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 Galway
Address of healthcare service:	Newcastle Road Galway Co. Galway H91 YR71
Type of inspection:	Unannounced
Date(s) of inspection:	8 and 9 May 2024
Healthcare Service ID:	OSV-1030
Fieldwork ID:	NS_0078

About the healthcare service

Model of hospital and profile

Galway University Hospitals is a model 4* acute teaching hospital and is comprised of University Hospital Galway and Merlin Park University Hospital. Galway University Hospitals are Health Service Executive (HSE) funded hospitals managed by the Saolta University Health Care Group (hospital group).† The hospitals provide a range of services to emergency and elective patients on an inpatient, outpatient and day care basis across the two sites. On the University Hospital Galway site the services provided include:

- acute medicine
- elective and emergency surgery
- emergency care
- critical care
- paediatrics and neonatal care
- obstetrics and gynaecology care
- diagnostic services
- outpatient care.

The hospital provides regional services for a wide range of specialities and is also a designated supra regional centre for cancer and cardiac services.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	724 inpatient beds (651 University Hospital Galway and 73 Merlin Park University Hospital) 167 day case beds.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and

* A model 4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care.
† The Saolta University Health Care Group comprises seven hospitals. These are; Letterkenny University Hospital, Mayo University Hospital, Merlin Park University Hospital, Portiuncula University Hospital, Roscommon University Hospital, Sligo University Hospital and University Hospital Galway.

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, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

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

Additional documentation and data was requested and reviewed following the inspection, to see if it reflected what inspectors observed and what staff, managements and people told inspectors on the day of inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with 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 before, during and following the inspection.

1. Capacity and capability of the service

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

[‡] 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)

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 compliance classification and the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1. The compliance plan submitted by the hospital following this inspection is included in Appendix 2.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
8 May 2024 9 May 2024	8:45hrs – 17:45hrs 8.45hrs – 16:45hrs	Nora O' Mahony	Lead
		Geraldine Ryan	Support
		Denise Lawler	Support
		Danielle Bracken	Support
		Elaine Egan	Support

Information about this inspection

An unannounced inspection of University Hospital Galway was conducted on 8 and 9 May 2024. HIQA last undertook an unannounced inspection of University Hospital Galway's emergency department in 2023 when compliance against four national standards was assessed — 5.5, 6.1, 1.6 and 3.1. Progress on the implementation of the compliance plan developed by the hospital following that inspection was reviewed as part of this inspection.

During this inspection, inspectors visited clinical areas on the University Hospital Galway site and therefore, most of the details in this report refers to University Hospital Galway. However, committees and other structures outlined in the report may refer to both sites under Galway University Hospitals.

This inspection focused on 11 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 were:

- infection prevention and control
- medication safety

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

The inspection team visited the following clinical areas:

- the emergency department (ED), including the acute medical assessment unit (AMAU), acute surgical assessment unit (ASAU) and the emergency department transitional area
- St Teresa's ward
- St Finbar's ward
- St Enda's ward.

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

- representatives of the hospital management team (HMT), the:
  - General Manager
  - Deputy General Manager
  - Director of Nursing (DON)
  - Assistant Director of Midwifery
  - Associate Clinical Director for the Medicine Directorate
- the Quality and Patient Safety (QPS) Manager
- the Human Resource Manager and Medical Manpower staff officer
- the Patient Advice and Liaison Coordinator
- representative for the non-consultant hospital doctors (NCHDs)
- a lead representative from each of the following areas:
  - infection prevention and control
  - medication safety
  - deteriorating patient (including sepsis)
  - transitions of care (including clinical handover).

Inspectors also spoke to hospital staff from a variety of disciplines in the clinical areas visited during this inspection.

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.

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

During this inspection, inspectors visited the emergency department including the AMAU, the ASAU and the emergency department transitional area. Inspectors also visited St Teresa's ward, St Finbar's ward and St Enda's ward.

The emergency department was comprised of nine cubicles for non-ambulatory patients, nine cubicles for ambulatory patients, seven cubicles for paediatric patients, three resuscitation bays and a negative pressure isolation room with ensuite toilet and shower (total 29 spaces). There were eight assessment bays — four in the minor injuries unit, two in the acute oncology services area, one general practitioner (GP) assessment room, one health and social care professional assessment area and one interview room. There was an ambulatory waiting area with approximately 24 chairs for ambulatory patients undergoing assessment and review within the emergency department.

The emergency department was busy, relative to its intended capacity. At 11am on the first day of inspection there were 96 patients registered in the emergency department with 29 (30%) admitted patients accommodated on additional trolleys in the emergency department corridor or on chairs in the waiting area of the ambulatory area within the emergency department.

St Teresa's ward was a 32-bedded renal and rheumatology ward, St Enda's ward was a 32-bedded older persons ward and St Finbar's ward was a 40-bedded orthopaedic and frail elderly ward. At the time of inspection all beds in these wards were occupied.

Inspectors observed staff actively engaging with patients in a respectful and kind manner. Staff were respectful and considerate in their interactions with each other. Inspectors observed staff promoting and protecting patients' privacy and dignity in clinical areas visited. However, privacy and dignity was difficult to maintain in large multi-occupancy rooms and for patients accommodated on the corridor in the emergency department.

Inspectors spoke with a number of patients about their experience of the care received in the hospital. Patients were complimentary about the staff and the care they had received commenting that '*staff are lovely', 'they can't do enough for you'.* When asked what had been good about their stay in the hospital so far, patients commented that there was '*very good care', 'very kind staff'*, '*timely pain management'* and that '*food was lovely'.* One patient commented that *'it has been a very pleasant experience'.* When asked if anything could be improved about the service or care provided, most patients commented '*nothing'* or '*happy with everything*.' Patients did comment on how busy staff were and that '*they were trying to do their best under very challenging circumstances*'. A patient in the emergency department did comment that it would be an improvement if they could '*get a*

bed,' another patient commented that they had asked to be moved from the noisy corridor in the emergency department, they could not be moved at the time but got a bed later.

Patients who spoke with inspectors outlined that if they had a complaint they would talk to a member of staff. Inspectors observed patient information leaflets about the HSE's complaints process *'Your Service, Your Say'* and the hospital's patient advice and liaison service displayed on all, except one, clinical area visited.

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

Capacity and Capability Dimension

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

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

The hospital's General Manager had overall responsibility and accountability for the governance of the hospital and reported to the Interim Chief Executive Officer of the hospital group. The General Manager was supported by the Hospital Management Team (HMT). The DON and the DOM were responsible for the organisation and management of nursing and midwifery services at the hospital. They reported to the General Manager and had a close working relationship with the Chief Director of Nursing and Midwifery for the hospital group.

An associate clinical director (ACD) for medicine, peri-operative, radiology, laboratory, women and children's and cancer services provided clinical oversight and leadership for these services at the hospital. The hospital group had well established Managed Clinical Academic Networks (MCAN)[‡‡] for women's and children's services and cancer services. Inspectors were informed that the MCAN structure was evolving with the development of additional MCANs for the medical and perioperative services.

The ACDs reported to the Clinical Directors of the hospital group and also provided updates reports on their respective directorate at HMT meetings. The ACD position for peri-operative services was vacant at the time of inspection. Inspectors were informed

[‡‡] A Managed Clinical and Academic Networks (MCAN) is a group wide management structure under which clinical services are organised across Saolta Hospitals.

that the position has been advertised without success. The hospital was actively recruiting to fill this position – in the interim the Clinical Director Perioperative Services for the hospital group represented the perioperative services at governance meetings.

Galway University Hospitals' HMT was the main governance structure at the hospital. The HMT was chaired by the General Manager and met monthly. The members of the HMT were accountable, through the General Manager, to the hospital group. Members of the HMT attended performance meetings with the hospital group on alternative months. Minutes submitted to HIQA after the inspection, showed that the HMT meetings took place in line with its terms of reference, followed a structured format and were action orientated. Organisational charts outlining the hospital's management structures concurred with documents reviewed and what inspectors were told during the inspection. The General Manager for Galway University Hospitals represented the hospitals on the Saolta University Health Care Group Executive Committee, which met monthly and was chaired by the hospital group Interim Chief Executive Officer.

The Galway University Hospitals' Quality and Patient Safety (QPS) Committee was assigned with overall responsibility to develop and deliver an integrated quality, safety and risk management programme. The committee was chaired by the General Manager, met quarterly and had appropriate multidisciplinary membership. The committee was accountable to and reported to the HMT. From minutes reviewed following this inspection, it was clear that the committee was action orientated with actions monitored from meeting to meeting.

The QPS Committee reviewed reports from various committees that reported into it such as — the Infection Prevention and Control (IPC) Committee, the Medication Safety Committee and the Deteriorating Patient Improvement Programme (DPIP) Implementation Group. The QPS Committee had oversight of the hospital's risk management process including review of the hospital's corporate risk register. The committee had oversight of incident analysis, implementation of recommendations from incidents and reviews, and the identification of trends from patients' feedback which including compliments and complaints.

During the inspection, inspectors were told that each directorate had a monthly quality and patient safety meeting – except for the laboratory directorate which had different quality and safety structures in place. Documents submitted to HIQA following the inspection had these committees with the title of Galway University Hospitals' MCAN Committees, although not a MCAN as defined by the group. For example, the medical directorate had a Galway University Hospitals' Medical MCAN Committees. Membership of this directorate committee was multidisciplinary from Galway University Hospital and chaired by the ACD of the service. The overall aim of the Galway University Hospital Medical MCAN Committee was to develop, deliver, champion, implement and evaluate a comprehensive quality and safety programme with associated structures, policies and

processes which were the vehicle for promoting a culture of quality improvement. The Galway University Hospitals' MCAN Committees reported monthly to the HMT.

