of services especially in relation to medication safety and transitions of care.

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.

Findings related to the emergency department

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. Senior clinical decision-makers[†††††] at consultant level were on-site in the hospital's emergency department Monday to Friday 8.30am to 8.30om and on Saturday 8.30am to 5.30pm. An emergency medicine consultant clinical lead had overall responsibility for the day-to-day clinical functioning of the department.

The emergency department had approval for eight WTE emergency medicine consultants. At the time of inspection there were five emergency medicine consultants on the roster, with two additional emergency medicine consultants due to commence employment in the hospital by year end. The emergency medicine consultant was operationally accountable and reported to the Associate Clinical Director for Medicine and Emergency Medicine Directorate. Consultants in emergency medicine at LUH were supported by 19 non-consultant hospital doctors, 10 registrars and nine senior house officers. All NCHD posts were filled at the time of inspection.

The emergency department had an approved complement of 70.27 WTEs nurses (including staff nurses and clinical nurse manager roles). Staff records provided to HIQA demonstrated that 69.64 of these posts were filled with a variance 0.63 WTE. This was an improvement on the previous inspection. On the day of inspection the department had its full rostered complement of nursing staff. However, inspectors were informed that this was not always the case. Nursing staff were supported by 10.12 WTE healthcare assistants (HCA), and as per records submitted to HIQA, all HCA positions were filled.

A clinical nurse manager grade 3 had overall nursing responsibility for the department and they reported to the ADON for cancer, ambulatory and emergency care. On the day of inspection a CNM2 was rostered to manage the ED, in the absence of the CNM3.

Staff in the emergency department had access to an infection prevention and control nurse. Staff also had access to an antimicrobial pharmacist and a consultant microbiologist. The ED had an assigned pharmacist and pharmacy technician. There was a security staff presence in the emergency department 8.00pm to 8.00am. Security were available via a bleep system to be called to ED during the day as required.

The hospital had a system in place to monitor and record staff attendance at mandatory and essential training, and this was overseen by the Clinical Nurse Manager 3. Training records submitted to HIQA outlined that 87% of nurses were up to date with training on the emergency national early warning system.

Findings related to the wider hospital and other clinical wards areas visited

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

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital's total approved complement of staff (all staff) in published data in Novembers 2023 was 2195 WTEs, an increase of 5% on December 2022.

Documentation submitted to HIQA outlined that the hospital's approved complement of staff nurses post was 572 WTEs, with 568 filled at the time of inspection which represents a variance of 4 WTEs (0.7%) between the approved and actual nursing complement. All CNM 1 and CNM2 posts were filled with one CNM3 post unfilled. This was an improvement on the previous inspection when 35 nursing post were unfilled.

The approved HCA posts on the three areas visited were fully filled except for a 0.5 WTE post on medical 3 (8% variance) and 0.68 WTE post on Surgical 1 (8% variance).

The hospital had an approved complement of 78.5 consultants, with 74 posts filled at the time of inspection. 54 (73%) consultant posts were permanent posts and 20 (27%) of consultants post were fill by locum consultants. The unfilled consultant posts included, a vacant emergency medicine consultant post and two vacant consultant radiologist's posts. At the time of inspection, eight locum consultants were not registered on the relevant Specialist Division of the Irish Medical Council. Inspectors were informed that these consultants were working through the process to gain registration, and in the interim appropriate supports with clinical and corporate oversight were in place.

The consultant staff were supported by 76 non-consultant hospital doctors at registrar grade and 96 at senior house officer grade. On the day of inspection, all non-consultant hospital doctor's positions were filled.

Absenteeism

The hospital's reported absenteeism rate for September 2023 was 7.8%, which was above the HSE's target of less than or equal to 4%. This absence rate was the highest of all Saolta University Health Care Group hospitals. Inspectors were informed that the recently revised HSE Managing Attendance Policy 2023, had been circulated in September and that refresher sessions were planned for the week following the inspection. Inspectors were informed that return to work interviews were held with staff, and staff's sick leave records were escalated to the relevant ADON following three consecutive sick leave episodes.

Pharmacy staffing

As mentioned previously under standard 5.5, documentation submitted to HIQA indicated that all approved pharmacists posts were filled at the time of inspection. This was an improvement on the previous inspection when there was a shortfall of 28% in the 32 WTE approved and funded posts at that time. As outlined earlier, the lack of approved clinical pharmacy staffing complement for the peri-operative services, and pharmacy staff on long-term leave impacted the availability of a clinical pharmacy service in surgical and some

medical areas, with the women's and children's services and the intensive care unit without a clinical pharmacy service at the time of inspection.

Pharmacy staffing levels at the time of inspection were reported as:

- one pharmacist executive manager
- one chief 2 pharmacist
- 12.87 senior grade pharmacists with 14.97 in post
- one basic grade pharmacist with five in post
- 16.87 pharmacy technicians with 22.4 in post.

From information provided to HIQA, the hospital should advance clinical pharmacy service to some of the clinical areas currently not covered considering the available resourcing.

Infection prevention and control and antimicrobial stewardship

The infection prevention and control team had its full approved complement of nursing staff at the time of inspection, a WTE clinical nurse specialist, two WTE clinical nurse managers and an infection prevention and control ADON. Since the previous inspection, two of the three approved WTE antimicrobial consultant posts were filled, with one consultant having been appointed recently. Two antimicrobial pharmacists (1.8 WTE) were in post, one post had only recently been filled. The hospital also had a surveillance scientist.

Transition of care

The patient flow team were operationally responsible for transitions of care within the hospital and included a designated lead for patient flow for the emergency department and the wards. The discharge liaison teams comprising three discharge coordination liaison nurses and an integrated discharge manager were operationally responsible for coordination of safe transition of care from the hospital.

Uptake of mandatory and essential staff training

It was evident from staff training records reviewed by inspectors that nursing staff in the hospital undertook multidisciplinary team training appropriate to their scope of practice every two years. The hospital had a system in place to record and monitor staff attendance at mandatory and essential training, and this was overseen by the clinical nurse manager grade 2.

Similar to findings on the previous inspections, HIQA found that staff attendance and uptake at mandatory and essential training could be improved, especially training on standard and transmission based precautions, basic life support and the Irish National and Irish Paediatric Early Warning Systems for all relevant staff:

Training records submitted to HIQA showed that:

- 84% of nurses and 89% off doctors were up to date with hand hygiene practices – below the HSE's target of 90%

- 40% of nurses and 15 % of doctors were up to date with standard and transmission based precautions
- 48% of nurses and 45% of doctors were up to date in basic life support training
- 54% of nurses of 58% of doctors were up to date with training on the Irish National Early Warning System
- 97% of nurses and midwives and 43% of doctors were up to date with training on the Irish Maternity Early Warning System
- 57% of nurses and midwives and 70% of doctors were up to date with training on the Irish Paediatrics Early Warning Score

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. The staffing levels in pharmacy and antimicrobial stewardship and nursing had improved since previous inspection. Attendance at and uptake of mandatory and essential training still required improvement, especially training on transmission based precautions, basic life support and the Irish National and Paediatric Early Warning Systems.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings from related to the quality and safety dimension are presented under national standards 1.6, 1.7, 1.8 from the theme of person-centred care, national standards 2.7 and 2.8 from the theme of safe and effective care and national standards 3.1 and 3.3 from the theme of safe care and support.

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

Finding related to the emergency department

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[‡‡‡‡‡] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using

[‡‡‡‡‡] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

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

At the time of inspection patients were accommodated in single cubicles with privacy curtains to support promotion of privacy and dignity. Patients who spoke with inspectors were aware of their plan of care but reported long wait times for a medical review or an inpatient beds.

