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:	South Infirmary Victoria Hospital
Address of healthcare service:	Old Blackrock Road Cork T12 X23H
Type of inspection:	Announced
Date(s) of inspection:	25 and 26 April 2023
Healthcare Service ID:	OSV-001092
Fieldwork ID:	NS_0039

1.0 Model of Hospital and Profile

About the healthcare service

South Infirmary-Victoria University Hospital is a voluntary acute hospital, and a member of the South/South West Hospital Group.[*] The hospital is the regional centre for Ear, Nose and Throat (ENT), Dermatology, Elective Orthopaedic, Opthalmology (In Patient and Day Cases) and Chronic Pain services. In addition, South Infirmary-Victoria University Hospital is primarily an elective hospital with a particular concentration on day surgery, short length of stay and day of surgery admission.

The following information outlines some additional data on the hospital.

Number of beds	177 inpatient beds

How we inspect

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

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

During the inspection, inspectors:

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

[*] The South/South West Hospital Group is made up of nine hospitals—Bantry General Hospital, Cork University Hospital, Mallow General Hospital, Mercy University Hospital, South Infirmary Victoria University Hospital, Tipperary General Hospital, University Hospital Kerry, University Hospital Waterford and Kilcrene Regional Orthopaedic Hospital.

[†] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 April 2023 Day 1 26 April 2023 Day 2	13:30 – 17:30hrs 08:45 – 15:20hrs	Emma Cooke	Lead
		Aoife Healy	Support
		Danielle Bracken	Support

Information about this inspection

An announced inspection of South Infirmary Victoria University Hospital was conducted on 25 and 26 April 2023.

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

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

The inspection team visited two clinical areas:

- ground floor south two (general surgery/ENT)
- level one Victoria (orthopaedic/trauma)

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

- representatives of the hospital's Senior Management Team:
  - Chief Executive Officer
  - Director of Nursing
  - Quality and Risk Manager
  - Clinical Director
  - Acting Human Resources Manager
  - Complaints Co-Ordinator
- Non-consultant hospital doctor (NCHD)
- representatives from each of the following hospital committees:
  - Clinical Governance
  - Infection Prevention and Control and Antimicrobial Stewardship
  - Deteriorating Patient
  - Drugs and Therapeutics
  - Bed Management

Acknowledgements

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

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

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

Inspectors visited two clinical areas during the inspection. Ground Floor South Two had an approved capacity for 22 beds but the actual number of beds in place on the day of inspection was 19, of which 14 beds were occupied. The ward was an open planned nightingale-style ward[††] comprising a three-bedded bay, a ten-bedded bay and a six bedded bay.

Level One Victoria had an approved capacity of 18 beds, of which 17 were occupied. The ward comprised four two-bedded rooms with en-suite facilities, two four-bedded rooms with en-suite facilities and two isolation rooms.

During the inspection inspectors spoke with patients about the care they received in the hospital. Patients were highly complementary of the service and overall feedback was positive. Patients reported that the hospital was perfect and that they '*could not fault anything'.* When asked to describe their experience, patients commented that staff were *'helpful,' 'caring', 'excellent and very helpful.'* When asked if there was anything that could be improved about their experience, patients commented in general that there was nothing specific but noted that the coffee shop was not open on a Sunday.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the patients spoken with. Patients' commented, '*staff ask if you are ok'* and *'anything I ask for they are happy to facilitate'.* Patients spoken with knew who to speak to if they wished to raise an issue and commented that they could speak with staff if they had a concern or complaint.

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

Capacity and Capability Dimension

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

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

[††] A nightingale-style room consists of one long ward with a large number of beds arranged along the sides, without subdivision of the room into bays. From an infection prevention and control perspective, the higher number of patients accommodated in nightingale wards increases the risk of infection transmission, especially if beds are spaced too close together.

the quality and safety of healthcare services. The hospital was governed and managed by the Chief Executive Officer (CEO) who was accountable to the Board of Directors and also reported to the CEO of the South/South West Hospital Group (SSWHG).

Organisational charts setting out the hospital's reporting structures detailed the direct reporting arrangements for hospital management, governance and oversight committees. However, not all committees were represented on organisational charts. For example, three bed management committees were not represented.

The Clinical Director provided clinical oversight and leadership to consultants and Non-Consultant Hospital Doctors (NCHDs) at the hospital. The Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital.

Executive Management Board

The Executive Management Board (EMB) was established as the senior operational board of the hospital. Terms of Reference (ToR) outlined that the Board met monthly and were accountable to the Board of Directors via the Chief Executive Officer. Meetings were chaired by the CEO and minutes for the most recent meetings submitted to HIQA outlined that meetings were action orientated with actions assigned to members, however, actions were not always time-bound.

The CEO attended monthly performance meetings between the hospital and the South/South West Hospital Group, where items such as finance, workforce, quality and safety risks, scheduled and unscheduled care access and activity were reviewed and discussed. Minutes of these performance meetings submitted to HIQA demonstrated that the hospital group had effective oversight of the quality and safety of healthcare services at the hospital and the implementation of actions agreed at meetings was progressed from meeting to meeting.

Senior Management Team

The Senior Management Team (SMT) was established to ensure a cohesive approach to management of services across the hospital. Among its many functions and responsibilities, the SMT were responsible for promoting continuous quality improvement and actively engaging in the delivery of healthcare services. Chaired by the CEO, the team met monthly, however terms of reference for the committee had not been updated since 2015. There was evidence from SMT meetings reviewed that matters pertaining to quality, safety and risk were discussed at SMT.

Clinical Governance Committee

The hospital's Clinical Governance Committee was assigned with overall responsibility for ensuring that adequate and appropriate governance structures, processes and controls are in place to deliver safe, high quality healthcare to patients. The committee, chaired by the Clinical Director and accountable to the EMB, met quarterly in line with its ToR.

The Committee had a standardised agenda and minutes were comprehensive and included time-bound, assigned actions and these along with interviews undertaken with key committee members on the day provided assurance of appropriate oversight of quality and safety matters.

Incident Review and Clinical Effectiveness Group

The Incident Review and Clinical Effectiveness Group were established as a sub-committee of the Clinical Governance Committee. The aim of this group was to allow for monitoring and extensive review surrounding the quality and effectiveness of the care provided to patients at the hospital. Activities of the group were co-ordinated by the Quality and Risk Manager and meetings were held quarterly. Meetings were action-orientated and progress with implementing agreed actions was monitored from meeting to meeting.