Galway University Hospitals' IPC Committee was responsible for the governance and oversight of infection prevention and control at the hospital. The IPC Committee met quarterly, was chaired by the General Manager and reported to the QPS Committee. Minutes of meetings of the IPC Committee submitted to HIQA after the inspection showed that the committee had a set agenda and appropriate membership. Meeting actions were assigned to a responsible person. From evidence gathered during and after this inspection it was evident that there was effective governance and oversight of infection prevention and control practices at the hospital.

The Galway University Hospitals' Drugs and Therapeutics Committee was assigned responsibility for the governance and oversight of medication safety practices at the hospital. The committee was chaired by a medical consultant, it met every second month (six times a year) and reported to the HMT. Meeting actions were recorded on minutes reviewed by inspectors, with a responsible person identified and actions reviewed from meeting to meeting. From evidence gathered during and following this inspection it was clear that there was effective governance and oversight of medication safety practices at the hospital.

The Galway University Hospitals' DPIP Implementation Group was set up to enable and guide the implementation of the relevant national early warning systems[§§] and the national clinical guidelines on sepsis management. The group was chaired by the Nurse Practice Development Coordinator and reported to the QPS Committee. The group had not convened in the first quarter of 2024 due to lack of availability of consultant leads. A meeting subsequently took place in May 2024 with a medical consultant clinical lead attending. Perioperative, obstetric and paediatric consultant clinical leads were not recorded as present in the minutes of the last three meetings viewed by inspectors following this inspection. Meetings followed a structured agenda and were action orientated with each action assigned to a responsible person.

The Galway University Hospitals' Winter Planning and Unscheduled Care Governance Group had responsibility to provide governance and oversight for unscheduled care. The Group was chaired by the General Manager and met monthly. Reporting structures were not outlined in the committee's terms of reference reviewed by inspectors following this inspection. However, unscheduled urgent and emergency care was an agenda item reviewed and discussed at HMT meetings and at the hospital's group performance meetings. The committee followed a set agenda with actions progressed from meeting to meeting.

[§§] Irish National Early warning System (INEWS), Irish Maternity Early Warning System (IMEWS), Paediatric Early Warning System (PEWS), Emergency Medicine Early Warning System (EMEWS) and National Clinical Guideline on Sepsis Management and the International Guidelines for the Management of Septic Shock & Sepsis-Associated Organ Dysfunction in Children.

Overall, it was clear from documentation reviewed by inspectors both during and following this inspection and from meetings with relevant staff, that there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. However, clinical leads for all specialities were not recorded as present in the minutes of the DPIP Implementation Group reviewed by inspectors, this is an opportunity for improvement.

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.

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of known harm which were the focus of this inspection – infection prevention and control, medication safety, deteriorating patients and transitions of care. There were management arrangements in place to manage patient flow throughout the emergency department, the hospital and on to the community. Although improved since the previous inspection, the operational arrangements in place were not fully effective in supporting patient flow through the hospital, which resulted in admitted patients accommodated on trolleys and chairs in the emergency department and delayed transfer of care on the wards.

The hospital had an overarching infection prevention and control programme as per national standards.[***] The infection prevention and control team had developed an infection prevention and control plan that set out objectives to be achieved in 2024. The infection prevention and control plan was overseen by the infection prevention and control (IPC) Committee and a performance report was submitted to the QPS Committee quarterly. Progress on implementation of the infection prevention and control objectives for 2024 was evident throughout this inspection. For example, the undertaking of audits, surveillance and staff education. The infection prevention and control team produced an annual report for the IPC Committee, which outlined the objectives achieved in the previous year, the draft 2023 report was viewed by inspectors.

The hospital's pharmacy service was led by the Chief Pharmacist. The hospital had a Medication Safety Subgroup of the Galway University Hospital's Drugs and Therapeutics Committee. The Medication Safety Subgroup reported to the Drugs and Therapeutics Committee. Medication safety was an agenda item on the QPS Committee and the

[***] National Clinical Effectiveness Committee. National Clinical Guidelines No. 30. Infection Prevention and Control. 2023. Available on line from: https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-summary-report.

Medication Safety Coordinator represented the subgroup at the the QPS Committee. The Medication Safety subgroup's purpose was to reduce avoidable harm to patients and increase patient safety. The Medication Safety Subgroup meetings were action orientated, there was evidence of quality improvements planned to minimise reoccurrence of incidents and an accountable person was identified to implement these changes.

The hospital's antimicrobial stewardship (AMS) team was responsible for the implementation of the hospital's antimicrobial stewardship programme. The AMS team was a subgroup of the Drug and Therapeutics Committee. The AMS team provided quarterly and annual reports to the Drug and Therapeutics Committee.

A medical consultant was the lead for the deteriorating patient improvement programme (DPIP) in the hospital supported by the ACD for medicine. The DPIP implementation was supported by nursing representatives from medicine, perioperative, obstetric and paediatrics services and representatives from senior management and the quality and patient safety department. The hospital group Assistant Director of Nursing (ADON) for the deteriorating patient and sepsis was a member of the committee and attended meetings. Advanced nurse practitioners on the critical care outreach team[†††] supported the management of the clinically deteriorating patients on a 24/7 basis.

The hospital's nurse practice development coordinator with support from the DON had responsibility for nursing clinical handover. The ACD for medicine had overall responsibility for medical clinical handover. There was no identified lead for perioperative services clinical handover. This was an area for improvement for the hospital.

The overall attendance rate at the hospital's emergency department in the year to date was 24,261, a 9% increase on the previous year. This equates to approximately 216 attendances every day, although on the first day of inspection the attendance rate was 264. There was evidence of strong clinical and nursing management in the emergency department to manage surges of people attending the emergency department. Overall clinical management of the emergency department was the responsibility of the Lead Consultant. The day-to-day clinical management of the emergency department was the responsibility of the consultants in emergency medicine supported by non-consultant hospital doctors. Outside core working hours,[‡‡‡] medical oversight of the emergency department was provided by the on-call consultant in emergency medicine. The management of patient flow throughout the emergency department was coordinated by the shift clinical nurse manager (CNM) grade 2.

The hospital had implemented a number of pathways into which patients could be streamed from the emergency department such as AMAU and the ASAU and to a GP

[†††] Critical care outreach team staffed by critical care nurses who review patients at risk of deterioration on the clinical wards. The critical care outreach team provides advice and clinical support to the ward staff by liaising with the primary and anaesthesiology teams as early as possible to respond and deliver the most appropriate management.

[‡‡‡] Core consultant in emergency medicine hours ranged between 8am-6pm or 8am-10pm Monday to Friday.

service available four day per week within the emergency department. The rapid access nurse was also introduced since the previous inspection in 2023. A rapid access nurse undertook a secondary triage, completed early investigations and referred selected patients to suitable pathways. The AMAU, the ASU and the emergency department's GP service were functioning as they should on the day of inspection to support patient flow from the emergency department. This was an improvement on the previous inspection in 2023, when the AMAU and ASAU were not functioning as alternate flow pathways for patients in order to take pressure from the emergency department.

The hospital had additional initiatives for admission avoidance or early discharge such as the frailty at the front door team. For example the frailty at the front door services was provided by a multidisciplinary team who reviewed patients over 75 years of age who present to the emergency department with frailty. The team provide a targeted assessment with the aim to avoid a hospital admission with alternative supports in place as required. The multi-allied response service[§§§] also reviewed patients to initiate early treatment to avoid hospital admission or reduce hospital length of stay with follow-up appointments as required. A consultant-led review clinic was run three days a week, which facilitated a cohort of patients to be discharged with return appointment for a consultant review. The conversion rate[****] for the emergency department year to date 2024 was 25.6%, which compares well to other model 4 hospitals and indicated that pathways in place were working well to manage the patient flow through the emergency department.

The hospital's patient flow team and discharge coordinators managed transitions of care through the hospital and into the community. The hospital had systems in place to support the management of patient flow such as, daily meetings at 9am and 2.30pm to review the hospital's situation and action initiatives to enhance the patients' journey through the hospital. Daily reports on the availability of beds in the community was distributed to key personnel to support patient discharge. There were multidisciplinary weekly integrated length of stay meetings for medical and surgical teams led by the discharge coordinator. Patients with a length of stay over 14 days were reviewed at this meeting, with the aim of progressing their care towards discharge. The Joint Discharge Planning Committee – Primacy Community and Continuing Care and Galway University Hospital met on alternate months to work together to process patient discharges to the community.

Despite all the systems in place to support patient flow, the demand for inpatient beds outweighed the hospital's bed capacity. The hospital was in full escalation at the time of inspection. Evidence of escalation actions as per the hospital's escalation framework were seen to be implemented. These included additional surge capacity beds in use and the

[§§§] Multi-allied Response Service, is a team of health and social care professionals who review patients with the aim to initiate early treatment to avoid admission or reduce hospital length of stay, with required follow up arrangements in place.

[****]Conversion rate – the rate of admission of patients to an inpatient ward

placement of patients on additional trolleys on clinical wards. The emergency department transit area was open to prioritise and move patients over 75 year of age from the busy emergency department. There was evidence that this unit was functioning as planned in that during the previous inspection in 2023, 35% of the patients in the department were 75 years of age or over while on this inspection only 10.4% of the patients in the emergency department were 75 years of age or over.

The CNM 2 led on the implementation of relevant actions in the emergency department's escalation plan, such as the allocation of additional nurses to the triage area when the triage wait times for 10 patients exceeded 20 minutes, as observed on the day of inspection.