Inspectors were informed that the hospital had just introduced the 'John's Campaign'§§§§§ whereby carers who normally provide care or family support for the patient at home would be exempt from visit hours. A family member or friend of a patient can apply for a carer's passport from any member of staff. A carer's passport agreement is completed and the carer is provided with a 'carer's passport' which allows them to come to the ward outside of visiting hours. The carer is there to support the patient and is not required to deliver care that would normally be delivered by hospital staff. Letterkenny University Hospital informed inspectors that it was the first hospital in the country to implement this new visiting policy, an initiative which strongly supports dignity and respect for patients.

Inspectors were informed that the hospital also undertake their own survey in the ED, the results of which are analysed by the PALS and reviewed at multidisciplinary management meetings.

Findings relating to the wider hospital and other clinical ward areas

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. For example, staff were heard providing an explanation of care to be provided in a pleasant and helpful manner.

Nursing staff promoted independence by promotion of the 'get up, get dressed, get moving'****** initiative, which was introduced across wards visited in the hospital. Chairs placed on the corridor of one ward supported patients to mobilise independently, but rest if required.

For the most part, the physical environment in the clinical areas visited by inspectors promoted the privacy, dignity and confidentiality of patients receiving care, through the use of privacy curtains and single rooms. This was substantiated by patients who spoke to inspectors.

§§§§§ Johns campaign is designed to ensure that people who are carers for their loved ones can be welcomed into the hospital environment as partners in patient care to provide support and care as agreed with the care team during the hospitalisation period

****** Get up Get dressed Get moving is a national campaign to promote independence and embed the concept of early and ongoing movement into culture and practice across health and social care.

However, there were two patients accommodated on the corridor of one ward visited by inspectors and their dignity and privacy and confidentially was compromised while accommodated on the ward corridor. There were privacy screens available for these patients, and inspectors were informed that a room on the ward would also be used for private conversations if required. Patient's personal information in the clinical ward areas visited during the inspection was observed to be protected and stored appropriately.

Staff tried to always accommodate patients at end of life in a single room. On one ward visited, a larger single room was used to accommodate patients at end of life This room had additional facilities such as a fridge and armchair to support relatives at this time.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department and this is consistent with the human rights-based approach to care supported and promoted by HIQA. The number of admitted patient accommodated in the ED was improved during this inspection and patients were accommodated in single cubicles. However, while patient are accommodated on corridors of ward their dignity and privacy and confidentially is compromised.

Judgment: Substantially complaint

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors, who described staff as very courteous and very kind.

An example of good practice observed by inspectors was the placement of writing desks along the corridor enabling staff to complete their clinical notes. This practiced resulted in a visible staff presence throughout the ward and staff were near patients if they needed support.

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

Judgment: Compliant

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

The hospital used the HSE's complaints management policy 'Your Service Your Say.'[††††††] The hospital had a designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints.

Your Service Your Say' leaflets were available in the hospital. There was a culture of complaints resolution at point of contact in the clinical ward areas visited.

At the time of inspection the Patient Advice and Liaison Service (PALS) was unfilled due to leave. However, information about the PALS was displayed on wards. Staff who spoke with inspectors highlighted the benefits of the PALS for patients. Evidence of the supports provided to patients by the PALS was seen in reports presented to the QPS Committee up to July 2023. The hospital's ability to respond promptly and effectively to patients complaints and to provide support throughout the process had been enhanced by this service. The hospital should endeavour to fill this vacant position. In the interim the QPS manager was supporting the complaints process.

The Quality and Patient Safety Committee had oversight of the complaints management process with the hospital. This Committee reported to the Hospital Executive Board. Compliance with key performance indicators related to complaints was monitored by the hospital and reported at the Quality and Patient Safety Committee.

The hospital was using the national Complaint Management System[‡‡‡‡‡‡] to manage complaints. Inspectors were informed that there had been a backlog of complaints when the system was implemented, and the QPS department were working through the backlog, with oversight by the QPS Committee. As a consequence, only approximately 30% of complaints were resolved within 30 working day, well below the national target of 70%. Inspectors were informed, that a letter was sent to all complainants when complaints exceeded 30 days, and a reminder was sent to the staff member from whom a response was required to complete the complaint report.

A new key performance indicator (KPI) added in 2023 outlined that recommendations from complaints should be implemented within 65 days. In September 2023 the hospital reported full compliance with this KPI.

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

[‡‡‡‡‡‡] The Complaints Management System (CMS) is a national database management system developed to support the HSE's complaints management process and to enable the end-to-end management and tracking of complaints, investigations, outcomes and recommendations at local level.

Feedback on complaints was generally provided to staff in the clinical area that were the subject of the complaint. Inspectors were informed that the area ADON would review all complaints with the CNM to prepare an appropriate response to the complaint, and identify any learning opportunities. Inspectors were informed that learning from complaints was shared with staff through 'staff briefing' held at the start of the nursing handover shifts and ward staff meetings.

A log of recommendations from complaints was viewed by inspectors. The PALS coordinator when in post, and the QPS Manager monitored the required actions to ensure recommendations were implemented. This was overseen by the QPS Committee at monthly meeting.

An example of the use of an independent advocacy services, to support international patients was outlined to inspectors.

A quality improvement plan in response to 21 recommendations made following an external review of the complaints process at the hospital was viewed by inspectors. The majority of recommendations had been implemented by the hospital.

Overall, while the hospital had progressed historical complaints and was endeavouring to manage complaints in a timely manner, the hospitals response times still exceeded required timelines. The contribution of the PALS was evidently beneficial in supporting patients and managing their complaints. The hospital should seek to recommence this service. More work is required by the hospital to respond promptly, and effectively to complaints and concerns raised by people using the service

Judgment: Partially compliant

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

On the day of inspection, inspectors visited surgical 2 and medical 3 clinical areas and observed that overall the hospital's physical environment was well maintained and clean with a few exceptions. There was evidence of general wear and tear observed, with paint work and wood finishes chipped on one ward inspected, this did not facilitate effective cleaning. Issues observed on inspections were also noted on environmental audit and action plans were in place with an ongoing maintenance plans. However, issued note on environmental audits such as tears on leather chairs were not addressed at the time of inspection. Appropriate measures were in place to ensure safety on the wards with secure access.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical

areas. Inspectors noted that some hand-hygiene sinks observed in clinical areas visited by inspectors did not conform to national requirements.§§§§§§ Physical distancing of one metre was maintained between beds in multi-occupancy rooms.

Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited. Staff were also observed wearing appropriate personal protective equipment in line with national guidelines.

Environmental and terminal cleaning was carried out by hospital cleaning staff. The clinical areas visited had a dedicated cleaner. Cleaning supervisors and clinical nurse managers had oversight of cleaning schedules in the clinical areas visited. CNM's who spoke with inspectors were satisfied with the level of cleaning staff in place to keep their clinical areas clean and safe.

Cleaning of equipment was assigned to nurses and healthcare assistants. In clinical areas visited, the equipment was observed to be clean. There was a green tag system in place to identity equipment that had been cleaned. Hazardous material and waste were observed to be stored safely and securely in clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

The hospital had implemented processes to ensure appropriate placement of patients. The infection prevention and control nurse liaised with bed management on the placement of patients daily. There was adequate isolation facilities on the wards visited on the day of inspection, and patients requiring isolation on these wards were facilitated in single rooms with en-suite facilities.

Lack of storage facilities on one ward visited, resulted in storage of boxes near a ward exit which might impact on safe exit for the ward in the event of an emergency, this was brought to the attention of staff on the day of inspection, a risk assessment was undertaken and the risk was mitigated.

There were other minor issues noted on the day of inspection which were brought to the attention of the clinical nurse managers and addressed. In summary, the physical environment of clinical areas visited on the day of inspection supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care.

Judgment: Substantially compliant

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

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

The hospital monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments and patient experience surveys.