Hospital management had established several hospital committees through which to govern services and address matters in relation to the four key areas of risk: Infection Prevention and Control and Antimicrobial Stewardship, Medication Safety, Deteriorating Patient and Transitions of Care. At operational level, HIQA was satisfied that the hospital had clear lines of accountability with devolved autonomy and decision-making for the four areas of known harm assessed during inspection.

Infection Prevention and Control (IPC) and Antimicrobial Stewardship Committee (AMC).

The hospital's Infection Prevention and Control and Antimicrobial Stewardship Committee, was responsible for the governance and oversight of infection prevention and control (IPC) and antimicrobial stewardship activity. The multidisciplinary committee was chaired by a consultant microbiologist and accountable to the hospital's Clinical Governance Committee. The committee had a standing agenda and met in line with its ToR.

It was evident from minutes reviewed that the committee had effective oversight of the implementation of the hospital's:

- infection and prevention control programme
- compliance with key IPC antimicrobial stewardship performance indicators
- relevant audit findings
- patient-safety incidents and risks
- development and implementation of relevant policies, procedures and guidelines
- staff education and training.

Meetings were well attended and there was evidence in meeting minutes to indicate that items discussed were being progressed. However, it was noted that minutes would benefit from having clearly defined actions which are time-bound and assigned to individuals.

The hospital did not have an overarching antimicrobial stewardship programme,[‡‡] however, performance targets were clearly outlined in the annual IPC report. There was documented evidence that updates related to the hospital's antibiotic consumption rates were provided to the IPC Committee and Drugs and Therapeutics Committee.

Operational responsibility for implementing the hospital infection prevention and control plan was assigned to the hospital's IPC team. The programme is discussed further in national standard 5.5. A number of sub-committees and groups reported into the IPC Committee including; decontamination, hygiene group, outbreak control team and cleaning contractors.

Drugs and Therapeutics Committee

The Drugs and Therapeutics Committee was responsible for the governance and oversight of medication safety practices at the hospital. The committee, chaired by a hospital consultant met every three months and was operationally accountable and reported to the Clinical Governance Committee. Minutes and agendas of meetings provided, showed that the committee met in line with its ToR.

It was evident from minutes submitted to HIQA that meetings of the committee were well attended and followed a defined agenda, which included items such as medication safety, medication process issues, medication selection issues, antimicrobial stewardship and nurse prescribing. Meetings were action-orientated and progress with the implementation of agreed actions was monitored from meeting to meeting.

Medication Safety Committee

The Medication Safety Committee was responsible for the day-to-day operational management of medication safety at the hospital. The committee, chaired by a hospital consultant met every three months and was operationally accountable and reported to the Drugs and Therapeutics Committee. Minutes of meetings demonstrated that the committee met in line with its ToR, had effective oversight of medication safety practices, were action-orientated and progress in implementing agreed actions was monitored from meeting to meeting.

The Medication Safety Committee developed an annual medication safety plan which outlined the key areas of focus and resources required to support safe medication practices at the hospital. This plan focused on a number of key areas including the governance of medication safety, medication risk management, high-risk medications, monitoring and evaluation of medication practices and medication-related staff education and training. The plan and annual report for the previous year is discussed further in standard 5.5.

Deteriorating Patient Committee

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

The Deteriorating Patient Committee was established in 2020 to provide oversight and guidance in relation to activities associated with the deteriorating patient. The committee's remit included cardiac arrest, resuscitation, Irish National Early Warning System (INEWS),[§§] deteriorating patient, sepsis and transitions of care. The committee, chaired by the Clinical Director at the time of inspection, met every four months in line with their ToR and reported to the Clinical Governance Committee.

The committee had a standardised agenda and updated minutes submitted by the hospital outlined that meetings were action-orientated and progress with implementing agreed actions was monitored from meeting to meeting.

Bed Management Committees

The hospital had three bed management committees; General Bed Management Committee, Orthopaedic Bed Management Committee and Ophthalmology Bed Management Committee. Each committee was chaired by a Clinical Nurse Manager three (CNM 3) and met weekly in line with its ToR. However the ToR did not outline who the committees reported to and these committees were not represented on organisational charts submitted to HIQA.

In summary: The hospital had formalised corporate and clinical governance arrangements in place, however:

- some committee meetings would benefit from having clearly defined, time-bound actions that are assigned to individuals.
- Terms of reference for some committees required updating and should reflect reporting and accountability arrangements.

Judgment: Substantially compliant

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

Effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm. These are discussed in more detail below.

Infection, prevention and control

[§§] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

The hospital had an infection prevention and control team comprising;

- one whole-time equivalent (WTE)[***]assistant director of nursing (ADON)
- 1.2 WTE clinical nurse manager grade two (CNM2)
- 0.5 WTE microbiologist
- 0.5 WTE surgical site infection surveillance (a temporary CNM2 post)
- one WTE hygiene co-ordinator
- one WTE antimicrobial pharmacist.

The IPC team had developed an infection prevention and control plan that set out the objectives to be achieved in relation to IPC yearly at the hospital. It was evident from documentation received and communication with staff members in relation to IPC, that considerable work was being undertaken in relation to infection prevention and control and this was reflected in the hospitals' annual report for infection prevention and control 2022.

The hospital had clearly documented risks and concerns relating to IPC at the hospital. These are further discussed in standard 3.1.

Medication safety

The hospital were approved for:

- 8.5 WTE pharmacists including one Chief Pharmacist
- 5.5 WTE pharmacy technicians.

Inspectors were informed that in the weeks prior to inspection that pharmacy resources at the hospital had benefited from the recruitment of two new WTE pharmacists and a medication safety pharmacist. This resulted in only 1.1 WTE pharmacy positions unfilled at the time of inspection which the hospital was actively recruiting for.

Hospital pharmacy services were available onsite Monday to Friday, 9.00am to 5.00pm. Outside of these hours, the ADON was the designated point of contact for access to pharmacy services. The lack of a comprehensive clinical pharmacy service[†††] resulted in a number of clinical areas not having a sufficient clinical pharmacy service. Pharmacist-led medication reconciliation was not always carried out for all patients on admission or discharge, but inspectors were informed that pharmacist-led medication reconciliation was prioritised for vulnerable patients. Inspectors were informed that a business case for an additional one WTE pharmacist had also been submitted with the aim of improving clinical pharmacy services at the hospital.

The hospital had developed an annual plan for medication safety which outlined key areas of focus for 2023. Progress against the annual plan for the previous year was outlined in

[***] 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.
[†††] 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.

the annual report of the medication safety group for 2022. It was evident from documentation reviewed and communication with staff members in relation to medication safety that progress was made against 2022 objectives for medication safety at the hospital.