Hospital management outlined a number of long term building projects at a various stages of progress toward the building of a new permanent emergency department, a cancer centre and ward block to address bed deficits.

At 11am on the first day of inspection, the emergency department was non-compliant with national patient experience times[††††] (PETS) and there were 29 patients accommodated in the emergency department awaiting an inpatient bed. The average length of stay (ALOS) for surgical patients was non-compliant with national targets – surgical elective ALOS was 5.87 (target less than or equal to 5), surgical emergency ALOS was 8.35 (target less than or equal to 6). There were 31 patients in the hospital with delayed transfers of care. Collectively these demonstrated that patient flow was not operating as efficiently and effectively as required to support the patients' journey from the emergency department through the hospital and onto the community.

Overall, it was evident that the hospital had defined management arrangements in place at the hospital to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. Evidence of the hospital's implementation of the majority of the immediate and medium-terms actions outlined in the updated compliance plan for standard 5.5 was provided to inspectors during or following this inspection. For example, there had been improvements to triage to support patient follow, additional staff had been employed for the patient flow team resulting in expanded cover 7/7 with patient flows coordinators assigned to specifics wards, there was cohorting of patient on wards to deliver an improved patient experience. Notwithstanding this, the risk of compromised quality and safety of patient care due to insufficient capacity to manage demand in the emergency department remained one the highest rated risks on the hospital's corporate risk register. On the day of inspection, patient flow within the hospital was still not functioning as it should. The mismatch between availability and demand for

[††††] Patient experience time measures the patient's total time in the emergency department, from registration time to emergency department departure time. Targets are set for the percentage of all attendees at emergency department who are discharged or admitted within six, nine and 24 hours of registration, and the percentage of all attendees aged 75 years and over at emergency department who are discharged or admitted within six, nine and 24 hours of registration.

inpatient beds resulted in 29 admitted patients being accommodated in the emergency department. This resulted in increased PETs and increased patient risk.

Judgment: Partially compliant

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

The hospital had monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. Evidence that monitoring and evaluation of services was used to improve practice was provided for some, but not all audits. This is discussed further under national standard 2.8.

The hospital had risk management structures and processes in place to proactively identify, monitor, analyse and manage identified risks. Documentation submitted to HIQA showed that key risks related to the four key areas of known harm, which were the focus of this inspection, were recorded on the hospital's corporate risk register. Existing controls and additional actions required to mitigate these risks were documented. The corporate risk register was reviewed at the QPS Committee with oversight by the HMT. Risks which required additional supports were escalated to the hospital group. The top five risks on the corporate risk register were outlined in the monthly quality and patient safety report to the HMT. These risks included – unscheduled care, scheduled care, infection prevention and control and staffing. These will be discussed in more detail throughout this report.

The hospital had a Clinical Audit Committee which reviewed, approved and guided the conduct of clinical audits. This committee reviewed completed audits and advised on the implementation of quality improvement plans and re-audits to complete the audit cycle. Evidence of quality improvement plans developed from audit findings were seen by inspectors for some, but not all audits completed. The hospital did not have an overarching audit plan, but audit plans for obstetrics, infection prevention and control and medication safety were reviewed by inspectors. Evidence of progress of these planned audits was seen by inspectors.

There were systems and processes in place at the hospital to proactively identify and manage serious incidents and serious reportable events. The QPS Committee were responsible for ensuring that all patient-safety incidents were reported in line with the National Incident Management System (NIMS) and managed in line with the HSE's Incident Management Framework with oversight from the Hospital Management Team. Serious reportable events and serious incidents were reviewed, tracked and trended by the quality and patient safety department each month. Each directorate committee had responsibility for the review and management of serious incidents and serious reportable events with oversight by the QPS committee, the HMT and SIMT. All serious incidents and serious reportable events were reported to the General Manager and reviewed by the ACD

and DON or DOM of the relevant directorate committee. A preliminary assessment report was completed and escalated to the hospital group's Chief Operation Officer and the hospital group's Clinical Director for Quality and Patient Safety for review and for management by the hospital group's Serious Incident Management Team (SIMT).

The hospital collected data on a range of different clinical measurements related to the quality and patient-safety of healthcare services, in line with the national HSE reporting requirements. The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governing committee and at performance meetings between the hospital and the hospital group.

Information from feedback, compliments and complaints from people who use the services was shared through the directorate committees. ADONs who attended these meetings provided feedback to CNM's, who in turn provide feedback to staff at ward meetings.

In summary, the hospital was monitoring performance against key performance indicators, but it was not fully evident that the finding from all monitoring and was used to implement changes to improve the quality and safety of the services at the hospital.

Judgment: Substantially compliant

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

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. However, these arrangements were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare in the emergency department and wider hospital.

The infection, prevention and control team comprised of the following WTE positions — 4.5 consultant microbiologists, one ADON, one CNM 3, three clinical nurse specialists and three CNMs, a staff nurse, two surveillance scientists and clerical support. All of these post were filled at the time of inspection. The hospital also had two approved WTE antimicrobial stewardship (AMS) pharmacist's posts. However, at the time of inspection only 0.8 WTE AMS pharmacist post was filled. Inspectors were informed that this shortage impacted on AMS pharmacist rounds and that the AMS pharmacist prioritised high-risk areas such as St Teresa's ward and St Enda's ward. Inspectors were informed that recruitment was in progress with an additional WTE AMS pharmacist due to take up the post in June 2024.

The pharmacy department had 36 approved WTE pharmacists in the hospital. At the time of inspection the hospital had two WTE unfilled pharmacists' positions, a 7.6% variance with additional staff on long-term leave. The unfilled positions impacted on the hospital's ability to provide a full clinical pharmacy service to clinical areas. The hospital demonstrated a risk matrix scoring system which prioritised clinical pharmacy cover for high-risk areas of the hospital. This will be discussed under national standard 3.1.

The emergency department maintained medical staffing levels in the emergency department at levels to support the provision of 24/7 emergency care. The hospital had approval for 10 WTEs consultants in emergency medicine for the adult emergency department, and two new WTE posts for consultants in paediatrics for the emergency department. On the day of inspection, 5.5 WTE of the adult consultant positions were filled which was an improvement on the previous inspection in 2023, when 2.5 WTE consultant positions were filled. There were an additional two consultants in emergency medicine due to take up position in the hospital in August 2024 and February 2025. A senior clinical decision-maker[‡‡‡‡] at consultant level or registrar level was on-site in the hospital's emergency department 24/7. The positive impact of the additional consultants in emergency medicine on site in the department was evident to inspectors and articulated by staff. The emergency department was busy relative to its intended capacity on the day of inspection but was well managed by the nursing management and the emergency consultants on duty.

Consultants in the emergency department were supported by 38 WTE NCHDs —14 at registrar grade and 24 at senior house officer (SHO) grades. All NCHD's positions in the emergency department were filled at the time of inspection, which was an improvement on the previous inspection when nine NCHD posts were unfilled.

The emergency department had an approved complement of 118 WTEs nursing staff, with 103 WTEs nursing positions filled on day of inspection, a variance of 13%. Nurse staffing levels had fallen since the previous inspection in 2023 when there was a variance of 9% in nurse staffing levels. Hospital management were actively recruiting to fill nursing vacancies. The hospital management had ongoing recruitment campaigns in progress to fill these positions which were not impacted by the HSE recruitment embargo. The department had its full complement of nursing staff rostered on duty on the first day of inspection. Inspectors were informed that unfilled shifts were filled by nurses working extra shifts or agency nurses to cover short-term absenteeism. A CNM 3 was rostered on duty on the day of inspection and had overall nursing responsibility for the department.

Inspectors visited St Enda's, St Finbar's and St Teresa's wards during this inspection. St Teresa's and St Enda's ward had their approved nursing compliment of staff with no shortages reported on the day of inspection. Inspectors were informed that St Finbar's ward, a 40-bedded surgical ward, had 35 WTE staff nurses with a shortfall of 5 WTE (14%

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

variance). On the day of inspection the ward was short three WTE nurses and two healthcare assistants. A review of the previous three weeks ward rosters identified that 14 of 21 shifts were short at least one nursing shift. The impact of the staff shortages was risk assessed by the hospital and patient-safety incidents recorded when necessary. However, inspectors were informed that the 'impact of care not given' was not recorded by the hospital.

The human resource department tracked and reported on staff absenteeism rates which were reviewed at meetings of the HMT and performance meetings with the hospital group. The hospital's most recent reported absenteeism rate in March 2024 was 4%, compliant with the HSE's target of 4% or less. Back to work interviews were undertaken by line managers and tracked by the human resource department.

Clinical nurse managers had oversight of mandatory and essential training for nurses and healthcare assistants on the clinical wards visited. Nurse attendance at mandatory and essential training on clinical area visited ranged from:

- 32% to 100% for standards and transmission-based precautions
- 32% to 100% for hand hygiene
- 45% to 100% for Irish National Early Warning System (INEWS)
- 50% to 100% for basic life support
- 50% to 100% for medication safety.

NCHDs attendances at mandatory and essential training in the emergency department was monitored by the human resource department. NCHD compliance with attendance at hand-hygiene training was 51%, INEWS training was 47% and basic life support training was 62%. Compliance rates with standard and transmission-based precautions and medication safety training were not provided for NCHD's in the emergency department.

Training records for nurses, doctors and healthcare assistants for the overall hospital was not provided to HIQA, except for hand-hygiene training which was 56% overall.

Overall, it was evident that hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. Since the previous inspection in 2023 the medical staffing levels in the emergency department had improved, with plans for additional consultants in emergency medicine to take up posts. However, the nursing staffing level had fallen by 4% since the previous inspection The hospital had made some progress with the implementation of actions in the 2023 compliance plan related to standard 6.1. However further progress related to recruitment of nursing and medical positions was still outstanding at the time of this inspection.