Patient surveys

An inpatient feedback survey commenced on all wards in January 2023, with an average of 67 patient survey forms returned to the Patient Advocate Liaison Service (PALS) monthly. The results were collated per ward and returned to the ward each month by the PALS, and reported to monthly QPS meeting. However, the most recent collated report seen by inspectors was for July 2023.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, Infection prevention and control audit summary reports reviewed by inspectors showed that the clinical areas visited on the day of inspection had achieved a high level of compliance with environmental and patient equipment audits ranging from 84% to 93% compliance over the previous three months of audits. Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices.

Quarterly monitoring of CPE surveillance testing was undertaken by the hospital to monitor compliance with required surveillance testing. CPE surveillance testing compliance rates had improved from 62% overall in February 2023 to 88% overall in November 2023. There was still opportunity for improvement in CPE surveillance testing compliance on some wards. Audit findings were shared with clinical staff and action plans were developed to address areas requiring improvement.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.******* The infection prevention and control team developed a monthly report which included surveillance data and IPC audit and monitoring reports. The AMS team had recently established the AMS programme in the hospital. At the time of inspection the team were providing monthly antimicrobial consumption surveillance data locally and nationally and planned to take part in the next yearly national point prevalent survey.

Medication safety monitoring

Limited evidence of monitoring and evaluation of medication safety practices at the hospital was provided during the inspection. The hospital was monitoring monthly

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

Nursing and Midwifery Quality Metrics which included a component of medication safety.[†††††††] Monthly results provided demonstrated compliance ranging from 84% to 100% against the medication safety metrics.

Deteriorating patient monitoring

Early warning score system was monitored monthly as part of the patient monitoring and surveillance component of the Nursing and Midwifery Quality Metrics. Overall hospital monthly compliance ranged from 80% to 100%. The Deteriorating Patient Improvement Programme INEWS observation chart compliance audit was also undertaken monthly and a sample of results was observed on one ward visited, with overall compliance on this ward ranging from 81% to 97%. The Deteriorating Patient Operational Steering Committee discussed audit results and in September 2023 meeting minutes outlined that overall poor results had been found in INEWS Escalation and Response Protocol Audit with overall results in quarter 1 of 41.5% and 28.8% in quarter 2. Plans to provide education to nurses and doctors on corrective action were outlined. This education should be prioritises to implement change, and then re-audited to ensure improvements in practice. Monitoring of the use of the ISBAR tool to escalate the care of the deteriorating patient was not seen by inspectors in line with national guidance.

Transitions of care monitoring

The hospital measured performance data in relation to admission, transfers and discharges in line with the national requirement. There was limited evidence of audit of transitions of care such as internal or external transfers, patient discharge, shift and interdepartmental handover.

The hospital did not audit compliance with national guidance on clinical handover or the use of the Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool. This should be introduced by the hospital as part of the implementation of the Clinical Handover Policy in line with national guidelines.

Overall, there was opportunity for improvement in the monitoring and evaluation of healthcare services provided at the hospital, especially in relation to medication safety and transitions of care. Healthcare practices should be monitored and audited regularly, with oversight by relevant governing structures to assure senior managers that any necessary continuous quality improvements are put in place.

Judgment: Partially compliant

[†††††††] Wrist band legible and correct, medication record identifications correct, allergy status recorded, legible prescription, medicine formulary available, medicine at prescribed frequency, minimum dose interval specified, independent verification of medicine, medicine related education.

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

Findings related to the emergency department

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the emergency department in line with the national HSE reporting requirements.

Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at local and group governance meetings.

Performance data collected on the day of HIQA's inspection showed that at 11am the hospital was not compliant with key performance indicators for the emergency department.

At 11am on the day of inspection, of the 64 patients in the emergency department it was found that:

- 31 patients (48%) were in the emergency department for more than six hours after registration — not compliant with the HSE's target PET that 70% of all attendees at ED are discharged or admitted‡‡‡‡‡‡‡ within six hours of registration.
- 27 patients (42%) were in the emergency department for more than nine hours after registration — not compliant with the national target that 85% of all attendees at ED are discharged or admitted within nine hours of registration.
- One patient (1.6%) was in the emergency department for more than 24 hours after registration - compliant with the national target that 97% of all attendees at ED are discharged or admitted within 24 hours of registration.
- Four of the fourteen patients (28%) in the emergency department aged 75 years or over were not discharged or admitted within nine hours — not compliant with the national target that 99% of all attendee aged 75 years at ED are discharged or admitted within nine hours of registration.
- No patient aged 75 years or over was in the ED over 24 hours — compliant with the national target that 99% of all attendees aged 75 years and over at ED are discharged or admitted within 24 hours of registration.

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were

‡‡‡‡‡‡‡ Total Emergency Department Time (TEDT) is measured from registration time to ED Departure Time.

co-ordinated at department level by the Clinical Nurse Manager with oversight of the process assigned to the ED management. Risks were reviewed by the ED management and escalated as required to the hospitals risk register. The highest ED rated risks escalated to the corporate risk register related to ED overcrowding. Another high-rated risk on the corporate risk register related to the hospital's non-compliance with ambulance turnaround time resulting in patient delays in treatment. This risk was also highlighted by staff on the day of inspection. A quality improvement plan for ambulance turnaround times was developed by the ED Improvement Team as previously discussed under standard 5.5.

Management of patient-safety incidents

Incidents were reported by staff directly to the National Incident Management System (NIMS) and all incidents were reviewed by a multidisciplinary ED team. Information was shared through daily 'safety briefs' and formal meetings. Inspectors were informed that nursing staff meetings were held twice a year where topics discussed included: incidents, complaints, quality improvement, metrics, staffing and health and safety. Inspectors were also informed that all incidents and risks were discussed at meetings between the ADON and all CNM grades twice a month.

Management of complaints

Complaints related to the emergency department were managed locally, in line with the hospital's complaints policy by nurse management with oversight from the Clinical Nurse Manager 3. Complaints relating to the department were tracked by the Quality and Patient Safety Manager and feedback was provided to the nurse managers. On the day of inspection, the patients who spoke with inspectors were not aware of how to make a complaint.

Infection prevention and control

The hospital had a system in place to assess patients for communicable infectious diseases on arrival at the hospital. A prioritisation system was used to allocate patients to the single cubicles and isolation rooms.

Infection prevention and control nurses visited the department daily. Staff had 24/7 access to a consultant microbiologist for advice.

Minimum physical spacing of one metre was maintained in the waiting area and emergency department, in line with national guidance. The emergency department environment was generally clean and well maintained. The department was on average 90% compliant in environmental audits carried out in April, June and August 2023

Medication safety

There was a pharmacist assigned to the emergency department and they undertook clinical medicine reviews and medication reconciliation for admitted patients. A pharmacy

technician visited the department to replace pharmacy stock. Staff in the department had access to an antimicrobial pharmacist.

Deteriorating patient

The hospital was so far the only hospital inspected by HIQA that had implemented the Emergency Medicine Early Warning Score (EMEWS) to support the recognition and response to a deteriorating patient in the emergency department. The implementation of the EMEWS is commended by HIQA. Documentation submitted to HQIA outlined that an audit plan for ED will commence in quarter 1 of 2024.

Multidisciplinary safety pauses were held in the emergency department at intervals throughout the day, to discuss the status of all patients in the department and identify patients that were of concern. Inspectors were informed that risks, incidents or complaints relevant to the department would be communicated at this time.

Transitions of care

The ISBAR$_3$ communication tool was encouraged for internal and external patient transfers from the emergency department. Delayed transfers of care further compounded the issue of availability of inpatient beds at the hospital and impacted on waiting times in the emergency department. This was highlighted as a risk and escalated to the hospital risk register. On the day of inspection, the hospital had 24 delayed discharges. Hospital management attributed some of the delays in transferring patients to a lack of carers in the community and some patient's complex discharge issues.

