Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	University Hospital Kerry
Address of healthcare service:	Rathass Tralee Co. Kerry V92 NX94
Type of inspection:	Unannounced
Date of inspection:	23 and 24 January 2024
Healthcare Service ID:	OSV-0001036
Fieldwork ID:	NS_0067

About the healthcare service

Model of Hospital and Profile

University Hospital Kerry is a model 3* acute teaching hospital providing healthcare services for the population of Kerry and surrounding geographic areas. It is a Health Service Executive (HSE) funded hospital managed by the South/South West Hospital Group (SSWHG).† The hospital provides a range of healthcare and maternity services and care for adults and children, these include:

- acute medical inpatient services
- elective surgery
- emergency care
- critical care
- coronary care
- orthopaedic services
- maternity care
- paediatric and neonatal care
- mental health services
- diagnostic services.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	254 inpatient and day case beds

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

† At the time of the inspection, the South/South West Hospital Group comprised ten hospitals — Cork University Hospital, Cork University Maternity Hospital, University Hospital Waterford, University Hospital Kerry, Mercy University Hospital, Tipperary University Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital, Mallow General Hospital and Kilcreene Regional Orthopaedic Hospital. The hospital group's academic partner is University College Cork.

How we inspect

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

To prepare for this inspection, the inspectors‡ reviewed relevant information, which included previous inspection findings, information submitted by the hospital and SSWHG, unsolicited information§ and other publicly available information.

During the inspection, the inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in University Hospital Kerry. It outlines whether there is appropriate oversight and assurance arrangements in place at the

‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.
§ Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

hospital and how people who work in the service are managed and supported to ensure the delivery of high-quality care.

2. Quality and safety of the service

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

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how University Hospital Kerry performed has been made under each of the 11 national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national standards. These are defined as follows:

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
23 January 2024	09.00 to 18.15hrs	Denise Lawler	Lead
24 January 2024	09.00 to 16.00hrs	Geraldine Ryan	Support
		Danielle Bracken	Support

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused on four key areas of known harm, these were:

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

The inspection team visited the following three clinical areas:

- Emergency department, which included the Acute Medical Assessment Unit (AMAU)
- Sceilig Ward
- Rathass Ward.

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

- Representatives of the hospital's Executive Management Board:
  - General Manager
  - Operations Manager
  - Director of Nursing (DON)
  - Director of Midwifery (DOM)
  - Clinical Director
- Representatives for the non-consultant hospital doctors (NCHDs)
- Human Resource Manager
- Assistant Director of Nursing (ADON) for patient flow
- Clinical Nurse Manager grade 3 (CNM 3) for patient flow

[**] 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.

- Complaints Coordinator
- Interim Risk Manager
- Members from the Programme GRO UHK Implementation Team
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control Committee
  - Drug and Therapeutics Committee
  - Deteriorating Patient Committee.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of receiving care in University Hospital Kerry.

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

Over the course of the inspection, the inspectors visited the emergency department, AMAU, Sceilig Ward and Rathass Ward. The emergency department was the only point of entry into the hospital for patients requiring unscheduled or emergency care. It provided undifferentiated care for adults and children 24/7. The department had a total planned capacity of 12 bays comprising a triage room, a three-bedded resuscitation area for the treatment of patients categorised as major and nine single self-contained cubicles. The paediatric emergency medicine area comprised four single assessment bays and a waiting area. There was audiovisual separation between the adult and children's emergency medicine area. Attendees to the emergency department presented by ambulance, were referred directly by their general practitioner (GP) or self-referred. Over the course of this inspection, the emergency department was busy, relative to its intended capacity. Ten (16%) of the 61 patients registered in the emergency department at 11.00am on the first day of inspection were accommodated on additional trolleys or chairs situated throughout the department.

Sceilig Ward was a large 28-bedded general medicine ward comprising three six-bedded multi-occupancy rooms, a three-bedded multi-occupancy room, a four-bedded multi-occupancy room and three single rooms. All patient rooms had en-suite bathroom facilities. The ward accommodated male and female medical patients. At the time of inspection, 27 of the 28 beds were occupied.

Rathass Ward was a large 30-bedded orthopaedic ward comprising six four-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and three single rooms. All patient rooms had en-suite bathroom facilities. The clinical area accommodated male and female patients. At the time of inspection, all 30 beds were occupied.

Inspectors spoke with a number of patients to ascertain their experiences of receiving care in University Hospital Kerry. Patients' experiences were generally very good. Patients were very complimentary about the staff, the care received and food provided during their hospital stay. Patients described the staff as '*lovely*', '*kind*', '*attentive*' and '*very good*'. Patients described how they '*got help to mobilise when needed*' and how '*staff always answered the call bells*'. University Hospital Kerry was described as a '*great hospital*'.

When asked what was good about the service or care received, some patients responded by saying '*you could not ask for better care*', that '*this place [hospital] is a gift*' and described how they felt '*well looked after*'. Similar to previous inspection findings, patients identified how the sharing of information regarding their ongoing plan of care could be an area of focused improvement.

Patients who spoke with inspectors received information about the hospital's complaints process. Inspectors observed patient information leaflets about the HSE's complaints process '*Your Service, Your Say*' displayed in the clinical areas visited. Information about independent advocacy services was also displayed. Overall, patients were very complimentary about the staff and of the care received in the hospital and this was consistent with what inspectors observed over the course of the inspection.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. University Hospital Kerry was found to be partially complaint with three national standards (5.2, 5.5 and 5.8) and non-complaint with one national standard (6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

Through discussions with staff and senior management at University Hospital Kerry, it was evident that at the time of inspection, the governance arrangements at the hospital were being reformed and rationalised. This followed the review of the hospital's operational effectiveness carried out in 2022 by a HSE review team and the findings from HIQA's inspection in 2022. After the HSE review and HIQA's inspection, hospital management commissioned a third party agency to review, improve and transform the hospital's governance structures. This resulted in the development of the Programme Growth, Rejuvenating, Optimising (GRO) UHK.[§§] This programme set out the actions across a number

[§§] Programme GRO UHK incorporates a wide range of improvement and transformation projects categorised according to the following seven themes introduced by the HSE Review Team in 2022: (1)

of themes to improve the clinical and corporate governance, and operational effectiveness and efficiency of University Hospital Kerry. At the time of this inspection, the governance and clinical leadership structures detailed in Programme GRO UHK were being implemented but inspectors were told that the process was significantly impacted by the staff resourcing issues incurred by the HSE recruitment embargo introduced in 2023. Inspectors found that while there was a clear governance structure in place, this was not as effective as it could be. Oversight of the hospital's quality and patient function, needed to be enhanced and strengthened. While there were defined lines of accountability and responsibilities for assuring the quality and safety of healthcare services, these arrangements were not as effective as they could be in ensuring and assuring the quality and safety of healthcare services and supporting quality improvement.

It was evident to the inspectors that the general manager was the accountable officer with overall responsibility and accountability for the governance of the hospital. The general manager, supported by the executive management board (EMB), had oversight of and responsibility for the quality and safety of the healthcare services. The general manager's reporting arrangements to the Chief Executive Officer (CEO) of the SSWHG were understood and clearly outlined in the organisational organogram reviewed by the inspectors. A clinical director was appointed on a rotational basis to provide clinical oversight and leadership of the clinical services provided at the hospital. The clinical director was a member of the EMB. The DON and DOM were also members of the EMB and were assigned with responsibility for the oversight, organisation and management of nursing and midwifery services. The DON and DOM reported to the hospital's general manager and had a close working relationship with the chief director of nursing and midwifery for the SSWHG.

The key corporate governance structures assigned with the responsibility for ensuring the quality and safety of healthcare services at University Hospital Kerry were the EMB and the Executive Quality, Risk and Patient Safety Committee (EQRPSC). The EMB was responsible for the overall governance of the hospital. The EMB comprised the senior management team and chaired by the general manager, it provided leadership and set the strategic direction for the hospital. The EMB met every two weeks and it was evident from minutes of the EMB meetings reviewed by inspectors, and discussions with staff representatives that the EMB was functioning effectively, in line with its terms of reference. The EMB was not as entwined in the day-to-day operational issues as found in HIQA's previous inspection. There was evidence of devolved accountability and responsibility from the EMB to the operational management team, which was the team assigned with the responsibility for the day-to-day operational management of the hospital. Through formalised arrangements, the operational management team and other governance structures reported to the EMB monthly providing assurances about the quality and safety of healthcare services provided at the hospital.

Values, Culture and Vision, (2) Governance Leadership and Management of Strategic Direction, (3) Clinical Effectiveness, (4) Internal Processes and Operational Effectiveness, (5) Quality, Safety and Risk, and (6) Resources and (7) Radiology.