Deteriorating patient

The hospital's deteriorating patient committee was responsible for progressing the hospital's deteriorating patient programme. The hospital was using the appropriate national early warning systems for the various cohorts of patients — Irish National Early Warning System (INEWS)[‡‡‡] and the Irish Paediatric Early Warning System (IPEWS). While the hospital reported low numbers of pregnant women attending services at the hospital, a number of staff had been trained in the use of the Irish Maternity Early Warning System (IMEWS).[§§§] A clinical lead had each been appointed for sepsis management, basic life support and early warning systems, however, the lead position for IPEWS was unfilled at the time of inspection. Inspectors were informed that this had been escalated to the clinical governance committee however, there was no agreed timeframe as to when an IPEWS lead would be in place. Hospital management should progress with plans outlined to inspectors to fill the lead position for IPEWS.

There was evidence of a number of audits being undertaken in relation to INEWS documentation, as well as trending of incidents, which will be discussed further in standard 2.8.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. Inspectors were satisfied that the hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. The hospital's Bed Management Committees were responsible for monitoring and overseeing the safe transitions of care within and from the hospital.

At the time of inspection, the average length of stay for medical patients was five days, which was below the HSE's target of seven days or less. The average length of stay for surgical patients was 1.2 days, which is significantly lower than the HSE's target of 5.2 days or less. Lead representatives for transitions of care within the hospital stated that

[‡‡‡] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.
[§§§] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

the hospital had good links with community services and that the arrangement was working well in supporting the patient discharge process.

Unscheduled presentations at the hospital were routinely discussed and escalated at senior management meetings. The hospital had developed a number of policies and pathways to support the safe transitions of patients in and out of the hospital such as;

- Standing Operating Procedure for the Management of Unscheduled Admissions and Transfers SIVUH.
- Standing Operating Procedure for the Management of Non-scheduled Presentations to the Hospital and Unexpected Medical Events.
- Guidelines for Planned and Unplanned Discharge.

The hospital was also trialling initiatives to enhance the safe transfer of patients to and from the hospital. These included:

- development of a Trauma Orthopaedic Rehabilitation Coordinator Role for the purpose of assessing patients to ensure their appropriateness for rehabilitation at the time of transfer.

Overall HIQA found that the hospital had systems and processes in place to support the safe transitions of patients out of the hospital. It was clear that initiatives in place to support the transition of patients out of the hospital were having a positive impact as evident by low numbers of delayed discharges at the hospital.

In summary, while effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm, a number of opportunities for improvement were identified as follows:

- progress the business case for an additional one WTE pharmacist which will improve clinical pharmacy services at the hospital and ensure that all clinical areas have access to sufficient clinical pharmacy services.
- progress with plans outlined to inspectors to fill the lead position for IPEWS.

Judgment: Substantially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on a suite of key performance indicators, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes

were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks. There was oversight of the management of serious reportable events and serious incidents, in line with the HSE's Incident Management Framework.

Monitoring service's performance

The hospital collected data on a range of clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). This data was discussed at Clinical Governance Committee meetings and the Executive Management Board, as evidenced in meeting minutes.

The hospital also monitored a range of performance activity associated with transitions of care and speciality services. These included: unscheduled admissions, day case overnight stay, single rooms utilised for isolation purpose, cancellations following admissions, delayed discharges and cancellations following admissions and transitions of care activity associated with orthopaedic trauma rehab.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risk. The Executive Management Board and Clinical Governance Committee had oversight of the management of identified risks. Risks were also discussed at meetings of the hospital's SMT. High-rated risks not managed at hospital level were escalated to the South/South West Hospital Group. Risks are discussed further in national standard 3.1.

On review, the hospital's corporate risk register detailed existing controls and actions taken to date in response to identified risk, and actions were time-bound and assigned to a risk owner. However, while there was evidence that the risk register was being discussed at senior management meetings, documentation did not reflect that risks which had been escalated to the SSWHG were being updated. For example, it was noted that risks relating to IPC that had been escalated at group level had not been updated and their status was overdue for review. Risks relating to IPC will be discussed further in national standard 2.7.

Audit activity

While the hospital did not have a clinical audit committee for oversight of all clinical audit activity, audit activity was overseen by the relevant governance committee. For example, IPC audits were overseen by the IPC Committee. The hospital should look to establish formalised structures and centrally control audit activity at the hospital to promote quality management of the audit process and shared learning. Audit findings were reviewed and discussed at the Clinical Governance Committee Audit findings and the learnings from

audit activity were shared with staff in the clinical areas through the use of information boards and at clinical handover. Audits will be discussed further in national standard 2.8.

Management of serious reportable events

The hospital's Incident Review and Clinical Effectiveness Group had oversight of the management of serious reportable events (SREs) and serious incidents which occurred in the hospital. This group was responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework and convened a Serious Incident Management Team (SIMT) in response to serious incidents. Minutes of meetings detailed discussions in relation to serious incidents and SREs current at that time. Evidence from meeting minutes confirmed that SREs were also discussed at the Performance Meeting for the South/Southwest Hospital Group, evidencing good oversight of the hospital's SREs. No serious reportable events occurred at the hospital in 2022, however one was reported in 2021. Inspectors were informed about changes of practices that had occurred at the hospital in response to this incident and how this change of practice is monitored on a regular basis.

Management of patient-safety incidents

There were effective systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. The hospital reported clinical incidents through the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. The Quality and Risk Manager was responsible for tracking and trending of incidents. Inspectors observed Health and Safety Incident Dashboards that were used to provide overviews on the tracking and trending of incidents at the hospital. These were also accessible to the clinical areas and observed by inspectors in one of the clinical areas inspected.

It was evident that incidents were discussed at the hospital's Clinical Governance Committee, SMT and Performance Meetings of the South/Southwest Hospital Group. The hospital also completed a detailed Annual Incident Management Report for 2022. Patient-safety incidents related to the four areas of harm are discussed further in national standard 3.3.

Feedback from people using the service

Findings from National Inpatient Experience Surveys were reviewed at meetings of the Clinical Governance Committee and updates were provided to the EMB. The hospital had developed a time-bound quality improvement plan in response to the National Inpatient Experience Survey findings (2022) to address areas for improvement.

In summary, the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of healthcare services. Opportunities for improvement were identified in relation to:

- ensuring risks on the risk register are updated to demonstrate that risks are being reviewed by the relevant oversight committees
- centrally controlling audit activity at the hospital and establishing formalised structures to promote quality management of the audit process and shared learning.

Judgment: Substantially compliant

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

Overall, HIQA found that hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare. However, there remained vacancies across the majority of disciplines and the current number of medical registrars was not sufficient to consistently provide out-of-hours cover.