There was a shortfall of in the approved complement of nurses in St Finbar's ward. The attendance at and uptake of mandatory and essential training required improvement in the areas visited by inspectors on the day of inspection, apart from St Finbar's ward which demonstrated good compliance. Hospital wide training records were not available for areas

requested related to the four areas that were the focus of this inspection, apart from hand hygiene.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

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

It was evident through observation of care provided, and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff working in clinical areas visited were observed communicating with patients in a manner that respected their dignity and privacy. Staff endeavoured to supported patients with their individual needs in a manner that protected their dignity and privacy. This was consistent with what patients told inspectors, as they commented that 'privacy is ok.'

Patients who spoke with inspectors were aware of their plan of care and commented that they received assistance when needed. Individual patient assessments were undertaken using validated assessment tools to determine the patient's individual risks and supports needed. On one ward visited, the level of assistance required by patients was identified by a traffic light system for example green–independent, orange–supervision and red–assist.

However, staff were challenged to maintain privacy and dignity on some wards visited by inspectors due to the layout and size of the wards. Also the overcrowding in the emergency department with admitted patients accommodated on trolleys and chairs did compromise the provision of dignity and privacy for these patients and was not consistent with the human-rights based approached supported by HIQA.

The lack of single rooms with ensuite toilet and shower facilities on wards, resulted in patients requiring isolation for communicable infectious diseases having to use commodes at the bed side, which impacted on their privacy and dignity. There was also limited access

to toilet and shower facilities both on wards visited and the emergency department, which also impacted on patient's dignity.

However, since the previous inspection the hospital had implemented the immediate and long term actions outlined on the hospital's 2023 compliance plan related to standard 3.1. The hospital had recruited a patient advice and liaison coordinator dedicated to the emergency department to support patient who had issues or complaints. The patient advice and liaison coordinator also proactively supported and assisted patients who were waiting in the department. The hospital had developed a patient information leaflet for the emergency department, a final draft of this leaflet was viewed by inspectors. A room which was used for patients' personal care had been used as a storage room during the previous inspection. This room had been decluttered and was no longer used as a storage room. An age friendly cubicle to support the patient with dementia had been developed. The emergency department transit area was opened to prioritise patients 75 years of age and over to provide a cubicle space and some privacy for this cohort of patients while awaiting an inpatient bed.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the clinical areas visited and the emergency department. However, staff were challenged to maintain privacy and dignity in large multi-occupancy rooms and in the overcrowded emergency department with patient accommodated on busy corridors.

Judgment: Partially compliant

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

Inspectors observed staff actively listening to and effectively communicating with patients in an open and sensitive manner. This was validated by patients who spoke with inspectors who commented that '*staff are very kind and caring'* and '*staff are lovely.'* The hospital had introduced initiatives to improve the patient experience within the emergency department with for example, dementia friendly cubicles to reduce environmental stress for this cohort of patients. The emergency department transit area prioritised admissions for patients over 75 years of age, to remove this cohort of patients from the busy emergency department environment.

The hospital had arrangements in place to facilitate access for patients to patient advice and liaison services when required. There was a dedicated patient advice and liaison coordinator in the emergency department who proactively spoke with patients, especially in times of overcrowding and long wait times to offer support and assistance as required.

Translation services were used to support effective communication with non-English speaking patients. Patient information leaflets were available and accessible. Some discharge information translated into the Irish language was observed by inspectors.

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

Judgment: Compliant

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

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say'*.[§§§§] The Quality and Patient Safety Manager hospital was the hospital's designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There were two patient advice and liaison coordinators in the hospital. One was allocated to the emergency department and the other to the remainder of the hospital. There was a culture of complaints resolution at point of contact in the ward areas visited.

'*Your Service Your Say'* leaflets and patient advice and liaison services leaflets were seen displayed around the hospital reception and on corridors throughout the hospital, although leaflets were not seen on display in all ward areas visited by inspectors. The hospital also had '*Your Service Your Say'* QR codes[*****] on display as an alternative method for providing feedback.

The Complaints Officer and patient advice and liaison coordinators formally reported on the number and type of complaints, verbal and written, received annually to the QPS Committee. Complaints were tracked and trended to identify the emerging themes, categories and departments involved. Complaints were discussed at ward level with CNMs and reviewed at directorates committees with oversight of complaints by the QPS Committee.

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

[*****] A QR (quick-response) code, is a type of two-dimensional matrix barcode, readable by imaging devices like cameras.

An overview of complaints was included on the quality and patient safety report submitted for review at HMT meetings. Complaints were shared by the CNM 2 with staff at ward meetings.

There was evidence that quality improvement plans were developed in response to patient feedback and complaints and examples of improvements implemented were outlined to inspectors during the inspection. The highest number of complaints in the emergency department was related to communication. In response the hospital had developed a patient information leaflet for the emergency department, a final draft of this leaflet was viewed by inspectors.

Following inspection, documentation submitted to HIQA indicated that 53% of complaints in 2023 and 24% of complaints for the year to date 2024 were resolved within 30 working days or less. This was not in line with the national target that 75% of complaints are resolved in 30 working days or less. Inspectors were informed that all complainants were informed, in writing, when there was a delay. Inspectors were told that staffing shortages in the quality and safety department were impacting on timely management of complaints. The hospital was actively seeking to backfill these posts with an expression of interest.

Overall, the hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, complaints were not responded to in a timely manner in line with national targets with only 24% of complaints responded to within 30 day in the year to date 2024.

Judgment: Partially compliant

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

During this inspection, inspectors visited St Teresa's, St Enda's and St Finbar's wards. St Teresa's ward was a 32-bedded renal and rheumatology ward, and St Enda's ward was a 32-bedded medical ward for older persons. Both wards comprised one four-bedded multi-occupancy room with no toilet or shower facilities, one eight-bedded room with no toilet or shower, one 13-bedded room with a shower and toilet. The wards had seven single rooms, two of these single rooms had ensuite toilet and shower facilities. There were additional toilets on the ward corridors.

St Finbar's ward was a 40-bedded ward which had seven single rooms, the additional 33 patients were accommodated in multi-occupancy rooms. At the time of inspection, all beds were occupied.

The environments in the ward areas visited by inspectors during this inspection were observed to be generally clean with few exceptions. This was validated by a patient who commented that '*there are good cleaning standards'.* The environment was generally well maintained, but did have some evidence of general wear and tear with woodwork and paintwork chipped. This did not facilitate effective cleaning and posed an infection prevention and control risk. There was a lack of storage facilities on some wards visited which resulted in equipment stored on corridors and inappropriate storage of supplies in a shower rooms – despite a lack of shower facilities in these ward areas.

The clinical wards visited had large multi-occupancy rooms with inadequate numbers of toilet and shower facilities. There was also a lack of appropriate isolation rooms in the hospital. This posed an infection prevention and control risk. The infection prevention and control nurses liaised with staff in the wards visited on a daily basis to support appropriate placement of patients. This process was supported by an isolation prioritisation policy. Risks associated with the aging infrastructure, inappropriate accommodation and the inadequate isolation facilities creating an infection prevention and control risk were on the hospital's corporate risk register. Requirement for an additional ward block with appropriate single rooms with ensuite facilities had been escalated by the hospital, with a plan at an early stage for the building of a new bed block.

Environmental and terminal cleaning[††††] was carried out by external contract cleaning staff. Regular cleaning staff were not always allocated to the ward areas visited. The cleaning supervisors had oversight of the cleaning and cleaning schedules in the ward areas visited. The ward clinical nurse managers linked with the cleaning supervisor to discuss staffing levels and cleaning supplies. Inspectors were informed that availability of cleaning staff and adherence to cleaning standards was challenging at times. This was escalated by the infection prevention and control team for discussion at the QPS Committee and was included in the hospital's corporate risk register. Environment hygiene audits were undertaken by the external contractor to measure compliance rates for cleaning undertaken by the company. The most recent environment hygiene audit results submitted to HIQA for the areas visited on the days of inspection demonstrated that St Teresa's ward was 94.7% compliant, St Enda's ward 89.5% and St Finbar's ward was 89.5%. This corresponded with what inspectors observed on the days of inspection.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical areas. Not all hand-hygiene sinks observed in ward areas visited on the day of inspection conformed to national requirements.[‡‡‡‡]

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

[‡‡‡‡] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from

Infection prevention and control signage in relation to transmission based precautions was observed in the ward areas visited. Personal protective equipment (PPE) was available outside single and multi-occupancy rooms. Staff were also observed wearing appropriate personal protective equipment in line with current guidelines. Adequate physical spacing was maintained between beds in most patient rooms, however this was challenging in the large 13-bedded multi-occupancy rooms.

In the ward areas visited, the equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned. Equipment audits were undertaken by the infection prevention and control team. The most recent equipment audit results for the ward areas visited by inspectors during this inspection demonstrated that St. Enda's ward was 83.9% compliant, this was an improvement on the previous month's audit which had been 77.2% compliant. St Teresa's ward was 80.9% compliant and St. Finbar's ward was 84.6% compliant. Quality improvement plans and monthly re-audit plans were put in place with an aim to bring equipment compliance up to over 90%.

Waste was managed appropriately in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

In summary, the physical environment did not fully support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care, especially vulnerable patients. The large multi-occupancy rooms in ward areas visited, the inadequate number of adjoining toilet and shower facilities and the lack of single rooms with ensuite toilet and shower facilities posed a risk of transmission of communicable infectious diseases.