The multidisciplinary EQRPSC managed the quality and safety of the healthcare services on behalf of the EMB and provided the EMB with assurances on the appropriateness and effectiveness of the clinical services, quality and safety of services, and risk management systems in place in the hospital. Chaired by the clinical director, the EQRPSC met every month, in line with its terms of reference and the chair reported and was accountable to the EMB. While the EQRPSC was functioning, the inspectors found it was not functioning as effectively as it should be. The committee focused mainly on day-to-day operational issues. Furthermore, the inspectors did not find evidence that the quality and safety function at the hospital had been improved and strengthened since HIQA's previous inspection. Hospital management, attributed the lack of progress in this area to the hospital's ongoing challenge in recruiting a quality, risk and patient safety manager. In the months prior to this inspection, the quality and patient safety directorate of SSWHG supported the quality and safety function at University Hospital Kerry. The inspectors were told that this arrangement was not sustainable in the long-term and the person providing that support had returned to their substantive post in the SSWHG. Consequently, the quality and safety function in University Hospital Kerry remains an area in need of focused improvement and strengthening. The EQRPSC devolved assigned responsibilities and functions for the four areas of known harm to the following five committees:

- Infection prevention and control committee (IPCC)
- Drugs and therapeutics committee (DTC)
- Antimicrobial stewardship committee (AMSC)
- Deteriorating patient committee (DPC)
- Integrated Discharge Group.

It was clear from documentation reviewed by inspectors and meetings with relevant staff that there was effective governance and oversight of infection prevention and control practices at the hospital. The well-established multidisciplinary IPCC were responsible for the oversight of the quality and safety of the infection prevention and control practices in University Hospital Kerry. Chaired by the hospital's general manager, membership was appropriate and included members of the hospital's infection prevention and control team, representatives from the EMB, a consultant microbiologist, chief medical scientist and surveillance scientist. The IPCC met every three months, in line with its terms of reference. The IPCC supported and oversaw the implementation of hospital's three-year infection prevention and control strategy and annual work plan. The chair of the IPCC submitted a progress and performance report on the implementation of the work plan to the EQRPSC two times a year.

It was clear from documentation reviewed by inspectors and meetings with relevant staff that there was effective governance and oversight of medication safety, including antimicrobial stewardship at the hospital. Responsible for the governance and oversight of medication safety practices in the hospital was the responsibility of the well-established multidisciplinary DTC. Chaired by a medical consultant, the DTC met every six to eight weeks, in line with its terms of reference. Membership was appropriate and included

members of the EMB, the chief and senior pharmacists, antimicrobial pharmacist and a consultant microbiologist. The DTC approved the hospital's medication safety management plan and monitored progress in implementing the plan. The chair of the DTC submitted a report on the progress in implementing the plan to the EQRPSC every three months.

It was clear from documentation reviewed by inspectors and meetings with relevant staff that there was effective governance and oversight of antimicrobial stewardship at the hospital. The hospital's antimicrobial stewardship programme[***] was implemented by the antimicrobial stewardship team with oversight by the AMSC. The AMSC, chaired by a medical consultant, met every three months, in line with its terms of reference. Membership of the AMSC was appropriate and included members of the EMB, members of the infection and prevention control team, antimicrobial pharmacist and a consultant microbiologist. The chair of the AMSC submitted a progress and performance report to the DTC and IPCC annually.

It was clear from documentation reviewed by inspectors and meetings with relevant staff there was governance and oversight of the hospital's level of compliance with national guidelines on the early warning systems,[†††] sepsis management and resuscitation. This was the one area where the most marked improvement in terms of governance and oversight had occurred since HIQA's previous inspection. Governance and oversight of the systems in place to recognise and manage the deteriorating patient was the responsibility of the DPC. The DPC was chaired by the clinical lead for the hospital's deteriorating patient improvement programme who was a consultant anaesthesiologist. The DPC met every month in line with its terms of reference. The DPC comprised two groups – an executive membership group with representation from the hospital and the SSWHG, and three multiprofessional clinical specialty groups (early warning systems, sepsis and resuscitation groups). Membership of the executive membership group included members of the EMB, an advanced nurse practitioner (ANP) in critical care outreach and a CNM for the deteriorating patient. Each clinical specialty group (early warning systems, sepsis and resuscitation groups) had a defined reporting arrangement to the DPC. The chair of the DPC submitted a progress and performance report on compliance with national guidance on the deteriorating patient to the EQRPSC two times a year.

Since HIQA's last inspection, hospital management had established an Integrated Discharge Group. This governance structure was still embedding and needed to be formalised at the time of inspection. Membership of the group included appropriate representation from University Hospital Kerry, Cork Kerry Community Healthcare and a representative from the SSWHG with responsibility for unscheduled care. The group met every week, in line with its term of reference to review complex discharge cases, patients with delayed transfer of care (DTOC) and issues that impacted on the effective flow of patients in the hospital. Performance data on scheduled and unscheduled care activity and inpatient bed capacity

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

was discussed at meetings of the EMB and reviewed at monthly performance meetings between the hospital and SSWHG. The chair of the Integrated Discharge Group reported to the EMB and CEO of Cork Kerry Community Healthcare.

Similar to findings from HIQA's previous inspection, the governance of clinical services in the hospital remained under the remit of the 12 governance committees, which included the following:

- Medical governance committee
- Perioperative governance committee
- Emergency department governance committee
- Radiology services clinical governance committee.

Some clinical governance committees had a subcommittee, working group or steering committee who focused on a defined clinical area such as stroke, acute medicine or hip fracture. All 12 clinical governance groups reported and were operationally accountable to the EQRPSC. It was clear from documentation reviewed by inspectors and meetings with relevant staff that the clinical governance committees had oversight of the quality and safety of the clinical services in its remit. Hospital management were committed to implementing a new clinical directorate model as set out in Programme GRO UHK. Through this framework, responsibility and accountability for continuously improving the quality and safety of clinical services will be devolved to five clinical directorates – women and infants; perioperative services; medicine and integrated care; diagnostics and paediatrics. Each clinical directorate will comprise a triumvirate[‡‡‡] structure with a clinical director, ADON or clinician and business manager who will form the core management team charged with responsibility to deliver the function and remit of the directorate. The clinical director for each directorate will report to the hospital's executive clinical director.

Overall, the inspectors found some improvement in compliance with this national standard, the corporate and clinical governance structures as set out in Programme GRO UHK was not implemented fully, due as referenced by hospital management, to the staff resourcing issue caused by the HSE's recruitment embargo. Consequently, the expected rationalisation, efficiencies and effectiveness in the governance arrangements had not been realised. The senior management team had been regularised and it was evident there was a good, collaborative working relationship amongst the team who, together with the SSWHG were commitment to implementing the reformed governance and leadership structures. However, further delay in implementing these structures will continue to impact on the effective and efficient governance of healthcare services at the hospital. Hospital management and the SSWHG, with support from the HSE, should continue to progress the implementation of the revised and transformed governance structures set out in Programme GRO UHK.

[‡‡‡] A triumvirate is a group of three different kinds of health professionals – medical, clinical and managerial – to lead and manage the directorate.

Judgment: Partially compliant

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

The inspectors found that University Hospital Kerry had some management arrangements, structures and mechanisms in place to achieve the planned objectives and support the delivery of safe, high-quality and reliable healthcare services. At operational level, the hospital's operational management team met every week to review and support the day-to-day operational management of the hospital. Chaired by the hospital's operations manager, the team reviewed operational issues across the hospital impacting on scheduled and unscheduled care, and support services. Briefings from meetings of the operational management team were presented to the EMB two weekly.

The hospital had a comprehensive three-year infection prevention and control strategy and annual work plan setting out the infection prevention and control objectives and prioritises for the year. The infection prevention and control team were responsible for implementing the work plan. The team submitted a progress report on its implementation to the IPCC every three months and a more detailed, comprehensive performance report was submitted annually to the IPCC.

The hospital's pharmacy service was led by the chief pharmacist. Measures to support medication safety practices at the hospital were set out in the hospital's medication safety strategy, which was approved by the DTC. There was a formalised process to report on the implementation of this strategy to the EQRPSC and EMB.

Since HIQA's last inspection, a deteriorating patient improvement programme, under the clinical leadership of a consultant anaesthesiologist had been implemented across the hospital. An ANP in the critical care outreach team and CNM supported the roll out of the deteriorating patient improvement programme. The critical care outreach team comprised two ANPs worked as part of the multidisciplinary team to identify patients at risk of clinical deterioration and patients with high early warning system scores.

There were management arrangements in place in the hospital to monitor issues that impacted on the effective and safe transitions of care and to respond to the demand for healthcare services. At the time of HIQA's previous inspection in 2022, the hospital did not have a ratified and formalised escalation plan to manage the demand for unscheduled and emergency care, and to ensure all available capacity and options were used. However, since then, hospital management has developed and ratified an escalation policy, which aligned with the HSE's escalation plan. Over the duration of this inspection, the hospital was in red (step 2) escalation and it was evident to inspectors that actions aligned with this level of escalation were being implemented to manage the demand for services. These actions

included ensuring rapid assessment and triage of patients and using the eight-bedded AMAU, as an alternate care pathway from the emergency department. Additionally, the ADON, CNM 3 and CNM 2s for patient flow managed and monitored the operational day-to-day issues that enabled better patient flow. A CNM had oversight of patient flow and patient discharge processes seven days a week (7/7). An integrated discharge team met monthly to review and discuss the discharge processes, issues and challenges to patient discharge. Real-time data was captured on the hospital's comprehensive electronic dashboard and this was used to support patient flow throughout the day.

A number of hospital admission avoidance pathways and measures were used to support efficient patient flow in the hospital. These included:

- Minor injuries and AMAU pathways in the emergency department.
- Frailty Intervention Therapy Team (FITT) pathway.
- Early Supported Discharge.
- Community Intervention Team (CIT).
- Early Supported Discharge.
- Home Support Service for Older People.
- Kerry Integrated Care Programme for Older Persons.