At the time of inspection the total WTE number of vacancies across the hospital was 65.4 WTE, this had decreased from 73 WTE in January 2023, however, there remained staff vacancies across all disciplines. The majority of which were within nursing, pharmacy, health and social care professionals and administration.

The hospital monitored and recorded workforce vacancies on a weekly basis. The shortfall in staffing levels was also recorded as a high risk on the hospital's risk register. There was evidence that staffing levels and vacancies were discussed at both the SMT and the Performance Meetings with the SSWHG.

The hospital's approved complement of nursing staffing was 340 WTE. At the time of inspection, 17.6 WTE nursing positions were unfilled. It was explained that a number of senior nursing management at CNM II grade were vacant also. Hospital management told inspectors that they were actively recruiting nursing staff to address current vacancies. The hospital's total approved posts for healthcare assistants (HCAs) was 51 WTE of which 46 WTE were filled resulting in five vacancies at the time of inspection.

Inspectors reviewed nursing staff rosters from the clinical areas visited for the preceding four-week period to inspection. During this period, neither clinical area had experienced any shifts where there was a significant shortfall in rostered nurse staffing levels. There were some occasions where there was a shortfall of one staff member on days or nights. However, this was occasional and any shortfalls were filled by hospital staff working additional shifts.

The hospital had an approved complement of 38.46 WTE consultants. At the time of inspection, there were three vacant consultant posts, however, it was explained that these were newly approved posts in ophthalmology and ENT and that recruitment campaigns

were ongoing to fill these posts. All permanent consultants at the hospital were on the specialist register with the Irish Medical Council.

Consultant staff were supported by 51.95 WTE non-consultant hospital doctors (NCHD) at registrar grade (Reg), senior house officer (SHO) grade and intern grade. Hospital management informed inspectors that the current number of medical registrars was sufficient to consistently provide in-hours medical cover. However, out-of-hours cover was more often than not provided by a locum medical registrar. This was identified as a risk by the hospital and recorded on the hospital's risk register. It was explained that a post had been approved for this position but the hospital was unable to fill this position despite an ongoing recruitment campaign. Inspectors were also informed that throughout 2022, there were approximately six incidents associated with delayed responses from the medical registrar on call at handover time, none of which adversely impacted patient care. In response to the incidents, the hospital had developed an 'Out of Hours Cover and On-call Arrangement Pathway' which provided guidance to staff for escalating patient-safety concerns during out of hours. Other controls in place to reduce the risk outlined by hospital management included the availability of an on-site anesthetic registrar, ENT registrar and access to medical consultants providing support from Cork University Hospital.

Staff absenteeism rate (excluding COVID hours) for quarter one 2023 was 3.74% which was less than the HSE's target of 4.0%.

Staff training

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice. However, inspectors found that improvement was required in relation to staff attendance and uptake at mandatory and essential training.

In the clinical areas inspected, compliance with hand hygiene training was 100% for nursing, HCAs and household/cleaning staff which was higher than the hospital average and above the HSE target of 90%. However, hospital-wide compliance for training in relation to IPC, specifically standard-based precautions, transmission-based precautions, donning and doffing required improvement. Compliance was 73% for nursing staff, 60% for HCAs, 50% for doctors, 92% for housekeeping/cleaning staff and 73% for health and social care professionals. Compliance with hand hygiene training for doctors was 56% which required significant improvement, being well below the HSE's target of 90%.

Training compliance on INEWS v.2 for nursing staff was 61% and 95% respectively, for the clinical areas inspected. ISBAR training was included as part of the INEWS v.2 training. Overall, hospital training on basic life support was 81% for nurses and 71% for HCAs. 100% of relevant staff had received sepsis training. No records were available for medical staff in relation to basic life support. Completion of medication safety training in one of the clinical areas inspected required significant improvement with only 37% of staff having completed this training compared with 100% of staff in the other clinical area.

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. This issue should represent a key focus for early improvement efforts following inspection.

In summary, it was evident that hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare. However, the following opportunities for improvement were identified:

- the reliance on locum medical staff to maintain the out-of-hours medical registrar roster is not sustainable in the long-term and must be addressed.
- hospital management must progress with recruitment efforts to address the shortfall in staff vacancies to support the provision of high-quality, safe healthcare.
- attendance at and uptake of mandatory and essential training for staff requires improvement.

Judgment: Partially compliant

Quality and Safety Dimension

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. Inspectors observed staff offering assistance to patients with their individual needs and protecting their privacy. Nursing staff were observed helping patients who needed assistance to mobilise.

For the most part, the physical environment in one of the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, patients were accommodated in individual cubicles surrounded by privacy curtains or in single rooms where available. However, this was not the case for patients in the nightingale ward. In this setting, it was impossible to maintain the patient's privacy and confidentiality. Others (patients, visitors and staff) could overhear patient-clinician conversations and the exchange of personal information between patients, medical and nursing staff. This was not consistent with a human rights-based approach to healthcare promoted and supported by HIQA. Notwithstanding this, it was clear that staff made every effort to uphold patients' dignity and inspectors observed good spacing between each bed.

Where patients required support for specific hygiene needs off the ward, inspectors were told that staff facilitated access to specific baths for specialised treatments. One patient

spoke about how they received very dignified treatment and are always treated with respect. What inspectors heard and observed in the clinical areas in terms of patients' privacy being upheld aligned with the findings from the 2022 National Inpatient Experience Survey (NIES), where, with regard to the following questions:

- 'Were you given enough privacy while you were on the ward?', the hospital scored 9.1 which was above the national average of 8.6
- 'Did the staff treating and examining you introduce themselves?', the hospital scored 9.4 which was above the national average of 8.7.

Patients' personal information in the clinical areas visited was observed to be protected and stored appropriately.

In summary, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity and privacy of people receiving care at the hospital, however:

- patients' privacy dignity and respect in the nightingale style wards could not always be protected.

Judgment: Substantially compliant

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

It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients whom inspectors met with were complimentary of the staff and the care provided to them. The results of the NIES 2022 found that 93% of patients reported overall they had a 'very good' experience while in the hospital, which was above the national average of 82%. This aligned to what inspectors were told by patients they spoke with on the day of inspection. Patients described the staff as *'helpful and caring,' 'excellent and attentive'* and *'couldn't fault them.'* Another patient communicated to an inspector that there was no issue when they call the bell and staff come with no delay.

Findings on inspection where comparable with findings of the 2022 NIES results where the hospital scored above the national average for the following:

- 'Overall, did you feel you were treated with respect and dignity while you were in the hospital? the hospital scored 9.4 which was above the national average of 8.7.'