Findings relating to the wider hospital and clinical ward areas visited

Service providers had arrangements in place to monitor, analyse and respond to information significant to the delivery of safe services.

The Quality and Patient Safety Committee were assigned with responsibility to review and manage risks that impacted on the quality and safety of the healthcare services. Risks were recorded on the hospital's risk register and controls were in place to manage and reduce identified risks.

The hospital's risk register was reviewed by the hospital's Risk Register Committee and new risks added to the register were reviewed and discussed. Risks that could not be managed at hospital level were escalated to the Saolta University Health Care Group.

High-rated active risks recorded on the hospital's corporate risk register related to HIQA's monitoring programme included: increased level of bed occupancy in LUH leading to overcrowding in ED, pharmacy aseptic services unit, recruitment and retention of appropriately skilled staff and compliance with infection prevention and control practices.

Infection prevention and control

The infection prevention and control team maintained a register of potential infection risks. Risks that could not be managed locally by the infection prevention and control team were escalated to the Quality and Patient Safety Committee and recorded on the hospital's risk register. Risk of harms to service user due to poor compliance in some areas of infection prevention and control practice in LUH was escalated to the QPS and recorded on the hospital risk register. Existing controls in place and additional actions required were outlined on the risk register.

The hospital undertook targeted surveillance testing of patients for Carbapenemase-Producing Enterobacterales (CPE) and MRSA. Surveillance testing was to be undertaken with 24 hours of admission as per national guidelines. This was supported by infection prevention and control staff who visited the wards frequently. Quarterly monitoring of CPE surveillance testing demonstrated gradual improvement across wards from 62% in February 2022 to 88% compliance in November 2023 with surveillance testing. However, there was still opportunity for improvement with surveillance testing on many wards and quality improvement plans were in place. In 2023 up to the time of inspection, there had been one reported CPE outbreak in the hospital affecting two patients.

The hospital's information patient management system alerted staff to patients who had previously been inpatients in the hospital with multi-drug resistant organisms to support the identification and appropriate management. Inspectors were informed that LUH was due to implement the ICNET§§§§§§§ system, which would alert staff to patients with IPC concerns who had been inpatients in other Saolta hospitals. This should help to improve identification of patients requiring surveillance testing on admission.

A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks, a copy of the most recent outbreak report was viewed by inspectors.

Medication safety

The hospital provided a clinical pharmacy service to medical areas of the hospital. However, at the time of inspection the intensive care unit and the maternity and paediatrics services were not provided with a clinical pharmacy service due to staff leave. On the wards assigned a pharmacist, a clinical medicines review and medication reconciliation was undertaken for patients, although the provision of these services was not audited or monitored. Wards visited had pharmacy technician services for medicine stock control.

As mentioned previously, the perioperative area did not have an assigned pharmacist due to lack of funding for this service. Inspectors were informed that a business case was submitted by the hospital for additional posts to cover the peri-operative areas, but approval was not received. The lack of a comprehensive clinical pharmacy service, which

§§§§§§§ ICNET is a clinical surveillance software that supports infection surveillance and prevention. The system connects multiple sites across the Saolta Healthcare University Group.

includes a medication reconciliation service for all clinical areas, should be addressed following this inspection.

Risks associated with the current pharmacy aseptic unit were highlighted to inspectors on the inspection. These high-rated risks were escalated to the hospital's risk register with existing controls in place to mitigate and reduce the risks. Inspectors were informed that a new aseptic unit building project was ongoing but only at design stage.

The lack of a defined track and trace system for pharmacy blood derived products administered to patient was a high-rated risk highlighted by staff on the day of inspection. This risk was escalated to the hospital's risk register and escalated to Saolta University Health Care Group for a coordinated approach as the issue affected all hospitals.

There was evidence of risk-reduction strategies in place for high-risk medicines such as insulin and potassium. Information and learning from incidents was shared through Medication Safety Minutes which were distributed to wards fortnightly. Medicines information, including prescribing and administration guidance, high-alert medicines and sound alike look alike drugs, could be accessed by staff electronically. However this information was not accessible to staff at the point of medicine preparation to support safe preparation and administration of medicine. This should be reviewed by the hospital following this inspection.

Medication safety incidents were tracked and trended and reviewed at both the Drugs and Therapeutics Committee and the QPS Committee.

LUH was progressing the antimicrobial stewardship programme within the hospital, which was an improvement since the previous inspection. Following the recent appointment of 1.8 WTE antimicrobial stewardship pharmacists (AMS) and an additional consultant microbiologist, the hospital had introduced, antimicrobial stewardship ward rounds and AMS pharmacist review. The AMS team were in the process of updating the antimicrobial prescribing guidelines, providing monthly antimicrobial consumption data locally and nationally and plan to take part in the next yearly national point prevalent survey.

Deteriorating patient

The hospital had systems in place to support the recognition and response to a deteriorating patient. The INEWS observation chart for adult's patients was in use in the hospital and the ISBAR communication tool was used when staff were escalating care. Inspectors reviewed a small sample of healthcare records and found that of all INEWS charts were completed and care was escalated as required. However, as mentioned under standards 2.8 overall poor results found in INEWS Escalation and Response Protocol Audit with overall results in quarter 1 of 41.5% and 28.8% in quarter 2 shoulder be actioned and re-audited to ensure improvement in practice.

Transitions of care

The hospital aimed to provide discharge letters to general practitioners for all patients discharged home or transferred to other services. Inspectors were told that there can be a delays in preparation of these letters and observed 16 charts on one ward awaiting discharge letters. A delay in the standard of communicating with a person's primary health care provider at the point of discharge poses a potential risk to their safety and quality of care. The hospital should ensure that primary health care providers have access to timely and information on their patients who have been transferred or discharged.

Patient predicted date of discharge (PDD) [********]was to be documented and managed throughout a patients stay as part of the SAFER patient care bundle.[††††††††] However, inspectors were informed that this was nurse led one some wards. PDDs observed on some clinical areas visited were not accurate as some PDD had already passed. To be effective the PDD should be identified by the admitting consultant in conjunction with the multidisciplinary team and proactively managed against the patient's treatment plan.

Inspectors were informed that the $ISBAR_3$ communication tool was currently not used for clinical handover. This is an opportunity for improvement and should be progressed by the hospital as part of the implementation of the clinical handover policy to ensure that interdepartmental and shift handover are conducted using the $ISBAR_3$ communication tool as a structured framework in line with national guidance

Clinical handover policy

The risk to patient safety due to ineffective handover or poor communication leading to missed care opportunities and possible poor patient outcomes was highlighted as a high-rated risk on the hospital's risk register. The action to mitigate and reduce this risk included the implementation of the Clinical Handover Policy hospital wide. The implementation of the Clinical Handover Policy was a long standing item on the minutes of HEB meeting minutes reviewed on the last inspection in November 2022 and had been highlighted by HIQA as an issue that should be addressed as a matter of priority. The Clinical Handover Policy had been approved for use at the hospital. At the time of this inspection, there was still work in progress to fully implement the hospital's Clinical Handover Policy. An LUH Clinical Handover Working group had been set up, as part of the LUH Change Plan Implementation Group, to develop a Clinical Handover Policy implementation and audit framework. Oversight was provided by the Steering Committee chaired by the Saolta CEO. At the time of inspection, the Clinical Handover Policy was being updated by this group, to reference Saolta and national policy for clinical handover,

[********] PDD should be based on the anticipated time needed for diagnosis and treatment to be carried out and for the service user to be clinically stable and fit for discharge

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

and was in the final stages of review. The hospital needs to progress the full implementation and monitoring of the Clinical Handover Policy as a priority following this inspection.

Policies, procedures and guidelines

The hospital had a suite of policies, procedures, protocols and guidelines. However, some of the documents reviewed by inspectors relevant to the focus of this inspection were overdue for review and infection prevention and control guidelines submitted to HQA still referenced outdated national guidance. The hospital should ensure that all policies, procedure and guideline are up to date and in line with current national guidance.