Notwithstanding the processes in place, inefficiencies with egress from the emergency department were evident during this inspection. This manifested in the lodging of admitted patients in the emergency department while waiting for an inpatient bed, non-compliance with the HSE's targets on emergency department patient experience times (PETs) and DTOC. Egress from the emergency department was a high-rated risk recorded on the hospital's corporate risk register. There was evidence that the measures applied to mitigate any risks to patient safety associated with ineffective egress were being implemented. These measures included focusing on the over 75 years of age cohort and ensuring a proactive focus on patient flow daily. However, the numbers of admitted patients (16%) lodging in the emergency department during this inspection would indicate that these measures where not completely adequate. All patients in the emergency department were triaged and prioritised in line with the Manchester Triage System.[§§§] The average waiting time from:

- registration to triage was seven minutes, which was within the 15 minutes recommended by the HSE's emergency medicine programme and was an improvement on the average of 38 minutes found in HIQA's previous inspection
- triage to medical assessment was 28 minutes, which was an improvement on the 41 minutes found in HIQA's previous inspection

[§§§] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

- decision to admit to admission to an inpatient bed in the main hospital was 4 hours and 21 minutes, which was also an improvement on the 14 hours to 95 hours range found during HIQA's previous inspection.

An average of 5% of patients left the hospital's emergency department before completion of care in 2023, which was less than the HSE's target of <6.5% and was comparable to other model 3 hospitals.[****] There was a system in place to follow up patients who left the emergency department prior to completion of treatment. Just over a fifth (21%) of patients were admitted to an inpatient bed from the emergency department, which was comparable to other model 3 hospitals[††††] and 14% of patients were admitted from the hospital's AMAU in 2023. Less than a tenth (8.6%) of ambulances who attended the emergency department had a turnaround time interval of less than 30 minutes in 2023. Over the course of this inspection, there were 22 DTOCs. The average length of stay (ALOS) for medical patients (10 days) and surgical patients (six days) was higher than the corresponding HSE targets of ≤7.0 and ≤5.0 days. Collectively, this would support the assertion that further improvements are needed to improve the efficiency and effectiveness of patient flow within and from the hospital.

In summary, inspectors found there were some improvement in the level of compliance with this national standard. There were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm, but these could be improved and strengthened. There were arrangements in place to manage and oversee the demand for unscheduled care but, as evident by the number of admitted patients lodging in the emergency department, waiting times and DTOC, further improvement was needed to support and enable more efficient and effective patient flow within and from the hospital.

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 inspectors found University Hospital Kerry had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital, but these arrangements were not as effective as they should be. Information on a range of different clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with the HSE's reporting requirements. Collated performance data provided the EMB with

[****] Comparison to Midland Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, Midland Regional Hospital, Mullingar and Portiuncula University Hospital (based on published data in the HSE's performance report, published up to September 2023).
[††††] Comparison with Connolly Hospital, Midland Regional Hospital Mullingar, Sligo University Hospital and Midland Regional Hospital Portlaoise.

assurances about the quality and safety of healthcare services. The performance data was reviewed at two weekly meetings of the EMB and monthly performance meetings between the hospital and SSWHG.

The formalised risk management structures and processes in the hospital aligned with the HSE's risk management framework. These support the proactive identification, analysis, management, monitoring and escalation of identified risks. Since December 2022, the hospital's risk manager position was filled on an interim basis, with the current post holder contracted until May 2024. The interim risk manager also oversaw the management of reported patient safety incidents. The interim risk manager reported to the general manager. Clinical governance committees oversaw the effectiveness of the hospital's risk management processes for the clinical services within their remit. Risks were identified, managed and monitored by the ADONs with support from the risk manager. CNMs were responsible for implementing corrective measures identified to mitigate any actual and potential risks identified in their areas of responsibility. Relevant high rated risks were escalated to senior hospital management and recorded on the hospital's corporate risk register. The EQRPSC and EMB oversaw and managed the risks recorded on the hospital's corporate risk register. The interim risk manager was a member of the EQRPSC and provided verbal updates on the effectiveness of the risk management processes to this committee. The five highest-rated risks and mitigating control measures were reviewed at the monthly performance meeting with the SSWHG.

University Hospital Kerry did not have a clinical audit committee or a coordinated approach to the auditing of clinical practice and processes. Inadequate auditing systems was a high-rated risk recorded on the hospital's corporate risk register. There was evidence that hospital management had applied a number of measures to mitigate any resulting risks to patient safety. These included providing clinical audit training for staff and submitting a business case for a dedicated staff resource to support audit activity at the hospital.

There were systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. The Serious Incident Management Team (SIMT) and medication incident review team (MIRT) were responsible for ensuring that all serious reportable events and serious incidents were reported to the National Incident Management System (NIMS)[‡‡‡‡] and managed in line with the HSE's Incident Management Framework. Serious reportable events and serious incidents were reviewed, tracked and trended by the quality and patient safety department each month. The SIMT, MIRT, EQRPSC and EMB had oversight of the effectiveness of the management of patient safety incidents reported in the hospital. There was a formalised policy in place that standardised the implementation of recommendations arising from completed reviews of patient-safety incidents. It was evident that the shortfall in staffing in the quality and patient safety department had impacted on the timely implementation of review recommendations and hindered the sharing of learning,

[‡‡‡‡] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

which is vital to ensuring quality improvement and preventing reoccurrence of similar incidents.

Findings from National Inpatient Experience Surveys were reviewed at meetings of the EQRPSC and relevant clinical governance committees, with updates to the EMB. Hospital management and the HSE had developed a quality improvement plan in response the findings of the 2022 National Inpatient Experience Survey. The inspectors did not find evidence that the quality improvement initiatives set out in the plan were being implemented at the time of inspection.

Overall, while there were systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services there was limited evidence that the quality and safety function was strengthened since HIQA's last inspection. Consequently, there was no improvement in the level of compliance with this national standard. It was evident from findings of this inspection that the staffing shortfalls in the quality and patient safety department continue to impact on the operational ability to proactively monitor and act on opportunities to continually improve the quality, safety and reliability of healthcare services delivered at the hospital.

Judgment: Partially compliant

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

The inspectors found that the workforce arrangements in place in University Hospital Kerry were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare in the emergency department and wider hospital. Five high-rated risks related to staffing were recorded on the hospital's corporate risk register and staffing was a standing agenda item for the monthly performance meeting with the SSWHG.

At the time of inspection, 60 whole-time equivalent (WTE) [§§§§] (94%) of the 64 WTE funded medical consultant positions across a range of specialties were filled. All permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Medical consultants were supported by 175 WTE NCHDs at registrar, senior house officer (SHO) and intern grades providing medical cover across the hospital 24/7. Seven (4%) of the 175 WTE NCHD positions (registrar grade) were unfilled at the time of inspection.

The hospital was approved for 9.4 WTE pharmacists and 7.4 WTE pharmacy technicians. At the time of inspection, 21% of pharmacist's positions and 24% of the pharmacy technician's positions were unfilled. The pharmacy staff shortfall impacted on the ability to provide a

[§§§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

comprehensive clinical pharmacy service[*****] across the hospital. The risks associated with pharmacy staffing shortfall were escalated to the DTC and recorded as a high-rated risk on the hospital's corporate risk register.

The infection prevention and control team comprised one WTE consultant microbiologist, one WTE surveillance scientist, two WTE antimicrobial pharmacists, 0.5 WTE surgical site scientist, one WTE ADON and one WTE CNM 3. The hospital had approval for two WTE consultant microbiologists. At the time of inspection, only one of the two consultant microbiologist's positions was filled on a locum basis, and the consultant microbiologist was not on site in the hospital. This arrangement was an area of concern raised by HIQA previously. The inability to successfully fill the microbiologist's positions permanently continues to impact on the accreditation of the hospital's microbiology laboratory. There were arrangements in place to ensure appropriate consultant microbiology support, but the workaround of remote support was not sustainable in the long-term.

Similar to other hospitals inspected to date by HIQA, University Hospital Kerry experienced challenges in recruiting to and filling health and social care professionals, especially physiotherapists and medical social workers. At the time of inspection:

- 29.13 WTE (73%) of the funded 40 WTE physiotherapist's positions were filled
- 1.5 WTE (43%) of the funded 3.5 WTE medical social worker's positions were filled
- 10.54 WTE (70%) of the funded 15 WTE occupational therapist's positions were filled.

