Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	University Hospital Kerry
Address of healthcare service:	Rathass Tralee Co. Kerry V92 NX94
Type of inspection:	Announced
Date(s) of inspection:	28 and 29 January 2025
Healthcare Service ID:	OSV-0001036
Fieldwork ID:	NS_0113

About the healthcare service

Model of hospital and profile

University Hospital Kerry (UHK) is a model 3* acute teaching hospital providing in-patient, day case and outpatient healthcare services for the population of Kerry and surrounding geographical areas of north Cork and west Limerick. It is a Health Service Executive (HSE) funded hospital managed by the South South West Hospital Group† (SWWHG). It has close links with the model 4‡ tertiary referral centre at Cork University Hospital. The hospital is affiliated to University College Cork as its primary academic partner. UHK provides a range of healthcare services for adults and children in addition to maternity services, these include:

- emergency medicine
- general medicine
- general surgery
- orthopaedic services
- endoscopy
- oncology day services
- palliative care
- dialysis
- critical care
- coronary care
- maternity and women's health
- paediatric and neonatal care
- diagnostic services.

There is a 34 bed acute mental health admission unit on the ground floor of the hospital, which was under the inspection remit of the Mental Health Commission.

The following information outlines some additional data on the hospital.

Model of hospital	3
Number of beds	283 inpatient beds 81 day case beds

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

† The South West Hospital Group comprises of seven hospitals – Cork University Hospital, Cork University Maternity Hospital, University Hospital Kerry, Mercy University Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital, Mallow General Hospital.

‡ A model-4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, an Emergency Department, including a Clinical Decision Unit on site.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility to set and monitor standards in relation to the quality and safety of healthcare services among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* .To prepare for this inspection, the inspectors[§] reviewed relevant information which included previous inspection findings, information submitted by the hospital, unsolicited information[**] and other publically available information.

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how University Hospital Kerry 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 University Hospital Kerry. It outlines whether there is appropriate oversight and assurance arrangements in place and

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

[**] Unsolicited information is defined as information, which is not requested by HIQA but is received from people including the public and or people who use healthcare services.

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

2. Quality and safety of the service

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

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
28 January 2025	08.45 to 18.00hrs	Marguerite Dooley	Lead
		Mary Flavin	Support
29 January 2025	08.45 to 16.30hrs	Sara McAvoy	Support
		Rosie O' Neill	Support

Information about this inspection

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

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

The inspection team visited the following clinical areas:

- Emergency Department (ED)
- Respiratory Isolation Unit (RIU)
- Acute Medical Assessment Unit (AMAU)
- Carrig medical ward
- Aghadoe surgical ward
- Ardfert antenatal ward.

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

- representatives of the hospitals Executive Management Board:
  - General Manager (GM)
  - Director of Nursing (DON)
  - Director of Midwifery (DOM)
  - Clinical Director (CD)
- representatives for the non-consultant hospital doctors (NCHDs)
- clinical lead for women and infants

[††] 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 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.

- Human Resource Manager (HR)
- Quality Risk and Patient Safety Manager (QRPSM)
- Risk Manager
- Quality Manager
- Complaints Facilitator
- representatives from each of the following hospital committees:
    - infection prevention and control
    - drugs and therapeutics
    - deteriorating patient
    - transitions of care

Acknowledgements

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

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

During the course of the inspection, the inspectors visited the acute floor which included the Emergency Department (ED), the Respiratory Isolation Unit (RIU), the Acute Medical Assessment Unit (AMAU) and the Torc discharge-transit lounge; Carrig medical ward, Aghadoe surgical ward and Ardfert antenatal ward. Emergency or unscheduled care admissions to University Hospital Kerry was through the ED and the AMAU. The ED had the following capacity: one triage room, nine bays for major presentations, three bays for minor injuries, one treatment room, a three-bay paediatric area with a separate waiting room providing audio separation between the adult and paediatric presentations and a three-bay resuscitation area for presentations categorised as immediate or urgent.

Attendees to the ED presented through the following pathways, by ambulance, referred directly by their general practitioner (GP) or self-referred. Over the course of this inspection the ED was experiencing high levels of activity and in line with the hospital's escalation plan was deemed to be in red escalation. There were seven patients in the ED awaiting an in-patient bed at 9am, six patients were accommodated on ward trolleys and 14 patients were accommodated in the day-care ward, which was being utilised as a surge area.

The RIU which came under the governance of the ED had four isolation rooms and one en-suite single isolation room. At the time of inspection two patients were in the RIU to include one patient with influenza. The AMAU comprised of eight bays and was located beside the ED, operating from 8am to 8pm. There was a designated medical consultant with oversight of the AMAU supported by NCHDs and nursing staff. Patients who met a specific criteria, were streamed to the AMAU from the ED, and the AMAU also accepted direct referrals from GPs.

Inspectors visited the Torc discharge-transit lounge to observe its operational function. The Torc lounge had five patient spaces and operated from Monday to Friday (8am to 8pm), accommodating patients identified for discharge from the ED or inpatient wards in turn releasing capacity within inpatient areas. Patients for discharge in the Torc lounge were not discharged from the hospital's inpatient management system (IPMS) until they left the hospital. Patients for day of surgery admission (DOSA) could be accommodated in the Torc lounge while their admission was completed, and until an inpatient bed became available. The lounge also accommodated patients in the ED who were awaiting inpatient beds, in an effort to decongest the ED in times of escalation. The lounge was staffed by a registered general nurse (RGN) and a healthcare assistant (HCA), at the time of inspection both staff were employed by an external agency.

Carrig ward was a 30-bedded medical ward comprising of four six-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and three single isolation rooms, two of which shared an ante-room. At the time of inspection, the ward was over capacity with 31 patients which included one patient accommodated on a ward trolley. Inspectors also observed mixed gender rooms, staff informed inspectors that this occurs in the enhanced care rooms and also during periods of escalation.

Aghadoe ward was a 30-bedded surgical ward comprising of four six-bedded multi-occupancy rooms, a three-bedded multi-occupancy room and three single rooms. At the time of inspection, 29 of the 30 beds were occupied, two admissions were expected which would bring the ward occupancy above capacity and would include one patient accommodated on a ward trolley overnight. Inspectors observed all the multi-occupancy rooms were mixed gender and a risk assessment had been completed.

Ardfert antenatal ward was a 16-bedded ward, comprising of one six-bedded multi-occupancy room, four single rooms, two side rooms and four labour ward beds. At the time of inspection, four of the 12 beds were occupied with three admissions expected. The antenatal ward was co-located beside the four suite labour ward and there were three women in the department at the time of the inspection.

Inspectors spoke with a number of patients and their relatives to ascertain their experiences of receiving care in the hospital. Responses were generally positive, patients were complimentary about the staff and the care received during their hospital stay. Patients described the staff as "obliging", "very helpful" and "very responsive". Patients

described how "they saw their doctor regularly", however a number of patients were unaware of their discharge date and one relative described one department as "chaotic".

Patients who spoke with inspectors said they would "speak to a nurse if they wanted to make a complaint", one relative had provided feedback to the hospital through e-mail correspondence. Inspectors observed information leaflets about the HSE complaints process *'Your Service, Your Say'* displayed in the clinical areas visited as well as information on advocacy services. Inspectors were informed about and observed information on the hospital website in relation to the process for individuals to provide feedback, make a complaint and the HSE *'Your Service, Your Say',* with an accompanying quick response (QR) code. Overall, patients were very complimentary about the staff and the care received in the hospital and this was consistent with what inspectors observed over the course of the inspection.

Capacity and Capability Dimension

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

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

Through discussions with senior management and staff, inspectors found that University Hospital Kerry had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services. Organisational charts seen by inspectors, set out the hospitals reporting structures detailing the direct reporting arrangements for hospital management, governance and oversight committees. The General Manager (GM) was the Senior Accountable Officer (SAO) with overall responsibility and accountability for the governance of the hospital and had a reporting relationship to the Chief Executive Officer (CEO) of the SSWHG. The Clinical Director (CD) provided clinical oversight and leadership to consultants and non-consultant hospital doctors (NCHDs). The Director of Nursing (DON) and the Director of Midwifery (DOM) were responsible for the organisation and management of respective nursing and midwifery services of the hospital. The DON and DOM had a professional reporting line to the Chief Director of Nursing and Midwifery SSWHG.

The hospital was in the process of implementing a directorate model structure which was a recommendation from the programme Growth, Rejuvenating, Optimising [***](GRO) UHK. The four directorates will have clinical governance and oversight of specialities within their remit, including medicine, obstetrics and gynaecology; peri-operative, diagnostics. At the time of the inspection three business managers had been appointed, Assistant Directors of Nursing (ADONs) had been identified but there had not been any applicants for two of the clinical directorate positions. The directorates will report to the CD of UHK.

The Executive Management Board (EMB) chaired by the GM, met every two weeks in line with the terms of reference, membership included the CD, DON, DOM, Operations Manager, QRPSM, Finance Manager and the HR Manager. Minutes from meetings reviewed by inspectors demonstrated that meetings followed a structured format, were action-orientated, assigned to a member for progressing, with timelines recorded as immediate or as soon as possible. The EMB set the strategic direction for the hospital and had oversight of and responsibility for the quality and safety of the healthcare services. An operational team who met on a fortnightly basis, reported into the EMB providing updates on scheduled and unscheduled care activity and associated challenges. The GM attended a monthly group performance meeting chaired by the CEO SSWHG and more recently by the Regional Executive Officer (REO). The group performance meeting was in line with the HSE performance and accountability framework 2023. Agenda items included finance, workforce, access to care and integration of services, activity, quality and patient safety, with review of risks held on the hospitals corporate risk register. Inspectors were informed by senior management that the GM met with the QRPSM on a weekly basis to ensure oversight of risk.

The Executive Quality, Risk and Patient Safety Committee (EQRPSC) was accountable to the EMB and managed the quality and safety of the healthcare services, providing the EMB with assurance on the appropriateness and effectiveness of clinical services. The EQRPSC, chaired by the CD was scheduled to meet monthly in line with the terms of reference, however inspectors were informed and on review of minutes, the EQRPSC meeting was cancelled in March, April and July 2024. The EQRPSC submitted an annual report to the EMB, membership was appropriate and representative of various groups within UHK. The EQRPSC also had governance of the oversight and management of complaints to UHK.

The serious incident management team (SIMT) was chaired by the GM and met on a weekly basis, to provide assurance to the GM that all serious reportable events (SREs) and serious incidents (SIs) were reported to the National Incident Management System (NIMS) and managed in line with the HSE incident management framework (IMF, 2020)

[***] Programme GRO UHK incorporated a number of improvement and transformation projects categorised according to seven themes: (1) Values, culture and vision, (2) Governance, leadership and management of strategic direction, (3) Clinical effectiveness, (4) internal processes and operational effectiveness, (5) quality, safety and risk, (6) Resources, (7) radiology.

and to ensure that a SIMT was convened within one working week of a category one occurrence. Terms of reference for SIMT required updating from October 2023.

The Clinical Governance Committees (CGCs) of the hospital reported into the EQRPSC. The hospital committees which reported to the EQRPSC and included the four key areas of harm were the deteriorating patient with subcommittees for resuscitation, sepsis and early warning score; drugs and therapeutics incorporating antimicrobial stewardship (AMS) and venous thromboembolism (VTE); infection prevention and control (IPC), falls, hospital blood transfusion, nutrition and hydration, health and social care professionals (HSCPs), end of life committee, health and safety.