Overall, on the day of inspection HIQA was not fully assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm. Prolonged waiting times in the emergency department are associated with increased frequency of exposure to error, increased inpatients length of stay and increased morbidity and mortality.

HIQA was not fully satisfied that the hospital had systems in place to identify and manage potential risk of harm for patients at the hospital. The clinical handover policy was still not fully implemented although a plan was now in place, the management need to ensure that it is implemented and monitored to ensure change is effective to reduce clinical handover risks at the hospital. There were potential risks to patient safety created by the lack of a clinical pharmacy services for the peri-operative areas and some medical areas and non-compliance with CPE surveillance testing. The use of $ISBAR_3$ for transitions of care should be introduced in line with national guidance.

Judgment: Partially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines.

Management of patient safety incidents

Patient-safety incidents were reported directly to the National Incident Management System (NIMS),[‡‡‡‡‡‡‡‡] in line with the HSE's incident management framework.

[‡‡‡‡‡‡‡‡] 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).

Incidents were tracked and trended by the QPS department and discussed at the QPS Committee meetings. Serious reportable event were reported and monitored by the QPS Committee.

Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported. Inspectors were informed that the area ADON and CNM discussed and reviewed patient-safety incidents at ward level and incidents and risks were discussed at 'Safety Briefs' held each morning on the wards. Inspectors were provided with an example of a quality improvement that had been put in place following a recent patient safety incident, which included distribution of 'medication safety moments§§§§§§§§' to share learning.

Medication patient-safety incidents were reviewed by the medication safety officer and the QPS manager and presented and reviewed at the Drugs and Therapeutics Committee meetings. In 2023 year to date, the hospital had 318 reported medication patient-safety incidents, none of these incidents were a major incident. Learning was shared through 'take a minute' posters developed by pharmacist and distributed to wards.

Serious incidents

Serious incidents were managed through the local incident management forum and referred and discussed at the Saolta University Health Care Group Serious Incident Management Team (SIMT). The hospital currently had a number of serious incident reviews in progress which were monitored though the SIMT. Recommendations from serious incidents were tracked and managed by the QPS department with oversight by the QPS Committee.

Metrics

The hospital monitored compliance against national metrics which were reviewed and monitored by the QPS Committee. In the most recent QPS report submitted to HIQA:

- 29% of reviews were completed within 125 days of category 1 incidents from the date the service was notified of the incident significantly below the national target of 70%
- 100% of reported incidents were entered onto NIMS within 30 days of notification of the incident compliant with the national target of 70%
- less than 1% of all incidents reported were extreme and major incidents which was compliant with the national target.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, particularly in relation to the four key areas of harm that were the focus of this inspection. There was evidence that the relevant governance committee and the QPS Committee had oversight of the management of

§§§§§§§§ Medication safety moments are short medication safety messages which can be read quickly by staff to share learning.

these incidents. The QPS Committee and Group SIMT had oversight of serious incidents and reportable events. However, there were still opportunities for improvement in the timely resolution of complaints with only 29% of reviews completed within the national target of 70% at the time of inspection.

Judgment: Partially compliant

Conclusion

HIQA carried out an unannounced inspection of Letterkenny University Hospital to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

The hospital had formalised corporate and clinical governance arrangements in place, attendance at meetings remains low relative to the membership outlined in terms of reference of some committees

The hospital had defined management arrangements in place to manage and oversee the delivery of care at the hospital. However, there were still long waits in ED for reviews and inpatient beds and conversion rates were high in comparisons to other hospitals. Targets such as PETs and ambulance turnaround time require more improvements. Areas for improvements highlighted through the ED Quality Improvement Plan need to be supported to make meaningful and sustainable improvements within the ED.

The hospital management implemented a range of measures on a daily basis to improve the patient flow through the hospital and on to the community. However, on the day of inspection these arrangements were not effective or functioning as intended, resulting in non-compliance with emergency department PETs and increased delayed transfer of care. The hospital needs to ensure that the recommendations from the Bed Utilisation Study are implemented.

HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. The staffing levels in nursing, pharmacy and antimicrobial stewardship had improved since previous inspection. Attendance at and uptake of mandatory and essential training still required improvement, especially training on transmission based precautions, basic life support and the Irish National and Paediatric Early Warning Systems.

Quality and Safety

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. There were risk management structures in place and monitoring and analyses of patient-safety incidents, complaints and performance data. Examples were provided where this information had been used to improve the quality and safety of services. Quality improvement initiatives were implemented in response to audit findings, patient safety incidents and feedback from people using the service

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. The number of admitted patients accommodated in the ED was improved during this inspection and patients were accommodated in single cubicles. However, while patient are accommodated on corridors of wards their dignity and privacy and confidentially is compromised. The hospital staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

While the hospital was endeavouring to manage complaints in a timely manner, the hospitals response times still exceeded required timelines. The contribution of the PALS had been beneficial in supporting patients and managing their complaints. The hospital should seek to recommence this service if possible.

The physical environment of clinical area visited on the day of inspection supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care.

The hospital were monitoring performance against key performance indicators in relation to the infection prevention and control and the deteriorating patient, but there was opportunity for improvement in the monitoring and evaluation of services especially in relation to medication safety and transitions of care. Healthcare practices should be monitored and audited regularly, with oversight by relevant governing structures to assure senior managers that any necessary continuous quality improvements are put in place.

HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents including serious incidents, particularly in relation to the four key areas of harm that were the focus of this inspection. There was evidence that the relevant governance committees had oversight of the management of these incidents. However, there were still opportunities for improvement in the timely resolution of complaints to be compliant with national targets.

At the time of inspection, the hospital continued to have an additional support in place from Saolta in the form of a Change Plan Implementation Manager to lead, co-ordinate, monitor and oversee the Change Plan at the hospital. A HSE Support Team commissioned by the Saolta Chief Operations Officer were also about to commence in the hospital, for seven weeks, to identify how improvements in LUH could be enabled. The benefits and

the gains from the input of these supports would take time to be realised. And ultimately, the impact of these supports would only be fully measurable when the hospital management are functioning effectively without such supports, and the planned changes were embedded within the organisation with local ownership.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity will continue to monitor the progress in relation to areas for improvement highlighted throughout this report.

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	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
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	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
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.	Partially compliant

Appendix 2 Letterkenny University Hospital Compliance Plan

Compliance Plan Service Provider's Response

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

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

Rate of admission of patients to inpatient ward

The HIQA inspection on the 7th and 8th of November 2023 noted the high conversion rate for the LUH Emergency Department (ie. the rate of admissions of patients from the ED to an inpatient ward). Throughout 2023 LUH has been engaged in a number of initiatives to improve the performance of our emergency patient service and flow. A number of the initiatives within this process came into effect when the second half of 2023 including a new Paediatric Emergency Pathway (September 23) and a new electronic triage system (08th January 2024). In addition to these initiatives a number of patient pathways have been introduced within the Emergency Department at LUH as outlined elsewhere in the HIQA report. The cumulative impact of these initiatives along with improved data collection have both reduced the number of patients required to be admitted and also ensured a more accurate recording of inpatient admission data. As a consequence we have seen the conversion rate for LUH reduced for the months of January 23 to Mid- March 24 are as follows:

- 2023 Summary Conversion rate 36%
- January 2024 Conversion rate 33%
- Mid- March 2024 Conversion rate 31%

Work is ongoing to further understand the dynamic underlying Emergency Admissions at LUH addressing factors such as the age profile of presentations to the Emergency Department, the acuity of these presentations, high levels of chronic illness in Donegal compared with the national average.