Medical workforce in the emergency department

Similar to HIQA's previous inspection findings, medical staffing levels in the emergency department were not maintained at levels to support the provision of 24/7 emergency care. The hospital was approved for five WTE consultants in emergency medicine. Three of the five WTE consultants in emergency medicine positions were filled permanently. A business case for a sixth consultant in emergency medicine was submitted to the SSWHG. A senior clinical decision-maker[†††††] at consultant level was on site in the emergency department each day during core working hours, but none of the three permanently appointed consultants in emergency medicine participated in an on call rota. Therefore, the inspectors found significant deficits in relation to the clinical governance of the emergency department and supervision of NCHDs working in the department outside core working hours. This was similar to the finding that was escalated to the executive management of the SSWHG following HIQA's previous inspection in 2022. At that time, a quality improvement plan was developed to ensure 24/7 clinical governance of the emergency department. Notwithstanding that, during this inspection, the inspectors found there was no improvement

[*****] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[†††††] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who has undergone appropriate training to make independent decisions around patient admission and discharge.

in the arrangements around consultant in emergency medicine cover and the clinical governance and supervision of NCHDs in the emergency department outside core working hours. This was also a long standing high-rated risk recorded on the hospital's corporate risk register. To mitigate any risk to patient safety, the inspectors were told that there was a work around arrangement in place, whereby NCHDs in the emergency department could refer and seek advice from the specialist consultants on call, but this arrangement was not formalised or sustainable. A consultant was rostered on-call in the specialties of medicine, surgery, obstetrics and gynaecology, orthopaedics and paediatrics. The inspectors' concerns about the consultant in emergency medicine cover outside core working hours were escalated to the executive management team of the SSWHG. The response from the hospital group reiterated the practice recounted to inspectors during inspection and as outlined in this report, no additional measures were introduced to mitigate the actual or potential risks to patient safety arising from the arrangements.

One of the three WTE consultants in emergency medicine was the assigned clinical lead who was responsible for the day-to-day operational functioning of the emergency department. Consultants in the emergency department were operationally accountable and reported to the clinical director. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and remained in the emergency department until an inpatient bed was available. The hospital was not an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. Consultants in the emergency department were supported by 19 WTE non-consultant hospital doctors at registrar and SHO grades — 12 registrars and seven SHOs. All these NCHD positions were filled at the time of inspection.

At the time of inspection, 38.62 WTE (6%) of the funded 649.95 WTE nurses and midwives (inclusive of management and other grades) positions for University Hospital Kerry were unfilled. This represented an improvement on the 15% shortfall reported during HIQA's previous inspection in 2022. The total of 649.95 WTE was inclusive of the additional 166.95 WTE nursing and midwifery staff approved and recruited as a result of the Department of Health's staff staffing frameworks.[‡‡‡‡‡] Shortfalls between the approved and actual nursing staff complement (including management grades) were reported in two of the inpatient clinical areas visited during this inspection. In the emergency department, the reported shortfall in nursing staff was 3.83 WTE (5%), in Rathass Ward it was 1.28 WTE (5%), but there was no shortfall in nursing staff reported in Sceilig Ward.

The delivery of patient care was supported by healthcare and maternity care assistants. At the time of inspection, 9.46 WTE (9%) of the approved 104.14 WTE healthcare and maternity care assistant's positions were unfilled. Hospital management did not measure the proportion of care delayed, unfinished or omitted as a consequence of the reported shortfall

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

in nursing, healthcare and maternity care assistant staff positions. Therefore, it was not possible for hospital management to quantify the specific impact that the reported staffing shortfalls had on care delivered. There was evidence that unfilled positions were staffed through agency staff, staff opting to work extra shifts and through continual, recruitment campaigns.

Nursing workforce in the emergency department

At the time of inspection, 78.69 (5%) WTE of the emergency department's approved 82.52 WTE nursing staff (including management grades) was unfilled. This 82.52 WTE included an uplift of 27.32 WTE since HIQA's previous inspection in 2022. The 5% reported nursing staff shortfall was a significant improvement on the 24% shortfall reported during HIQA's previous inspection. A CNM 3 was rostered on duty in the emergency department Monday to Friday during core working hours. The CNM3 had overall nursing responsibility for the department. A CNM 2 was rostered on each shift (day and night). A CNM 2 was assigned to care for admitted patients lodging in the emergency department while waiting for an inpatient bed in the main hospital.

In addition, as discussed in national standard 5.8, challenges in recruiting a quality and patient safety manager for the hospital and other staffing shortfalls in the quality and patient safety department, impacted on the proactive monitoring and improvement of the healthcare services delivered at the hospital.

The human resource department tracked and reported on staff absenteeism rates and these rates were reviewed at meetings of the EMB and monthly performance meetings with the SSWHG. The hospital's most recent reported absenteeism rates had improved slightly from the 9% reported during HIQA's previous inspection to 4.32% in December 2023 and 7.30% in January 2024 (non COVID-19 6.72%; COVID-19 0.58%). There were processes in place to support and promote a positive culture of staff attendance. Occupational and other support systems were in place to support staff in the delivery of high-quality, safe healthcare. Nevertheless, the hospital's reported absenteeism rates was above the HSE's target of 4% or less so this should be an area of focused improvement following this inspection.

There was no centralised mechanism in the hospital to record and monitor the uptake of staff attendance at mandatory and essential training. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system.[§§§§§] Attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at clinical area level by the clinical skills facilitators and CNMs with oversight by the DON and DOM. Nursing and midwifery staff were required to complete essential and mandatory training in infection prevention and control, medication safety and

[§§§§§] The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

the early warning systems on the HSE's online learning and training portal (HSELanD). Training records reviewed by inspectors showed that the uptake of essential and mandatory training in hand hygiene, transmission and standard-based precautions, early warning systems, basic life support, the Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk (ISBAR3) communication tool,[******] the management of obstetric emergencies[††††††] and interpretation of fetal heart recordings should be an area of focused improvement following this inspection. The training records also showed that the uptake of essential and mandatory training for medical staff – consultants and NCHDs – was sub-optimal and should be an area of focused improvement following this inspection. Midwifery and nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in the hospital.

Overall, while medical, nursing and midwifery staff resourcing had improved in University Hospital Kerry since HIQA's previous inspection, hospital management continued to experience challenges in filling staff positions in the areas of quality and patient safety, and health and social care professionals for example pharmacy staffing, physiotherapist and medical social workers providing front-line care. In addition, despite being raised as a risk during HIQA's previous inspection, there was no improvement in the consultant in emergency medicine cover and the clinical governance and supervision of NCHDs working in the emergency department outside core working hours. There was a work around arrangement, whereby NCHDs in the emergency department could refer and seek advice from the specialist consultants on call, but this arrangement was not formalised or sustainable. Staffing shortfalls in the quality and patient safety department also impacted on the operational ability to proactively monitor, improve and act on opportunities to improve the healthcare services at the hospital. Medical, nursing and midwifery staff uptake of mandatory and essential training is an area that requires substantial improvement.

Judgment: Non-compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. University Hospital Kerry was found to be compliant with one national standard (1.7), substantially compliant with three national standards (1.6, 1.8 and 2.7), partially complaint with two national standards (2.8 and 3.3)

[******] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk (ISBAR3) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.
[††††††] The Practical Obstetric Multi-Professional Training (PROMPT) course is an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies.

and non-complaint with one national standard (3.1) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

It was evident to the inspectors that all staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients and this was consistent with the human rights-based approach to care promoted by HIQA. Staff were committed and dedicated to promoting a person-centred approach to care. Staff were observed being kind and caring. Staff engaged with patients in a respectful, kind, cordial and sensitive way. Staff listened to patients and responded to patient's individual needs in a dignified and respectful manner. Staff also helped patients to mobilise and provided assistance with personal cares. Privacy curtains were used to support privacy while patients received care. A sitting room in one of the clinical areas was used when patients wanted privacy with family members and other visitors. A support person was positioned in the emergency department to assist patients. Patient's privacy and dignity was supported and promoted for those located in individual cubicles in the emergency department. However, despite the efforts of staff, this was not the case for those in multi-occupancy areas, on extra trolleys and chairs. The hospital had 23 single, isolation rooms with en-suite bathroom facilities, which meant that some patients requiring transmission based precautions could be cohorted together in multi-occupancy rooms. In this case, patients used commodes at the bedside and this practice impacted on their privacy and dignity. Staff tried to always care for patients at end of life in a single room. In general, the inspectors observed patients' healthcare records and patients' personal information stored in line with data protection and regulation standards. Where this was not the case, it was brought to the attention of the CNM for immediate remedy.

Judgment: Substantially compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. Inspectors observed staff to be respectful, kind and caring towards patients in the clinical areas visited. This was confirmed by patients who spoke positively about their interactions with staff. A culture of kindness, consideration and respect was promoted through the development of a number of quality improvement initiatives. A number of validated assessment tools were used to assess patient's individual risks and determine specific supports needed in the areas of nutrition and hydration, falls and delirium. Translation services were used to support effective communication with non-English speaking patients. Patient information leaflets with information on a range of health topics were available and accessible. There was no Patient Advice and Liaison Service (PALS) in the hospital, but the UHK Volunteer initiative was

recently reinstated and a patient communications liaison person was available to support patients in the emergency department.

Judgment: Compliant

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

The inspectors found there were systems and processes in place in University Hospital Kerry to respond to complaints and concerns. Since HIQA's last inspection, a complaints coordinator was appointed to support the effective and timely management of complaints and there was a coordinated response to people who made a complaint. Complaints management training was mandatory for all staff. The complaints coordinator had oversight of staff uptake of that training. The general manager was the hospital's designated complaints officer. The HSE's complaints management policy '*Your Service Your Say*' was used. Point of contact complaint resolution was promoted and supported in line with national guidance. Verbal complaints were not recorded at the hospital, which was a missed opportunity. Hospital management formally reported on the number and type of complaints to the HSE annually. The majority of complaints received in 2023 were resolved within the HSE's 30-day timeframe, this was a significant improvement on previous inspection findings. Complaints were tracked and trended to identify emerging themes, categories and departments involved. The complaints coordinator confirmed that providing feedback from the tracking and trending process and learning from the complaints resolution process were areas of focused improvement for 2024. The complaints coordinator submitted reports on the number and types of complaints received, the timeliness and outcomes of the complaints management process to the EQRPSC and EMB.