UHK had the following 12 CGCs that reported into the EQRPSC and EMB: peri-operative to include hip fracture; medicine with sub-committees for stroke, renal and oncology; emergency department, cardiology, critical care, radiology, laboratory, Kerry specialist palliative care services, neonatal, maternity, paediatric services and the endoscopy user group. The CGGs reported into the EQRPSC providing assurance on the quality and safety of healthcare services. At the time of inspection, there was not an assigned individual for clinical audit within UHK, the EQRPSC had a role in supporting clinical audit, and had developed an algorithm which the inspectors viewed, outlining the process to undertake clinical audit. The responsibility for clinical audit was the remit of the CGCs and included implementation of recommendations from findings and re-audit. Inspectors were informed that there was not a schedule for audit or a criteria to determine how to prioritise audit activity.

The Infection Prevention and Control Committee (IPCC) was directly accountable to the EQRPSC and the EMB, providing assurance on the governance and oversight of infection prevention and control (IPC) practices within UHK. The IPCC have oversight for the implementation of the hospitals 3-year IPC strategy (2023-2025) and annual work plan which set out objectives and priorities. Chaired by the GM, the IPCC meet quarterly, in line with their terms of reference (ToR). However through communication with staff and review of documents it was noted that the IPCC was convened on only three occasions in 2024. Membership was multidisciplinary and included a consultant microbiologist, surveillance scientist, antimicrobial pharmacist, IPCT and representatives from the EMB. Reports are furnished to the EQRPSC annually and as required, providing data on surveillance, trends, feedback from audits and results. As per the IPCC ToR and organogram, the following subgroups and committees reported to the IPCC, furnishing twice yearly reports; outbreak management (convened as required); hygiene services, decontamination, environmental monitoring, IPCT, waste, antimicrobial stewardship, clinical governance groups. The multidrug resistant organism (MDRO) taskforce, as listed in the IPCC organogram, was not in place and inspectors noted the IPCC ToR was not signed. In speaking with staff and as per the organogram, the IPCC had a reporting structure to the SSWHG IPCC however the IPCC, were not required to furnish written reports to the group.

As documented in the terms of reference, the Drugs and Therapeutics Committee (DTC) was responsible for the expert governance oversight and review of the service, to ensure safe and effective medication usage in UHK. The DTC was an advisory committee with oversight including development of policies, procedures, protocols and guidelines (PPPGs), formulary oversight, medication related risk register and risk assessments, audit and quality improvement, nurse prescribing, medication safety and communication. The following sub-committees reported into the DTC: Antimicrobial Stewardship (AMSC), VTE, inpatient palliative care services report and the Medication Incident Review Team (MIRT). Chaired by a medical consultant, the DTC met every six weeks or eight times a year. The DTC reported to the EQRPSC, submitting a twice yearly report and also had a direct reporting structure to the GM and CD. Review of minutes from meetings, showed actions were assigned to an individual but were not time-bound. Inspectors were informed that representatives from hospital management had not been in attendance for the DTC meetings held in 2024 and this was evident from the minutes. The QRPSM was added as a member of the DTC and risk was a standing item on the agenda. On speaking with staff and on review of documentation inspectors were not assured of the oversight of medication safety due to staffing deficits within the pharmacy department which will be discussed further under standards 6.1 and 3.1.

The AMSC, a subcommittee of the DTC had oversight of the hospital's antimicrobial stewardship programme[†††]. Inspectors were provided with the stewardship programme for 2023 to 2025. The AMSC provided an annual report and an antimicrobial consumption report to the DTC and the IPCC. The AMSC, chaired by a medical consultant met quarterly and membership included members of the EMB, IPCT, antimicrobial pharmacist and a consultant microbiologist. Following review of documentation, there was strong evidence of governance and oversight of antimicrobial stewardship at the hospital.

The Deteriorating Patient Committee including sepsis (DPC) had governance and oversight of the systems and processes in place to recognise and manage the deteriorating patient. This included implementation and oversight of the Deteriorating Patient Improvement Programme (DPIP), implementation and oversight of the National Clinical Guidelines (NCG) on sepsis management and NCGs on communication as applied to the deteriorating patient [escalation and identify, situation, background, assessment and recommendation (ISBAR**3**)]. Chaired by a consultant clinical lead, the DPC consisted of an executive sponsorship group with representatives from the EMB and SSWHG as well as three clinical speciality groups; the Early Warning System (EWS), sepsis and resuscitation, all three of which reported into the DPC. The DPC met on a monthly basis submitting a report to the EQRPSC twice a year, in line with the ToR. The EWS group was chaired by a consultant physician. The EWS met and reported into the DPC on a quarterly basis. The inspectors reviewed minutes which illustrated that meetings followed a structured format, were action-orientated and were assigned to an individual but were not

[†††] An antimicrobial stewardship programme refers to structures, systems and processes that a service has in place for safe and effective antimicrobial use.

time-bound. The resuscitation group was chaired by a consultant cardiologist, it met and reported into the DPC on a quarterly basis. Meetings followed a structured format and actions were assigned to individuals for progressing, however actions were not time-bound. The sepsis group was chaired by the ADON in critical care, it met and reported quarterly into the DPC. Meetings followed a structured format and actions were assigned to individuals for progressing but were not time-bound. Inspectors noted some actions remained outstanding from quarter three 2023 and quarter one 2024.

The Integrated Discharge Group (IDG) met weekly, in line with the terms of reference to discuss delayed transfers of care (DTOC), complex discharges and barriers to egress and flow within UHK. Membership included representatives from the SSWHG and Cork Kerry Community Healthcare (CKCH). The IDG reported to the ADON UHK, and the general management of UHK and CKCH. The ToR were not signed and required updating from October 2023. The DTOC Integrated Operational Group (IOG) met weekly. Chaired by the GM in rotation, the IOG provided an opportunity to escalate issues to the strategic group, the ToR were not signed or dated. The DTOC Strategic Escalation Group (SEG) met fortnightly and had regional oversight with associated quality improvement work streams. A clinical handover steering group had been established in the hospital with an associated policy document. Minutes reviewed by inspectors noted a plan of engagement with the CGCs. Inspectors were informed that challenges for the group included access to information and communications technology (ICT).

There was evidence of improvement since the previous HIQA inspection in January 2024. Staffing deficits in the QRPS department were addressed and progress had been seen towards the implementation of the clinical directorate model. Areas for focused improvement:

- continue to progress the clinical directorate model
- ensure governance and oversight committees meet in line with the ToR
- ensure ToR for governance and oversight committees are reviewed annually.

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 inspectors found that there were management arrangements structures and mechanisms in place to support the delivery of safe, high quality and reliable healthcare services at UHK, however they were not as effective as they could be.

An operational team, chaired by the operations manager met on a fortnightly basis and reported into the EMB, providing updates on scheduled and unscheduled care activity and any associated challenges. Inspectors were told by staff that challenges for the hospital

included available inpatient capacity, lack of single isolation rooms (of which there were 25), lack of available community beds for an ageing demographic, the ability to provide home supports and appropriate placements for some patients under the age of 65 years. Challenges were posed by complex presentations requiring input from mental health services and lack of appropriate discharge placement to meet the needs of the service users. Data reviewed by inspectors showed there were 44,701 ED attendances to UHK up to 29 December 2024 which was a 7% increase in comparison to 2023 and a 30% increase in attendances compared to 2021.

At 11am on the first day of inspection nine (21%) ED attendees were accommodated on additional trolleys in designated ED corridor escalation areas. Senior management informed inspectors that the hospital had secured the use of 15 inpatient beds from a private hospital, and on occasion this could be increased to 20. Inspectors were informed that acceptance of transfers was on a consultant-to-consultant basis and with the informed consent of the patient. In these cases governance remained with the private provider but following discharge patients attended UHK for follow-up review, however there was no local policy, procedure, protocol or guideline (PPPG) governing this pathway.

All patients attending the ED were triaged and clinically prioritised, in line with the Manchester Triage System[‡‡‡]. At 11am on the first day of the of the inspection documentary evidence provided to inspectors showed there were 43 attendees registered in the ED, nine (21%) had been referred from a GP, six (14%) had arrived by ambulance and 28 (65%) had self-referred. There were 14 (32.5%) attendees who were over the age of 75 years. HSE urgent and emergency care (UEC) data, up to 29 December 2024 illustrated ED attendances over the age of 75 years were 7,399, with a 53.4% conversion rate to admission. Admissions over 75 years in 2024 accounted for 29.7% of overall admissions to the hospital. Senior management informed inspectors that weekday and weekend conversion rates were 14% and 24% respectively. However UEC data from 01 January to 29 December 2024 indicated ED admissions were 13,270 out of 44,701 attendances, a conversion rate of 29.7%. There were 2,907 patients streamed through the AMAU in 2024 with a conversion rate of 21.6% (628) patients. The number of patients who left the ED without being seen or before completion of treatment was tracked. A quality improvement plan had been recently implemented, outlining the process and escalation measures if the patient was deemed urgent. For remaining presentations, the consultant in emergency medicine reviewed the patients' chart and diagnostic results the following day and issued correspondence to the individuals GP. UHK as requested, provided data to inspectors in relation to ambulance handover times of less than 30 minutes. Compliance was recorded as 8.63% in 2023 and 8.99% in 2024. The HSE KPI for the percentage of patients arriving by ambulance at ED to physical and

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

clinical handover within 20 minutes of arrival is 80%. The national ambulance service (NAS) data submitted on a daily basis indicated that UHK were not meeting this target.

The mean time from registration to triage was 30 minutes and the mean time from triage to medical assessment was 8 hours and 27 minutes. Of the total attendances in the ED, 51% were waiting over six hours and 47% were waiting over nine hours from registration. These were below the HSE patient experience times (PETs) key performance indicator (KPI) targets of 70% and 85% respectively. Of the patients over the age of 75 years, 11 (25.5%) were waiting over six hours and 10 (23%) were waiting over nine hours. This was below the HSE KPI target of 95% and 99% respectively. No individual was waiting over 24 hours. Senior management informed inspectors and UEC data illustrated that there was a 26% reduction in ED trolley numbers from 2023. The hospital had systems and process in place to support patient flow through the hospital to include a daily hospital status update meeting in the ED attended by senior personnel, attendance and actions were recorded in a proforma document. Two additional medical consultants were rostered for core hours at weekends throughout January and it was expected that this measure would be extended to February. A dedicated medical consultant worked in the ED from Monday to Friday (8am to 8pm) providing access to a senior decision maker. UHK utilised additional inpatient capacity in a private hospital. A hospital ambulance liaison person (HALP) rostered in the ED seven days a week assisted with ambulance handover times. An additional triage room was opened during periods of escalation and a hub operated in ED staffed by a healthcare assistant, trained in phlebotomy and recording electrocardiographs (ECGs). Ward ways of working board rounds were conducted which included attendance by consultants and this facilitated discussions for the rationale in instances of extended lengths of stay. Admission avoidance pathways in ED included Pathfinder and the extension of the AMAU service to weekends throughout January, with the expectation that this measure would be extended to February. The ED also had a geriatric emergency multidisciplinary service (GEMS) for assessment of patients over the age of 75 years reviewing alternative pathways to admission or supported early discharge.