Judgment: Partially compliant

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

The quality and safety of care was measured using national performance indicators and benchmarks such as hospital patient safety indicators. The hospital had monitored and reviewed information from sources that included; risk assessments, audit activity, patient-safety incident reviews and patient feedback. Evidence that monitoring and evaluation of services was used to improve practice was provided for some, but not all audits as discussed below.

The IPC Committee were actively monitoring and evaluating infection prevention practices in the hospital. The infection prevention and control team collected surveillance data and submitted a quarterly report to the QPS Committee. The hospital reported monthly on rates of *Clostridioides difficile infection*, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections, as per the HSE's requirements

The IPC Committee had oversight of findings from monitoring and audits such as environmental, equipment and hand-hygiene audits. Audit findings were shared with clinical staff and time-bound action plans developed to address areas requiring improvement. The most recent hand-hygiene audits of the clinical area visited during this inspection, submitted to HIQA following this inspection, demonstrated that St Finbar's ward was 76.7% compliant, St Teresa's ward was 83.3% compliant and St Enda's ward was 80% compliant. These areas were not compliant with the HSE's target of 90% for hand-hygiene practices. Examples of quality improvement plans and re-audit plans were provided to HIQA.

Environmental hygiene audits were undertaken by the external cleaning company to monitor the standard of the cleaning carried out by the company. Action plans were developed for areas of non-compliance with actions allocated to a responsible person to implement. However, evidence of completion of these actions was not included in the quality improvement plan. Evidence of re-audit for area of non-compliance was provided. Results were circulated to clinical area managers.

Equipment audits were undertaken by the infection prevention and control team, with evidence of quality improvement plans developed for areas of non-compliance. Actions to be completed, person responsible, and timeline for completion were all outlined in these quality improvements plan. A section outlining the date the action was completed was included in the quality improvement plans which was a good practice. This section was completed for some, but not all quality improvement plans reviewed by inspectors.

The infection prevention and control team also had set guidance for the quality improvement plans to be put in place based on audit results for audits such as equipment, hand hygiene, and CPE. By way of example, results under 80% required a monthly re-audit, results between 80% and 90% required a two monthly re-audit and results over 90% were re-audited at three month intervals. Evidence of compliance with this guidance was seen through documentation submitted to HIQA following this inspection.

There was evidence of monitoring and evaluation of medication safety practices at the hospital. The Drugs and Therapeutics Committee had oversight of medication safety audits and monitoring. Examples of medication safety audits carried out were submitted to HIQA with recommendations to improve practice outlined. However, quality improvement plans to support implementation of all recommendations made were not submitted to HIQA. An example of a quality improvement following a medicines reconciliation audit in March 2024 was seen in practice whereby pharmacists were allocated to review patients on admission in the emergency department, the emergency department transit area and the acute medical assessment unit, where medication reviews and medicines reconciliation was under taken for patients on multiple medications as they enter the hospital.

Medication safety was monitored monthly through nursing and midwifery quality care metrics with compliance ranging from 94%–100% year to date, for ward areas visited on the day of inspection.

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study and monitoring of key performance metrics related to antimicrobial use and meropenem restricted prescribing policy. Compliance against all measured key performance indicators (KPIs) of appropriate antimicrobial use in the hospital was maintained at high levels in 2023. The antimicrobial stewardship team reported to the IPC Committee and the Drugs and Therapeutics Committee.

Monthly nursing and midwifery quality care metrics were undertaken for patient monitoring and surveillance on the ward areas inspected, with evidence of compliance between 81%–100% year to date 2024. The hospital was auditing adherence to completion of the INEWS observation chart. Examples of clinical area audits submitted to HIQA following this inspection demonstrated on average a 75% compliance with the completion of INEWS observation charts. No evidence of quality improvement plans to address areas of poor compliance were submitted to HIQA.

The findings from sepsis audits were reviewed at the DPIP Implementation Group, with discussion regarding action required to improve areas of poor performance. A quality improvement plan had not been developed in response to the July 2023 sepsis audit. This was discussed at the DPIP Implementation Group meeting in May 2024, with a-time-bound action outlined, which was assigned to responsible persons.

An audit of nursing handover was provided to inspectors following this inspection. However, the standards being audited were not outlined and no recommendations or quality improvement plans were submitted. Audit of medical clinical handover was undertaken using the observation audit tool for shift clinical handover.[§§§§§] The hospital was fully compliant in six of the nine elements and partially compliant with three of the elements audited related to — sign in, documentation of decisions and storing of information. The hospital had not developed a formal quality improvement plan to address the areas requiring improvement. The areas for improvement were under the responsibility of the ACD for medicine with oversight by the directorate committee. The Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk[******] ($ISBAR_3$) communication format was not formally used for medical handover.

[§§§§§] Resource Manual & Facilitator Guide For Clinical Handover: An Inter-disciplinary Education Programme (2017) Available on line : https://healthservice.hse.ie/filelibrary/onmsd/resource-manual-facilitator-guide-for-clinical-handover-an-inter-disciplinary-education-programme.pdf

[******] Identify, Situation, Background, Assessment, Recommendation, Read- Back, Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover

Data in relation to hospital activity and performance was measured by the hospital, this included patient experience time, delayed transfers of care and average length of stay. This data was reviewed at the Unscheduled Care and Winter Planning Steering Group.

Staff in two ward areas visited by inspector's outlined an improvement related to the provision of discharge information provided to patients as a quality improvement plan following the 2022 national inpatient experience survey. The Hospital's Patient Experience Committee had commenced in the previous month before HIQA inspection, and inspectors were informed that this committee will have oversight of the national inpatient experience survey 2024, which was advertised and promoted by posters seen throughout the hospital.

Overall, the hospital was monitoring and evaluating healthcare services provided at the hospital to improve care. However, evidence that monitoring and evaluation of services was used to improve practice was not provided for all monitoring and audit activity, especially in relation to medication safety, sepsis management and clinical handover.

Judgment: Partially compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks for people using the service. Risks were managed at department level by the CNM 2 with oversight and support from the CNM 3. Risks were recorded on local risk registers with evidence of existing controls in place observed by inspectors during this inspection. Risks which could not be managed locally were escalated to the ADON and upward to the relevant directorate meeting and escalated to the HMT for addition to the corporate risk register if necessary.

The hospital's corporate risk register was reviewed at the QPS Committee with oversight by the HMT. High-rated risks related to the focus of this inspection included insufficient capacity to meet demand in the emergency department, inability to recruit and retain suitably quality staff and risks to maintaining infection prevention and control standards due to insufficient appropriate accommodation and ageing infrastructure. The existing controls and additional actions required were outlined on the corporate risk register.

Patients were screened on admission to the hospital for multi-drug resistant organisms (MDROs) in line with national guidelines. All patients were screened for CPE, with weekly screening on high-risk wards. The hospital's information patient management system alerted staff to patients who were previously inpatients in the hospital with MDROs. Monitoring of adherence to CPE surveillance screening was undertaken by the infection prevention and control team with 90-100% compliance on the last three audits seen by inspectors. The hospital staff who spoke with inspectors described the management of the

last outbreak of infection. A multidisciplinary outbreak team was convened to advise and ensure the management of the outbreak was aligned with best practice standards and guidance. An outbreak report was developed with oversight by the IPC Committee. Staff in the hospital had access to microbiology advice on a 24/7 basis.

Patients with communicable infection diseases were isolated according to the hospital's isolation prioritisation policy with support and advice from the infection prevention and control team. During this inspection, all patients with communicable infection diseases in the ward areas visited by inspectors were in single rooms. However, due to a lack of appropriate isolation facilities inspectors observed that some of these patients were in single rooms without ensuite toilet and shower facilities.

The provision of a clinical pharmacy service on wards was prioritised based on a formal assessment of the cohort of patients in each clinical area, ranging from red to green rating. By way of example, St Teresa's ward visited by inspectors on the day of inspection was a red-rated ward and had a full clinical pharmacy service. Clinical pharmacists also undertook clinical pharmacy reviews and medicine reconciliation for patients on wards which did not have a clinical pharmacist service, based on priority or as requested by staff. As mentioned previously, clinical pharmacy service were provided in the emergency department, the emergency department transit area and the AMAU to focus clinical pharmacy reviews and medicines reconciliation for priority patients at the point of entry to the hospital.

The hospital had a list of high-risk medications, and there was a list of sound-alike look-alike medications (SALADs). A pharmacy technician did visit wards to replace pharmacy stock. Prescribing guidelines, antimicrobial guidelines and medicines information was available and accessible to staff at the point of care. There was medicine information in electronic and hard copy format on most ward areas visited. The antimicrobial guidelines were under review by the hospital at the time of inspection, with oversight by the Drugs and Therapeutics Committee.

The hospital was using the national early warning systems for the various cohorts of patients — the INEWS2, Irish Early Maternity Warning System (IMEWS), Irish Paediatric Early Warning System (IPEWS) to support the recognition, response and management of a deteriorating patient. The $ISBAR_3$ communication tool was used for the escalation of the care of the deteriorating patient. The hospital had not yet implemented the emergency medicine early warning system (EMEWS) for patients awaiting medical review in the emergency department. Inspectors were informed that roll out of the EMEWS was under consideration by the hospital, but was impacted by staffing levels in the emergency department – an ADON had been assigned to lead on the implementation of the EMEWS.

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 (PDD) and the hospital had implemented patient cohorting[††††††] by specialty on

[††††††] Any group of individuals affected by common diseases, environmental, temporal influences, treatments, or other traits.

three wards to facilitate effective review by medical teams, and improve the patients' journey. The introduction of patient cohorting was audited by the hospital in 2023 with evidence of a reduction in the patients' median length of stay between 2 and 18 days on the cohorted wards. The PDD was audited at that time with 96%–98% compliance rate on wards audited. However, no re-audit plan to measure if improvements were sustained was identified. Evidence of cohorting of patients was noted by inspectors in ward areas visited on the day of inspection, but the recording and updating of PDDs was varied across clinical area visited.