It was evident that quality improvement plans were developed to ensure recommendations from the complaints resolution process were implemented. Implementation of these recommendations was monitored by the complaints coordinator, the EQRPSC and EMB. At the time of inspection, twelve of the 14 recommendations arising from the complaints review process were closed and the remaining two recommendations – identify key learnings and disseminate the information on trends and learning to staff were being progressed. Information about the HSE's '*Your Service Your Say*' was displayed in the clinical areas visited. The hospital did not have a dedicated patient advice and liaison service, but hospital management had approval from the SSWHG to implement this service. However, the service could not be introduced because of the HSE recruitment embargo. Patients had access to information on independent advocacy services and staff were aware of these services.

Overall, since HIQA's last inspection, there was a significant improvement in the management and oversight of complaints at the hospital. The majority of complaints and concerns were resolved promptly and efficiently in line with HSE timelines. Hospital management should continue to implement a formal standardised system to facilitate the sharing of learning from the complaints resolution process and progress with the implementation of the dedicated patient advice and liaison service.

Judgment: Substantially compliant

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

During this inspection, the inspectors observed the physical environment in the clinical areas visited was generally well maintained and clean with few exceptions. There was evidence of some general wear and tear with woodwork and paintwork chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk.

Environmental cleaning was carried out by an external contract cleaning company and the process was underpinned by a formalised policy. Cleaning supervisors and CNMs had oversight of the standard of cleaning in their areas of responsibility. Discharge and terminal cleaning[‡‡‡‡‡‡] was carried out by designated cleaning staff. CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place and the timeliness of the maintenance service during and outside core working hours. Patient equipment was observed to be generally clean in all clinical areas visited. Cleaning of patient equipment was assigned to healthcare assistants and there was a system in place to identity cleaned equipment. Environmental and patient equipment audits were carried out frequently and these are discussed further under national standard 2.8. Hazardous material and waste was safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Hand hygiene sinks throughout the hospital conformed to requirements.[§§§§§§] There was a formalised process in place to ensure appropriate placement of patients requiring transmission-based precautions. This process was overseen by the infection prevention and control team. Hospital management expressed how the 23 single, isolation rooms with en-suite bathroom facilities were insufficient for a model 3 hospital. This was a high-rated risk recorded on the hospital's corporate risk register and control measures were being applied to reduce the actual and potential risks to patients. A capital development project approved for the hospital will, when completed result in 120 single

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

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

rooms – 80 replacement beds and 40 new beds – at the hospital. Signage in relation to the correct and appropriate use of transmission-based precautions was displayed. Personal protective equipment (PPE) was available outside single, isolation rooms and multi-occupancy rooms where patients requiring transmission-based precautions were cohorted. Staff were also observed wearing PPE appropriately and correctly, in line with public health guidelines at the time of inspection. Adequate physical spacing was maintained between beds in multi-occupancy rooms in the inpatient clinical areas. While supplies and equipment were stored adequately and appropriately, adequate storage facilities was an issue in some clinical areas visited.

In summary, at the time of inspection, the physical environment and patient equipment was observed to be generally clean and well maintained. The physical environment mostly supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care in the hospital. The number of single, isolation rooms with en-suite bathroom facilities was inadequate for the number of patients receiving care at the hospital.

Judgment: Substantially compliant

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

The inspectors found that there were systems and processes in place at University Hospital Kerry to monitor, analyse, evaluate and respond to information from a variety of sources. These included key performance indicators (KPIs), findings from audit activity, risk assessments, patient-safety incident reviews, complaints and patient experience surveys and their families. It was evident that hospital management used this information to compare and benchmark the quality of their healthcare services with other similar hospitals in and outside the SSWHG, and to support the continuous improvement of healthcare services provided in the hospital. However, the inspectors found these processes were not as effective and efficient as they should be.

The IPCC had oversight of and actively monitored the effectiveness of infection prevention and control practices in the hospital. The infection prevention and control team collated infection prevention and control surveillance data and submitted a comprehensive report to the IPCC every three months. Every month, as per the HSE's requirements, hospital management reported on rates of *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections, hospital-acquired COVID-19 and outbreaks.

Environment, patient equipment and hand hygiene audits were undertaken by CNMs and the quality coordinator for hygiene services using a standardised approach. In the months preceding HIQA's inspection, compliance rates with environmental and patient equipment hygiene practices ranged from 76.9% (AMAU) to 91.7% (emergency department). There was evidence that time-bound action plans were developed when hygiene standards fell

below expected standards (85%). Responsibility for the implementation of these action plans lay with the CNMs with oversight by the infection prevention control team. Household staffing shortfalls and the resulting challenges in auditing and maintaining hygiene was a high-rated risk recorded on the hospital's risk register. The actual or potential risks to patients were being managed with appropriate corrective measures with oversight by the IPCC.

Regular hand hygiene audits were carried out across the hospital and in the months preceding HIQA's inspection, the hospital was compliant with the HSE's target of 90%. This was an improvement on the previous inspection findings of 2022. There was also evidence of a high level of compliance with peripheral vascular catheter and urinary catheter care bundles. CPE screens in the range of 281 to 393 were processed monthly in 2023. Screening for CPE was monitored monthly to ensure compliance with national guidance and most clinical areas visited were over 90% compliant.

Medication audits were carried out using a standard approach and audit findings were reported to the DTC. Medication audits carried out in quarter four of 2023, showed a variation in compliance ranging from 58% to 100% with paracetamol use. Audit findings also showed good compliance with best practice standards for medication management (range from 88% to 94%) in the emergency department and Acute Floor. Medication practices were also monitored monthly as part of the nursing and midwifery quality care metrics. Quality improvement initiatives to improve medication safety practices were identified at the end of medication audit reports, but the inspectors did not find any evidence that time-bound action plans were developed to implement these initiatives. This finding was similar to previous inspection findings in 2022 and should be an area of focused improvement following this inspection.

There was evidence that antimicrobial stewardship practices at the hospital were monitored and evaluated. The hospital's findings from the antimicrobial point prevalence survey and audit (December 2023), showed non-compliance with defined targets in a number of areas – documentation of allergies, review/stop dates, indication for treatment and compliance of choice of agent with local policy. Quality improvement initiatives to improve antimicrobial stewardship practices were identified at the end of the survey report, but the inspectors did not find any evidence that time-bound action plans were developed to implement these initiatives.

Compliance with the early warning system escalation and response protocol was audited monthly as part of the nursing and midwifery quality care metrics and compliance rates in the months preceding the inspection varied (range from 72.6% to 86.3%) across the clinical areas visited. Findings from the nursing and midwifery quality care metrics were displayed on quality boards in each clinical area visited. The 'Sepsis 6' care bundle was being implemented across the hospital at the time of inspection. The inspectors did not find any evidence of monitoring of compliance with the national guidance on clinical handover and the use of $ISBAR_3$. National guidelines recommend that compliance with guidance be audited

regularly to ensure continuous quality improvements. This should be an area of focused improvement following this inspection.

The number of new attendances to the hospital's emergency department, PETs, medical and surgical patients ALOS and DTOC were tracked at the hospital in line with the HSE's requirements. Collated data was submitted as part of the daily situational report and reported monthly at meetings of the EMB.

Staff in the clinical areas visited were not aware of the hospital's findings from the 2022 National Inpatient Experience Survey. Hospital management had, with the HSE, developed a quality improvement plan to address the survey findings, but staff could not provide examples of quality improvement measures implemented to improve patient experiences.

Overall, there were some systems in place to monitor and evaluate healthcare services, but similar to previous inspection findings in 2022, the auditing of compliance with national guidance on clinical handover and $ISBAR_3$ should be an area of focused improvement. Full implementation of the 'Sepsis 6' care bundle should be progressed and its use audited. Time-bound, quality improvement plans should be developed, when indicated from audit findings to ensure improvements to services are realised.

Judgment: Partially compliant

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

The inspectors found that there were systems and processes in University Hospital Kerry to identify, evaluate and manage immediate and potential risks to patients, but these were not as robust and effective as they should be. Risks identified at local clinical area level were reported to the interim risk manager, who with the CNMs and ADON assessed and analysed the risk. Control measures were applied to mitigate any potential and actual risk to patient safety. Responsibility for implementing and overseeing the effectiveness of the control measures lay with the CNMs. The interim risk manager, CNMs and ADON reviewed the risks recorded on the risk register and mitigating measures applied quarterly. The interim risk manager was a member of the EQRPSC and provided verbal updates on the active and open risks at meetings of this committee. It was evident that the EMB had oversight of the risks and effectiveness of control measures recorded on the hospital's corporate risk register. Risks were also discussed at the monthly performance meeting with the SSWHG.