Inspectors were informed of quality improvement initiatives implemented as a result of feedback from patients, for example, food choices and timing of meals and snacks. Feedback from patients in relation to these changes was reported to be positive.

In summary, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The complaints coordinator was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. The hospital had a complaints committee which was chaired by the complaints coordinator. The committee met monthly and reported to the hospital's Clinical Governance Committee who had oversight of hospital complaints. However, inspectors noted that the complaints committee was not represented on organisational charts submitted to HIQA.

All complaints were risk rated and logged on a computerised complaints management system. The hospital formally reported on the number of formal and verbal complaints received annually. Documentation reviewed by inspectors showed that the hospital had received 134 complaints in 2022, 81 formal and 53 verbal. Complaints were tracked and trended and categorised according to the most common complaint. The top three complaints for 2022 related to communication, medical treatment and access/waiting times. Quality improvement plans were developed in response to complaints and updates and progress were discussed at the Clinical Governance Committee.

Patients were aware of the complaints process and knew that they could raise a concern with staff members if required. Inspectors did not observe information leaflets on how to make a complaint on display for patients in the clinical areas visited. Information leaflets on how to make a complaint were available, however, it was explained that they were provided to patients if the wanted to make a complaint.

There was a culture of complaints resolution at a local level in the clinical areas visited and this process was described to the inspector in the clinical areas visited. Feedback on complaints was generally provided to staff in the clinical area that were the subject of the complaint.

At the time of inspection, staff in clinical areas had not received any formal complaints management training, and this concurred with the training records submitted to HIQA. Notwithstanding this, annual complaints reports reviewed by inspectors outlined plans to provide complaints management training to staff.

In summary, there were structures, systems and processes in place for the management of complaints at the hospital. Opportunities for improvement were identified in relation to the following:

- information on how to make a complaint was not on display in the clinical areas inspected.
- the hospital should progress with plans to provide staff with formal complaints training.

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.

On the day of inspection, inspectors visited two clinical areas and observed that overall the hospital's physical environment was clean with some exceptions, however the infrastructure of the hospital continues to challenge the maintenance, cleanliness and safety of the physical environment. In the 2022 NIES, the hospital scored 9.5, above the national average, in relation to the cleanliness of the hospital room or ward.

The fabric and infrastructure of the hospital continued to present ongoing challenges to the maintenance and upkeep of the physical environment. Similar to findings from previous HIQA inspections the infrastructure in the clinical areas inspected was outdated and was not in line with recommended specifications and standards of a modern patient care facility. This was most evident in the large multi-occupancy nightingale-style ward which had no isolation facilities to accommodate placement of people who required transmission-based precautions. The other clinical area inspected had only two isolation rooms with en-suite facilities. Inspectors were informed that cohorting of patients with the same microorganism is facilitated following consultation with the IPC team and based on a risk assessment. The poor physical infrastructure and the outdated design of the nightingale wards were documented on the hospital's overall risk register along with many control measures to mitigate the risks associated with the hospital infrastructure.

It was evident that in many instances the hospital had themselves clearly identified areas of concern and had sought external assistance in dealing with many of these risks. For example, submissions to the SSWHG and HSE for capital investment, however no final decision had been made and there was no agreed timeframe in place as to when these issues may be addressed.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available in clinical areas and hand hygiene signage was clearly displayed throughout the clinical areas. Inspectors noted that some hand hygiene sinks did not

conform to national requirements.[****] Physical distancing of one metre was observed to be maintained between beds in all clinical areas visited and privacy curtains were clean and changed as required.

Inspectors were informed that cleaning services were available at all times. Inspectors observed the use of the green clean tagging system in clinical areas and were informed that all equipment was cleaned by HCAs and nursing staff. Terminal cleaning was carried out by cleaning staff with oversight by cleaning supervisors and ward managers.

In summary, inspectors found that the physical environment in the clinical areas inspected was clean, however:

- the fabric and infrastructure of the hospital continued to present ongoing challenges to the maintenance and upkeep of the building as well as patient safety.
- there were insufficient isolation facilities in both inpatient clinical areas visited.

Judgment: Partially compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services. This provided assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level.

National performance indicators and benchmarks in line with HSE national reporting requirements were used by the hospital to measure the quality and safety of the service it provided.

Infection prevention and control monitoring

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection. The IPC team submitted a comprehensive infection prevention and control report to the IPC Committee annually. The report detailed all the activities put in place during the year to minimise the transmission of healthcare associated infections at the hospital.

Inspectors were satisfied that the IPC Committee were actively monitoring and evaluating infection prevention practices in clinical areas. It was evident from meetings with IPC leads and staff in clinical areas that some IPC related audits were being undertaken.

[****] 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

In line with the HSE national reporting requirements, the hospital was monitoring a number of performance indicators including;

- rate of new cases of hospital associated *Clostridium difficile* infection
- rate of new cases of hospital associated Methicillin-Resistant *Staphylococcus aureus* (MRSA) blood stream infections
- number of Carbapenemase Producing Enterobacteriales (CPE) ‡‡cases

The IPC Team informed inspectors that targeted surveillance on alert organisms*** and conditions††† were routinely carried out at the hospital and provided advice to staff as needed for example on patient placement and infection and prevention measures required. Inspectors reviewed surveillance reports produced by the surveillance scientist on a quarterly basis which were presented to the IPC Committee and to the Executive Management Board. Data from the *Clostridioides difficile* surveillance reports showed a slight increase in the rate of *Clostridioides difficile* infection in the last year when compared with previous year's data. The overall rate of hospital acquired MRSA was decreasing when compared with other years. Surveillance reports reviewed demonstrated root cause analysis was routinely performed at the hospital in respect of all hospital acquired *Clostridioides difficile* and MRSA infections.

To date the hospital have had no cases of hospital acquired CPE. The hospital reported a total of 46 new cases of CPE in 2022 which had been identified on admission screens as a result of patients having a previous history or being close contacts of a confirmed case prior to admission. Notwithstanding this the total number of new cases being managed by the hospital has been steadily increasing compared to the previous two years which is a challenge for the hospital particularly in relation to access to isolation facilities. Inspectors were informed that an annual audit of CPE screening was undertaken in 2022, with the most recent results finding 100% compliance with CPE screening requirements.

The hospital scored 92.6% in the national hand hygiene audit completed in May/June 2022 which was above the HSE target of 90%.