Delayed discharges:

There is a daily focus on delayed transfers of care with two updated reports at 08.00 hours and 14.00hours. There is a daily update at the Safety Flow Navigational Meeting each

week day at 11.00 hours. The Integrated Discharge Manager in CHO 1 is onsite 4 days per week to assist with any issues in the transfer of patients to community hospital beds. There is an increase to the Discharge Liaison Team with 3 CNM 2s and a staff nurse to support the service. There is an Integrated Discharge Round every Tuesday to include Public Health Nurse, Community Intervention Team, Home Care Package Co-ordinator, Discharge Liaison CNM, Palliative Care Liaison and the Integrated Discharge Liaison Manager. There is a Complex Discharge meeting every Thursday to discuss ongoing complex cases with community to include Physical and Sensory Services, Disability Services and Social Worker. There are weekly reports produced that focus on 14 day> length of stay to ensure patients are being followed up with any outstanding issues/diagnostics being addressed.

PET times KPI

The Median PET in LUH ED was as follows;

- 2022 235 minutes (3.9 hrs)
- 2023 355 minutes (5.9 hrs)

This increase in PET time reflects the pressures resulting from increased ED attendances at LUH. Building on work commenced in mid 2023, a Rapid Assessment process has been introduced, new clinical pathways agreed between Emergency Medicine and Specialty Medical and Surgical teams. A Rapid Assessment and Treatment ANP has been recommended, and we are currently seeking to progress their appointment in the context of the HSE recruitment controls. The AMAU has also been reinstated from 08th January 2024. All these measures are targeted to improve patient flow within the Emergency Department and reduce Patient Experience Time.

Ambulance turn around times

QPS are engaged with NAS in relation to reporting of breaches turn around times KPI. A SOP for reporting and action is being developed between NAS and LUH. Reflecting the ongoing work to improve Ambulance TAT LUH had reduced the number of ambulances delayed in excess of 6 hours to 4 for the period of 06 Nov 2023 to 19 Feb 2024 which compares favourably with the 95 delayed over 6 hours for the same period in the previous year.

Opportunity to increase AMAU referrals in line with Operational Policy.

The standards for Acute Medical Units in Ireland for a Model 3 hospital are as follows:

- An AMAU will see GP referred patients with the entire spectrum of acute medical conditions, some of whom may require urgent medical care.
- It will have assessment trolleys / chairs in a defined area, ideally located beside the ED preferably in an acute floor configuration.
- The National Early Warning System should be used for all registered patients

- Admissions from the AMAU will be to in-patient beds including specialist units (e.g. CCU, ICU, HDU, acute stroke unit). Patients who require level 3 or 3S ICU support will have guaranteed transfer to a model 4 hospital.
- A decision regarding discharge/admission should be made within 6 hours and will be facilitated by dedicated radiology, laboratory and other services, including nursing, therapy professionals and medical social workers.
- In the event of discharge, the relevant GP will be informed (on the same day) of the decision together with all relevant clinical details and care plans.
- The unit should not serve as a location for scheduled day case treatments or for outpatient appointments.
- Ambulatory care services, supported by the range of nursing, diagnostic and therapy services may be available within the space available, or in an easily accessible area close by.
- Every AMAU should have a designated lead consultant physician, clinical nurse manager and therapy lead.

In LUH our AMAU is a designated unit adjacent to the Emergency Department with 11 designated assessment trollies (including 1 PPVL isolation room and a second single room) for the assessment and treatment of patients presenting to Letterkenny University Hospital Emergency Department with acute medical needs. The primary function is the immediate and early specialist management of adult patients (ie. aged 16 and older) with a wide range of medical conditions. Its aim is to provide rapid assessment, diagnosis and commencement of appropriate treatment, to avoid medical admissions.

The AMAU Standard Operational Policy was reviewed (led by the Associate Clinical Director: Medicine) and updated on the 24th January 2024. The new SOP has widened the range of conditions deemed appropriate for the AMAU pathway.

The AMAU falls under the governance of Associate Clinical Director, under the structure of the Medical Directorate. In the absence of the AMAU Consultant, the Consultant Physician on call is responsible for the organisation, operation and standards of care provided to patients in the AMAU. The Clinical Nurse Manager (CNM2) for the AMAU is responsible for the day-to-day organisation and delivery of clinical care. He/She is accountable to the CNM III in the Emergency Dept.

The AMAU operational hours are from 10am- 6pm Monday to Friday with the time of last referral accepted at 5pm. The AMAU accepts all GP referred medical patients over the age of 16 who have been triaged as P3, P4 and P5. P2 patients are also accepted if deemed appropriate by the Consultant in Emergency Medicine.

The patients who have been identified as not requiring inpatient admission may be asked to return for further assessment or treatment. The following are pathways for AMAU patients who do not require inpatient admission:

- First pathway is that patient will return to the AMAU Clinic (AMAU Consultant led once a week in AMAU) after necessary investigations completed. Further decisions on their care will be made by the AMAU Consultant.
- Second pathway is that the patient will be discharged to GP care with appropriate documentations and recommendations.
- Third pathway is that the patient will be referred to the Specialist clinic after necessary investigations done/arranged.

This is supported locally with a written standard operating procedure for AMAU that has been developed.

Status of the implementation of the recommendations of the Bed Utilisation Survey

Following the Bed Utilisation survey undertaken in 2022, a total of 20 recommendations were developed. A total of 13 have been fully implemented or closed:

- Post-take medical redistribution has been implemented from the 19th February 2024, supported by a morning handover meeting.
- Roles and responsibilities of the Patient Flow Co-Ordinators have been updated in conjunction with the Rapid improvement Event undertaken at LUH between December 2023 and March 2024.
- The Discharge Liaison Team has been enhanced with 3 CNM2s in post supported by a staff nurse.
- Discharge planning at ward level has been further developed to focus on discharge planning from patient admission. Measures adopted include, Predicted Date of Discharge (PDD) signs in place at each bedside and a discharge information leaflet for each patients/family given on admission. New Discharge Information Boards are currently being procured to be located at the entrance of each ward.
- Measures to enhance management of patients in hospital in excess of 14 days for discharge have been implemented, including amalgamation of the Integrated Discharge Round and Multi-disciplinary Team Meetings.
- The Navigational Hub has been relocated and enhanced with visual tracking information displayed and updated every 2 hours. Each ward also has a thermometer gauge integrated with the white board to highlight current escalation level of the hospital and Emergency Department.
- A weekly report on patients awaiting transfer to the Stroke and Medical Rehabilitation Unit is generated and circulated to relevant Consultants, Patient Flow and Service Managers.
- The CNM2 (or CNM1) for the Stroke and Medical Rehabilitation Unit (SMRU) attends the Safety Flow Huddle each morning as per the Bed Utilisation Report recommendation.
- An Infection Prevention and Control Nurse (IPCT) is allocated to the SMRU and link in on a daily basis providing guidance in line with best practice.

- The Safety Flow Huddle has available data on the radiological and cardiology diagnostic demand and agrees escalation plans with the Radiology and Cardiac Investigations Managers who are in attendance at the Safety Flow Huddle.
- A robust pathway is in place for Patients requiring oxygen therapy on discharge. Turnaround time for home delivery is 24/48 hours.
- An SOP has been developed and implemented to improve the efficiency of planning and delivery of the Emergency Theatre List (Dec.2023).
- Following engagement with the National Team supporting the LUH Rapid Improvement Event, a decision was taken (Dec. 2023) not to reinstate the Discharge Lounge (as recommended in the Bed Utilisation Report) but rather to focus on Discharge home by 11am. Ward posters and patient information leaflets have been developed to support this initiative.

with another 7 in progress-

- A project team has been established to enhance clinical documentation within LUH. This Multi-Disciplinary Team is currently developing documentation standards and guidance with a specific focus on inpatient care.
- A plan to deliver specialty based ward cohorting of inpatients is currently being developed in the context of the reintroduction of post-take redistribution of patients. This cohorting is scheduled to be implemented in June 2024.
- Work continues with Consultants and NCHDs to ensure delivery of Predicted Dates of Discharge for all inpatients. Teaching sessions for NCHDs have been introduced on discharge planning (July 2023). A weekly meeting with NCHDs from all medical teams has been established (Dec 2023) to identify patients for discharge including highlighting weekend discharges for the on-call team.
- White boards across the hospital were standardised in 2023 and are now being updated following learning from the Rapid Improvement Event (to be completed May 2024).
- Use of the SAFER bundle is being reviewed following process changes arising from the Rapid Improvement Event, (to be completed May 2024).
- The establishment of weekly specialty MDT meetings is to be reviewed following the development of the cohorting plan and appointment of the new Associate Clinical Director for Medicine.
- A new Consultant Psychiatrist has taken up post and has clinical governance over the Self-Harm Service and is supporting LUH in the management of emergency presentations.