On the day of inspection, despite significant efforts from all members of staff, patient flow was not operating as effectively as it should be, this resulted in patients remaining in the ED while awaiting an inpatient bed and non-compliance with HSE PETs. There was evidence that measures to mitigate any risks to patient safety were being implemented including an RGN designated to the escalation areas of the ED, a clinical nurse manager 2 for admitted patients and a focus on patients over 75 years. However the number of patients (nine) lodged at 11am in the ED, accommodated on ward trolleys (six), surge capacity in use (14) and use of private bed capacity (15) would indicate these measures were not as effective as they should be. Inspectors were informed and reviewed evidence that unscheduled care was recorded as a high-rated red risk on the hospital's corporate risk register. The average length of stay (AvLoS) for medical patients was 9.2 days which was higher than the HSE KPI of less than or equal to seven days. The AvLoS for surgical patients was seven days which was higher than the HSE KPI of five days for elective

surgical patients and six days for emergency surgical patients. At the time of inspection, there were 22 patients who has completed their acute episode of care and were experiencing delayed transfers of care (DTOC) and were subsequently recorded on the HSE national DTOC portal, inspectors were told one patient was on the DTOC list for an extended period of time. Inspectors were told that the threshold for DTOC in UHK was 10 to 12 and review of the HSE UEC data showed DTOC numbers in UHK ranged from 15 to 32 since mid-November 2024.

Theatre capacity from a private provider was secured to mitigate delayed access to care for orthopaedic elective surgery. Consent to have the surgery carried out in the private provider setting was obtained from patients and governance remained with the consultant in the private hospital, follow-up review was carried out in UHK. In the case that an adverse event might occur to UHK patients attending the private provider, there was no PPPG outlining the process to be followed.

Whilst a QRPSM was now in post, it was acknowledged by staff that there was a considerable plan of work required in 2025 to strengthen the quality and safety function within the hospital, to include training for hospital staff in risk assessment and risk management. Inspectors were informed that validation of the corporate risk register had been undertaken in December 2024 and the process for implementation of reviews was in place.

The hospital had a comprehensive three-year infection prevention and control strategy and annual work plan setting out the infection prevention and control objectives and priorities for the year. The infection prevention and control team were responsible for implementing the work plan. The team submitted a progress report on its implementation to the IPCC on a twice yearly basis.

The hospital's pharmacy service was led by the chief pharmacist. A gap analysis review document was provided to inspectors, highlighting risk due to the lack of a dedicated medication safety pharmacist and lack of provision of a clinical pharmacy[§§§] service to wards and departments.

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. UHK had the following EWS in place to support the recognition, escalation and response to the deteriorating patient; Irish National Early Warning System (INEWS), Irish Paediatric Early Warning System (IPEWS), Irish Maternity Early Warning System (IMEWS) and the Emergency Medicine Early Warning System (EMEWS). There was an assigned consultant lead for the deteriorating patient improvement programme (DPIP) which included sepsis. The hospital had two advanced nurse practitioners (ANPs) operating a critical care outreach service in place which monitored patients transitioning from critical care to ward areas, and early support if

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

patients required transfer to critical care. They also provided advice and support to clinical and nursing colleagues.

It was evident to inspectors that there were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four key areas of harm, but these could be improved and strengthened. Focused areas for improvement include:

- continued support from local and regional management to reduce DTOC
- continued focus on PETs to align with HSE KPIs
- continued focus AvLoS to align with HSE KPIs
- address the risk posed by the deficit in the oversight of medication safety
- address the risk posed by the deficit in the provision of a clinical pharmacy service to departments
- outline the process for patients undergoing elective orthopaedic surgery in a private provider setting
- strengthen the quality risk and patient safety function by developing a plan for QRPS for 2025 to include, validation of the corporate risk register, introduce staff training on risk management and risk assessment
- develop a PPPG for transfer of patients to a private provider, outlining the inclusion and exclusion criteria and process for transfer to access inpatient capacity.

Judgment: Partially compliant

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

The inspectors found University Hospital Kerry had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital however these arrangements were not as effective as they could be.

Information on a range of clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with HSE reporting requirements. This data provided assurances to the EMB at fortnightly meetings, to the SSWHG at monthly performance meetings and to the GM at weekly meetings convened with the QRPSM.

The EQRPSC had formalised risk management structures and process in place, aligned with the HSE incident management framework (IMF, 2020). Following review of the corporate risk register and in speaking with staff, a validation of the hospitals corporate risk register had taken place in December 2024. There were risks on the hospital risk register related to staffing, medication safety, clinical pharmacy service, capacity and

infrastructure; infection control and those relating directly to the four key areas of harm prioritised under HIQA's monitoring programme which will be outlined further under standard 3.1. The EQRPSC had developed an algorithm outlining the process for escalation of risk to the corporate risk register, CGCs had oversight, governance and management of risk in the clinical services within their remit and reported to the EQRPSC. However inspectors noted there were still open recommendations from a review in 2022. The QPSM had oversight of the complaints and feedback received by the hospital.

Patient safety incidents were reported directly on the National Incident Management System[****] (NIMS) through an electronic direct point-of-entry (ePOC) and staff had been provided with training on the ePOC. Inspectors were informed reporting of incidents was predominately carried out by nursing staff and on review of documentation and speaking with staff, there were concerns that there may be under-reporting. This may be addressed by ready access to electronic point-of-entry system but the opportunity for comprehensive reporting should be further improved by management. Incidents were tracked and trended by the QRPSM and reports were submitted to the EMB which met fortnightly. Incidents were rated by the number, category and severity, and the GM discussed the top-rated risks with the SSWHG at monthly performance meetings. Learnings from incidents were shared informally with staff through the CGCs, at ward level through the ADON and CNM, and at weekly grand rounds. UHK noted that Maternity Incident Management Team (MIMT) meetings are convened, maternity incidents are reviewed by the team and QPS, recommendations are developed and implemented by the clinical governance committee.

The Serious Incident Management Team (SIMT) who met weekly and the MIRT were responsible for ensuring that all serious reportable events (SREs) were reported to NIMS and managed in line with the HSE IMF. UHK noted that all medication incidents are reviewed monthly by the multidisciplinary team and the Medications Errors Reporting Programme (MERP) taxonomy is applied, serious medication incidents go to SIMT. UHK collected data which was submitted monthly to the HSE and publicly reported as the hospital patient safety indicator report (HPSIR). The HPSIR was reviewed and approved by the GM ensuring that the Senior Accountable Officer (SAO) had oversight of all reports.

Unscheduled care activity was captured through the HSE UEC portal which was populated by the hospital four times daily. This data was reviewed at the monthly group performance meetings. Inspectors reviewed the weekly performance update which captured 2024 activity. The hospital had an inpatient management system that linked to the HSE health performance visualisation platform (HPVP), which provided live data on the activity status of the hospital with access rights at national HSE, group and hospital level. Scheduled care activity was extracted from the IPMS and publicly available through the national treatment purchase fund (NTPF) website. Inspectors were informed that the

[****] The National incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State's Claims Agency (Section 11 of the National Treasury Management Agency Act 2000 as amended).

hospital had 2,500 untriaged referrals in 2024 but senior management were taking steps to address this issue which included linking with individual specialties.

Infection prevention and control surveillance data was submitted monthly to the HSE business information unit (BIU). Inspectors reviewed the IPC annual report for 2024 that was submitted to the EMB. Antimicrobial consumption was reported to the health protection surveillance centre (HPSC) and there was strong evidence of antimicrobial stewardship audit within the hospital.

Inspectors reviewed the hospitals Maternity Patient Safety Statement (MPSS) for October 2024 which was publicly available. The aim of the report is to provide assurance that maternity services are delivered in an environment that promotes open disclosure. The MPSS was reviewed and approved by the SSWHG CEO ensuring oversight and clinical governance of this service at hospital group level. UHK did not have a clinical audit committee or a centralised coordinated approach to the audit of clinical practice and processes. While the QRPS department supported clinical audit, the GM advised inspectors that a business case had been submitted for a dedicated resource. In any case, management should progress an interim solution to develop a coordinated approach to audit of clinical practice and processes.

While inspectors observed that UHK had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital. However these arrangements were not as effective as they could be. Areas for focused improvement:

- establish centralised coordination for clinical audit
- develop a schedule for clinical audit, identifying the criteria for prioritising audit activity
- continued focus on addressing risk posed through untriaged referrals
- raise awareness with staff in relation to the importance of incident reporting
- training for staff in the proactive identification, analysis, monitoring and escalation of identified risks.

Judgment: Partially compliant

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

Inspectors found the workplace arrangement in place in UHK could be improved to further support and promote the delivery of high-quality, safe and reliable healthcare. There were four high-rated risks relating to staffing recorded on the hospital's corporate risk register and workforce was discussed at the monthly group performance meetings with the

SSWHG. Inspectors were provided with a breakdown of the whole-time equivalent[††††] (WTE) workforce for the hospital and the WTE position as of 31st December 2024 was 1533.84 WTE, which did not include unpaid leave or maternity leave.

Inspectors noted that consultant staffing levels in the emergency department had improved since HIQA's previous inspection in January 2024, with the provision of a 24 hours a day, seven days a week on call rota and oversight of the NCHDs. The hospital had approval for seven WTE consultants in emergency medicine, at the time of the inspection there were three permanent consultants and two locum consultants (5 WTE), appointment of the two permanent posts was at the final stages of recruitment. While the hospital was not a recognised training centre for NCHDs in emergency medicine, it required 19 WTE NCHDs to cover the rota in the ED. At the time of the inspection, 16 WTEs (84%) were in post due to delayed starts. Senior management had identified a requirement to improve the staffing levels in the ED at night. Recruiting an additional nine WTE to include four registrars and five senior house officers (SHOs) would allow two registrars to be on duty at night, with one SHO. Recruitment was at an advanced stage, with the expectation that decision numbers would be provided within two weeks.

Inspectors were provided with a written breakdown of nursing and healthcare assistant staffing in the ED:

- 1 WTE CNM III in post
- 8 WTE CNM II with 7 (87.5%) WTE in post and a deficit of 1 (12.5%) WTE
- 9 WTE CNM I with 8 (88.9%) WTE in post and a 1 (11.1%) WTE deficit
- 5.86 WTE ANPs which include an ANP for paediatrics and two cANPs with 5.6 (95.5%) WTE in post
- 1 WTE approved post for a clinical nurse specialist in frailty remains vacant
- 58.52 WTE RGNs
- 8 HCA WTE with 7.92 (99%) in post and a (1%) WTE vacancy.

The CNM 3 had overall nursing responsibility for the acute floor and was rostered on duty in the emergency department from Monday to Friday during core working hours. A CNM 2 shift leader was rostered on each shift for both day and night duty. A CNM 2 (0.64 WTE) was in post during core working hours from Monday to Friday to care for admitted patients in the ED awaiting an inpatient bed. Inspectors were informed that one WTE ANP post for the AMAU was in the early stages of the recruitment process.

The December 2023 and 2024 WTE position for NCHDs was 165.29 and 170.67 respectively. The total WTE required was 177, 168 (95%) were in post with 7 (4%) delayed starts and 2 (1%) outstanding vacancies. The Department of Health framework for

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

safer staffing[‡‡‡‡] had been implemented across the nursing discipline and the improvement in nurse WTE levels was noted by inspectors, following review of rosters and was acknowledged by staff who spoke with inspectors. The December 2023 and 2024 WTE position for nursing was 539.47 and 555 respectively. The HR manager informed inspectors that there was 545 WTE in nursing with nine permanent posts vacant and a number of temporary leaves. There was one WTE ADON and one WTE clinical nurse specialist (CNS) in IPC with two vacancies. The December 2023 and 2024 WTE position for nursing HCAs was 96.24 and 93.15 respectively. The establishment was 104 WTE HCAs, with 93.15 WTE in post with a deficit of 11.23 (10.8%) WTE.