The hospital had policies, procedures, protocols and guidelines in relation to infection prevention and control, medication safety and the deteriorating patient. A number of these were overdue for review by the hospital. Policies, procedures, protocols and guidelines were accessible to staff via the hospital's document management system. The hospital's escalation framework was out of date and under review by the hospital at the time of inspection.

Data on the emergency department PETs collected at 11am on the first day of this inspection showed that the hospital was non-compliant with the majority of the HSE's targets, although improved on the previous inspection's PETs. At 11am:

- 63.7% of patients in the emergency department were in the department for more than six hours after registration.
- 55% of attendees to the emergency department were in the department for more than nine hours after registration
- 8.6% of attendees to the emergency department were in the department for more than 24 hours after registration
- 0.8% of attendees aged 75 years and over who were in the emergency department were admitted or discharged within nine hours of registration. This was compliant with the HSE's target, and 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.

On the day of inspection, the hospital had 31 delayed discharges. Hospital management attributed the delay in transferring patients mainly to lack of community beds, outlining that a number of nursing homes beds had been closed in recent times.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. Despite systems in place to support patient flow and care for patients in the emergency department, the design and delivery of healthcare services in the emergency department did not fully protect people awaiting review or admitted on trolleys and chairs from the risk of harm.

The EMEWS was not yet implemented by the hospital. A number of policies, procedures, protocols and guidelines related to medication safety and infection prevention and control were due for review. The hospital did not have a full clinical pharmacy service.

Judgment: Partially compliant

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

While 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, the hospital was not uploading all patient-safety incidents to the National Incident Management System (NIMS) or completing category 1 incident reviews in a timely manner in line with national targets.

Patient-safety incidents were uploaded by staff to the hospital's electronic system. Line managers reviewed incidents which occurred in their area in conjunction with the CNM 3 and the Quality and Patient Safety Manager, to sign off and ensure that all corrective actions were completed. Incidents were shared with ward staff at meetings. Staff who spoke with inspectors were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported.

The quality and patient safety department tracked and trended patient-safety incidents in relation to the four key areas of harm that were the focus of this inspection, and incidents reports were submitted to relevant directorate committee meetings for review. All patient-safety incidents were reported and reviewed at the QPS Committee and included in the quality and patient safety report for the HMT.

All serious patient-safety incidents and serious reportable events were reported to the General Manager and a preliminary assessment report (PAR) was completed by the ACD and DON of the relevant directorate with support from the Quality and Patient Safety Manager. All completed PARs were escalated to the SIMT to determine the nature of the review if required, ongoing management or closure. All PARs and internal and external reviews in progress were discussed at the relevant directorate committee's meetings. The implementation of recommendations from reviews of patient-safety incidents was the responsibility of the relevant directorate committees, monitored by the quality and patient safety department and the SIMT. During this inspection inspectors visited the maternity unit where evidence of following up on quality improvement plans from a serious incident review was provided to inspectors.

In 2023, the hospital inputted 75% of incidents onto the NIMS within 30 days in line with national target (70%). In the year to date only 50% of incidents were inputted within the 30 day target. However, inspectors were informed that all serious red and amber rated

incidents were inputted into NIMS. The hospital was not completing category 1 incident reports within the 125 days national target. Inspectors were informed that shortages in staffing levels in the quality and patient safety department was impacting on the completion of reviews and the inputting of patient safety incident into the NIMS.

Medication-safety incidents were reviewed by the medication safety pharmacist who categorised the incidents in terms of severity. Medication-safety incidents were discussed at the Medication Safety Committee meetings with oversight at the Drug and Therapeutics Committee.

The hospital management reported the number of clinical incidents per 1,000 bed days used (BDU) to NIMS monthly as part of the Hospital Patient Safety Indicator Report. However, the hospital had not reported on this indicator since July 2023. In 2023, the available data showed the number of patient-safety incidents reported at the hospital ranged from 5.40 to 10.20 per month per 1,000 BDU, which was lower than other model 4 hospitals, and less than the national average rate of 21.7 per 1,000 BDU over the previous 24 month period (January 2021 to December 2022).

Overall, the hospital had a system in place to identify, report, manage and respond to patient-safety incidents. The hospital were tracking and trending patient-safety incidents. There was evidence that the relevant committees had oversight of the management of these incidents and that the SIMT and the HMT had oversight of serious incidents and reportable events. However, the hospital was non-compliant with the entering of reported incidents onto NIMS within 30 days of notification, and the completion of category 1 incidents reports within 125 days.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of University Hospital Galway to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

University Hospital Galway had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. There were defined management arrangements in place at the hospital to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. However, patient flow within the hospital was not functioning as it should. The mismatch between availability and demand for inpatient beds resulted in admitted patients being accommodated in the emergency department.

The hospital management were planning, organising and managing their nursing, medical and support staff in the hospital to support the provision of high-quality, safe healthcare. However, there was still a shortfall in the approved complement of nurses in two clinical areas visited during this inspection. The consultants in emergency medicine staffing levels, although improved since the previous inspection, still had a shortfall in the approved compliment. The attendance at mandatory and essential training required improvement in the most ward areas visited by inspectors. Hospital training records were not available for training related to the four areas that were the focus of this inspection, apart from hand-hygiene training.

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the ward areas visited. However, staff were challenged to maintain privacy and dignity in large multi-occupancy rooms and in the overcrowded emergency department. Hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

The hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, the timely response to complaints in line with national targets was not achieved by the hospital.

The physical environment did not fully support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care, especially vulnerable patients. The large multi-occupancy rooms in some ward areas visited and the lack of single rooms with ensuite toilet and shower facilities posed a risk of transmission of communicable infectious diseases.

The hospital was monitoring and evaluating healthcare services provided at the hospital to improve care. However, evidence of action taken to improve areas of non-compliance or evidence of implementation of recommendations from audit findings was not provided for all monitoring and audits activity done, especially in relation to medication safety, deteriorating patient, sepsis and clinical handover.

The hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm that were the focus of this inspection. Despite systems in place to support patient flow and care for patients in the emergency department, the design and delivery of healthcare services in the emergency department did not fully protect people awaiting review or admitted on trolleys and chairs from the risk of harm. The EMEWS was not yet implemented by the hospital. The hospital did not have a full clinical pharmacy service.

The hospital had a system in place to identify, report, manage and respond to patient-safety incidents. The hospital were tracking and trending patient safety incidents. There was evidence that the relevant committees related to four areas of harm had oversight of the management of these incidents. However, the hospital was not reaching the national

targets with entering incidents to NIMS and the completion of category 1 incidents reviews.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing actions being employed to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Overall Governance	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
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.	Partially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Appendix 2 Compliance Plan Service Provider's Response

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

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

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.
(b) (b) where applicable, long-term plans requiring investment to come into compliance with the standard

(1) *"There was no identified lead for perioperative services clinical handover".*

Action Complete: In July, 2024 An Associate Clinical Director for the Perioperative MCAN was appointed who will be responsible for Clinical Handover going forward.

(2) *On the day of inspection, patient flow within the hospital was still not functioning as it should. The mismatch between availability and demand for inpatient beds resulted in 29 admitted patients being accommodated in the emergency department. This resulted in increased PETs and increased patient risk.*

Interim / Ongoing Actions:

- **EDTA:** We continue to use the Emergency Department Transit Area for surge capacity and prioritise patients >75 years, providing cubicle spaces and privacy while the patients await a bed at ward level.
- We continue to focus on those **patients >75 years** being prioritised for a bed and waiting no longer than 24 hours. Breaches >24hrs are recorded as incidents. These are monitored closely.
- **Bed Utilisation Study** undertaken week commencing 20th May, 2024 findings and recommendations have been used to draft an action plan. The 15 actions are tracked over time, with relevant responsible person appointed. (Q4 2024)
- We continue to seek additional support from the community and meet regularly with our community colleagues through integrated length of stay meetings when delayed transfer of cares are discussed in order to determine a suitable pathway or accommodation for the patient. Weekly Integrated Length of Stay (ILOS) rounds with Discharge coordinator, Patient flow coordinator, Medical Social work and CHO colleagues (Integrated Discharge manager, CIT, PHN), with focus on >14 LoS patients. Weekly tracker meetings to review all patients to progress discharge. Patients that are not progressing are escalated to DGM GUH or GM CO CHO office.

- **Cohorting:** For phase one of the cohorting pilot, three wards were selected for the initiative (Geriatrics/Enda's; Gastro/Dominic's and Mary's/Cardiology). During this pilot, key metrics showed improvements including percentage patient cohorted to base ward, safari scores, average and median LoS. For phase two, the roll out will focus on all medical teams, with the commitment to fill the allocated base ward beds with the correct specialties. The Metric tool will be adjusted to capture this KPI. The intention will be to cohort all medical teams to their allocated base ward beds.

  A significant change in the operational structure for the patient flow team is going to be trialled, moving the alignment of the patient flows from ward based to clinical team based. The Acute Medical Assessment Unit (AMAU) is also included in phase two of the project, the aim of which is to reduce the patients boarding in the unit that are not under the AMU team. Go-live for this second phase is 11th September, 2024 and will run for 2 months, with weekly meetings to review performance and actively manage the project.
- Initiatives with the aim of Hospital Avoidance for patients are progressing. Currently the **Navigational Hub** pilot programme has the potential to significantly reduce ED attendances and save hospital bed days. Over a five month period the hub has dealt with 108 referrals with two thirds of these patients avoiding an ED visit as a result. 59 patients were diverted to new or existing pathways. Within one week of receiving the referral in the Navigational Hub, 78% of patients were seen by the appropriate specialist. For patients aged 75 or older, 35 were referred to the hub and 28 (80%) avoided ED attendances as a result.