The IPC Committee also had oversight of equipment and environmental audits which were co-ordinated by the hygiene committee. Inspectors were informed that environmental and hygiene audits were carried out weekly by a team including the hygiene coordinator, household and catering manager, contract cleaners manager and health and safety officer. Infrastructural walkabouts were also carried out quarterly and as required prior to projected works by a specific team. Hygiene audit reports reviewed by inspectors demonstrated compliance levels of greater than 80% for the majority of clinical areas. Action plans were developed if compliance was less than 80%. The green clean equipment tagging system was in place in clinical areas and inspectors were informed that HCAs undertook additional weekly checks to ensure equipment was clean.

The IPC team monitored outbreaks and inspectors reviewed documented evidence of outbreak reports being completed. In February 2023, an outbreak of invasive Group A

streptococcus was declared at the hospital. The process of managing an infection outbreak was underpinned by a formalised up-to-date policy. Outbreak management team meetings were held as appropriate and the Local Department of Public Health was notified. The report outlined control measures and actions taken to mitigate the risk to patient safety. However, the report did not provide descriptive outcomes of cases or learning opportunities in line with best practice.

Antimicrobial stewardship monitoring

As noted in standard 5.5 the hospital did not have an AMS programme in place. Notwithstanding this, antimicrobial stewardship was a standing item agenda at IPC Committee and Drugs and Therapeutic meetings and was being actively monitored by the antimicrobial pharmacist. In line with the Antimicrobial Resistance Infection Control (AMRIC) Action Plan, the hospital had identified the following targets for 2023:

- consumption of antibiotics in acute settings
- compliance with surgical antibiotic prophylaxis duration.

The annual infection prevention and control report detailed the hospital's overall antibiotic consumption rate and trends in the use of the most commonly used antibiotics for the previous three years (2020-2022).

Inspectors were informed that the hospital's antimicrobial guidelines were overdue for review and had been placed on the hospital's risk register. It was explained that the updating of guidelines at the hospital was currently on hold as the SSWHG are in the process of recruiting a group antimicrobial stewardship pharmacist. In the interim the hospital were advising staff to use Cork University Hospital Guidelines via a dedicated 'Application' (App).

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication audits were carried out in the following areas:

- medication reconciliation
- patient controlled analgesia
- custody and storage of controlled drugs
- compliance with completion of medication prescription administration record (MPAR).

There was evidence that quality improvement initiatives were introduced following audit activity to improve medication safety practices at the hospital. For example, red boxes for identifying and segregating high-risk medications on wards. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The Deteriorating Patient Committee had oversight of audit of compliance with national guidance on INEWS v.2 and compliance with national guidance on clinical handover or the use of the ISBAR communication tool.

In June 2022, an audit was conducted on compliance with the use of the national INEWS v.2 guideline. The results indicated an overall compliance of 92%. While audit findings were higher than previous audits, results fell below the expected compliance of the new guidance for the INEWS v.2 chart. The audit included a number of recommendations and actions but these were not time-bound and did not identify persons responsible for implementation of actions.

Quarterly positive blood culture reports were completed by the sepsis lead. Findings from the most recent audit in March 2023 found non-compliance with staff use of the sepsis pathway and completion of forms. In response to these findings, staff received further education from the sepsis pathway and an action plan was implemented to support the ongoing monitoring of the management of sepsis at the hospital.

Transitions of care monitoring

The hospital was monitoring key performance indicators (KPIs) in relation to transitions of care, including Average Length of Stay (ALOS) for all inpatients, which was 3.2 days (September 2022, most recent data publicly available), which was below the target set by the HSE of 4.2 days.

HIQA received a draft copy of the hospital's quality audit schedule for 2023 which included a number of audits in relation to the four key risk areas, such as nursing documentation, hand hygiene, medication and sepsis audits.

In summary, the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources, however opportunities for improvement were identified in relation to the following:

- outbreak reports did not provide descriptive outcomes of cases or learning opportunities in line with best practice
- further work is required to ensure ongoing compliance with sepsis pathways and documentation.

Judgment: Substantially compliant

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

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of

known harm. The Clinical Governance Committee had oversight of risks. Risk management was a standing item on the agenda of meetings and there was evidence in meeting minutes that risks were discussed. There was evidence that the risk register was discussed at Clinical Governance Committee Meetings and SMT meetings from meeting minutes reviewed by inspectors. Risks that could not be managed at hospital level were escalated to the Executive Management Board.

At the time of inspection, there were 35 risks on the hospital risk register of which 23 were rated high. Risks related to the four areas of known harm included:

- hospital infrastructure
- nightingale wards
- outdated antimicrobial stewardship guidelines
- lack of medication reconciliation
- staffing recruitment challenges.

Risks identified had controls and time-bound actions were assigned to individuals.

Infection prevention and control

The infrastructure of the hospital continued to present ongoing challenges to the maintenance and upkeep of the building. As noted under national standard 2.7, the infrastructure of the some of clinical areas visited was outdated and was not in line with recommended specifications and standards of a modern patient care facility. There were no designated isolation facilities in the nightingale-style ward for patients with known or suspected transmissible infection. Inspectors were informed that if a patient required isolation, the patient would be transferred to a clinical area with isolation facilities as soon as a room became available and that infection prevention and control measures were implemented pending the availability of a single room. Any delays in in transferring a patient to an isolation room were escalated to bed management. However, there were limited isolation facilities in the other clinical areas visited. A prioritisation system was in place for allocating patients who required isolation to single rooms and this was routinely monitored by hospital management. Inspectors observed reduced numbers of beds in multi-bedded wards which enabled appropriate bed spacing.

Inspectors were informed that Aerosol-generating procedures (AGPs)[††††] were routinely carried out on the nightingale-style ward. Given the design and layout of the clinical area, this posed a potential risk to patient safety and a formal risk assessment had not been completed. This was subsequently completed and submitted after the inspection and inspectors were satisfied that the controls in place would minimise the potential risk to patient safety.

[††††] Aerosol-generating procedures (AGPs) are medical procedures that produce minute particles that become suspended in the air (known as aerosols). They are of concern as they potentially increase the transmission risk for pathogens that can spread via aerosols.

The hospital had identified infection prevention and control risks within the hospital water systems and this was an ongoing risk for the hospital. However, it was noted that this did not feature on the hospital's overall risk register. Notwithstanding this, inspectors were informed that a number of control measures in relation to legionella prevention such as routine flushing had been implemented at the hospital and some of these control measures were audited on a quarterly basis to ensure compliance with control measures in place. Inspectors reviewed an audit of legionella control measures for 2023 which identified some opportunities for improvement. While the hospital developed a quality improvement plan in response to findings, the plan did not outline persons responsible and associated timelines. A local legionella risk assessment was carried out in 2021 by an external provider, however the report was noted to be in draft form. Following this inspection, the hospital provided HIQA with a legionella risk assessment report which had been approved by hospital management.