The December 2023 and 2024 WTE position for maternity was 100.79 and 85.26, respectively. The establishment number for midwives and registered nurses (all grades) was 105.84 WTE, actual staffing was 86.35 WTE (81.6%) leaving a deficit of 19.49 WTE (18.4%). The December 2023 and 2024 WTE position for maternity HCAs was 8.57 and 9.07, respectively. The establishment number for maternity healthcare assistants was 8.7 WTE, actual staffing was 8.17 WTE (94%) leaving a deficit of 0.53 WTE (6%).

Two WTE locum consultant microbiologists were in post, both of whom worked on site, in their absence, cover was arranged through remote on-call arrangements.

When compared to the previous inspection, inspectors were informed that there were now no staffing deficits in the QRPS department. Positions included one WTE QRPS manager grade VIII, one WTE grade VII interim risk manager, one WTE grade VII quality manager, one WTE complaints facilitator, administrative support to the department comprised of three WTE grade Vs, one WTE grade IV and one grade III.

The December 2023 and 2024 WTE position for pharmacy was 13.6 and 12.6, respectively. The establishment number for pharmacy was 17.6 WTE with a deficit of 7.7 WTE:

- 1 WTE pharmacy manager grade II in post
- 7.6 WTE senior pharmacists with 5 (65.8%) in post with a deficit of 2.6 (34.2%) WTE
- 2 WTE staff grade pharmacists (100% deficit)
- 2 WTE senior pharmacy technicians (100% deficit)
- 5 WTE staff grade pharmacy technicians with 3.9 (78%) with a deficit of 1.1(22%) WTE.

At the time of inspection, two senior pharmacist posts had been approved for advertising and one staff grade pharmacy technician was expected to commence the following week. The risks associated with the staffing shortfall in pharmacy were discussed at the DTC and

‡‡‡‡ The Framework for Safer Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland and the Framework for Safe Nurse Staffing and Skill-Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

were escalated to the EMB for inclusion as a high-rated risk into the corporate risk register. Inspectors were also provided with a gap analysis related to pharmacy staffing.

At the time of the inspection there was one WTE radiology consultant and one consultant radiologist working 24 hours a week. The hospital used an external radiology reporting service and UHK consultants operated a one-in-five weekend on-call rota.

The December 2023 and 2024 WTE position for radiology was 38.64 and 37.7 respectively. The establishment number for radiology was 45.6 WTE with 34 WTE in post and approval was received for nine WTEs.

The December 2023 and 2024 WTE position for the laboratory was 57.7 WTE and 58.2 WTE, respectively. The establishment number for the laboratory was 69.3 WTE with 46.61 (67%) WTE in post. At the time of inspection, approvals were received for six WTE posts and were at various stages of recruitment.

The following information was provided in relation to HSCP staffing:

- 26.04 (65.1%) WTE of the establishment 40 WTE physiotherapists post were filled with approvals received for five WTE
- 6 WTE of the establishment 6 WTE social worker posts were filled
- 12.14 (71.4%) WTE of the established 17 WTE occupational therapists post were filled with approvals received for three WTE

The human resource department tracked and reported on staff absenteeism rates and this data was reviewed at meetings of the EMB and at monthly performance meetings with the SSWHG. The absenteeism rate for UHK in 2024 ranged from 5.88% to 8.07%, with December recorded as 7.7% which is above the HSEs target of less than or equal to 4%. Employees were supported by their line managers and HR. Staff could avail of the employee assistance programme (EAP) and could be referred to occupational health, if required.

Representatives from the EMB told inspectors that the majority of consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). However the numbers of consultants who were not on the specialist register was not provided to HIQA, when asked during interview. The remaining consultants went through a formal interview with the GM and clinical director. A risk assessment was developed and forwarded to the SSWHG for oversight.

Inspectors were informed that there was not a centralised data-base within the hospital to record and monitor the uptake of staff attendance at essential and mandatory training. Attendance at essential and mandatory training by NCHDs was recorded on the national

employment record[§§§§] (NER) system. Nursing, midwifery and healthcare assistants attendance was monitored by direct line managers with oversight by the DON/DOM.

Mandatory and essential training included hand hygiene, transmission and standard based precautions, early warning systems, basic life support, (ISBAR3)[*****] communication tool, PROMPT[†††††] training for the management of obstetric emergencies and interpretation of foetal heart recordings. Training records reviewed by inspectors showed that compliance with mandatory training was suboptimal, QIPs had been developed specifically for nursing and HCA staff to address non-compliance within their remit.

Inspectors acknowledge hospital improvements in relation to staffing for consultants, NCHD, nursing and QRPS departments since HIQAs previous inspection in January 2024. There remains a significant deficit in the areas of midwifery and pharmacy. Areas for focused improvement include:

- address the risk posed by the deficit in pharmacy staffing to include a medication safety pharmacist
- address the risk posed by the deficit in midwifery staffing
- focus on current absenteeism rate of 7.7%
- improve compliance with mandatory and essential training.

Judgment: Partially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support and safe care and support. University Hospital Kerry was found to be compliant with two national standards (1.7, 1.8), substantially compliant with two national standards (1.6, 2.7) partially compliant with two national standards (2.8, 3.1) and non-compliant with one national standard (3.1) assessed. Key inspections findings informing judgements on compliance with these seven national standards are described in the following sections.

[§§§§] The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise resistive paperwork requirements for NCHDs and eliminate duplication when rotating between employers.
[*****] ISBAR3 – Identify, Situation, Background, Assessment, Recommendation, Read Back, is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.
[†††††] PROMPT – The Obstetric Multi-Professional Training course is an evidence based training package that teaches healthcare professionals how to respond to obstetric emergencies.

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, promoting the dignity, privacy and autonomy of patients. Inspectors observed communication between staff and patients to be respectful and kind. For the most part the physical environment in the ward clinical areas visited promoted the privacy dignity and confidentiality of patients receiving care. However inspectors observed patients were accommodated in mixed gender rooms, for the purpose of enhanced care or in times of escalation. Staff were observed offering assistance to patients with their individual needs, using privacy curtains while attending to patient care. Inspectors were shown designated rooms where private discussions could take place between hospital staff, patients and family members. Healthcare records and personal information was protected in ward areas visited with the exception of one clinical area where inspectors observed details of patients on the patient white board. Patient information leaflets and posters were available with information on the HSE '*Your Service, Your Say'*, advocacy and 'my patient journey'. Patients could also access the '*Your Service Your Say'* through a quick response (QR) code on the hospital website. The hospital had 25 single isolation rooms with en-suite facilities which resulted in some patients requiring transmission-based precautions being cohorted in multi-occupancy rooms. While patients' privacy and dignity was supported for patients in individual bays in the acute floor, this was not the case for patients allocated in designated escalation areas of the ED.

In the 2024 National Inpatient Experience Survey (NIES) the hospital scored 7.3% which was below the national average score of 7.6% for admissions and experience in the ED which included respect for privacy. A resource was allocated to the ED from Monday to Friday (10am to 2pm) to communicate with patients and address any queries they may have about their wait times or respond to any feedback. The hospital had volunteers working at the main hospital reception to assist service users with queries. Inspectors were informed that the hospital had access to translator services to meet specific patient requirements.

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity and privacy of people receiving care at the hospital. However compliance was not met in areas where patients were accommodated on trolleys in escalation areas of the ED, and in instances where patient details were visible on the white board. Areas for focused improvement:

- review the appropriateness of designated escalation areas in the emergency department
- review the patient communication board in the AMAU to ensure patient confidentially is maintained

- review the risk associated with mixed gender rooms.

Judgment: Substantially compliant

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

It was evident, through the development of a number of quality improvement initiatives that a culture of kindness consideration and respect was actively promoted for people accessing and receiving care at the hospital. Patients with whom inspectors met, were complimentary of the staff and the care provided to them. Inspectors observed staff to be respectful, kind and caring towards patients in the clinical areas visited. This was confirmed by patients who spoke positively about their interactions with staff. Inspectors observed the 'Nurses Philosophy', the 'Philosophy of Midwifery' and the patients' charter 'putting patients first' on display in some of the clinical areas visited. The hospital had access to translator services to meet specific patient requirements and a number of forms were available in various languages in the emergency department.

Judgment: Compliant

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

The inspectors found there were systems and processes in place in UHK to respond to complaints and concerns in a coordinated and timely manner. The complaints facilitator was the designated person assigned with the responsibility for managing complaints and reported to the QRPSM, who had oversight of all complaints to ensure governance and oversight. Quarterly reports seen by inspectors were provided to the EMB, feedback on complaints was provided to the various CGCs or heads of departments for the dual purpose of governance and oversight. Managers within clinical areas (or where applicable the CD), reviewed the complaint and prepared a reply which the complaints facilitator used to develop a response to the complaint. Inspectors were informed by staff that learnings from complaints were discussed at local level, with the departmental manager and staff, communication books were also used. The national database complaints management system (CMS) was in use in the hospital to enable the end-to-end management and tracking of complaints, investigations, outcomes and recommendations at local level. Inspectors were told that administrative support was available to assist in extracting valuable data from this system.

Inspectors were told that the hospital had introduced a tracking system to capture verbal complaints and were shown carbon copy books held at department level, (a copy of the

complaint was sent to the complaints facilitator). An algorithm was also developed to support staff in dealing with complaints, who were encouraged to resolve the complaint locally, in line with national guidance. As a number of complaints to the hospital related to wait times, a resource was allocated to the emergency department to communicate with patients and address any queries they may have about their wait times or respond to any feedback from Monday to Friday, (10am to 2pm). The hospital website held a repository of information outlining the process to provide feedback or make a complaint to the hospital, information on '*Your Service Your Say'*, the office of the Ombudsman and independent patient advocacy service. Third parties could make a complaint on behalf of a patient once a consent form was signed. The website also included a complaints policy statement with a QR code. Inspectors observed information posters on the HSE 'Your Service, Your Say' in clinical areas visited. Inspectors were told that a point-of-contact complaints resolution was to be piloted. The National Maternity Experience Survey is scheduled to take place in 2025 and information will be provided to patients when they attend the hospital. Inspectors observed results of the National Inpatient Experience Survey displayed in one clinical area visited.

Inspectors through review of documentation and in speaking with staff, noted that the hospital complaints mainly related to communication, wait times in the emergency department, access to information and appointments. In relation to level 2 complaints, inspectors were told that patients were encouraged to deal directly with the hospital by providing a generic e-mail address on the hospital website. The HSE National Service Plan 2025 key performance indicator (KPI) is 75% for the percentage of complaints investigated within 30 working days of being acknowledged by the complaints officer. The hospital's compliance with five day acknowledgement ranged from 98.5% to 100%. Compliance with complaints investigated within 30 days ranged from 77% in quarter one 2024 to 94% in quarter four, and this was above the HSE national KPI. Inspectors were informed there were two stage three complaints open in 2025 which related to care and referral to a level four tertiary hospital. One complaint was sent to the Ombudsman. Where a level three complaint is made, the hospital group notify the hospital general manager and the administration of the complaint is handled by a review officer.

Inspectors were told and reviewed evidence that complaints management training was provided and compliance ranged from 0% to 100% across 17 departments out of 23. There was a focus to make complaints training mandatory for staff and a 'buddy app' was used to raise awareness around training with clinicians. Staff were aware that there was a generic communication module on HSELand. Five communication training workshops were facilitated in 2024 and inspectors were informed that a number of staff had completed a 'train the trainer' programme. The number and types of complaints was reported to the HSE, on an annual basis. The complaints facilitator submitted reports on the number and types of complaints received, the timelines and outcomes of the complaints management process to the EQRPSC and the EMB. Copies of these reports were provided to inspectors for review for quarter one and two of 2024. The hospital had a complaints policy and audits were provided to inspectors, in relation to compliance with staff training.