There were 31 high-rated risks related to the four areas of harm on the corporate risk register at time of inspection. These included risks related to staff resources across all professionals and services, non-compliance with best practice standards and national guidance, shortfalls in microbiology and intervention radiology services, infrastructure and physical environment, capacity and capability issues and staff training. The inspectors found evidence that mitigation measures were being applied to reduce any actual and potential threats to patients arising from the recorded risks. However, over the course of the two-day

inspection, inspectors identified six potential risks to patient safety that raised concerns. Subsequently, the inspectors requested six risk assessments be completed. These related to the:

- suitability of the emergency department as an area to place a vulnerable patient with complex needs
- consultant staffing and the appropriate clinical governance and supervision of NCHDs in the emergency department outside core working hours
- shortfalls in the hospital's quality and patient safety function
- suitability of one of the overflow corridors for use during times of high demand in the emergency department, specifically the proximity of that corridor from the main emergency department and the lack of suitable facilities and services there
- mixed gender wards
- staff resourcing to support the one to one care for vulnerable patients.

While the completed risk assessments and mitigation measures set out therein provided some assurance that the immediate risks to patient safety arising from the six risks were being managed, the inspectors were concerned that the recognition and identification of risk was not as established or proactive and embedded as in other model 3 hospitals. Furthermore, findings and concerns related to the suitability of the emergency department as a placement for a vulnerable patient with complex needs, consultant staffing in the emergency department outside core working hours and shortfalls in the quality and patient safety function were escalated to the SSWHG so that immediate measures could be implemented to mitigate the actual and potential risk to patients. Subsequent assurances from the SSWHG's executive management team were provided to the inspectors. However, at the time of writing this report, HIQA continue to engage with the SSWHG's executive management team to ensure appropriate arrangements are implemented to support adequate clinical governance and supervision of NCHDs in the emergency department 24/7.

Patients admitted to University Hospital Kerry were screened for multi-drug resistant organisms (MDROs) — *Clostridioides difficile* infection, CPE, *Staphylococcus aureus* blood stream infections, *Vancomycin Resistant Enterococci* (VRE), MRSA and COVID-19. The hospital's information patient management system (iPMS) supported the identification and appropriate management of patients with MDROs by alerting staff to patients who were previously inpatients in the hospital with MDROs. Compliance with MDRO screening was audited by the infection prevention and control team with oversight by the IPCC. Patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. If isolation facilities were not available, suitable patients were cohorted in multi-occupancy rooms. At the time of inspection, there was a CPE outbreak in one clinical area. A multidisciplinary outbreak team was convened to advise and ensure the management of the outbreak aligned with best practice standards and guidance.

A limited clinical pharmacy service was provided at the hospital and pharmacy-led medication reconciliation was not undertaken on all patients. It was carried out for patients in prioritised clinical areas. Medication stock control was carried out by pharmacy technicians every week.

Staff applied risk-reduction strategies with high-risk medicines and this practice was underpinned by a formalised policy. The hospital's list of high-risk medications aligned with the acronym 'A PINCH'[*******] and there was a list of sound-alike look-alike medications (SALADs). Up-to-date prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care in hard copy format and through an application for smart phones. The hospital did not have a quality information management system to support its quality and safety function.

Staff used the most recent version of the national early warning systems for the various cohorts of patients — the Irish National Early Warning System (INEWS), Irish Early Maternity Warning System (IMEWS), Irish Paediatric Early Warning System (IPEWS) and Emergency Medicine Early Warning System (EMEWS) and $ISBAR_3$. Staff in the clinical areas visited were knowledgeable about the INEWS escalation and response protocol and there were effective processes in place to ensure the timely management of patients with a triggering early warning system. The hospital's critical care outreach team were also available to review patients with a triggering early warning system. The inspectors reviewed a sample of healthcare records and found that the INEWS charts were not always calculated correctly and the recording of clinical practice was not always consistent with acceptable standards. These findings were escalated to and discussed with the CNM during inspection.

There were systems and processes in place to support the discharge planning and safe transfer of patients within and from the hospital. Each patient had a planned date of discharge and there was cohorting of specialty, which supported and enabled ward more efficient rounding by medical teams. Daily bed management meetings were held with representatives from the SSWHG to support patient flow though and from the hospital. Weekly meetings were held with representation from the hospital, Cork Kerry Community Healthcare and SSWHG to review complex discharge cases, patients with delayed discharges and patients with lengths of stay over 16 days. The hospital had access to approximately 35 beds in five community hospitals[†††††††] and a private hospital for patients requiring convalescence, transitional and or rehabilitative care. The transfer of patients from hospital to community services was not always supported by the timely issuing of discharge summaries to GPs and primary healthcare services. Clinical handover occurred as per national guidance and the ISBAR format was used.

The overall attendance rate to the hospital's emergency department has increased year on year over the last five years. In 2022, there were 41,682, attendees to the emergency department, which represented a 5% increase on 2019 (39,518) attendances (and a 7.4% increase on the 2021 (36,719) attendances. These attendance rates equated to an average of 3,474 attendees monthly or 114 attendees daily. Attendance numbers to the emergency department had increased by circa 415 attendees monthly and 13 attendees daily since

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

[†††††††] These five hospitals are Killarney Community Hospital, Listowel Community Hospital, Kenmare Community Hospital, Cahersiveen Community Hospital and Dingle Community Hospital.

HIQA's last inspection. The increase in demand for unscheduled care, issues with patient flow as manifested in the 16% of admitted patients lodging in the emergency department while awaiting an inpatient bed in the main hospital contributed to longer PETs for patients receiving care in the emergency department.

Data on the emergency department PETs collected at 11.00am on the first day of inspection, showed that the hospital was non-compliant with the majority of the HSE's targets. At 11.00am:

- 48% of patients in the emergency department were in the department for more than six hours after registration. This was not in line with the HSE's target that 70% of patients be admitted or discharged from the department within six hours of registration, but it represented an increase on the 45% found during HIQA's previous inspection.
- 54% of attendees to the emergency department were in the department for more than nine hours after registration. This was not in line with the HSE's target that 85% of patients be admitted or discharged from the department within nine hours of registration and it represented an increase on the 43% found during HIQA's previous inspection.
- 12% of attendees to the emergency department were in the department for more than 24 hours after registration. Again, this was not compliant with the HSE's target of 97% for this KPI, but it represented a decrease on the 15% found during HIQA's previous inspection.
- 2% of attendees aged 75 years and over who were in the emergency department were admitted or discharged within nine hours of registration — slightly below the HSE's target of 99%, but much improved on previous inspection findings.
- All attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration in the department.

The hospital had a range of local and national infection prevention and control policies, procedures, protocols and guidelines, but some were in draft format and or needed to be updated. The hospital also had a range of medication policies, procedures, protocols and guidelines, but some of these were in draft format. All policies, procedures, protocols and guidelines were accessible to staff via the hospital's Intranet.

In summary, as evident in the findings detailed above, the systems in place to identify and manage potential and actual risks associated with the four areas of known harm were not as robust, proactive and effective as they should be. Hospital management should support, enable and embed a proactive approach to the recognition, identification, management and ownership of risks at departmental and corporate level. Hospital management should ensure that all policies, procedures, protocols and guidelines are up to date and in line with current national guidance. The hospital did not have a quality information management system. This system would support document control and staff accessibility to documents.

Judgment: Non-compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.
While the hospital had systems to ensure patient-safety incidents were identified, reported and managed, similar to previous inspection findings, there were delays in implementing recommendations from reviews of patient-safety incidents. Hospital management reported the number of clinical incidents per 1,000 bed days used (BDU) to NIMS monthly. Staff who spoke with HIQA were knowledgeable about what and how to report, and manage a patient-safety incident and were aware of the most common patient-safety incidents reported — falls and slips. The infection prevention and control team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective actions. Infection prevention and control related patient-safety incidents were reported to the IPCC. Medication patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Medication related patient-safety incidents were reported to the DTC and MIRT. Information about the number of clinical incidents reported onto NIMS in 2023 was incomplete. That year, the available data showed the number of patient-safety incidents reported at the hospital ranged from 12.80 to 20.70 per month, which was similar to other model 3 hospitals, but was less than the national average rate of 21.7 per 1,000 BDU over the previous 24 month period (January 2021 to December 2022). The hospital's quality and patient safety department collated information on the number and types of reported clinical incidents, dangerous occurrences and serious reportable events. This information was presented in a comprehensive report that was submitted to the EQRPSC, EMB, SIMT, MIRT and SSWHG. Electronic point of entry of patient-safety incidents onto NIMS was being introduced across the hospital at the time of inspection, which when fully implemented will further support the timely entry of clinical incidents onto NIMS. The implementation of recommendations from reviews of patient-safety incidents was monitored by the quality and patient safety department, the SIMT and relevant governance committees. Hospital management confirmed that the staffing shortfalls in the quality and patient safety department had contributed to the delays in implementing recommendations from reviews of patient-safety incidents. The inspectors did not find evidence of a structured process to share learning from patient-safety incidents, which was a missed opportunity. Feedback on patient-safety incidents was shared informally by CNMs sometimes. The implementation of recommendations and sharing of learning from reviews of patient-safety incidents are central to supporting a reduction in reoccurrence of similar incidents and should be a focus of improvement following this inspection. Overall, while there was an effective and robust system in place to manage patient-safety incidents, the sharing of learning and timely implementation of recommendations from the review of patient-safety incidents and

serious reportable events are areas that require improvement to further support the delivery of safe, quality care at the hospital.