Implementation of actions following Rapid Improvement Event with the HSE support team

In mid-December 2023, LUH engaged with a National Improvement Team to further enhance the patient flow improvements already underway with support from the Saolta Unscheduled Care General Manager. A key focus of this engagement with the National

Team involved a week long Rapid Improvement Event between LUH and CHO1 facilitated by the National Team. Key outputs from this event with a 90 day roll out period included:

- Implementation of visual management and near real time (2 hourly) data.
- Enhanced the new Visual Device including the development of an integrated visual data board.
- Governance, Roles, Responsibilities and Daily Flow Operations have been promoted.
- Develop and circulate communications to support operationalisation of the Navigation Hub.
- Implementation of the Golden Patient initiative: Patients to be identified for discharge prior to 11am each day.
- Implementation of Predicted Discharge Dates and promote Discharge Planning from Admission.
- Increased Awareness and developed and circulated communications to support with discharge before 11am and Golden Patient concept.
- Meeting with NCHD leads regarding education and awareness on discharge processes, discharge before 11am and SAFER bundle. Inclusion of this education and awareness as part of NCHD induction programme.
- Developed NCHD Education programme – Discharge process, discharge before 11am and SAFER flow bundle.
- Ensured Transport for discharged patients is arranged at the earliest opportunity.
- Communication to key stakeholders to ensure nurses are involved on all ward rounds.
- Implementation of Thursday and Friday Clinical and Discharge Meetings. Identification and Handover Documentation developed. Communication campaign to support weekend discharges.
- Re-established protected diagnostic slots and reschedule OPD to facilitate additional inpatient tests.
- Implemented MDT Huddles to focus on discharge planning. Documentation has been developed and circulated to support this.
- Developed a communication campaign to ensure discharge home by 11 is understood by patients and family members.
- Definition and circulation of a clear communication for delayed transfer of care Patients and family members.
- Implemention of a solution to ensure IPMS Data Entry 24/7 in the Emergency Department.
- Implementation of processes to ensure no patients are admitted under Emergency Medicine.
- Linked with HPO to review decision to Admit/Admission Time Input.
- Developed and circulated communications to support Nurse led discharge planning.
- Developed and delivered education and awareness campaign detailing community services for staff and public.
- Implemented clear processes for management of Delayed Transfers of Care.

- Reviewed processes for urgent radiology reporting for GP Diagnostics and implement defined processes.
- Reviewed and updated Community Nursing Unit Admission Policy.
- Implemented weekly team meeting to track and monitor actions against completion plan and KPIs; discuss and agree countermeasures to keep improvement on track.

Timescale: Q2 2024

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

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

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

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

Vacant nursing posts

At as March 2024, LUH has 129 nursing vacancies which are a combination of replacement, maternity leave and sick leave positions. This figure also includes 64 (TBC) nursing posts as per the implementation of the Safer Staffing Framework. LUH has been affected by the recruitment embargo that came into place in November 2023 following memo 054/2023 from Mr. Bernard Gloster, HSE CEO. This was a national directive. However, recent memo from the HSE CEO dated the 28th February 2024 has outlined a number of exemptions for specific cohorts of staff for recruitment. These exemptions include Nursing - ED/Acute Medical Assessment nursing, Critical Care nursing and Midwifery. A derogation process is in place within the Saolta Group whereby requests can be submitted for critical posts only. All vacant positions are required to be reviewed in line with management of WTE approval for the hospital.

Vacant Consultant posts (ED and Radiology)

Vacant ED Consultant Posts.

LUH has approval for 8.0 WTE Emergency Medicine Consultants. As of today's date there are 5 Consultants in Emergency Medicine in post and on the Specialist Register (one of whom is on long term leave). In addition there are 4 fixed term contract Consultants in

post (one of whom is on the Specialist Register). LUH is continuing in its efforts to recruit to those posts not filled permanently Consultants on the Specialist Register.

Vacant Consultant Radiologist Posts

LUH is approved for 7.0 WTE Consultant Radiologists. There are currently 7 WTE Consultant Radiologists in post. Two of these Consultants are permanent appointees and on the Specialist Register. 4 Consultants are in fixed term contract posts (3 of whom are on the Specialist Register), with the fifth a permanent employee seconded from another hospital within the Saolta Group. In addition a further full time Consultant Radiologist (on the Specialist Register) is joining the department on a fixed term contract basis mid-July. All permanent Consultant Radiologist posts have been advertised and there are applicants for the majority of these vacancies. Public Appointments Services are currently in the process of arranging interviews for these posts.

8 locum Consultants not registered on the relevant specialist division of the Irish Medical Council

As noted above there is a very active ongoing recruitment process underway at LUH with interview dates already established for a number of posts or shortly to be established via the PAS. The outcome of these interviews will be the appointment of Consultants on the Specialist Register of the IMC eliminating the need for temporary appointments of Consultants not on the Specialist Register. 10 Consultants currently employed at LUH are not on the specialist register of the IMC. This equates to 12% of our Consultant staff numbers.

In April, this will reduce to 9 Consultants not being on the specialist register of the IMC or 11% of our Consultant staff numbers. As we recruit more permanent consultants (interviews on-going in many specialties) it is expected this number will reduce further, but we do not have start dates for those personnel at present.

There are a number of Consultants currently employed that are going through the Specialist Registration process at the moment either with the IMC.

Absenteeism

Current absence figures for LUH as at January 2024 is 8.76%, which is acknowledged is above national target of 4%. A number of HR Circulars have been issued in relation to Managing Absence and Changes in Public Sick leave scheme. HR Circular 022/2023 provide revisions to the Managing Attendance Policy and HR Circular 024/2023 & 040/2023 are in relation to changes in the Public Service Sick Leave Scheme around provision of TRR. LUH has held information sessions with Heads of Departments in relation to absence management and monitoring and in particular in line with the new changes under the public service sick leave scheme. This process is monitored regularly by the LUH SAP HR team with provision also of weekly reports to line managers. Absentee rates in the hospital

as also monitored as part of HR monthly KPIs with data recorded of return to work interviews.

Clinical pharmacist provision to peri- operative and Women and Childrens

Both our Senior Pharmacists with responsibility for clinical pharmacy service provision to the Women's and Children's directorate and to the Intensive Care Unit are currently off on maternity leave. Despite backfill being approved, no suitable candidates were identified to recruit in these roles. To date, we have not received funding approval to establish any additional roles in the Peri-Operative directorate. Submissions were made for two new posts in this area in June 2023 following HIQA report recommendations, but these posts were rejected due to lack of specified National funding.

Vacant Consultant Microbiologist post

LUH has approval for two Hospital Permanent Consultant Microbiologist and a further (3rd) post shared between CHO 1 and the hospital on a 50/50 split. At present there are two Consultant Microbiologists employed within the hospital, one on a permanent basis and one on a fixed term contract. Both the shared community post and the second hospital post are currently progressing through the recruitment process and scheduled to be advertised shortly by the Public Appointment Service. In the interim as noted above the hospital post is filled with a consultant on a fixed term contract basis. Another candidate has accepted a fixed term contract for the shared community post and we are awaiting confirmation of a start date. All consultants will be / are on Specialist Register.