Inspectors reviewed quality improvement plans (QIPs) in relation to verbal complaints, some QIPs dated October to December 2024 had actions assigned to a responsible person, but were not all time-bound.

In summary it was evident that University Hospital Kerry had systems and processes to deal with complaints in a timely and effective manner and audit of compliance with the HSE key performance indicators were met. One focus for improvement is to ensure QIPs are time-bound.

Judgment: 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.

At the time of inspection, inspectors observed the overall physical environment in the clinical areas visited was generally well-maintained and clean with few exceptions. There was evidence of some general wear and tear with woodwork and paintwork chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk. Double doors within one clinical area required maintenance due to chipped woodwork and the door to the dirty utility also required maintenance to facilitate door closure. While there were security arrangements in the hospital there was not full-time security personnel assigned to the emergency department, however appropriate measures were in place to ensure secure and authorised access to clinical areas.

Wall-mounted alcohol hand gel dispensers were strategically located and readily available for patient and staff use with signage promoting the five moments of hand hygiene clearly displayed in clinical areas. While hand hygiene sinks were available, not all sinks conformed to national requirements. Inspectors observed appropriate spacing between beds in the inpatient areas visited. However available inpatient capacity which will be (discussed further under 3.1) resulted in a number of six-bedded multi-occupancy mixed gender rooms. There was adequate spacing between trolleys in both the AMAU and patient bays in the emergency department, with the exception of the additional trolleys within designated escalation areas. Patients requiring isolation for transmission based precautions were accommodated based on the HSE antimicrobial resistant infection control (AMRIC) national prioritisation guidance, in line with NCG number 30. The process was overseen by the infection prevention and control team who communicated with clinical areas on a daily basis from Monday to Friday, a consultant microbiologist was available to provide advice, to include out of hours. Inspectors were informed that there were 25 single en-suite rooms in the hospital but this did not meet the current demand. Lack of available isolation rooms was a high-rated risk on the hospitals corporate risk register. While control measures were being applied to mitigate the actual and potential risk to patients, inspectors were shown documentary evidence of 28 healthcare-

associated outbreaks of infection in the hospital in 2024. Senior management informed inspectors that works were ongoing to provide additional inpatient capacity.

Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited with a readily available supply of personal protective equipment (PPE) and instruction on use. Staff were observed wearing appropriate PPE in line with national guidelines and were encouraged to conduct a point-of-care risk assessment when caring for patients. Inspectors were informed about and viewed a risk assessment for aspergillosis relating to building works.

Across the acute floor, there were 19 toilets and two showers for patient use including two wheelchair accessible toilets in the waiting room. The antenatal ward had six toilets for patient use and five showers. The six bedded patient rooms and two of the single rooms had en-suite facilities on Aghadoe ward and the remainder had toilet facilities only. There was a wheelchair accessible toilet and shower on the corridor. In the Carrig ward all patient rooms had en-suite facilities. There was a wheelchair accessible toilet and bathroom on the corridor.

Hygiene services in the hospital were provided by employees of the HSE and external contract cleaners, this was underpinned by a formal policy. Clinical nurse managers (CNMs) and cleaning supervisors had oversight of environmental cleaning. Designated cleaning staff were responsible for carrying out cleaning of the bed space following patient discharge, and terminal cleaning‡‡‡‡‡. Hygiene services implemented an increased cleaning schedule during periods of outbreaks. Disposable curtains were in use in clinical areas and were dated when changed, but inspectors did not see evidence of a schedule for curtain changing in a number of clinical areas visited. There was evidence of water testing for legionella on a quarterly basis with reports viewed by inspectors and evidence at ward level of tap flushing. While there was evidence in some clinical areas of cleaning 'sign off' sheets to indicate that cleaning had been carried out, this practice was not consistent and inspectors observed out-of-date sign off sheets and illegible writing, one treatment room was observed to require cleaning. Overall, staff felt that adequate hygiene staff were available to maintain environmental hygiene standards. Environmental audits were conducted and will be discussed further under standard 2.8.

Cleaning of equipment was primarily the role of healthcare assistants (HCAs) with oversight by the CNM. Equipment was tagged with an 'I am clean' label once it was cleaned and decontaminated, however inspectors observed lack of consistency with this practice, as some stored equipment did not have tags. Chairs requiring repair to their arm coverings were observed in one waiting area. Inspectors observed evidence that the service history of equipment was in date and inspectors were informed that service history details were held with the biomedical department. Staff completed an online request to maintenance if equipment required repair and there was generally a timely

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

response. Equipment audits were conducted and will be discussed further under standard 2.8. There was dedicated medication preparation areas and medications were stored securely and appropriately, this was supported by review of the nursing quality care metrics audits.

While visiting clinical areas, inspectors were told by staff that there was inadequate storage space for equipment, inspectors observed stock on the floor to include sterile solution bags for irrigation. One inspector observed equipment stored in single patient cubicles and were told the cubicle would be decanted, prior to use by a patient. There was evidence of mixed stores in one storage room where femoral traction splints were stored with walking frames, three litre fluids for irrigation and tensol cleaning solution. While the door to the storage room had an authorised access swipe mechanism, inspectors observed the door was open whereby unauthorised access could be gained. In another clinical area, the day room was used to store patient equipment which included hoists, PPE and cleaning products. In two clinical areas the corridor appeared 'cluttered'.

Inspectors observed compliance with the storage of chemicals and posters on how to deal with chemical spills. Inspectors observed clinical and non-clinical waste bins and appropriate disposable of sharps. There were dedicated medication preparation areas in the clinical areas with evidence of secure and appropriate medication storage. Sharps bins were signed and dated and partially closed. There was appropriate segregation of clean and used linen.

In summary, the physical environment and patient equipment was observed to be generally clean and well-maintained. However at the time of inspection there were insufficient single isolation rooms available to meet demand, this will be addressed further under 3.1. Areas for focused improvement:

- address the risk posed by the lack of appropriate storage facilities
- ensure consistency and oversight of 'sign off' of cleaning sheets

Judgment: Substantially compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information, from a variety of sources in order to inform continuous improvement of services. National KPIs in line with HSE national reporting requirements, were used by the hospital to measure the quality and safety of the service it provided. This was further supported by information collected from audit activity, risk assessments,

patient safety incident reviews and complaints. The general manager attended monthly performance meetings with the SSWHG where performance was evaluated in line with the HSE performance and accountability framework 2023.

Risks were identified, managed and monitored by the EQRPSC and the EMB. Governance and oversight of clinical risk was managed by the specific clinical governance committees who reported into the EQRPSC. Departmental managers were responsible for proactively identifying risk, developing a risk assessment, determining the impact and likelihood of the risk occurring, applying a risk-rating and implementing control measures to mitigate the impact of the actual or potential risk identified to patients within their area of responsibility. The hospital submitted monthly MPSS and HPSIR reports to the HSE, all of which were publicly reported. However the proactive identification and review of risk was not as effective as it could be.

Inspectors were informed by staff and were shown documentary evidence of the following audits; PETs in the emergency department where a weekly breakdown was provided to the CNM for the acute floor, daily ambulance handover times submitted to the hospital by the NAS and data in relation to the number of patients who left without been seen or before completion of treatment. Data in relation to PETs and AvLoS was tracked in line with HSE national service plan 2025. PET data was returned on a daily basis through the HSE UEC portal. Audits were conducted for time from registration to triage, March and October monthly average times ranged from 22 to 25 minutes with compliance ranging from 15% to 69%, inspectors did not see evidence of a QIP. QIPs were developed for Manchester triage category two patients and zero tolerance to patients over 75yrs in the emergency department over 24 hours, both were timely and actions assigned to individuals. Inspectors were told that data was collected on patients presenting with the following conditions, stroke, myocardial infraction and fractured neck of femur and data was presented at specific hospital meetings. Data related to time to surgery within 48 hours for hip fractures was publicly available on the HSE HPSIR and compliance ranged from 80 to 82% in quarter one and two of 2024, slightly below the HSE KPI 85%.

The infection prevention and control committee (IPCC) had oversight of infection prevention and control (IPC) practices within UHK. There were two high-rated risks on the hospital's corporate risk register in relation to staffing. Surveillance data relating to rates of *clostridium difficile infection* (CDI), *carbapenemase-producing enterobacterales* (CPE), hospital-acquired *staphyloccus aureus blood stream infections* (HA SA BSI), hospital-acquired COVID-19 and IPC outbreaks was submitted by the hospital to the HSE BIU. The IPCT submitted an annual report to the IPCC and as requested. The UHK IPC surveillance report January 2025 covering January to November 2024 provided the following detail, the mean HA SA BSI rate for UHK was 0.9 per 10,000 bed days used (BDU) above the national KPI target of less than 0.7 per 10,000 BDU. The mean HA CDI rate for UHK was 4.6 per 10,000 BDU above the national KPI target of less than 1.8 per 10,000 BDU. The

mean HA COVID-19 rate for UHK was 11.8 per 10,000 BDU above the national mean of 10.5 per 10,000 BDU.

Hand hygiene audits were conducted by the IPCT using a standardised tool, audits reviewed by inspectors showed the compliance rates ranging from 85% to 93.3% across the various clinical areas visited. Overall hand hygiene compliance for UHK was maintained above the HSE KPI of 90% in 2024. Care bundles were also monitored, the results were available on the UHK noticeboard and reported to the IPCC quarterly. There was some evidence that quality improvement plans were in place when results fell below the recommended KPI of 90%. The development of a QIP was the responsibility of the CNM to address non-compliance for areas within their remit with oversight from the IPCT. Inspectors noted this practice was not consistent and actions were not always assigned to an individual. Inspectors noted IPC had developed an overarching QIP to increase compliance with hand hygiene in UHK. Additional QIPs developed related to transmission-based precautions (TBP) and influenza outbreak.

Universal screening for CPE was not in place in the hospital, which is not in line with HSE AMRIC guidance from December 2022 where patients should be screened within 24 hours of admission. Targeted CPE screening was in place in the hospital and IPC had developed a criteria for this process, this included CPE screening of inpatients in an acute setting in the past 12 months. All admissions to clinical areas such as critical care, special care baby unit (SCBU) and haemodialysis had an admission screen and weekly screens thereafter. Surgical site infection for laparoscopic cholecystectomy was monitored in the hospital in 2024 and a report was furnished where only one case of infection was detected.

There was evidence of medication audits being carried out on a monthly basis captured through the nursing quality care metrics where a specified number of healthcare records were reviewed. Nursing metrics included medication storage and custody, medication safety and weight recorded on medication drug chart, review of health care records showed compliance with documentation of allergy status. Medication safety audit results ranged from 75.1% to 100% across the clinical areas visited. However there was not a consistent practice of developing a QIP in response to non-compliance of a result below 90%. The National Venous Thromboembolism (VTE) Programme, rates of defined and suspected hospital-associated VTE in UHK, ranged from 7.0 to 13.1 between June to September 2024, UHK was above the national level in August and September. VTE was reported on the HSE HPSIR October 2024 as 5.4 to 17.5. A QIP had been developed which included input into the new Medicines Prescriptions and Administration Record (MPAR) that was being introduced in 2025 and implementation of VTE prophylaxis administration standardised as a once daily dose at 6pm. Audit results were reported to the DTC, however the DTC had not developed an audit schedule for medication safety for 2025, citing staffing deficits as a contributing factor. The DTC provided an annual report to the EQRPSC and EMB while pharmacy submitted an annual service plan.