Judgment: Partially compliant

Conclusion

An unannounced inspection of University Hospital Kerry was carried to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. Overall, the inspectors found evidence of a slight improvement in compliance with some of the national standards assessed. However, significant non-compliance remains with some national standards, specifically those relating to arrangements to support good governance, workforce and risk management. Further focused improvements are needed to bring the hospital into full compliance with the national standards.

After the onsite inspection at the hospital, concerns relating to a number of findings were escalated to the executive management of the SSWHG so that immediate measures could be implemented to mitigate any actual or potential risks to patient safety. These concerns related to the suitability of the emergency department as an area for a vulnerable patient with complex needs, consultant staffing in the emergency department outside core working hours and shortfalls in the quality and patient safety function at the hospital. Subsequent assurances from the executive management team of the SSWHG were provided to the inspectors, but at the time of writing this report, HIQA continue to engage with the SSWHG's executive management team to ensure appropriate arrangements are implemented to support adequate clinical governance and supervision of NCHDs in the emergency department 24/7.

Capacity and Capability

During the course of this inspection, the inspectors found some improvement in how the corporate and clinical governance structures functioned at the hospital, but further improvement was needed to strengthen these structures to assure and ensure the delivery of high-quality, safe and reliable healthcare services. The inspectors found the senior management team were more cohesive and were working more collaboratively to ensure the focus was on the quality and safety of healthcare services delivered at the hospital. There was some evidence of devolved accountability and responsibility in the operational day-to-day management of the hospital. Staff who engaged with the inspectors were committed to ensuring that the revised corporate and clinical leadership and governance structures set out in Programme GRO UHK would be fully implemented, but hospital management need to be further supported by the SSWHG and the HSE in this undertaking. While some of the operational improvements in Programme GRO UHK were implemented, the majority of clinical leadership and corporate governance reforms were still to be implemented. The delay in progressing these revised structures meant that the rationalisation and expected efficiencies and effectiveness in the governance and leadership arrangements at the hospital had not been fully realised. Furthermore, any further delays in implementing these structures

will continue to impact on the effective and efficient governance and oversight of the quality of the healthcare services provided at the hospital. The inspectors found no improvement in the level of compliance with the national standard on workforce. Medical, nursing and midwifery staff resourcing had improved in the hospital since HIQA's previous inspection, but hospital management continued to experience challenges in filling other staff positions. While efforts were underway to improve and strengthen the quality and patient safety function at the hospital, the long standing challenge of recruiting staff to the quality and patient safety department, along with the HSE recruitment embargo introduced at the end of 2023, had significantly impacted on the ability to improve this function. Staffing shortfalls in the quality and patient safety department also impacted on the operational ability to proactively monitor, improve and act on opportunities to continually improve healthcare services at the hospital. Additionally, when compared to previous inspection findings, there was no improvement in the consultant in emergency medicine on call rota, which impacted the clinical governance and supervision of NCHDs in the emergency department outside core working hours. An arrangement was in place to seek advice from the specialist consultants on call, but this arrangement was not sustainable in the long-term. Medical, nursing and midwifery staff attendance at and uptake of mandatory and essential training was sub-optimal and should be an area of focused improvement following this inspection. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

Staff promoted a person-centred approach to care and the inspectors observed staff being kind and caring towards patients. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients, which was consistent with the human rights-based approach to care promoted by HIQA. Patients also spoke positively about their experiences of receiving care in hospital. While the inspectors found a significant improvement in the management and oversight of complaints and concerns since HIQA's last inspection, the systems in place to identify and manage potential and actual risks to patient safety were not as robust and effective as they should be and were not as established, proactive and embedded as in other model 3 hospitals. A formal standardised system should be introduced to facilitate the sharing of learning from the complaints resolution process. Hospital management should also progress with the implementation of a dedicated patient advice and liaison service. The hospital's physical environment mostly supported the delivery of high-quality, safe, care and protected the health and welfare of people receiving care in the hospital. There were some systems in place to monitor and evaluate healthcare services provided at the hospital. However, similar to previous inspection findings, the auditing of compliance with best practice standards and national guidance should be strengthened to provide assurances on the quality and safety of healthcare services and to assist in identifying areas for improvement. Additionally, time-bound, quality improvement plans should be developed and fully implemented to ensure improvements identified through monitoring activity are realised. Despite some improvements in the emergency department

PETs, performance with the six and nine hour PETs had not improved since HIQA's last inspection and fell significantly short of the defined HSE targets. This presented a risk for patients who were in the emergency department for prolonged periods of time. The inspectors found there was a system in place to identify, report and manage patient-safety incidents, and the reporting of patient-safety incidents onto NIMS was timely. However, the sharing of learning and timely implementation of recommendations from the review of patient-safety incidents are areas that could be further improvement to support a reduction in reoccurrence of similar incidents.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity (Appendix 2), continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance classifications

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

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

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

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

Appendix 2 – Compliance plan submitted to HIQA

Compliance Plan for University Hospital Kerry OSV-0001037

Inspection ID: NS_0067

Date of inspection: 23 and 24 January 2024

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

University Hospital Kerry (UHK) welcomes HIQA's recognition of improved compliance of the Hospital in meeting the requirements of this standard.
As referenced in the report the inspectors found the Executive Quality Risk Patient Safety Committee (EQRPSC) was functioning but not as effectively as it should be.

- Staff member will be redeployed into the hospital Quality Manager role on an interim basis **(Immediate)**
- Integrated Quality, Risk and Patient Safety Department (including complaints) has been established with ways of working documented and all staff working to support the integrated functions. Recruitment for Grade VIII Quality, Risk & Patient Safety Manager and Grade VII Quality Manager posts will continue whilst awaiting derogation **(Ongoing)**
- Chair of the EQRPSC and the Interim Quality Manager to support the implementation of the revised and transformed clinical and corporate governance structures as outlined in the Growth, Rejuvenating, Optimising (GRO) UHK Programme. There will be an immediate focus on reviewing and updating the reporting templates from the different clinical operation groups and departments that report in to EQRPSC. **(Q2 2024)**
- The REO has requested that the hospital manager explore the possibility of further re-deployment of quality, risk and patient safety staffing from the hospital group and community healthcare organisation until derogation for critical posts is received **(Q2 2024).**

Medium to long term actions:
As referenced UHK have undertaken a comprehensive review of the formalised governance arrangements that has culminated in the GRO UHK Programme. Since the 2022 HIQA inspection the Hospital has amalgamated the compliance plan from the 2022 inspection into the GRO UHK Programme.

- The full implementation of the GRO UHK Programme (80 projects, 48 in progress, 12 complete and 12 further to commence) and specifically the corporate and clinical governance restructuring initiative remains a priority for the Hospital. While work on the GRO programme continues, progress is hindered by the current recruitment pause on management and administrative grades.

Timescale: as per actions

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

UHK welcomes HIQA's recognition of improved compliance of the Hospital in meeting the requirements of this standard.
HIQA Inspection report notes the improvement in Emergency Department (ED) wait times since the 2022 inspection, and mechanisms in place to manage and oversee the demand for unscheduled care, but suggests additional improvements to enable more efficient and effective patient flow from the ED.

- UHK has implemented a discharge/transit lounge that aims to improve the Patient Experience Time and egress through ED. The discharge /transit lounge will also enable earlier daily discharges from inpatient wards creating improved patient flow. The effectiveness of the discharge/transit lounge will be monitored closely by the Patient Flow ADON and the Operations Manager. **(Ongoing)**
- The 'Ward Ways of Working' project (under the GRO UHK Programme) commenced end of 2023. The effectiveness of the project (in the delivery of efficiencies in discharge times and reduced length of stay) will be monitored closely by EMB **(Ongoing)**
- Operations Manager overseeing full implementation of Health Performance Visualisation Platform (HPVP) to support patient flow by **(Q3 2024)**
- Hospital Manager to commission an audit of the compliance against the UHK escalation policy **(Q2 2024).**

Medium to long term actions:

- Under the GRO UHK Programme there is a significant number of projects specific to improving patient flow and ED Egress including the acute floor, SAFER, and the five fundamentals. Each individual project has key deliverables and timelines, and the project plan has been shared with HIQA. This work is in progress and monitored by the GRO oversight group and the UHK EMB. **(Ongoing)**
- Development of Minor Injury Unit for the Kerry region is being progressed
- First REO Unscheduled Care Workshop has been held to inform the development (and reconfiguration) of services across acute and community in line with Slaintecare.

Timescale: as per actions

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

HIQA inspection report notes monitoring arrangements are in place to continually improve quality, safety and reliability highlighted the absence of a clinical audit committee or a coordinated approach to the auditing of clinical practice. The inspection report acknowledges how the staffing shortfalls in the Quality, Risk and Patient Safety Department continue to impact on the operational ability to proactively monitor and act on improvement opportunities.