Uptake of mandatory training (PEWS, BLS, transmission based precautions)

As noted at the HIQA visit a mandatory training working group was set up within Saolta with HR Managers Reps and the Saolta Group Learning and Development Officer. LUH HR are continuing to liaise with line managers as to current processes of recording mandatory training. A template has been devised (attached) with has been sent out to all line managers for completion of staff in their areas. This template has an alert system to monitor training of staff in their areas. Work continues regarding the input of data on this template and this information feeds into a central repository in LUH HR. Data Access Managers have also been assigned to all sites in Saolta for training on running reports from HSE Land.

Timescale: Q4 2024

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

Outline how you are going to improve compliance with this standard. 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

Unfilled PALS post

There is currently a 1 WTE vacant PALS post which we cannot currently recruit into due to the HSE recruitment freeze.

The PALS officer that is in post was on long term sick leave at the time of the HIQA inspection. However, elements of the post were absorbed by the QPS and Consumer Services Department. They are currently on a phased return to work.

Complaints KPI

There is a backlog of complaints that fall outside of the 30 day KPI. This is being monitored on the Complaints Management System and reported to the Quality and Patient Safety Committee and the Hospital Management Team. There are currently significant staff vacancies in the Consumer Services Department due to retirement and long term sick leave. We have been unable to recruit into these posts due to the HSE recruitment freeze. However the Quality and Patient Safety Manager is providing limited cover in addition to her role and has made contact with all the complainants that are awaiting responses. The historical backlog has been addressed and we are currently developing a standard operating procedure to improve KPI compliance to make it more contemporary and user friendly. We have also developed a guideline for clinicians to ensure a good standard of response is given for matters of clinical judgement and this is currently being rolled out nationally by the NCGLT.

Timescale: Q2 2024

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

CPE surveillance

QIPs to address non compliance with CPE admission screening remains in place for some wards but overall hospital compliance has increased to 91 % Q3 23, 88% Q4 23 & 90% Q1 24

Monitoring and evaluation of medication safety practices

We have 1.5 WTE Senior Pharmacists currently working in Medication Safety roles. They are responsible for monitoring medication-related safety incidents in conjunction with the QPS Department, trending these based on various factors and feeding back on an individual basis to healthcare staff involved in these incidents. Incident trending reports are generated on a 3-monthly basis for discussion at the D&T committee, with any notable incidents or emerging trends discussed on a monthly basis as necessary. These trends feed into our prescriber & nursing education sessions, grand rounds presentations and fortnightly "Medication Safety Minute" topics. Horizon scanning for emerging medication safety issues is performed through links with both the Irish & International Medication Safety Networks and regular discussion with colleagues in other hospitals, as well as actioning any recommendations from National Patient Safety Alerts (e.g. hyperkalaemia).

Audit of compliance clinical handover

As part of the ongoing governance improvement project underway between LUH and Saolta the Clinical Handover policy at the hospital was reviewed and updated. The new Clinical Handover policy has recently been approved by the LUH Hospital Management Team and is currently in the process of implementation. An audit tool has been developed and forms part of the implementation. It is planned to audit this policy in June and September 2024. We are currently rolling out the National Healthcare Communication Programme which includes training on effective clinical handover.

Timescale:Q3 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

ED KPI compliance (PET times)

See standard 5.5

Patient aware of how to make a complaint

There is significant signage erected throughout the hospital site in relation to how patients can make a complaint. The Quality and Patient Safety Department collect and analyse service user feedback every month in the form of patient questionnaires. The Quality and Patient Safety Department launched the bedside Patient Safety bedside poster in September 2023. To improve patient engagement and to empower and engage with patients to improve safety, the Quality and Patient Safety Department have launched the Quality and Patient Safety bedside poster. The aim is to give patients relevant information to empower and enable to them to be active participants in their care. The information includes themes such as falls prevention, pressure ulcer prevention, infection prevention and control advice, smoking cessation advice, medication safety advice, discharge planning and safekeeping of property. The themes were identified from an aggregate analysis of the most commonly reported patient safety incidents. There is also an invitation to complete the patient feedback questionnaire and how to submit a complaint. There is a QR code on the poster for the "Your Service- Your Say" portal if patients wish to feedback through that route. It also extends an invitation to join the Patient and family experience group and how patients can join the group.

Delayed transfers of care

See above response in standard 5.5

Track and trace system for pharmacy blood derived products

There is no update on this. Genuine traceability required development and implementation of a bespoke digital solution that is beyond the scope of LUH. It has been referred on to Saolta for discussion at the Regional Drugs and Therapeutics Committee.

Medication information at the point of of medicine preparation

We are currently engaging with the Pharmacy dept. in GUH in an effort to adapt their "MedInfo Galway" intranet page for local use. This would allow us to tailor the information available to nursing & medical staff on the wards so as to provide locally approved guidance at the point of prescribing and administration.

Discharge letters done at point of discharge

PDDs not accurate and nurse led- needs consultant input and proactive management

- A Standard Operating Procedure for developing PDDs has been developed and is in use.
- Regular reminders are sent to the Consultants and their Teams regarding the documentation of PDDs for each patient.
- All CNMs are actively encouraged to document PDDs if not readily available from the Medical/Surgical teams.
- All patients have the PDD documented on the White Boards at their bedside as part of the SAFER Bundle rollout.
- There is signage at every bedside to highlight PDD for every patient.
- Education sessions are given by patient flow and the Discharge Liaison Teams to new NCHDs and Staff Nurses on the importance of PDDS for every patient.
- As part of Discharge Information patients are encouraged to ask for their PDD if not already discussed.

Clinical pharmacy services

Through a number of recent successful recruitment campaigns, we were able to fill a number of long-standing vacancies across Pharmacy services, including clinical pharmacy service provision. We had reached a stage where clinical pharmacy services were being provided to every medical ward in LUH as well as filling speciality posts in Palliative Care, Antimicrobial Stewardship, Oral SACT and Aseptic Services. Due to resignations and maternity leaves, we have a number of unfilled vacancies currently, but we are still providing clinical pharmacy service to: Medical 2,3,4,5 & 6; Surgical 1; Acute Stroke Unit; Emergency Dept & Haematology/Oncology. We continue to resource our Dispensary to address medication queries from all other areas of the hospital in the absence of dedicated clinical pharmacy service provision.

CPE surveillance testing

QIPs to address non-compliance with CPE admission screening remains in place for some wards but overall hospital compliance has increased to 91 % Q3 23, 88% Q4 23 & 90% Q1 24.

Timescale:Q3 2024

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

Outline how you are going to improve compliance with this standard. 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

Serious Incidents KPI 125 days

All incidents are reported directly to NIMS at source improving the timelines for reporting of all patient safety incidents. Category 1 Incidents and Serious reportable events (SRE's) are all reviewed in addition to some category 2 incidents with the support of the Quality and Patient Safety Team. All of these reviews are discussed at the monthly Local incident Management Team and recommendations made. Reviews are also presented at the Saolta Serious Incident Management Team. There were a total of 47 Category 1 incidents and SRE's reported to NIMS in 2023 and the first 2 months of 2024. 34 of these have been closed within the 125 day KPI timeframe. Over 100 incident reviews of various levels of complexity were undertaken in 2023 with 1 WTE QPS Manager (with oversight in other area) and 0.8 CNM resource in QPS that is dedicated to incident management. There is a 1WTE Grade 7 vacant post that we cannot recruit into due to the HSE recruitment freeze. LUH will continue to pursue approval to recruit to this post.

Timescale: Q2 2024 and continuing