There was strong evidence that antimicrobial stewardship (AMS) practices in the hospital was monitored and evaluated. This included AMS programme of quarterly reports for 2024, AMS annual programme 2024, AMS consumption report 2023, Health Protection Surveillance Centre (HPSC) annual consumption report June and July 2024, audits on meropenem use (range 0.8 to 1.4 in 2024), and consumption, and clostridium difficile rates. Inspectors reviewed the AMRIC point prevalence survey (PPS) 12th September to the 9th October 2024 where the overall compliance for duration was 94.4% which was above the national score of 89.3%. The overall compliance with consultant microbiologist approval 94.4% which was above the national score 86.8%. Antimicrobial PPS audit report from 26 November 2024 showed compliance with documenting allergy status on the MPAR was 78%, below the 95% target. The hospitals HCAI indication at 22.6% was above the national median score of 16.7%. Inspectors were provided with evidence of information posters in, relation to use of the 'watch' antibiotic vancomycin.

Inspectors were provided with evidence that audits related to the deteriorating patient including sepsis were being monitored and evaluated with time-bound QIPs developed in response to audit findings. Results were discussed at the DPC. In QIPs viewed by inspectors, the actions were assigned to specialties rather than a designated individual. INEWS escalation and response audits for quarter four 2024, showed compliance with response and required actions varied, from response adhered to (which included informing the nurse in charge) at 25%, documentation following review was 50% and compliance with taking and recording vital signs was 87.5%. Inspectors were informed that the hospital had ward-based clinical teams which may be a contributing factor to the documentation compliance, as clinicians were readily available in clinical areas to provide timely review. Maternity services within the hospital conducted monthly Irish Maternity Early Warning System (IMEWS) audits and the Clinical Midwifery Manager (CMM) linked with the Clinical Nurse Manager (CNM) for the deteriorating patient in relation to compliance results which ranged from 75.3% to 84.5%. A QIP seen by inspectors showed actions were not assigned to an individual and were not time-bound. There was evidence that compliance varied between clinical areas. Staff informed inspectors that compliance with EWS had improved through the DPC efforts to increase awareness. This was evident by improvements noted in one clinical area, which demonstrated an increase in compliance from 20% in May, to 58% in October 2024. Audit results provided to inspectors indicated that this remains an area for focused improvement. In response to recommendations from reviews, the antenatal ward had implemented an hourly co-sign for cardiotocography (CTG) recording, compliance was 70%.

The sepsis six bundle was in use in the hospital. Sepsis audits for quarter four 2024 indicated non-compliance with recording fluid balance and urinary output (29%), lactate (90%), blood cultures were taken (86%), oxygen as applicable (100%), antimicrobials given with one hour (31%), IV fluids administered (36%). A QIP was developed in response to the audit findings, it was dated, and time-bound but actions were assigned to

specialties. The hospital requires significant focus to improve compliance across specialties in relation to identification of sepsis.

As per the quarter four 2024 DPC report, compliance with ISBAR ranged from 0 to 40% across clinical areas. Inspectors viewed results from an observational audit for 'end of shift' clinical handover in line with NCG number 11, conducted in July and August 2024. Results highlighted that the ISBAR3 tool was not in use, read-back was not conducted, safety pauses were not practised and there was a number of interruptions. A detailed QIP was developed with recommendations such as the requirement to highlight concerns or patients of concern at the handover, introduce twice daily safety huddles at 9am and 3pm which were to take place at bedside unless IPC precautions in place, and mandatory training on HSELand. A nursing and HCA clinical handover flowsheet was developed and was included with the QIP. Reports were to be submitted to the nursing quality meeting which was chaired by the DON, learnings would be shared at ward level through communication boards, team meetings and safety huddles. However inspectors noted that the time the audit was conducted (July and August 2024), and the time for review was quarter one 2025, but bedside handover was being conducted in a number of clinical areas visited. A clinical handover audit was conducted in January 2025 by the ED, focussing on ISBAR3 communication between ED and ward areas, supported by the ISBAR3 tool in the adult booklet, a local QIP was in place with a monthly review schedule. The adult booklet incorporating the ISBAR3 communication tool was in use in the AMAU. The DPC linked with CGC to discuss audit findings and secure engagement. Oversight of risk remained with the CGC and the quality manager had plans to link with CGC in 2025 to develop QIPs.

Multidisciplinary morning clinical handover took place in the antenatal ward on a daily basis, arising from an audit of compliance with attendance, anaesthetics were asked to attend and audits are scheduled twice a year. A UHK clinical handover steering group was established with a meeting convened in September 2024, and recommendations and next steps included engagement with CGCs. However staff identified the availability of ICT to meet the requirements of the group as a significant challenge.

Delayed transfers of care (DTOC) were submitted daily to the HSE and were publicly available on the national UEC dashboard. While the hospital threshold was 10 to 12, the DTOC numbers had ranged from 15 to 32, since November 2024. Specific detail on the category of the DTOC was populated on a national dashboard. The AMAU collated data on a daily basis in relation to activity and admission rates, and conducted monthly audits on documentation. Nursing and midwifery quality care metrics were conducted on a monthly basis and results were displayed in a number of clinical areas visited.

Environmental audits were conducted by hygiene services using a standardised tool. Recent environmental audits reviewed by inspectors showed the compliance rates ranged from 57.3% to 96.1% and varied from each month and by specific clinical area. QIPs were developed but actions were not always time-bound or assigned to an individual.

Equipment audits were conducted by the CNM using a standardised tool, compliance was recorded as 86.5%. However inspectors did not find evidence of equipment audits in three of the clinical areas visited. The hospital had developed a QIP, seen by inspectors, to address non-compliance with mandatory training for nursing and HCAs, and actions were time-bound and assigned to individuals.

Overall, there was opportunity for improvement in the monitoring and evaluation of healthcare services provided at the hospital. Areas for focused improvement:

- significant focus required to ensure compliance across all clinical departments and specialties with sepsis six bundle
- ensure compliance with EWS escalation and response process and documentation
- ensure equipment audits are conducted consistently across all departments and QIP developed in instances of non-compliance below 90%
- strengthen oversight to assure senior managers that any necessary and effective time-bound quality improvements plans are in place to address audit findings
- address UHK HCAI that are reported as above the national target
- address the risk of not completing pharmacy-led audit for medication safety.

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 in place to identify, monitor analyse and respond to information relevant to the provision of safe services related to the four key areas of harm. However these systems were not as effective as they should be.

A senior-decision maker[§§§§§] at consultant level was on site in the ED each day from Monday to Friday, during core working hours and also participated in an out of hours on-call rota which provided clinical governance and ensured supervision of NCHDs within the department. This practice mitigated some of the specific concerns raised in a previous HIQA inspection (conducted in January 2024) and inspectors were assured through speaking with staff that there were no issues contacting consultants out of hours. One of the consultants in emergency medicine was assigned as the clinical lead and was responsible for the day-to-day operational functioning of the ED. Consultants in emergency medicine were operationally accountable and reported to the CD of UHK.

A CNM 3 had oversight for nursing and HCA staffing across the acute floor, the CNM 3 could escalate concerns through their line management reporting structure. While there were not scheduled meetings with the QRPS department, inspectors were informed that

[§§§§§] A senior- decision maker is defined here as a doctor at registrar grade or consultant, who has undergone appropriate training to make independent decisions around patient admission and discharge.

the QRPSM could be readily contacted by e-mail or telephone. Inspectors were informed that risks within the department were reviewed by the CNM 3 and ADON and also discussed at the ED CGC. UHK noted that a representative from QRPS attends all CGC meetings and risk is a standing item on the agenda. There were five high-rated risks on the hospital corporate risk register which inspectors were told had recently been reviewed at the CGC meeting. However on review of documentation inspectors observed that a number of risks were dated 2023 and control measures that had been identified were in place but the risk assessment had not been updated accordingly. The risks related to infrastructure, staffing, non-compliance with PETs and IPC. A risk related to accommodation of vulnerable patients under the age of 18 years who did not require acute admission but remained in the ED while awaiting suitable placement was on the hospital corporate risk register. Inspectors noted that there was not a PPPG in place outlining the governance arrangements for this cohort of patients while they remained in the ED.

Attendances to the ED were assigned to the on-call consultant in emergency medicine until the decision was taken to admit or discharge. If a decision to admit was made, the patient was admitted under a specialist consultant and remained in the emergency department until an in-patient bed was available. Inspectors were informed, ward-based teams were in place whereby patients were admitted under the ward consultant. Over the course of the inspection, the ED was experiencing high levels of activity and in line with the hospital's escalation plan was deemed to be in red escalation. Seven patients were in the ED at 9am awaiting an in-patient bed, six patients were accommodated on ward trolleys and a further 14 patients were accommodated in the day-care ward, which was being utilised as a surge area. On the first day of inspection at 11am, nine (21%) ED attendees were accommodated on additional trolleys in designated escalation areas, away from the central nurses' station and outside of the immediate view of the ED staff. To mitigate the risk a nurse was assigned to the escalation areas and was observed monitoring vital signs of patients.

While inspectors were shown a risk assessment identifying patients who were more suitable to being accommodated in escalation areas of ED, inspectors observed incidences where greater consideration could have been given to identification of patients to be placed in surge areas, based on two examples of patients seen by inspectors on the day. Documentary evidence provided by senior management at 11am on day one of the inspection, showed the mean time from registration to triage was 30 minutes and the mean time from triage to medical assessment was 8 hours and 27 minutes. Of the total attendances in the ED, 51% were waiting over six hours and 47% were waiting over nine hours from registration, this was below the HSE PET KPI targets of 70% and 85%, respectively. Of the patients over the age of 75 years 11 (25.5%) were waiting over six hours and 10 (23%) were waiting over nine hours, this was below the HSE KPI targets of 95% and 99%, respectively. No individual was waiting over 24 hours.

Measures were in place to mitigate the risk to patients from prolonged PETs, which included a medical consultant in the ED from Monday to Friday, streaming patients who met inclusion criteria to the AMAU, which operated at weekends throughout January. The hospital had a local arrangement whereby assistance was provided by paediatric clinicians in times of surge. HALP assisted with ambulance turnaround times and the patient flow ADON assisted with exploring alternative discharge pathways.

Inspectors were informed that the safer staffing framework was implemented and staffing was sufficient to meet the needs of the acute floor. Following review of the discharge-transit lounge, inspectors were informed that nursing staff were not relieved during break periods and that the discharge lounge nurse attended the inpatient ward areas to take handover and transfer patients to the lounge. On the day of inspection, the RGN and HCA in the discharge lounge were from an external agency and one nurse was assigned to the three-bay paediatric area. This was brought to the attention of senior management who noted that one paediatric nurse is assigned to the paediatric area and as patients present, ED nursing staff are redirected to this area. Inspectors recommend that a nurse would remain in the discharge lounge at all times while in use, to mitigate potential or actual risk to patients.

Data was collated on the number of patients who had left without assessment or prior to completion of treatment, an action plan was developed to identify the process to be followed in the event of a patient leaving. Hospital management reported challenges with available inpatient capacity with inspectors noting mixed gender rooms. However building works were underway to provide an additional nine inpatient single rooms en-suite in 2025 with a plan for a further 30 single rooms en-suite.

Patients admitted to UHK were not universally screened for multi-drug resistant organisms (MDROs) such as *clostridium difficile, CPE, staphylococcus aureus blood stream infections* (SA BSI), *vancomycin resistant enterococci* (VRE), *methicillin-resistant staphylococcus aureus* (MRSA) and COVID-19 with the exception of haemodialysis, critical care and SCBU. Targeted screening took place in line with specific criteria and based on the result of a risk assessment conducted on admission. Compliance with MDRO screening was audited by the IPCT with oversight by the IPCC, with compliance ranging from 85% to 93%. The IPMS supported the identification of patients with MDROs by means of an alert symbol. Patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. A patient placement algorithm was viewed by inspectors, which showed that if an isolation room was not available, suitable patients were co-horted in multi-occupancy rooms and IPC had oversight of accommodation through daily contact with ward areas and the bed manager. There were 25 single isolation rooms in the hospital and one negative pressure room in critical care, and representatives from IPC noted this capacity was not meeting the current demand. Staff had access to a consultant microbiologist and an antimicrobial pharmacist.