- Staff member will be redeployed into the hospital Quality Manager role on an interim basis **(Immediate)**
- Clinical Director to appoint a Consultant Lead for Clinical Audit supported by a working group with representation from the different clinical operational groups to oversee clinical audit project within the GRO UHK Programme.**(Q2 2024)**
- Interim Quality Manager will oversee the promotion, communication and overall management of this year's National Inpatient Experience Survey (NIES) survey. **(April 2024 – July 2024)**
- Interim Quality Manager will develop the 2024 Quality Improvement Plan (QIP) when results are analysed and available. **(August – November 2024)**
- Interim Quality Manager will communicate results from the survey to all disciplines and hospital committees. Survey results and subsequent improvements will be prominently displayed in both clinical and non-clinical areas including staff rest rooms and public notice boards throughout the Hospital. **(August – November 2024)**
- Interim Quality Manager will promote the clinical audit and quality improvement training available through HSELand, and all line managers should promote these courses across all disciplines and grades. **(Q3 2024)**
- The Chair Executive Quality Risk Patient Safety Committee (EQRPSC) and Interim Quality Manager will connect with the HSE National Centre for Clinical Audit to deliver on-site training to consolidate the online HSELand training.**(Q4 2024).**

Medium to long term actions:
Quality Risk & Patient Safety (QRPS) Department had worked on several projects to enhance the functionality of an integrated QRPS Department, including the development of a QRPS strategy.

- Under the Clinical Audit Project (GRO UHK Programme) a hospital wide clinical audit programme will be developed with standardised processes to support a consistent UHK approach to audit.
- A clinical audit facilitator has been sought to support the hospital and funding stream is to be identified. The consultant lead for clinical audit position will need to be formalised in time. The timeline for this work is dependent on recruitment.

Timescale: as per actions

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

As documented in this inspection report and on the Hospital's risk register, there are key positions that remain unfilled and these continue to be an immediate priority for Hospital management.

- UHK has again secured a locum to support the fourth Emergency Medicine Consultant post, and continues to progress recruitment of the permanent fourth and fifth posts**.(Ongoing)**
- Following the inspection in January the Clinical Director has formalised support arrangements with a standard operating procedure outlining the clinical governance and effective supervision arrangements for the NCHDs in the Emergency Department. **(Feb 2024)**
- Nursing Posts in Emergency, Acute Medical assessment and Critical care, along with Midwifery posts will continue to be recruited to meet approved posts as per HR update Memo 020/2024 April 3rd **(Ongoing)**
- A staff member will be redeployed to the Hospital Quality Manager role on an interim basis **(Immediate)**
- The REO has requested that the hospital manager explore the possibility of further redeployment of quality, risk and patient safety staffing from the hospital group and community healthcare organisation until derogation for critical posts is received **(Q2 2024)**
- The Consultant Microbiologist working in UHK is now onsite. Recruitment efforts to fill the second post on a permanent basis continue. (**Ongoing)**
- There is a panel in place and recruitment continues for Social Workers, whilst awaiting national derogation for the posts. The S/SWHG continue to provide on-site Principal Social Worker support to UHK. The hospital is also supported with the S/SWHG Social Worker leads for Assisted Decision-making and Safeguarding. **(Ongoing)**
- Recruitment campaigns will continue for all HSCP vacancies whist awaiting derogation. **(Ongoing)**
- The Hospital and S/SWHG will continue to advocate for all critical posts to be considered for derogation and prompt recruitment. **(Ongoing).**

HIQA have identified a need for focussed improvement in essential and mandatory training (uptake of training in Hand hygiene, transmission and standard –based precautions, early warning system, Basic life support, ISBAR3, as well as training specific to maternity services i.e. PROMPT and foetal heart recording interpretation training)

- Hospital has received approval to recruit a training and development officer on a permanent basis and will proceed to recruit the post whilst awaiting derogation. **(Ongoing)**
- The Hospital Manager to request all line managers develop a plan to ensure staff complete all mandatory and essential training specific to their respective place of work. The plan will include the process for maintain training records**. (Q2 2024)**

• All line managers to report through the corporate and clinical governance structures against their respect mandatory and essential training plan on a quarterly basis **(Q3 & ongoing)** • Medical Staff – The Medical Manpower Manager will work with the Clinical Director to review existing practices around the uptake and recording of mandatory and essential training amongst consultant's and NCHD's. They will then develop a training plan to address these requirements. **(Q2 2024).** **Medium to long term actions:** • In line with GRO UHK Programme and Implementation Roadmap • The Hospital will purchase and implement an electronic quality information management system. This system will facilitate document control and will include a module for recording mandatory training and other training courses done by each employee. **(Q4 2024)** • Development of UHK Workforce Plan, expansion of the training and education function and the development of a HR strategy **(Q1 2025).**
Timescale: as per actions

<table>
<tr><th>National Standard</th><th>Judgment</th></tr>
<tr><td>Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.</td><td>Partially compliant</td></tr>
<tr><td colspan="2">The inspection reports acknowledges that there are systems and processes in place to monitor and evaluate healthcare services but focussed improvements are required

Implementation of national Guideline for Clinical Handover is an identified priority project for the hospital with many of the ongoing work-stream to be aligned into an overall project plan with supporting project team (Q2 2024)
A hospital wide Implementation Plan will be developed and implementation will commence by (Q4 2024)
Interim Quality Manager to develop a standardised time bound action plan template for use post audit with priority for use in medication safety, & antimicrobial stewardship (Q3 2024)
Monitoring of audit results and realisation of quality improvement plans will be undertaken by clinical operations groups and department reporting to Executive Quality Risk Patient Safety Committee (EQRPSC) (Q4 2024 and ongoing).

Medium to long term actions:

Under the GRO UHK Programme there is a significant number of projects specific to improving the overall effectiveness of monitoring, evaluating and improving systems.
Chair of Deteriorating Patient Committee will ensure full roll out of the Sepsis 6 bundle along with an audit schedule of compliance inclusive of ISBAR3 (Q1 2025)
The Hospital will purchase and implement an electronic quality information management system. This system will facilitate an audit module, quality improvement plan and action log to reduce the administrative burden associated with monitoring a hospital wide clinical audit programme (Q4 2024).
</td></tr>
<tr><td colspan="2">Timescale: as per actions</td></tr>
</table>

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.	Non-compliant

The inspection report outlines that there are systems and processes in place to identify, evaluate and manage immediate and potential risks to patients, however these were not as robust in as they should be.

- Risk Manager will develop an implementation and training plan (against the HSE Enterprise Risk Management Policy 20230 **(Q2 2024)**
- All line management staff will complete 'The Fundamentals of Enterprise Risk Management' course on HSE Land **(Q4 2024)**
- Risk Management Department will continue to deliver support and training on risk assessment and risk registers **(Ongoing)**
- The Deteriorating Patient Lead and Deteriorating Patient CNM2 will review audit tool to ensure measurement of compliance for all elements of INEWS charts are captured **(Q2 2024 & ongoing thereafter)**
- Deteriorating Patient Committee will continue to oversee the audit schedule, Quality improvement plans of EWS across all departments to ensure audits are being actioned, and plans are being closed out. **(Ongoing)**
- The Interim Hospital Quality Manager will draft the process to be adopted by the hospital for developing, approving and updating hospital policies **(Q3 2024)**
- Emergency Department (ED) governance group undertaking a review of risk assessments of overflow corridors with immediate actions to mitigate against their use is being undertaken **(Q2 2024)**
- The hospital, supported by hospital group and community healthcare organisation will complete an after action review in respect of the suitability of the Emergency Dept as an area for a vulnerable patient with complex needs **(Q3 2024)**
- ED governance group will develop an inclusion and exclusion criteria for allocation of patients to overflow corridor is to be decided at ED Clinical Governance and formal process to be implemented **(Q2 2024)**
- The hospital has implemented a discharge lounge to assist in the reduction of patient experience times, improve egress in patient flow **(Complete).**

Medium to long term actions:

- First REO Unscheduled Care Workshop has been held to inform the development (and reconfiguration) of services across acute and community in line with Slaintecare
- Electronic discharge summary to GP's and primary healthcare services currently being explored. This will support the timely discharge of patients from hospital to community services as well as those discharged home. **(Q1 2025)**

In line with GRO UHK Programme and Implementation Roadmap

- Continue to progress ward ways of working and initiatives per the five fundamentals framework
- Acute ED Ambulatory Care & geriatric ED MDT service initiatives also in progress
- The Hospital will purchase and implement an electronic quality information management system. This system will facilitate electronic access to staff at the point of care to prescribing guidelines, including antimicrobial guidelines. **(Q4 2024).**

Timescale: as per actions

<table>
<tr><th>National Standard</th><th>Judgment</th></tr>
<tr><td>Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.</td><td>Partially compliant</td></tr>
<tr><td colspan="2">The inspection team found there was an effective and robust system in place to manage patient-safety incidents, but improvements are required to ensure the timely implementation of recommendations and that learning from all incidents are shared throughout the hospital.
Risk Manager and Interim Quality Manager will undertake a gap analysis to determine the up to date status of all known open recommendations and submit to Chair of the EQRPSC and Hospital Manager. (Q3 2024)
Risk Manager and Interim Quality Manager will meet with relevant clinical operation groups and department heads to support the development of actions plans arising from review recommendations (in line with the hospital-approved process for the management of recommendations from patient safety incidents and serious reportable events). (Ongoing and following action above)
A status report on the implementation of recommendations will be included on the updated clinical governance reports to EQRPS Committee, providing assurance to this committee and to the EMB. (Q3 2024).</td></tr>
<tr><td colspan="2">Timescale: as per actions</td></tr>
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