Inspectors noted that the hospital had an up-to-date suite of infection prevention and control policies procedures and guidelines which covered aspects of standard precautions, transmission-based precautions and outbreak management.

Medication safety

As noted in national standard 5.5 there were limited clinical pharmacy services at the hospital and pharmacy-led medication reconciliation was not undertaken for all patients on admission or discharge. This was primarily attributed to staffing deficits within the clinical pharmacy department. It was noted in the meeting with lead representatives for medication safety that there were plans to reintroduce medication reconciliation, in line with the recruitment of an additional clinical pharmacist. Notwithstanding the deficit in clinical pharmacy services, staff who spoke with inspectors in the clinical areas visited stated that they felt supported by clinical pharmacists and the pharmacy technician and that they were very accessible. Medication stock control in the clinical areas visited was carried out by pharmacy technicians daily.

Inspectors were satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications underpinned by a formalised policy which was represented by the acronym 'NEARPINCH'.[‡‡‡‡] Inspectors observed the use of some risk reduction strategies to support the safe use of medicines. The hospital had also developed a list of sound-alike look-alike medications (SALADs), which were on display in medication preparation areas.

Deteriorating patient

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose condition acutely deteriorates. Inspectors

[‡‡‡‡] Medications represented by the acronym 'NEARPINCH' include neuromuscular blockers, epidural and intrathecals, anti-infective agents, anti-psychotics, rate critical medications, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

were informed that the early warning system, INEWS v.2 was implemented on wards and all staff spoken with were aware of the system and described when and to whom to escalate care of a patient. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating.

A sample of healthcare records reviewed showed that in the case where care of a patient was escalated, it was done so in line with protocol. The ISBAR communication tool was used to support communication between staff in relation to a patients care. Evidence of this was observed on the ward. The hospital had recently developed an anticipatory care plan to provide guidance to doctors and nurses who may not be familiar with a patient as to what approach to take in the event of their acute deterioration, for example, a patient who may have recently transferred over from another hospital.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning.

Inspectors reviewed a sample of documentation and noted that the status of multidrug resistant organism or other transmissible infection was not consistently recorded on all patients' records. In addition it was unclear from the review of documentation if patients had been vaccinated against COVID-19 or not. This is an area which requires improvement.

The ISBAR tool was in use in the hospital and stickers were available to place in patients records following an episode of patient deterioration and escalation. ISBAR was also used for clinical handover and safety huddles where any issues that may impact on patient safety and a patient's care plan were discussed.

The hospital had a clear protocol in place to transfer patients to model 4 hospitals, including CUH, where additional specialist care could be provided when not available at the hospital. Staff in clinical areas and lead representatives for the deteriorating patient and transitions of care described the Protocol 37 arrangements that are in place which are guided by 'Protocol 37 The Emergency Inter-Hospital Transfer Policy'.

In summary, the hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. However, inspectors found that:

- not all risks identified by the hospital were represented on the hospital risk register, for example, legionella.
- medication reconciliation arrangements for patients on admission and discharge requires implementation
- patients' infection status was not consistently recorded on patient records.

Judgment: Substantially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital's Incident Review and Clinical Effectiveness Group provided a governance structure to the hospital's management of category one incidents and other SREs which occurred in the hospital, to ensure that all incidents were managed in line with the HSE Incident Management Framework 2020. Meeting minutes and annual incident management reports reviewed by inspectors indicated that incidents were managed appropriately, and with the required level of oversight by the Clinical Governance Committee.

Inspectors reviewed a copy of the Annual Incident Management Report 2022 for the hospital, which gave a detailed breakdown of the incidents that occurred at the hospital between January and December 2022. A total of 1257 occurred at the hospital and the report categorised incidents according to type, location, time and injury occurred where applicable. Documentary evidence of health and safety dashboards relating to incidents were reviewed by inspectors which showed higher rates of incident reporting in previous years. For example, the numbers of incidents reported in the previous years ranged from 1300 to 1900.

Staff who spoke with HIQA were knowledgeable about the incident reporting process in place within the hospital. Staff described the process to inspectors, including the sharing of incident data in the form of dashboard reports and reported that the quality and safety department followed up incidents at ward level. Incidents were discussed at CNM meetings and inspectors were informed that learning from incidents was then shared by CNMs at handover. There was evidence that quality improvement plans had been introduced in response to incidents and that practice changes had occurred.

Where incidents occurred in relation to one of the four key risk areas, inspectors reviewed documentary evidence that incidents were discussed at the relative meetings and measures were taken to address any immediate risks, and where necessary quality improvement initiatives were undertaken. Medication patient-safety incidents were reviewed by the pharmacy department who categorised the incidents in terms of severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. These were also further broken down into the type of medication involved and at what stage of the medication process the error had occurred. In 2022, 109 medication patient-safety incidents were reported in the hospital, a decrease on the number of incidents reported when compared to 2021

(125). Higher incident reporting rates are generally indicative of a positive medication safety culture.

In summary, inspectors were satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm. Notwithstanding this:

- opportunities for improvement were identified in relation to improving incident reporting rates at the hospital noting higher rates of reporting in previous years.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of South Infirmary Victoria University Hospital to assess compliance with national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was judged to be:

- compliant in one national standard (1.7)
- substantially compliant in eight national standards (1.6, 1.8, 2.8, 3.1, 3.3, 5.2, 5.5, 5.8)
- partially compliant in two national standards (2.7, 6.1).

Capacity and Capability

HIQA was satisfied that the hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, attention is required to ensure that actions arising from meetings of all committees are time-bound and are assigned to individuals and terms of reference are reviewed as required. All committees should also be clearly represented on organisational charts.

The hospital had effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. The hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the management of clinical areas visited during the inspection. It was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care of patients and that operationally, the clinical areas were functioning well. The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas.

Systematic monitoring arrangements were in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on a suite of KPIs and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks. There was oversight of the management of SREs and serious incidents, in line with the HSE's Incident Management Framework. The hospital should look to establish formalised structures and centrally control audit activity at the hospital to promote quality management of the audit process and shared learning as discussed with management during inspection.

It was evident that hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare. However, hospital management must progress with recruitment efforts to address the shortfall in staff vacancies and the reliance on locum medical staff to maintain the out-of-hours medical registrar roster. 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

The hospital promoted a person-centred approach to care.

Inspectors observed staff being kind, caring and respectful towards patients. It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients who inspectors met with were complimentary of the staff and the care provided to them. Inspectors found that service users' complaints and concerns were responded to promptly, openly and effectively.

The clinical areas visited were found to be clean with few exceptions. However, the physical environment posed a number of challenges to staff and patients, including the limited isolation, en-suite and toilet facilities throughout the hospital. The poor physical infrastructure and the outdated design of the nightingale ward are a risk to patient safety and will continue to present ongoing challenges to the maintenance and upkeep of the building. The hospital needs to be supported within group and national structures to effectively address issues in relation to hospital infrastructure.

The hospital had systems in place to monitor, evaluate and continuously improve services. Audits were being undertaken across the four key risk areas, however the hospital would benefit from ensuring that audits are centrally controlled within the hospital.

Opportunities for improvement were identified in relation to medication reconciliation and completion of elements of healthcare records and discharge documentation.

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Opportunities for improvement were identified in relation to improving incident reporting rates at the hospital when compared with previous years.

SIVUH as a member of the South/South West Hospital Group, needs to be supported within group and national structures to effectively address issues in relation to hospital infrastructure and resources in order to facilitate compliance with the National Standards for the Prevention and Control of Healthcare Associated Infections and other existing national healthcare standards.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the *National Standards for Safer Better Healthcare.*

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

Compliance classifications

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

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

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

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

Compliance Plan for South Infirmary Victoria University Hospital

Inspection ID: NS_0039

Date of inspection: 25-26 April 2023

Compliance Plan Service Provider's Response

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

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

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

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

Medical Registrar

Short term

While clear escalation procedures are in place, the reliance on locum medical staff out of hours is acknowledged. We will revisit the possibility of local hospitals providing medical cover to SIVUH. A new elective hospital would need to incorporate medical cover in order to avoid this issue. Person Responsible: Clinical Director

Long term

A longer term plan is under development to recruit and train a team of Advanced Nurse Practitioners in acute medicine to undertake this role. A proposal for funding for this initiative to be made to SSWHG by end Q3 2023. Person Responsible: Director of Nursing / Clinical Director

Recruitment

Short-term

- Ongoing nursing recruitment including participation in the HSE International Recruitment Rounds. We have currently submitted for Round 13. We've just closed a national recruitment campaign with 100 plus applicants awaiting short-listing.
- We also participate in the Magnet for Europe (M4E) Research Project which looks at the US Magnet principles of wellbeing and a healthy work environment to make the hospital a more attractive workplace for staff.
- Onboarding Project for new recruits in Nursing won a poster presentation award at the M4E International conference in Oslo.
- In relation to CNM II vacancies, 6 new CNM IIs have commenced. Further interviews are scheduled in July.
- A recruitment campaign is currently on going for HCAs.
- For Administration Staff, a number of recruitment campaigns are currently ongoing, including the campaign for Grade III staff which is currently at interview. Compliance with pay scales means that Grade III recruits cannot be given incremental credit for private sector service unlike nursing grades.
- The recruitment market nationally is extremely competitive. In addition, difficulty in finding accommodation in/close to the city affects all grades and groups of staff.
- In terms of optimising employee engagement levels, we now have approval to recruit for a Health & Wellbeing Officer 0.6WTE.

IPEWS Clinical Lead

A Clinical Lead for IPEWS is now in place.

Clinical Audit

Short term
In order to centrally control audit activity at the hospital, the next meeting of the Clinical Governance Committee scheduled for 17 July 2023 will consider the findings of this report in relation to Clinical Audit and how to progress same. Person responsible: Quality & Risk Manager

Staff Training

Short term

The Training Database (Mandatory & Additional including CPD) complete for Nursing & HCAs and will facilitate tracking and targeting. Our existing systems and HR access to HSELand reporting is limited. This is a challenge for all voluntary hospitals.

Immediate actions will be undertaken to:
- Convene a Training Review Group to review our existing system and identify the gaps and ideas to drive improvement. Person Responsible: Quality & Risk Manager.
- SMT to ensure managers and staff are advised of the need to be compliant with mandatory and essential training requirements.

Person Responsible: Quality & Risk Manager

Timescales:

Short term - end of Q3 2023

Medium term – end of Q4 2023

Long term – Q2 2026

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

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

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

Short-term/ongoing

Detailed risk assessments with substantial additional controls are in place for the Nightingale wards across 3 areas: IPC, Patient Dignity and Moving & Handling. These will continue. These controls include proactive management of patients with MDROs via weekly bed management meetings pre-admission, where patients with MDRO are identified and placed in isolation rooms on other wards. Secondly for patients identified on screening or becoming symptomatic while on the Nightingale wards, these patients are always transferred to an appropriate isolation room.

Any delay in isolating a symptomatic patient would only relate to the time it takes to make the necessary arrangements as this occurrence requires immediate escalation to the Duty Bed Manager and is deemed an immediate priority. While the arrangements are being made, bedside precautions are implemented, the curtains are pulled, the patient is given a mask and designated toilet etc.

We plan to audit the time taken to transfer symptomatic patients to an appropriate isolation room. Person Responsible: IPC ADON

Legionella
Our Hospital Safety Statement, which is updated annually, includes a local risk assessment for Legionnaires' disease. This carries a residual risk rating of 6 due to the control measures in place. Only risks rated 15 or greater are escalated to the corporate risk register.

An external risk assessment for Legionella was completed in November 2021 and has been finalised. The Environmental Monitoring committee (EMC) uses this to further reduce the risks. This external risk assessment is due for external review in Q4 2023. Person Responsible: Facilities Manager

Isolation Facilities
An IPC business case to SARI was funded for 2 Redi Rooms. These will enable us to isolate patients with certain MDROs on an open ward (i.e. those requiring contact precautions only NOT droplet/airborne). Person Responsible: IPC ADON

Upgrade of toilet/sink facilities
Funding has been received from AMRIC for the upgrade of the toilet block and replacement of the sinks in GFS2. These works are scheduled for Aug 2023. Person Responsible: Facilities Manager

Family Room
From a patient dignity perspective, a Family Room has been upgraded and reopened post-covid and is available for families of patients who are very unwell and for meetings between medical staff and patients / families.

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

Further external capital investment is required for reconfiguration of the Nightingale wards. We will continue to engage with SSWHG on this. The Capital Development Plan previously submitted to SSWHG & HSE Estates in January 2022 which included plans for the Nightingale wards will be raised with the Hospital Board and with the SSWHG CEO by the **end of Q3 2023** with a view to re-escalating nationally to secure commitment and funding. Person Responsible: CEO

Timescale:
Short term – end of Q3 2023

Medium term – end of Q4 2023

Long term – Q2 2026