At the time of inspection there was an active influenza outbreak and a norovirus outbreak. Hospital management had implemented a mask-wearing policy in the clinical areas. Outbreak control (OCT) meetings were convened to advise and ensure the management of outbreaks aligned with best practice standards and guidance. Inspectors viewed OCT minutes and were informed that e-mail correspondence replaced an outbreak control meeting on some occasions. Inspectors were informed that there were 29 outbreaks in the hospital in 2024 but documentary evidence listed 28 which included two CPE outbreaks. Greater clarity is required in relation to recording outcomes and actions arising from an outbreak management meeting. The hospital had six-bedded multi-occupancy rooms where patients requiring aerosol generating procedures (AGPs) were accommodated, occupancy on these occasions was not reduced. Inspectors observed posters displayed in the clinical areas raising awareness on the five moments of hand hygiene and the overall audit of hand hygiene for the hospital was 92%. Compliance with mandatory hand hygiene training ranged from 36% to 85%, transmission based precautions and standard based precautions ranged from 31% to 84% across disciplines.

Risks identified at local clinical level were assessed and analysed by the CNM and ADON, with input from the risk manager as required, control measures were applied to mitigate any potential and actual risk to patient safety, and responsibility for implementing and overseeing the effectiveness of the control measures lay with the CNM. Inspectors were told that staff did not have formal training on developing risk assessments or in relation to risk management. It was evident that the EMB had oversight of the risks and effectiveness of control measures on the hospitals corporate risk register and risks were discussed at the monthly performance meetings with the SSWHG. There were eight high rated risks related to the four key areas of harm on the hospitals corporate risk register at the time of inspection, related to staffing resources across services, non-compliance with best practice standards and national guidance, and IPC and medication safety. The inspectors found evidence that mitigation measures were being applied to reduce any actual or potential negative impact to patients arising from the recorded risks. The hospital had a direct electronic point-of-entry to the National Incident Management System (NIMS). The wider hospital did not have a quality document management system with the exception of maternity services, all policies were available on the UHK noticeboard. There was an electronic healthcare record (eHCR) in use in the maternity services, however, if a patient had to transfer to the theatre department the theatre department scanned documents for upload to the eHCR.

The pharmacy provided a dispensing and top up service to clinical areas with a two hour dispensing service provided on Sundays. A pharmacy-led medication reconciliation was not undertaken for the majority of patients, and in the absence of a dedicated resource, the DTC could not assure governance and oversight of medication safety. A limited clinical pharmacy service was provided at the hospital. There was evidence that patient medications were reviewed by clinicians in the AMAU and in maternity. An antimicrobial pharmacist was available to provide advice for patients on antibiotics. Staff applied risk-reduction strategies with high-risk medicines and this practice was underpinned by a

formalised policy for review in 2025. The hospitals list of high-risk medications and sound-alike look-alike medications (SALADS) were available on the UHK noticeboard, but posters were not observed in a number of clinical areas visited. High-risk medications aligned with the acronym 'A PINCH'[******]. Up-to-date prescribing and antimicrobial guidelines and medication information were available and accessible to staff at the point-of-care in hard copy format and on computer desktops. A list of references to access medication information was available on the DTC terms of reference. It was noted that the medication icon was not available on the PC in the resuscitation area of the ED at the time of inspection and this was brought to the attention of the departmental manager and the DTC. The childrens' formulary dated 2019 in use in UHK was also being updated. A new MPAR was being introduced in 2025 and pathways for insulin administration had been developed. There were dedicated medication preparation areas in the clinical areas with locked drug refrigerators with evidence that the daily temperature log was being recorded and signed, however this practice was not consistent. There was evidence of secure and appropriate medication storage. Inspectors observed medication stored in the controlled drugs press in one clinical area which was brought to the attention of representatives of the drugs and therapeutic committee. Inspectors were informed during interviews that due to the staffing deficits within the pharmacy department, audit activity would be negatively impacted in 2025 and a schedule for audit had not been developed at that point.

There were a range of complex services provided by the hospital and inspectors were informed that two oncology pharmacy staff assisted in preparing oncology medications. There was not a compounding unit in the hospital and up to 50 monoclonals were prepared and reconstituted every week with an increasing demand for this service and close monitoring of prescriptions in place to identify any potential errors. Workload demand on the pharmacy department was expected to increase with the appointment of specialist medical consultants. Pharmacy staff presented on medication safety at NCHD induction and pharmacy were available for advice, if required. There were two medication safety training modules on HSELand and mandatory training stood at 40% for nursing staff, but there was not a report for clinical staff. The hospital had 54 nurse prescribers and oversight was through the ADON in clinical practice development and the DON. Inspectors were informed that alerts issued by the Health Protection Regulatory Authority (HPRA) were notified through the QRPSM.

There was evidence that national early warning systems were used in the hospital; INEWS, IMEWS, IPEWS, EMEWS and ISBAR3. EMEWS was utilised in the AMAU and recorded on the acute adult booklet where there was evidence of ISBAR3 handover. Compliance with EWS mandatory training ranged from 57% to 100% across specialities while basic life support ranged from 39% to 75%. Compliance with the sepsis six bundle

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

was suboptimal and requires significant focused improvement within clinical areas. The hospital had two ANPs in the critical care outreach team who were available by bleeper from Monday to Friday (7.30am to 8pm). The team reviewed patients recently discharged from critical care, provided early support for patients transferring to critical care, and support to nursing staff and NCHDs. The DPC had arranged a number of training opportunities and on-site study days on the deteriorating patient to include sepsis and had provided instruction on airvo developing a draft policy expected to be approved in 2025. There were laminated algorithms for the deteriorating patient including post-partum haemorrhage in maternity. The DPC had presented at grand rounds and at NCHD induction engaging with clinical staff to have designated NCHD champions for the deteriorating patient. The DPC were also looking to progress NCHD led safety night huddles.

There were systems and processes in place to support the discharge planning and safe transfer of patients within and from the hospital. Senior nurse managers were assigned to ward areas during periods of escalation, to assist with egress and multidisciplinary ward board rounds were conducted on a daily basis with attendance by hospital consultants. Inspectors were informed that all inpatient lengths of stay were monitored through daily board rounds, and every patient had a planned date for discharge (PDD). However audit results found 47% of PDDs converted to discharges. There were hospital daily bed management meetings at 11.30am and 3.30pm. Daily bed management meetings were convened with the SSWHG at 10am to support patient flow and egress. There were twice weekly integrated discharge rounds. DTOC, complex discharges and barriers to discharge were discussed at the following meetings, weekly DTOC integrated operational group, fortnightly DTOC strategic escalation group chaired by the REO and a weekly DTOC integrated discharge group with the SSWHG, UHK and representatives from Cork Kerry Community healthcare. Challenges escalated to the REO related to access to long term care beds, enhanced care packages, home supports and appropriate placements for patients under the age of 65 years.

Inspectors were informed that a radiology review was underway in the hospital with oversight from a clinical subgroup. Inspectors viewed a number of radiology PPPGs, related to communication of time critical results which indicated that communication should be voice to voice within one hour, urgent within 24 hours and clinical staff confirmed this practice was followed. However inspectors noted one PPPG was in draft and the other required review from 2020. One serious incident (SI) indicated a follow up diagnostic was not carried out as recommended, this SI was dealt with in line with the HSE IMF process.

The hospital had a range of local and national PPPGs for IPC, medication, acute floor, ToC, QRPS and maternity services. A number of ToC PPPGs were in draft format which included the clinical handover hospital wide policy UHK including ISBAR3 and nursing clinical handover policy. The National Inpatient Experience Survey (NIES) conducted in

2024 rated the care during discharge at 7%. While unchanged from the NIES 2022, it was lower than the national average of 7.2%.

In summary, the systems in place to identify and manage potential and actual risks associated with the four key areas of harm were not as robust, proactive and effective as they should be. Areas for focused improvement:

- compliance with sepsis six bundle and EWS escalation and documentation across clinical areas
- review and update of PPPGs related to communication of time critical radiology results
- review of the suitability of the escalation areas in the emergency department
- review of patients within escalation areas to ensure timely review and treatment
- continued focus on PETs, DTOC, AvLoS
- ensure outbreak control meetings are convened for all outbreaks with multidisciplinary attendance
- review allocation of staffing across the acute floor to ensure appropriate skill mix and ensure RGNs presence in the Torc and paediatric area at all times
- address the risks posed due to the deficits in pharmacy staffing and lack of a pharmacy-led medication reconciliation and limited clinical pharmacy service
- address non-compliance with mandatory training
- training for staff in relation to developing risk assessments and risk management
- develop a protocol outlining the governance arrangements for complex presentations of vulnerable patients under the age of 18 years where a decision to admit has not been taken but the patient remains in the emergency department awaiting placement.

Judgment: Non-compliant

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

The hospital had patient safety incident management systems in place to identify, report, manage and respond to patient safety incidents in line with national legislation, policy and guidelines. UHK had completed a validation of the corporate risk register in December 2024, a master log of recommendations was in place and the hospital was progressing the implementation of outstanding recommendations. The QRPS planned to review and circulate all relevant recommendations to owners to ensure awareness of responsibilities and review the timeframe for completion with the development of specific and timely QIPs. QRPS were updating a PPPG to reflect the KPI for implementation of recommendations from complaints.

Patient safety incidents were reported directly to NIMS, in line with the HSE IMF however inspectors noted when speaking with staff that there was a concern of under-reporting of incidents. Incidents were tracked and trended by QRPS and discussed at the EQRPSC. SREs were reported to the weekly SIMT and monitored by the EQRPSC. Risks were also discussed at CGC meetings, shared learning was cascaded informally to staff across the various specialties through local departmental meetings and daily ward safety pauses. IPC patient safety incidents were reported to the IPCC.

Medication patient safety incidents were categorised according to the severity of outcome, as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Inspectors were informed that medication safety incidents were reviewed at Medication Incident Management Team (MIRT) meetings and were reported to the DTC. There were 85 medication-related incidents reported between January to November 2024 as viewed in the QRPS DTC report with the highest incidence, (15), reported in the ED. Forty-five medication incidents related to prescribing and 36 related to administration. Representatives of the DTC said incidents reported to MERP were categorised as no harm incidents. Rates of defined and suspected hospital-associated VTE ranged from 7.0 to 13.1 between June to September 2024, as per the national VTE programme, above the national level in August and September. VTE rates reported on the HSE HPSIR October 2024 ranged from 5.4 to 17.5. A QIP had been developed which included input into the new MPAR that was being introduced in 2025, and implementation of VTE prophylaxis administration standardised as a once daily dose at 6pm.

Weekly maternity incident management meetings were convened in the hospital and with the SSWHG clinical director on a monthly basis, there was also a monthly consultant forum with the SSWHG. The hospital submitted a monthly maternity patient safety statement and Irish maternity indicator system report. Hospital management reported the number of clinical incidents per 1,000 BDU to NIMS on a monthly basis with 2,407 reported for 2024. There were 13 SIs reported and 17 SREs. Inspectors viewed the monthly QPS dashboard report from the SSWHG for UHK. However it did not have detail relating to the hospital's compliance with the 125 day KPI completion of review following category one incidents.