Capacity v Demand

Medium Term Action (Q4 2024/Q1 2025): A Service plan submission for staff is being progressed to create 4 additional rehab beds in Merlin Park University Hospital. This will assist in the improvement in rehab activity for the unit as a whole, reducing length of stay in the unit and will also have a positive cascade effect, as freeing up capacity in MPUH and will allow greater transfer of patients from UHG, on the rehab waiting list. Due to the demand/capacity deficit in Rehab, there is a constant list of patients, some of which are rehabbed on the UHG site, reducing capacity on the acute site.

Long Term Actions (5-10 years):

A Galway University Hospitals Capital Programme Oversight Board was established by the CEO for Saolta in late 2023 with membership from both Saolta, the GUH site, Estates, Community, National Acute Hospitals, University of Galway and patient representatives. The Oversight Board will oversee the development of a Model 4 Hospital design to allow the delivery of a comprehensive future proofed Model 4 Hospital. The development of an integrated Strategic Masterplan for Galway University Hospitals (GUH) will play a pivotal role in delivering on National and Regional healthcare policies.
GUH has prioritised four key major infrastructural projects. Each of these projects can proceed independently of each other on the campus of each site but form part of an agreed overall integrated plan. The delivery of each, either individually, or in parallel, will result in significant improvements in the capacity of the hospital to meet the needs of the population into the future. When all four projects are complete, they will integrate fully to become a functioning Model 4 hospital for the region.

The four key projects are:

- Emergency Department, Women & Children's Block, UHG
- Laboratory UHG
- Ward Block and Cancer Centre UHG
- Elective Hospital, Surgical Hub, Outpatients Department & Adult OPD Cystic Fibrosis Unit, MPUH

The above projects need to align with an overall campus masterplan which is being developed to define the proposed hospital service provision to meet the current and future needs of the population served.

Timescale: As above

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

(1) Staff Vacancies: 0.8 WTE AMS post filled and was additional AMS post filled in June

Action Complete: This post is now filled as the staff member was on maternity leave and has since returned in June 2024 (there is no additional post).

(2) Staff Vacancies: 36 WTE pharmacists and 2 unfilled

Interim Actions: There are currently 2 unfilled posts (of 2024 vacancies) of 36 approved WTE Pharmacists. HR will continue to recruit for same. Of the 5 (2023) posts not filled, 1 includes the Medicine Safety Senior Pharmacist. All posts are submitted to Hospital Group for replacement, however there are challenges with current ceilings and budget constraints as expenditure limits have been set based on 2023.

(3) ED consultants update and plans to increase:

Interim Actions: One Emergency Department Consultant has commenced in post since the 1st of August, 2024. There are 5.5 posts which remain unfilled. Another Consultant has confirmed to take up post in Spring 2025 (date to be confirmed).

(4) ED Nursing posts had a variance of 13%:

Interim Actions: Currently there is an approved WTE of 118. There are currently 103 WTEs in post with 96.96 WTE available to roster. We continue to recruit. Interviews are ongoing for Staff Nurse Positions.

(5) Shortfall of Nurses on St. Finbar's Ward (35 approved WTE with shortfall of 5)

St. Finbar's: Currently 31 of 35 approved WTE in post. Evidence of the risk assessment re impact of care not given was undertaken for St. Finbar's Ward (01/07/2024) and reviewed. Mitigation of risks noted.

Interim Actions – Continue to recruit. Plans in place to mitigate risks:

- Additional work shifts offered to all staff
- Agreed support from use of Agency Staff Nurse Resource currently in place
- Utilisation of Clinical Skills Facilitator at floor level to support, educate and participate in care provision as part of available skill set at ward level
- Risk assessment completed and monitored in respect of staffing resource to provide care
- Incident reporting reviewed fortnightly with Quality and Risk Department.
- Recruitment process in respect of CNS to be revisited (Interview process completed) via ECC
- Staff deployment from other Surgical Ward areas where and if appropriate
- Education ongoing
- Attendance at the Hospital Safety Huddle highlighting capacity demand and patient flow complexities in line with staffing resource

(6) Mandatory Training Records for Doctors, Nurses & HCAs

Immediate & Interim Actions (Q4 2024/ Q1 2025)

- **Mandatory Training:** The capturing of Mandatory Training Data is currently being reviewed. A meeting has been arranged with Management, HR, Nursing & Medical Manpower to streamline same.
- Nursing are currently using the Mandatory Education Training tool (**METT**). This is being rolled out to both sites (UHG & MPUH) to standardise the way in which nursing, record training and Nursing admin have an overview and access on a shared Drive. This is currently used in UHG with further roll out to Merlin Park.
- Medical Manpower are now capturing all NCHD Mandatory Training on DIME:
  Medical Manpower are utilising **DIME** (Doctors Integrated Management E system) which is the National Doctors Training Programme (NDTP) portal for all doctors. This requires all doctors to submit their mandatory training as set out by the NDTP, onto this system for approval. This captures the end date of the validity of the certification and also sends out automatic remainders to recertify when they are nearing expiry of certs. This will also allow

us to run compliance reports. Regular reminders are issued to NCHDs to complete their mandatory training.

NCHD Mandatory Training Compliance

Hand-Hygiene: 51% May 2024 / 60% dated 2nd of September, 2024
I**NEWS:** 47% May, 2024 / 64% dated 2nd of September, 2024
BLS: 62% May, 2024 / 62% dated 2nd of September, 2024
These figures are now based off the new intake of NCHDs in July 2024.
There are regular sessions being held and communications issued on same. Emails and discussion are been held with Department Leads and Consultants to ensure there is full adherence to training as required. This continues to be a work in progress.

Compliance rates with standard and transmission-based precautions and medication safety training is not part of mandatory training framework set out by NDTP and is not currently captured on DIME for NCHDs. This will be addressed through the working group to be convened on this matter.

Timescale:Q4 2024/Q1 2025

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially Compliant

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

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

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

The Emergency Department still does not have enough capacity or isolation cubicles to meet demand. The use of the Emergency Department Transit Area (EDTA) is used to prioritise elderly patients and those with infection control issues…..Challenge to maintain Privacy and Dignity

Action –Immediate / Interim Actions:

- The **ED Transit Area** continues to be used in order to prioritise elderly patients and ensure they have some level of dignity and privacy (and avoid waiting on corridor based trolleys) who may be awaiting a bed on the ward and also to prioritise those with infection control issues. This area is utilised in times of surge and high attendances to the Emergency Department. There are 4 single rooms plus curtain cubicled areas.

- Our **Patient Advocacy Liaison Service** allocated to the Emergency Department assists those patients who may need support in this regard. There are age friendly dementia cubicles allocated as required.
- **Red beds** are maintained on the IPC ward at all times for any patients that are diagnosed with Covid-19 to move them as soon as possible from the Emergency Department to an isolation room.
- Use of **private beds** in the Galway Clinic to support egress and capacity.
- A Service plan submission for staff is being progressed to create **4 additional rehab beds** in Merlin Park University Hospital. This will assist in the improvement in rehab activity for the unit as a whole, reducing length of stay in the unit and will also have a positive cascade effect as freeing up capacity in MPUH and will allow greater transfer of patients from UHG on the rehab waiting list in the short term. **(Q4 2024/Q1 2025)**

Action- Long term plans (5-10 years):

- Building of new permanent ED and W&C building.
- Seeking capital funding to provide an additional beds (cancer centre & ward block submissions to address the 222 bed deficit highlighted in the 2019 external options appraisal undertaken).

The Women & Childrens ED Block - The development of a new Emergency Department & Women & Children's Block at University Hospital Galway is key to addressing current suboptimal accommodation and associated risk issues, meeting service demands and national standards as set out in The National Emergency Programme. This capital development is a key prioritiy for the GUH site.
A Strategic Assessment-Preliminary Business Case (SA-PBC) has been completed approved by the HSE Board in November 2023 and submitted to the Department of Health as Approving Authority. The DOH issued feedback on the SA-PBC on the 31st of January, 2024 which was reviewed and updated by Estates and GUH, for response to the DoH. Once approved, we will move towards the detailed design and tendering process. We will be able to provide a date for the planning application for the new ED and Women & Children's development at UHG once that is complete.

Timescale: As above

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

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

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

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

(1) "Complaints not responded to in a timely manner"

Interim Actions:

- A QPS Co-Ordinator for the Medical and Cancer MCAN is now in place and the backlog is being addressed.
- There are plans in place to introduce NIMs as the incident management system instead of Q Pulse by December 2024. This will ensure all incidents are on NIMs. A resource is required to support this rollout and a Grade V QPS Facilitator has been approved and the interview has taken place. We are currently awaiting approval to release this post.
- A Business Case has been submitted for a QPS Co-Ordinator to manage the Perioperative MCAN and Radiology Directorates.

Timescale: Q4 2024 / Q1 2025

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

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

(1) *Cleaning and wear and tear on wards and storage St Teresas and St Endas and St Finbarrs & Inappropriate storage in shower rooms - There was a lack of storage facilities on some wards visited which resulted in equipment stored on corridors and inappropriate storage of supplies in a shower – despite a lack of shower facilities in these ward areas.*

Immediate Actions (Q3 2024)

- Equipment from the shower rooms on St Enda's and St Teresa's wards have been moved to a designated storage room. Shower rooms have been deep cleaned including changing the shower heads and cleaning the shower drains. Water samples have been taken for Legionella. Once negative results are received, the shower rooms will be reopened.
- The storage issues for St Enda's & St Teresa's wards have been addressed with additional storage facilities located outside each ward.

- Maintenance /repair requests are logged on the PEMAC (Maintenance) system at ward level.
- Ongoing monitoring and auditing of the cleaning standards with QIPs in place to address any actions arising.

(2) *Not all Hand Hygiene Sinks complied to Not all hand hygiene sinks conformed to national requirements*

Medium Term Action (Q4 2024/ 2025):

- The replacement of Hand Hygiene sinks is carried out on an ongoing basis.
- Currently staffing deficits in the Buildings & Maintenance department has impacted on this replacement programme and continues to be a work in progress.

(3) *Inadequate toilets and showers and lack of en-suite rooms, issues with multi - occupancy rooms with 13 beds (Ongoing)*

Interim Action: Toilets in wards with 13 beds are cleaned/disinfected every 4 hours. The quality of cleaning is monitored by the infection prevention and control team during daily visits to the ward and UV audits are performed.

(4) *In summary, the physical environment did not fully support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care, especially vulnerable patients. The large multi-occupancy rooms in ward areas visited, the inadequate number of adjoining toilet and shower facilities and the lack of single rooms with en-suite toilet and shower facilities posed a risk of transmission of communicable infectious diseases.*

Long Term Action (5-10 years):

As part of the Capital Development programme, a requirement for an additional Ward Block in UHG has been submitted. A Development Control Plan & Masterplan for GUH is being developed to include a requirement for an additional Ward Block which would provide appropriate accommodation (single rooms/ensuite), address the issue of existing older infrastructure particularly on the "nightingale wards" and also address the issues of risk associated with meeting demand / address overcrowding /patient flow, lack of capacity to deal with HCAI outbreaks and adequate isolation facilities. The risk of a lack of isolation facilities has been highlighted nationally and is documented in our Corporate Risk Register. We will continue to seek additional bed capacity and endeavour to progress same through capital projects.

Timescale: As above

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

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

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

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

(1) *Hand Hygiene St Teresa's St Enda's and St Finbarr's not compliant QIP and re audits were provided*

Immediate Actions

All wards were re-audited with the following results noted:

- St Finbar's June 73%, **July 80%**
- St Enda's June 70%, **July 80%, August 77%**
- St Teresa's June 80%, **July 83%**
- QIPs have been reviewed for same. A quality improvement project was also introduced to improve hygiene compliance.

(2) *Environmental hygiene audits - non-compliance action plans in place however evidence of completion requires attention -Environmental Hygiene Audit Results St Teresa's ward 94.7% compliance, St. Enda's ward 89.5% & St Finbar's ward 89.5%*

Interim Actions:

- St. Enda's 89.5% Re-Audit Results of the 7th of June, 2024 were 90.8%. A review of the corrective action took place and these were actioned on the 7th of June to address any non-compliances noted. Re-audits are undertaken if the audit does not pass a 90% score.
- In July 2024, a separate QIP has been developed in the Services Department to monitor and address follow up and close out of any non-compliances noted. This QIP includes the recommendations / corrective actions to be addressed, the actions to be undertaken, responsible person, target date for completion and date of completion/close out.
- St Finbar's 89.5% - Re-Audit Results on the 12th of July were 96%. Corrective Actions took place on the 12th of July to address non-compliances. The QIP notes follow up and close out of same.

(3) *Equipment audits - non-compliance actions plans and QIPs in place and dates for actions completed in some not all -Equipment Audit Results St Teresa's ward 80.9% compliant, St Enda's ward 83.9% & Finbar's 84.6% compliant*

Interim Actions: Equipment audits were undertaken by the Infection Prevention and Control team with evidence of Quality Improvement Plans developed for areas of non-compliance. A section outlying the date and the action was completed and this was included in the Quality Improvement Plan which was good practice.
A meeting was held regarding the QIP assigned to equipment audits. IPC CNS/CNM II were informed to complete all sections of the QIP. A folder was created in a shared drive where QIPs will be saved. IPC ADON/CNM III will review the QIP and escalate if there is no improvement in the results of equipment audits.

(4) *INEWS audit 75% compliance on observation charts however no evidence of QIP for same in areas of poor compliance*

INEWS re-audits took place in August 2024 with QIPs in place on a National audit template for St. Enda's and St. Teresa's wards.

(5) *Audit of nursing handover - QIPs not visible - Re-audit of Handover in St. Finbar's results viewed 87.7% compliance*

Handover audits supplied in May were deemed pilot audits. This data set has been reconfigured with the MEG tool last week and audits are to commence in Q4 2024.

(6) *Audit of medical Handover compliant in 6 of 9 elements - formal QIP required and ISBAR not formally used*

Interim/Medium Term Actions: Work in progress regarding sign in, documentation and use of ISBAR tool for medical handover - aim to be fully compliant in next 12 months. Re-audit of compliance to be undertaken in Q4 2024.

(7) *Medication Safety - Recommendations provided however QIP to support implementation of of all recommendations were not submitted.*

Immediate Action complete: QIPs provided for all Medication Safety Audits reviewed undertaken by the Medicine Safety Senior Pharmacist.
Ward Medication Safety Audits are a work in progress. QIPs will form part of the audit results and recommendations going forward. The MEG Tool is being configured at present to include a summary QIP for each ward. (**Q4 2024)**

Timescale: As above

National Standard	Judgment

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

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

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.
(b) where applicable, long-term plans requiring investment to come into compliance with the standard

(1) Due to a lack of appropriate isolation facilities inspectors observed that some of these patients (with communicable infectious diseases) were in single rooms without en-suite toilet and shower facilities.

Interim / Ongoing Actions: Two wards are used for IPC and contain 25 single occupancy ensuite isolation rooms. Patients are allocated to this ward according to HCAI priority / isolation status. However, there are still a number of older wards and infrastructure which need to be upgraded in terms of single rooms and bathrooms.

Long Term Action (5-10 years):

As part of the Capital Development programme, a requirement for an additional Ward Block in UHG has been submitted. A Development Control Plan & Masterplan for GUH is being developed to include a requirement for an additional Ward Block which would provide appropriate accommodation (single rooms/ensuite), address the issue of existing older infrastructure particularly on the "nightingale wards" and also address the issues of risk associated with meeting demand / address overcrowding /patient flow, lack of capacity to deal with HCAI outbreaks and adequate isolation facilities. The risk of a lack of isolation facilities has been highlighted nationally and is documented in our Corporate Risk Register. We will continue to seek additional bed capacity and endeavour to progress same through capital projects.

(2) EMEWs not implemented

A plan is in place for the roll out of EMEWS within the Emergency Department. A meeting with key stakeholders will take place in September to discuss progression of same. The progress of this roll out is dependent on the filling of current vacancies within the department which may facilitate a phased roll out.

(3) PDD Re audit Plan and Record of PDD on wards varied

PDDs are discussed an updated on the whiteboard after every MDT. New Medical Proforma in place for the Medical Directorate. Plans to audit PDD compliance in Q4 2024. Weekly

cohorting metrics report are circulated to the Clinical Leads involved in Phase 1 of the Cohorting Pilot.

Phase 2 of the Cohorting project is going 'live' on the 11th of September, 2024 expanding its focus to all Medical specialties including AMU. Weekly cohorting reports will be in place to monitor performance.

(4) Hospital Escalation Framework out of date to be updated and version signed off

Immediate & Interim Actions (Q4 2024) - This document is in draft and currently being updated, before review and sign off.

(5) Plan to improve PETs

Immediate & Interim Actions: ED Attendance/Admission avoidance (Q3-Q4 2024):

- We will continue to work with CHO colleagues with the expansion of Integrated care of older persons (ICPOP) teams, Enhanced Community Care (ECC) & Chronic Disease Models (CDM)
- GUH/National Ambulance Service Pathfinder- team of Physiotherapist, Occupational Therapist and Advanced Paramedics attend ambulance call outs to the home to prevent conveyance to the ED.
- GP liaison nurse- key link for GPs within the community to ED, improve communications and signposting for patients to appropriate alternative pathways
- Navigational Hub- Slaintecare project in place for GPs to contact and signposting for patients to appropriate alternative pathways

Improvements within flow/egress-
Integrated Patient Flow team (Q3-Q4 2024):

Immediate Actions:

- Alignment of Patient Flow Coordinators to change from ward based alignment to clinical teams, this change in work practice is aligned to the go live date of phase 2 cohorting. **(Q3 2024)**
- Continue with a Data driven approach to flow (establishment of ED & flow dashboards to track progress and weekly deep dive reports).
- Continue to use the Operational control centre- Central physical location with multiple stakeholders from Patient Flow Coordinators, Discharge Co-Ordinator, Unscheduled care team, Bed Management, CHO Integrated Discharge Manager, etc.
- Conitue to develop IT solutions to provide lean processes to data gathering.

(6) A number of policies, procedures, protocols and guidelines related to medical safety and infection prevention and control were due for review.

Immediate & Interim Actions (Q3/Q4 2024)

A number of documents are being reviewed and updated accordingly.

- Standard base precaution and Transmission base precaution guidelines are updated and awaiting approval.
- Infection Control & Prevention Guidelines on Decontamination and Hospitals Infection Control Guidelines for Management of an outbreak of Infection –that documents are

presently being updated based on latest AMRIC guidance (August 2024). They will become available by end September 2024. ▪ Medication Safety documents are being reviewed and will also be approved at the next Drugs & Therapeutics Committee meeting.
Timescale: As above