Areas for focussed improvement:

- increase awareness around the importance of reporting clinical incidents
- establish a formal process to ensure shared learnings from incidents
- investigate reasons for reported medication incidents in the ED.

Judgment: Partially compliant

Conclusion

HIQA conducted an announced inspection of University Hospital Kerry to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four key areas of harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall the inspectors found evidence of compliance with two national standards (1.7, 1.8) substantial compliance with three national standard (5.2, 1.6, 2.7) partial compliance with five national standards (5.5, 5.8, 6.1, 2.8, 3.3) and non-compliance with one national standard (3.1).

After the inspection at the hospital, correspondence was issued to the hospital outlining concerns relating to placement of patients on trolleys in a designated escalation area of the emergency department, in order that immediate measures could be implemented to mitigate any actual or potential risks to patient safety.

Capacity and Capability:

During the course of this inspection, improvement was noted in the corporate and clinical governance structures within the hospital. Staffing deficits within QRPS had been addressed and measures to strengthen the effectiveness of the QRPS function in the hospital should be a continued area of focus. Implementation of the directorate model was progressing, however, a number of directorate posts remained vacant.

It was evident to inspectors that senior management and staff within the hospital were endeavouring to manage and address non-compliance with ED PETs and DTOCs with a range of measures implemented. The hospital had experienced a 30% increase in ED attendances since 2022. Challenges to meet the increase in service demand were reported as a lack of available inpatient capacity, in particular single room isolation and availability of supports for a number of service users to egress from the hospital once deemed fit for discharge. The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services, however this was not as effective as it should be. Validation of corporate risks and oversight of recommendations following reviews are areas for continued focus. Lack of coordinated clinical audit is an area for focussed improvement. Staffing deficits within key areas such as pharmacy and maternity pose a risk to service users, and actions must be implemented to mitigate these risks. The level of absenteeism was above the national average and compliance with mandatory training should be improved.

Quality and Safety:

The hospital staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. Patients spoke positively about their experiences of receiving care in the hospital but within the escalation areas of the ED,

patient experiences were less positive. Inspectors found significant improvement in the management and oversight of complaints and feedback. The hospital's physical environment mostly supported the delivery of high-quality, safe care and promoted the health and welfare of people receiving care in the hospital, but lack of available single isolation rooms and storage facilities for departments remained a challenge.

The hospital was monitoring performance against KPIs for IPC, ED and the deteriorating patient, but there was opportunity for improvement in relation to medication safety. Inspectors found inconsistency in putting in place time-bound QIPs as a result of non-compliant audit findings. Continued focus on improving compliance with EWS, escalation and response and in particular sepsis six bundle is required. PET times within the emergency department did not meet HSE national KPIs, however at the time of the inspection there were no patients in the ED over 24 hours. This presented a risk for patients who were in the emergency department for prolonged periods of time. Deconditioning due to prolonged inpatient length of stay was also a concern. The inspectors found there was a system in place to identify, report and manage patient-safety incidents and the reporting of patient safety incidents on NIMS were timely. However the sharing of learning and timely implementation of recommendations from the review of patient safety incidents are areas that could be further improved, to support a reduction in recurrence of similar incidents.

Following the inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity (appendix 2), continue to monitor the progress of the hospital in implementing the short, medium and long term actions being employed to bring the hospital to 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 national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, 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 progress in implementing the action(s) set out in any compliance plan submitted.

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

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

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

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially compliant

Compliance Plan for University Hospital Kerry

OSV-0001036

Inspection ID: NS_0113

Date of inspection: 28 and 29 January 2025

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 national standard. This should clearly outline:

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

DTOC

1) Developed oversight arrangements through daily integrated calls with DON & GM in community and weekly integrated meetings. Re-establishment of a regional steering group**. Q2 2025**

PET

1) A nine bed unit is in construction phase (seven of the nine beds are single rooms) **Q4 2025**
2) Standard Operating Guideline developed for review of patients with an admission of greater than 14 days, overseen by EMB **in place**
3) 30 beds (20 single rooms, five twin rooms), seven are due for completion **Q4 2025**
4) Remainder 23 beds due for completion **Q3 2026**
5) Operational process in place to ensure Zero tolerance of patients +75yrs waiting for >24 hours- **in place**
6) Progress recruitment of OPAT CNM II, establish OPAT service **Q3 2025**
7) Single Point of Operational Contact (SPOOC) x 3 posts currently in recruitment process - The post will work as part of the operations team to ensure a seamless patient journey, to enable the hospital to meet the key strategic and operational objectives. They will have day-to-day operational responsibility for ensuring the smooth running of all aspects of capacity management and site management **Q2 2025**

8) MDT working Group established to provide evidence based /metric driven recommendations and solutions to bring about optimal efficiency of 'End to End' processes on the Elective Surgery Patient pathway **Q4 2025**

AvLoS

1) AvLoS- Evaluation of Ward Ways of Working to measure effectiveness and adherence to principles of Safer, develop QIP on evaluation results. Q2 2025

Private Provider

1) Develop & implement a protocol for transfer of patients to private provider to specify inclusion/exclusion criteria/outline process for patients transferred from UHK for ongoing treatment. **Q2 2025**

Risk Management

1) Continue validation process of Corporate risk register with EMT**. Q2 2025**
2) Develop schedule for face to face Risk Management & Assessment training **Q2 2025**

Medication Safety

1) New and existing deficit in Pharmacy at recruitment stage, including planned uplift due to increasing bed capacity. **Q3 2025**
2) Once current recruitment is finalised within the Pharmacy department, a review is to be undertaken by the Chief Pharmacist to ensure delivery of;

- Pharmacy led audit schedule overseen by D&T **Q3 2025**
- Delivery of Medication safety strategy **Q4 2025**
- Medication reconciliation service prioritisation **Q4 2025**

3) Develop Medication Safety awareness (focusing on High Risk & Time Critical) quality improvement plan for the Emergency Department **Q2 2025**

4) Hospital wide Quality improvement plan developed on Insulin management and administration overseen by Drugs & Therapeutics**, in place**

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

We recognise that additional inpatient capacity is necessary to alleviate overcrowding in not only in the Emergency department but also to reduce the volume of inpatients awaiting admission in surge areas

1) 108 bed block approved, initial funding of 1.0 million has been allocated to this design brief in 2025

2) As the current complement of Pharmacists is successfully recruited into, business cases for additional resources to support service developments will continue to be developed and submitted.

Timescale:

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

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

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

1) Progress implementation of open recommendations via Clinical Governance structure ensuring SMART QIPs in place, status updates to be overseen at Executive QRPS **Q3 2025**
2) Through the Clinical Governance structure promote clinical audit prioritisation & registration process to enhance capture of clinical audits underway in UHK. **Q2 2025.**
3) Implementation of Clinical Audit findings will be tracked at directorate level **Q3 2025**
4) Weekly real time training on the importance of, and how to report an incident on ePOE i**n place**
5) Schedule face to face risk management and risk assessment training **Q2 2025**
6) **Untriaged referrals**
   - Approval received for an increase in WTE for central referrals, local recruitment to take place to expedite process **Q3 2025**
   - Audit undertaken of longest waiting referrals from every speciality, audit findings to be implemented - **in place**

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

1) Progress recruitment of Clinical Audit facilitator to support development and oversight of hospital wide clinical audit function in UHK **Q4 2025**
2) Progress submission for funding and resourcing of document management system to include audit and QI modules for ease of oversight **Q3 2025**

Timescale:

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 national standard. This should clearly outline:

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

1) Currently pharmacy posts are in the recruitment process (2.0 Senior in process of recruitment, 2.0 new seniors approved for medication safety and posts sent for advertising, 0.5 senior approved for new beds sent for advertising).**Q3 2025**
   As the current complement of Pharmacists is successfully recruited into, business cases for additional resources to support service developments will continue to be developed and submitted.
2) Midwifery staffing Maternity leave replacement is now approved.**in place**
3) Absenteeism rates –
   - Audit compliance with Back to Work interviews / EAP referral signposting for staff. **Q3 2025**
   - UHK HR to scope out what resources would be required to undertake full review of short and long term sick leave, and to provide training and support to managers in managing absence. Business case to be submitted **Q2 2025**
   - Request update on approval for the staff health and wellbeing officer to support reducing absenteeism **Q2 2025**
   - Human Resource dept. to have monthly meeting with ADONs to review long term sick leave **Q2 2025**
4) To provide oversight of compliance of mandatory training- request update on approval of training and development officer. **Q2 2025**
5) Continue to promote the use of NERS for NCHDs training records**. In place**
6) Progress implementation of actions of QIP for Mandatory training compliance
   - QIP for Consultant and NCHD training to align with and be overseen at Clinical Directorate level.**Q2 2025**
   - monthly reporting on NCHD and consultant training at EMB via Clinical Directorates **Q3 2025**
   - develop submission for funding and resourcing of a document management system- training can be recorded and monitored centrally **Q3 2025**
   - DON / DOM - Progress open actions from Nursing & Midwifery QIP on Mandatory training. **In place**

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

Timescale:

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 national standard. This should clearly outline:

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

1) Sepsis : Schedule of Sepsis audits in line with National standards in ED and ward level. Update Sepsis QIPs to ensure SMART aims and reflective audit cycle in place to improve compliance, compliance to include training compliance to be monitored at Nursing Quality & Risk,Clinical Governance meetings and Exec QRPS. DPID standing agenda item at all CGC. i**n place**
2) EWS-Schedule of audits in place in line with National Standards. Hospital wide QIP's in place, oversight at nursing Quality & Risk Committee, compliance to include training also to be monitored at Clinical Governance meetings and Exec QRPS, DPIP standing agenda item on all CGCs **in place**
3) Continued roll out of safety huddles to increase the recognition and appropriate escalation of deteriorating patients **in place**
4) Implement weekend safety huddle **Q3 2025**
5) CNM daily EWS review of all patients on medical wards, **in place**
6) Implement routine use of AAR to rapidly identify and reinvest learning for improvement of deteriorating patients **Q2 2025**
7) Equipment audits – Strategy to be put in place through Hygiene services to ensure compliance and appropriate oversight of equipment audits for all areas. **Q2 2025**
8) Implementation of HSE root cause analysis process **in progress**
9) Pharmacy led medication audit schedule to be developed and overseen by D&TC **Q3 2025**

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

Timescale:

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

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

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

1) Sepsis as per 2.8
2) Sign off Policy Time Critical Results in Radiology **completed**
3) Develop Algorithm for Suitability of escalation areas ED to include review and treatment, this will be supported by dynamic risk assessment **Q2 2025**
4) PET/AvLoS/DTOC as per 5.5
5) Outbreak control meetings in place after each outbreak. **completed**
6) Nurse staffing of Torc to be reviewed and findings implemented.**Q2 2025**
7) Review of Paediatric nurse staffing for ED to be undertaken. Paediatric nurses to rotate from Paediatric Ward to Paeds area in ED **Q2 2025**
8) Pharmacy deficits see 6.1
9) Mandatory training see 6.1
10) Risk Management as per 5.8
11) Develop and Implement protocol for outlining the governance of complex patients in ED decision not to admit but remains in department **Q2 2025**

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

Timescale:

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

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

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

1) Open recommendations see 5.8
2) Real time training on incident identification and ePOE. **completed**
3) Real time Incident Management training sessions **in place**

4) Shared learning process to be expanded by developing a local learning casebook and QRPS newsletter **Q2 2025**
5) Weekly reviews of DPIP incidents reported by DPIP Clinical Lead and DPIP CNM providing direct feedback and incorporating learning points into educational initiatives. **in place**

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

Timescale: