Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	South Infirmary Victoria University Hospital
Address of healthcare service:	Old Blackrock Road Cork T12 X23H
Type of inspection:	Unannounced
Date(s) of inspection:	11 and 12 February 2025
Healthcare Service ID:	OSV-001092
Fieldwork ID:	NS_0120

Model of hospital and profile

About the healthcare service

South Infirmary Victoria University Hospital is an acute voluntary hospital and is a member of the South South West Hospital Group.* The hospital delivers services on behalf of the Health Service Executive (HSE) through a service level agreement (SLA). The hospital provides services to both adults and children and is primarily an elective hospital providing surgical services as day surgery and short stay in-patient admissions. The hospital is the regional centre for:

- Ear, Nose and Throat (ENT)
- Orthopaedics
- Ophthalmology
- Dermatology
- Chronic Pain Services

In addition the hospital also provides an orthopaedic rehabilitation service.

The following information outlines some additional data on the hospital.

Number of beds	121 inpatient beds 59 day care beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* Version 2 (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors† reviewed information which included previous inspection findings (where available),

* The South/South West Hospital Group is made up 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. The hospital group's academic partner is University College Cork.

†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.

information submitted by the provider, unsolicited information[‡] and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- 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 the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

[‡] 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 February 2025	09.05 – 18.30 hrs	Rosie O'Neill	Lead
12 February 2025	08.30 – 15.40 hrs	Marguerite Dooley	Support
		Mary Flavin	Support
		Angela Moynihan	Support

Information about this inspection

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

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

The inspection team visited four clinical areas:

- day surgery unit (plastics, general surgery, ENT, maxillofacial, dermatology)
- level one south elective (elective orthopaedic)
- level two Victoria (general surgery)
- children's ward (orthopaedics, general surgery, ENT, dermatology)

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

- representatives of the hospital's Executive Management Committee
  - Chief Executive Officer (CEO)
  - Director of Nursing (DON)
  - Clinical Director (CD)
  - Quality and Risk Manager (QRM)
  - Human Resource Manager (HR)
  - Chief Financial Officer (CFO)

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.

[**] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.

[††] 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.

- representatives from each of the following hospital committees:
  - Clinical Governance (Quality & Safety)
  - Infection Prevention and Control and Antimicrobial Stewardship
  - Drugs and Therapeutics
  - Deteriorating Patient
  - Bed Management

- Non-consultant hospital doctor (NCHD)

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

Acknowledgements
HIQA would like to acknowledge the 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 the service.

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

Inspectors visited four clinical areas during the inspection. The day surgery unit was an 11 bay unit comprised of eight beds and three chairs in the discharge area, with an adjacent theatre and treatment room. The unit was open five days a week, Mondays (07.45 am to 6.00 pm) and from Tuesday to Friday (07.45am to 7.15pm) and provided services to adults, and children from 12 to 16 years. Level One South was a 14-bedded elective orthopaedic ward comprised of eight single rooms and two three-bedded rooms. Level Two Victoria was an 18-bedded general surgical ward comprised of 12 single rooms and three two-bedded rooms. The children's ward was a 14-bedded ward comprised of two four-bedded rooms, three two-bedded rooms.

Inspectors observed staff speaking and interacting with patients and their families in a respectful and kind manner. It was evident that staff took time to listen to and talk with patients. On the day of inspection, inspectors spoke with a number of patients. All the patients were complimentary about the staff and the care they received commenting that "*everything was great*", "*the care was very good*", and "*there is good privacy*". The patients inspectors spoke with were not aware of the hospitals complaints policy, but outlined that they would raise any concerns with the nursing staff.

Capacity and Capability Dimension

This section describes the key inspection findings and judgements from national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and their effectiveness in ensuring that a high-quality and safe service was provided. The section also includes compliance with national standard 6.1 from the theme of workforce.

South Infirmary Victoria University Hospital was found to be compliant with one national standard (5.8) and substantially complaint with three standards (5.2, 5.5, 6.1) assessed. Key inspection findings leading to the judgment of 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.

South Infirmary Victoria University Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare. The hospital was managed by a Board of Directors, who appointed a Chief Executive Officer who was accountable to the Board and had a collaborative working relationship with the South South West Hospital Group (SSWHG).

An organisational chart demonstrated the hospitals governance, management and committees structures. While the chart was detailed not all structures were represented. The reporting relationship to the SSWHG was not shown nor was the hospitals Senior Management Committee (SMC) and the three bed management committees.

The Clinical Director (CD) provided clinical governance and oversight to consultant colleagues and NCHDs. The hospital provided extensive surgical services for paediatric patients up to 16 years across a number of specialities. Clinical governance of paediatric care in the hospital was led by the hospitals' anaesthesiology service, with the hospitals CD also an anaesthesiologist. The Director of Nursing (DON) was responsible for the organisation, management and delivery of nursing services in the hospital and had a collaborative working relationship with the Chief DON, SSWHG.

Board of Directors

South Infirmary Victoria University Hospital was a voluntary hospital providing services on behalf of the HSE through an SLA under Section 38 of the Health Act 2004[§§]. Inspectors reviewed the Board's Code of Governance which stated that the function of the Board was to manage and operate the hospital. The 12-member Board was led by the Chairperson

[§§] *Health Act 2004.* Dublin: The Stationery Office; 2004. Available online from: Health Act 2004

and meetings were held monthly. Inspectors reviewed agendas and minutes from meetings which showed comprehensive reporting on hospital services, finance, medicine, nursing and research. Actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Executive Management Committee (EMC)

The Executive Management Committee was the senior strategic management committee within the hospital. Terms of Reference (ToR) outlined the committee reported to the CEO who was accountable to the Board of Directors. In line with the ToR the committee was responsible for the strategic and operational leadership of the hospital. Membership was appropriate and the committee chaired by the CEO met monthly. Minutes of the most recent meetings submitted to HIQA demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

The CEO also attended monthly performance meetings with the SSWHG in line with the HSE performance and accountability framework 2023. Inspectors reviewed minutes from the most recent performance meetings, items discussed included scheduled care, quality and safety, workforce, finance and capital expenditure. The minutes demonstrated that the hospital group had comprehensive oversight of services in the hospital, actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Senior Management Committee (SMC)

The Senior Management Team led by the CEO provided operational governance of the day-to-day management of all services across the hospital. As per the ToR membership was appropriate and the committee chaired by the CEO met weekly. Documents submitted to HIQA show a standard agenda, and minutes demonstrated the team had oversight of the hospital's activities and performance of quality and safety indicators. Actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Governance (Quality and Safety) Committee

In line with the ToR the Clinical Governance (Quality and Safety) Committee (CGQSC) was responsible for ensuring that appropriate governance structures, processes and controls were in place to deliver safe, high quality healthcare to patients. A number of other committees in the hospital reported to the CGQSC that included the Infection Prevention, Control and Antimicrobial Stewardship Committee (IPPC), Drugs and Therapeutics Committee (DTC) and Deteriorating Patient Committee (DPC). The committee, chaired by the hospitals CD was accountable to the EMC and met quarterly. Documentation submitted to HIQA showed committee responsibilities included reviewing the hospital's risk register, patient-safety incidents, complaints, health research, clinical audit, the national standards for safer better healthcare and approval of procedures, protocols and

guidelines (PPG's). Subcommittees furnished reports to the CGQSC on a quarterly basis. Actions were assigned to named individuals, were time-bound and followed up from meeting to meeting. Inspectors were satisfied that the committee had effective oversight of the quality and safety of healthcare services at the hospital. At the time of inspection the QRM also met with the SSWHG Quality and Patient Safety (QPS) manager every six weeks in a collaborative relationship to discuss general risk management and QPS issues in the hospital.

Incident Review and Clinical Effectiveness Group

The Incident Review and Clinical Effectiveness Group (IRCEG) was a sub-group of the CGQSC. In line with the ToR the purpose of the group is to allow for monitoring and extensive review and discussion surrounding the quality and effectiveness of the care provided to patients at SIVUH. The group was chaired by the hospitals CD and met quarterly. Documents submitted to HIQA show a standard agenda, and minutes demonstrate actions arising from meetings were assigned to named individuals, were time -bound and followed up from meeting to meeting. Inspectors were informed that in the event of a serious patient safety incident occurring, a local serious incident management team (SIMT) was convened within five days to determine initial management, this is in line with the HSE Incident Management Framework (IMF) 2020[***]. The SSWHG QPS manager was also available for advice and support as required.

Infection Prevention and Control Committee and Antimicrobial Stewardship Committee

In line with the ToR, the Infection Prevention and Control Committee (IPCC) was responsible for managing prevention and control of health care associated infection and antimicrobial resistance in the SIVUH. The committee was chaired by a consultant microbiologist, was accountable to the CGQSC and met every two months. The day-to-day management of infection, prevention and control (IPC) was assigned to the IPC team. Documents submitted to HIQA show a standard agenda, and minutes demonstrate actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting. Inspectors were informed that the IPC team also linked with the SSWHG IPC team on a regular basis. Inspectors were satisfied with the governance and oversight of infection prevention and control practices and management of outbreaks of infections at the hospital.

Antimicrobial Stewardship Committee

The hospital had recently established an Antimicrobial Stewardship Committee (AMSC) with formal responsibility for the hospital AMS[†††] programme. The ToR outlined the purpose of the committee was to oversee the development, implementation and ongoing review of the AMS programme in the hospital. The first meeting was held in January

[***] Incident Management Framework and Guidance. 2020. Available online from: HSE - Incident Management Framework and Guidance 2020

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

2025. Inspectors reviewed documents that showed AMS was already an agenda item on both the IPCC and DTC with oversight and management in the hospital.

Drugs and Therapeutics Committee

In line with the ToR the purpose of the DTC was to assure rational and appropriate drug therapy, and to facilitate the development of policies and procedures to ensure the safe, effective and economic use of drugs. The committee was chaired by a hospital consultant, was accountable to the CGQSC and met quarterly. Documents submitted to HIQA show a standard agenda, and minutes demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Medication Safety Committee

In line with the ToR the objective of the Medication Safety Committee (MSC) was to promote safe medication practices within the SIVUH by coordinating a process to evaluate and improve medication management through pharmacy, nursing and medical staff. The committee was chaired by a medical consultant, accountable to the DTC and met quarterly. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Deteriorating Patient Committee

In line with the ToR the Deteriorating Patient Committee (DPC) provided governance and oversight of activities associated with the deteriorating patient. Areas covered included cardiac arrest, resuscitation, Irish National Early Warning System (INEWS)[‡‡‡], deteriorating patient, sepsis and transitions of care. The committee was chaired by the hospitals' CD, was accountable to the CGQSC and met quarterly. Documents submitted to HIQA show a standard agenda, and minutes demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Bed Management Committees

The hospital had three bed management committees in place: General Bed Management, Orthopaedic Bed Management and Ophthalmology Bed Management. In line with the ToR's the focus of the three committees was to ensure that elective in-patient admissions were planned in an organised and co-ordinated manner. The committees were chaired by the bed manager and met weekly. The ToR did not outline the reporting arrangements for these committees, nor were they represented on the organogram received on inspection. Inspectors confirmed accountability was to the DON.

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

In summary, it was clear to inspectors that the hospital had formalised governance arrangements in place for the delivery of high quality, safe and reliable healthcare. Details outlined in organisational charts, terms of reference, agendas and meeting minutes was articulated in meetings with lead representatives during inspection. Areas for improvement identified:

- ensure all governance structures are represented on hospital organisational charts
- the terms of reference for some committees required review and updating and should reflect accountability arrangements.

Judgment: Substantially compliant

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

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

Infection Prevention and Control

The IPCC oversaw the implementation of the hospitals IPC and AMS programme. The IPC team had an annual work plan in place that set out the objectives to be achieved in 2025. This plan included hand hygiene, screening, surveillance and a focus on infrastructure. The full suite of IPC Policies, Procedures, Protocols and Guidelines (PPPG's) were updated in February 2025 in line with national guidance. It was clear from the review of data and in communications with staff that the IPC team were highly visible, available to staff and were meeting their objectives and reporting through the hospitals governance structures.

Medication Safety

The hospital had a clinical pharmacy service[****] in place that was available from Monday to Friday (09.00 am to 17.00 pm). Outside of core hours the operational Assistant Director of Nursing (ADON) was the designated point of contact. Pharmacy staff could be contacted for emergency support and there was an out of hour's guideline in place to support staff. Inspectors were informed that, due to staffing levels, a hospital wide pharmacy-led medication reconciliation could not be offered and was carried out on a tiered approach. In the outpatient pre admission assessment unit (PAAU) medication reconciliation was carried out by the PAAU pharmacist for a defined cohort of patients undergoing preassessment for orthopaedic procedures. For inpatients, on high risk

[§§§] Infection prevention and control, medication safety, the deteriorating patient (including sepsis) and transitions of care

[****] 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

medications, admitted for medical rehabilitation and patients for planned discharge on anticoagulation therapy (blood thinning medication) medication reconciliation was carried out first. Patients identified by medical and nursing staff were prioritised for same day pharmacist review. All healthcare professionals could also request a same day pharmacist review via an online referral form.

This hospitals corporate risk register recorded that a lack of a comprehensive pharmacy-led medication reconciliation service resulted in reconciliation not carried out on 71% of patient admissions. Antimicrobial medication management was supported with staff access to a dedicated pharmacist, consultant microbiologist and an on-call microbiology service. The pharmacy service had a 2025 annual work plan for medication safety that set out objectives to be met, which focused on, surveillance, prescribing and medication use evaluation.

Deteriorating Patient

The DPC was led by the hospitals CD with membership from the wider hospital community including anaesthesiology, nursing, haemovigilance, and nurse practice development. The hospital had two standard operating procedures (SOPs) in place for the management of unscheduled presentations, admissions to, transfers within and transfers from the hospital. Inspectors noted one SOP required review from 2018 and were informed that an updated policy was being developed at group level. To support the clinical staffs' skills, knowledge and confidence in managing an acutely deteriorating patient, multidisciplinary training was offered monthly that provided practical case based scenario sessions and simulation training for the clinical management of adults and children.

The hospital had guidelines in place that outlined the care pathway for the routine paediatric admissions and for complex paediatric admissions. All paediatric care was consultant led. Clinical decisions on patient transfers to and from the hospital was consultant to consultant decision only. The hospital had a clinical lead for paediatric anesthesiology but not for paediatric surgery. The hospital did not have a dedicated onsite paediatric consultant service. Consultant level support was provided, where required, by the paediatric service at Cork University Hospital (CUH) with children either being reviewed by a consultant paediatrician in SIVUH or transferred to CUH. The hospital had the HSE Child Safeguarding Risk Assessment and Child Safeguarding Statement in place. The lack of a dedicated paediatric service and shared services between adults and children due to environmental restrictions were recorded on the hospitals child safeguarding statement.

Inspectors reviewed the out-of-hours and on-call arrangements for medical staff, which demonstrated effective clinical cover across all specialities. The onsite NCHDs were surgical or medicine trainees only. NCHDs were required to escalate concerns regarding

deteriorating children to the anaesthesiologist NCHD and consultant anaesthesiologist on call in the first instance.
The hospital had access to the National Ambulance Service (NAS) Protocol 37 [††††]which ensures that patients with urgent medical needs outside the scope of the hospital are transported directly to CUH or other hospitals, to provide specialised clinical care.

Transitions of Care
The hospitals bed manager and discharge co coordinators were responsible for daily admissions and discharges of patients. The bed manager was responsible for scheduled admissions and interhosptial transfers during core hours, at all other times the operational ADON was responsible. The two discharge coordinators were responsible for the discharge of complex patients to home or community settings. The hospital had a trauma physiotherapist in position which liaised closely with CUH in prioritising patients for transfer to the hospital for orthopaedic rehabilitation. At the time of inspection the threshold for delayed transfers of care (DTOC) was two and there were two DTOC patients in the hospital. From review of the HSE urgent and emergency care (UEC) data, inspectors noted the DTOC numbers generally ranged from two to four. The discharge coordinators described good links with community services and a regional forum, which assisted in supporting patients being discharged from the hospital.

As the regional centre for a number of clinical specialities the hospital provided an acute admission service for the region, and transfers from other hospitals for specialist clinical care twenty four hours a day, seven days a week. The hospital had an ENT emergency room near the main entrance. This was staffed 24 hours a day, seven days a week. The hospital also provided a 24 hours a day, seven days a week ophthalmology emergency service. Patients, GPs, consultants, other hospital emergency departments or opticians telephoned the department and following triage an appointment was issued. Patients who presented at the department were also triaged and were either seen immediately or offered an appointment. Emergency presentations, primarily ENT, triggered an escalation response pathway. At the time of inspection the average length of stay for medical patients was 5.4 days. The average length of stay for surgical patients was 1.2 days, both were below the HSE's target outlined in the National Service Plan 2025.

In summary the hospital had effective management arrangements in place to support the delivery of high quality, safe reliable healthcare with some areas for improvement identified. These include:

- the further progression of a comprehensive, hospital-wide medication reconciliation service

[††††] The Emergency Inter-Hospital Transfer Policy Protocol 37 has been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

▪ update inter-hospital transfer SOP
Judgment: Substantially compliant

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

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services provided, relevant to the size and scope of the hospital.

Risk Management

There were risk management structures in place to proactively identify, manage and minimise risks. The hospital maintained a corporate risk register of identified hospital risks. The existing controls in place and the additional controls required to minimise these risks were outlined in the risk register viewed by inspectors. The risk register was reviewed quarterly at the CGQSC and was a standing item at monthly EMC and Board meetings and updates were provided at the SSWHG performance meetings. These risks are outlined further in national standard 3.1.

Monitoring services' performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported monthly for the HSE's hospital patient safety indicator report (HPSIR) and the HSE's management data report. Performance and activity data was reviewed at the CGQSC and the EMC.

Audit activity

The hospital had an audit plan for infection, prevention and control, medication safety, the INEWS, Paediatric Early Warning System (PEWS)[‡‡‡‡] and the clinical communication tool using Identify, Situation, Background, Assessment and Recommendation (ISBAR). Audit reports were reviewed by the relevant governing committees such as the IPCC, DTC and the DPC, with evidence of quality improvement plans to address compliance and reaudit. Audits were also reviewed at the CGQSC and EMC. Feedback on audits were shared with staff through education, poster presentations and email communications to department managers. Inspectors reviewed documentation which showed committees had oversight and were carrying out audits with follow up quality improvements, reaudit and dissemination of findings to staff. At the time of inspection there was no dedicated

[‡‡‡‡] Paediatric Early Warning system (PEWS) is an early warning system to assist staff in the detection and/or timely identification of, and response to, deterioration in improving clinical outcomes for children aged 0-16 years in inpatient hospital settings. It is not for use within neonatal and maternity units, paediatric intensive care units or perioperative settings. PEWS is not an emergency triage system and should not be used for this purpose.

clinical audit resource in the hospital. Inspectors were informed that this was due to funding constraints, but this is a function the hospital wished to progress.

Management of patient-safety incidents

The hospital proactively identified, documented and monitored patient-safety incidents. Patient-safety incidents were reported to the National Incident Management System[§§§§] (NIMS), in line with the HSE's Incident Management Framework (IMF) 2020. The hospital had recently implemented the electronic point of entry (ePOE)[*****] NIMS, a paperless system which facilitated staff to enter incidents directly onto the NIMS. The benefits of the ePOE system included, elimination of duplication, availability of real-time data on incidents or near misses and provision of prompts to review and commence risk mitigation processes. Staff training on the new system had been provided and was ongoing at the time of inspection.

The CGQSC provided oversight and management of all patient safety incidents which occurred within the hospital and were tracked and trended by the quality and patient safety department. Incidents were discussed at local governance committees, the SMC, the EMC, monthly reports to the board and performance reports to the SSWHG. The ePOE system allows tracking and trending of incidents by department, at the time of inspection this functionality was being introduced across all departments. Inspectors were satisfied there were processes in place to share learning from patient-safety incidents through communication through the various hospital committees, line management structures and at local ward safety pause meetings.

Feedback from people using the service

Findings from the National Inpatient Experience Survey (NIES) were published in November 2024. 96% of survey participants who responded to the survey said they had a good or very good experience in the hospital. This was higher than the 2022 survey of 93% and above the 2024 national average of 85%. The NIES did not outline any specific areas for improvement by the hospital.

To summarise, the hospital had monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services in the four areas of known harm relevant to this inspection.

Judgment: Compliant

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

[*****] The electronic point of entry (ePOE) reporting is where frontline line staff enter incidents directly onto the National Incident Management Framework System eliminating the need for paper reporting.

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

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.
The HR manager reported to the CEO and was a member of the SMC. The hospital also had a dedicated ADON that managed nursing workforce in conjunction with the HR manager.

Workforce
In 2024 the total absenteeism rate was 3.98% which was below the HSE's key performance indicator (KPI) of 4% or less. Employees were supported by their line managers and HR. There were systems in place to support staff to access occupational health services and the employee assistance programmes (EAP). In addition the hospital could initiate a critical incident protocol to support staff in the aftermath of a critical incident occurring in the hospital.

At the time of inspection the total whole time equivalent (WTE)[†††††] was 1001.74. This was above the December 2024 WTE position of 995.83 which was explained by the addition of pre-registration student nurses. The total vacancy rate was WTE 12.19 which were approved posts in various stages of recruitment.

The January 2025, the WTE position in medicine was 121.69. The vacancy rate was WTE 1.5 in registrar positions. The previous HIQA report highlighted that the out of hour's medical registrar post was being covered by locums. This has since been addressed with a rota of medical registrars from other hospitals in the SSWHG group covering the out of hour's service. This risk remains on the risk register and was last reviewed in January 2025. The hospital employed nine permanent consultant anesthesiologists', inspectors were informed that any newly appointed consultant required one year of consultant anesthesiology experience in pediatrics' prior to commencing work in the hospital.

The January 2025, WTE position in nursing services was 370.15. The vacancy rate was WTE 0.96. Applications were ongoing for inclusion in the Department of Health's, Safer Staffing Framework[‡‡‡‡‡].

[†††††] *Whole-time Equivalent (WTE)* - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0 WTE which refers to a full-time worker, while 0.5 WTE refers to a person who works half of the full-time hours.
[‡‡‡‡‡] Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospital in Ireland 2018 Department of Health Recommendations Nurse Taskforce Cover 6mm Spine.indd

The January 2025 WTE position for Health and Social Care Professionals (HSCP) that included physiotherapy, occupational therapy and speech and language therapy professionals was 102.64, there were no vacancies.

Staffing levels for staff nurses and Health Care Assistants (HCAs) from the clinical areas visited on the day of inspection were reviewed. It was evident that there were sufficient staffing numbers in these areas to ensure the delivery of high quality, safe care.

The hospital had an IPC team in place compromising 0.32 WTE, consultant microbiologist, one WTE ADON, 1.69 WTE's Clinical Nurse Manager (CNM) 11's, one hygiene coordinator and 0.5 WTE administrative support. There was an out of hour's on-call microbiology service also available.

The hospital had 8.5 WTE pharmacists and 5.5 WTE pharmacy technicians. One WTE post was a dedicated antimicrobial pharmacist. The lack of a hospital-wide pharmacy-led medication reconciliation service was recorded on the hospital risk register.

Training

It was evident from staff training records reviewed by inspectors that nursing staff in the hospital undertook multidisciplinary team training appropriate to their scope of practice. The hospital had a system in place to monitor and record staff attendance at mandatory and essential training. Monitoring of attendance at training was overseen by the departmental manager and the nurse practice development department.

Training records from the clinical areas visited on the day of inspection were reviewed. In three of the areas there was close to full compliance rates for the mandatory training related to IPC, INEWS, PEWS, basic life support (BLS) and training on the clinical communication tool, ISBAR for the nursing and healthcare assistant staff as relevant. In one clinical area, inspectors noted 57% compliance with the clinical communication tool, ISBAR and 76% compliance with BLS.

Inspectors reviewed training records for mandatory and essential training. Compliance with required training for hospital staff varied across specialities, with the following ranges observed: 7% to 77% for infection prevention and control training, 73% to 94% for hand hygiene training (HSE's target of 90%), 46% to 76% for INEWS training, 42% to 82% for BLS training, 100% of staff nurses were up to date on PEWS training and 77% of staff nurses were up to date with the clinical communication tool, ISBAR training.
INEWS and the clinical communication tool, ISBAR was part of the twice yearly mandatory hospital NCHD induction, with a record of attendance maintained by the hospital. Inspectors were told this was also part of training which graduates received prior to commencing employment in the hospital. It was the responsibility of the doctor to upload certification to the national doctors integrated management e-system (DIME).

In the clinical areas where paediatrics were managed, nurses were not all paediatric trained, which was not in line with recommendations in the National Model of Care for Paediatric Healthcare. To mitigate this risk the hospital offered weekly paediatric education and paediatric specific simulation training for the clinical management of children, and BLS training covered paediatric life support. The hospital also offered targeted multidisciplinary Paediatric Advanced Life Support (PALS) training. Inspectors were informed that due to challenges in accessing PALS and other specialised paediatric training courses for staff, the hospital were currently working towards offering these training courses 'in house', which would ensure a greater number of staff could avail of appropriate paediatric specific training. The hospitals child safeguarding statement stated that it was mandatory for staff to undertake Children's First training every three years. This was online via the HSE training platform HSEland. It was the responsibility of the staff member to submit the certification of attendance to their line manager.

Overall, inspectors found that hospital management were planning, organising and managing their healthcare workers to support the provision of high-quality, safe healthcare. Areas for improvement include:

- compliance with mandatory and essential training for the overall staff in the hospital could be improved in all areas relevant to the focus of this inspection

Judgment: Substantially compliant

Quality and Safety Dimension

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

Key inspection findings leading to these judgments are described in the following sections. South Infirmary Victoria University Hospital was found to be compliant with three national standards (1.6, 1.7, 2.8) and substantially compliant with three national standards assessed (1.8, 2.7, 3.1, 3.3).

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

It was evident to inspectors during visits to four clinical areas that the patients' dignity, privacy and confidentiality was promoted.

Staff were observed drawing curtains around patients' beds when delivering care and speaking to patients' in a respectful manner. Information was communicated in a clear and easily understood way and supported with relevant written information. Inspectors were informed that offices were available to patients' for private conversations relating to their care. Access to translation services were available to support communication with patients' in their native language. Patients who spoke with inspectors described that staff "*explained my plan of care numerous times and were easy to talk to"* and "*everything is explained in plain english"*. Inspectors observed call bells at each bed in three of the four areas visited. Call bells were not observed in all the patient rooms and toilets on the children's ward, any real or potential risk should be addressed.

Staff communication white boards were in place with patients' initials used only. Patients' healthcare records (HCRs) were stored appropriately.

In the clinical areas visited the physical environment was clean, neat and free from clutter with some evidence of minor wear and tear.

The findings of the NIES 2024 demonstrated that what inspectors observed in the clinical areas aligned with the people who responded to the survey which dealt with dignity and respect while attending the hospital. When patients were asked: Were you given enough privacy while care was being provided the hospital scored 9.3, which was above the national average of 8.0.

In summary, it was evident that hospital management and staff were committed to ensuring that patients' dignity, respect and autonomy was respected and promoted.

Judgment: Compliant

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

Inspectors observed that a culture of kindness consideration and respect was actively promoted by all staff in the clinical areas visited.

Staff were observed actively listening to patients' and responding in a considered and caring manner. This was validated by patients' who expressed their satisfaction with the

care and kindness they received. For example patients' stated that "*communication is very good*" "*plan of care is discussed*" and "*the staff are lovely*".

Findings on inspection were comparable with the results of the 2024 NIES results where the hospital scored above the national average for the following question: Did you feel you were treated with dignity and respect, the score was 9.1, which was above the national average of 8.3.

In summary, it was evident hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital

Judgment: Compliant

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

The hospital had a designated complaints officer who was under the remit of the QRM and was assigned responsibility for managing complaints in line with the hospital policy and for the implementation of recommendations arising from reviews of complaints at the hospital. The QRM provided quarterly reports on complaints to the CGQSC.

For verbal complaints, local resolution at the point of care was encouraged in the first instance. Verbal complaints were tracked locally and the complaints manager was informed. Complaints that could not be resolved locally were escalated to the complaints officer. Written complaints were managed by the complaints officer with input from key stakeholders. Feedback from complaints was shared with staff individually, through email, communication books and departmental staff meetings or safety huddles where the complaint arose.

The hospital utilised the national Complaints Management System (CMS) for recording, reporting, and tracking and trending of complaints. In 2024 the five day acknowledgment rate was 91%, which was above the national KPI of 75%. 88% of complaints are investigated within 30 working days of being acknowledged by the complaints officer, which was above the national KPI of 75%. In 2024 a total of 194 complaints were recorded which included 64 verbal complaints and 130 written complaints. This was an increase of 50% on the 2023 figures with one service accounting for 20.50% of complaints submitted. Inspectors were informed that these were mainly related to issues of access to care.

Inspectors observed posters at the main entrance promoting the National Advocacy Service. Inspectors did not observe posters promoting the hospitals complaints process in the clinical areas visited. Inspectors were told that if a patient wished to make a complaint they were given an information leaflet, these were not on display in the public areas in the clinical areas visited. Inspectors observed feedback cards at the main entrance that could be posted in the 'Have Your Say' box at the main reception desk. Inspectors did not see any of the feedback cards on display in the clinical areas visited. Inspectors noted links to feedback forms on the hospitals website that the public could access.

Complaints management training was online via the HSE training platform HSEland. It was the responsibility of the staff member to submit the certification of attendance to their line manager. The 2023 HIQA report identified that the hospital did plan to provide in-house complaints management training to staff. At the time of inspection training had been provided for administrative staff, but had not been progressed for clinical staff as yet.

Inspectors were informed that following the 2022 NIES report, a quality improvement plan was ongoing to raise awareness of the complaints process. Inspectors were informed that the hospital was introducing additional information posters and cards that would contain relevant details for making a complaint. At the time of inspection the implementation of this initiative across the hospital was at an advanced stage.

At the time of inspection the hospital had no Patient Advocacy and Liaison Service (PALs)[§§§§§] . Inspectors were informed that this post was an area of focus but was dependant on funding.

In summary, inspectors found that the hospital had systems and processes in place to respond to and manage complaints raised by people using the service. Areas for improvement included:

- ensure patients have access to information on the complaints process.

Judgment: Substantially compliant

[§§§§§] The Patient Advice and Liaison Service Co-ordinator acts as the main contact between patients, their families, carers and the hospital. They ensure that the patient voice is heard either through the patient directly or through a nominated representative

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

During this inspection, inspectors visited the day surgery unit, level one south elective, level two Victoria and the children's ward and overall observed that the physical infrastructure was clean and well maintained with some minor exceptions. In the 2024 NIES report the hospital scored 91% in relation to the cleanliness of the hospital room or ward, which was above the national average of 88%.

The day surgical unit comprised eight beds and three chairs in the discharge area, patients' had access to two toilets in the unit and one on the corridor outside the unit. Level one south elective comprised eight single rooms, and, two three-bedded rooms, patients had access to 12 toilets and 10 showers.
Level two Victoria comprised 12 single rooms and three two-bedded rooms, patients had access to 15 toilets and showers. The children's ward was a 14-bedded ward comprised of five multi-occupancy rooms and one single room with a total of 11 beds and three cots, patients had access to four toilets, five showers and one bath. There was also a play room on the ward.

In the clinical areas visited physical distancing of greater than one metre was observed between beds and cots in the multi-occupancy rooms and between trolleys in the day surgery unit. Alcohol hand gel dispensers were strategically located and readily available with hand hygiene signage outlining the World Health Organisation (WHO) 5 moments of hand hygiene clearly displayed throughout the four clinical areas.

Inspectors reviewed documentation for environmental hygiene and patient equipment sign off sheets and audits. The compliance rates for the four clinical areas visited ranged from 84% to 100%, with Quality Improvement Plans (QIPs) in place to address non-compliance.

Inspectors were informed that there was cleaning services available at all times. Inspectors observed a green clean tagging system to indicate equipment had been cleaned in the clinical areas and were informed that nursing staff and HCA's carried out all of the equipment cleaning. Terminal cleaning****** and environmental cleaning was carried out by the cleaning services staff. Oversight of cleaning was by the household and catering manager and the hygiene coordinator (member of IPC team) and ward managers.

Inspectors observed appropriate waste management in the clinical areas visited with clinical and non-clinical waste bins and appropriate disposal of sharps. There were

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

dedicated medication preparation areas in the clinical areas visited with evidence of appropriate and secure medication storage. Sharp bins were partially closed, signed and dated. There was appropriate segregation of clean and used linen.

In the three months prior to inspection the four clinical areas were compliant with the HSE's target of 90% for hand hygiene practices. Inspectors noted that not all the hand hygiene sinks for use in clinical areas conformed to recommended standards. [††††††] Inspectors were satisfied that the hospital had appropriate infection prevention and control surveillance and monitoring in place.

The hospital had systems and processes in place to support the bed allocation of patients. The IPC team worked closely with bed management for scheduled admissions and liaised with staff daily to prioritise patients for single-room isolation as required. The hospital had 37 ensuite isolation rooms, this was not sufficient to meet current demand.

The infrastructure was recorded as a high rated risk on the hospital risk register with particular reference to the impact on IPC. The hospital had secured capital funding to refurbish and upgrade a number of toilet and shower facilities, but to date this has not been progressed due to the impact of bed closures for the duration of the upgraded works. Senior management informed inspectors that challenges with the hospitals environment were reviewed daily, and that senior management and the IPC team carried out monthly infrastructure walkabouts with ongoing mitigation controls put in place as issues arose. Business cases had been submitted to the SSWHG to secure capital funding to carry out major infrastructural reconfiguration to remediate a number of the risks identified.

In summary, inspectors found that the physical environment in the clinical areas visited was clean and well maintained and supported the delivery of high quality, safe, reliable care and protects the health and welfare of people using the services. Inspectors noted:

- the physical infrastructure of the hospital continues to pose challenges in the upkeep and maintenance and is a daily focus for hospital management.
- due to the infrastructural constraints the hospital continues to share services between paediatric and adult patients in some clinical areas.

Judgment: Substantially compliant

[††††††] Health Protection Surveillance Centre, 2024. Infection Control Guiding Principles for Building.pdf

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

Inspectors were satisfied that the hospital had effective systems and processes to systematically monitor, evaluate and improve the healthcare services provided.
The hospital collated data on a number of national key performance indicators for scheduled care including, admissions, discharges, average length of stay and delayed transfers of care. The hospital also collected, collated and reviewed data relating to, infection prevention and control, patient safety incidents, complaints, workforce and risks that had the potential to impact on the quality and safety of services.

Infection prevention and control monitoring

The IPCC had oversight of the IPC practices in the hospital. Surveillance data relating to rates of *clostridium difficile infection* (CDI), hospital-acquired *staphylococcus aureus blood stream infections* (HA SA BSI), *carbapenemase-producing enterobacterales* (CPE), hospital-acquired COVID-19 and IPC outbreaks was submitted by the hospital to the HSE Business Information Unit (BIU). The hospitals' surveillance report for January 2025, covering the last 13 months showed the mean CDI rate was 1.08 which was below the national KPI of 2 per 10,000 bed days used. The surveillance report for 2024 showed the mean HA SA BSI rate was 0.4, which is below the national KPI of 0.8 per 10,000 bed days used. The mean COVID-19 rate was 4.7 which is below the national mean of 10.5 per 10,000 BDU. Inspectors were satisfied that the IPCC had oversight of monitoring of infection prevention and control practices in the hospital

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of AMS practices in the hospital. These included participating in the national antimicrobial point prevalence study and reporting on compliance with key performance indicators every quarter. In the national point prevalence study in October 2024, the prevalence of antimicrobial prescribing in the hospital was 49.4% compared to 40.2% nationally, of which 92.9% were compliant with local guidelines or Microbiology or Infectious Diseases approved prescribing, compared to 86.8% nationally. Inspectors reviewed the 2024 annual report which demonstrated ongoing monitoring and evaluation of antibiotic consumption, antibiotic prophylaxis and antibiotic prescribing. The report outlined education and training provided, outcomes of quality improvements and a summary of clinical guidelines updated or developed.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were carried out in medication safety, medication storage and custody and medication prescribing. Inspectors were informed that initiatives were introduced to improve medication safety practices in the hospital. For instance following an audit of slow release opioid prescribing, ongoing education of alternative prescribing options was introduced, this initiative resulted in a reduction from 64% to 13% opioid

prescribing in the patient cohorts audited. Documentation reviewed showed audits were discussed, improvement plans to address compliance and reaudit agreed with an assigned owner. The hospital reported to the HSE HPSIR on the rate of hospital acquired venous thromboembolism (VTE), with structured data collection and audit part of the medication safety yearly plan. Inspectors were informed of recent initiatives to support VTE management that included prescribing guidelines, poster presentations and patient information booklets. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital collated performance data through monthly audits of INEWS, PEWS observation charts and the clinical communication tool, ISBAR to monitor compliance as part of the quality care metrics in nursing and midwifery.[‡‡‡‡‡‡] From 01 January to 30 November 2024 the hospitals compliance rate for INEWS was between 97% and 100%. From 01 January to 30 December 2024 the hospitals compliance with PEWS was between 86% and 100%. From 01 January to 30 November 2024 the hospitals compliance rate with ISBAR was between 93% and 100%. Inspectors observed QIPs to address incidences of non-compliance.

The hospital collected, collated and reviewed data on sepsis management. Inspectors reviewed the annual sepsis report for 2024, and minutes from meetings which showed a comprehensive approach to sepsis management in the hospital. The hospital tracked and trended all patients screened for sepsis using the clinical decision support tool (sepsis form) regardless of outcome. Non-compliance was reported via the incident management structures and followed up accordingly. The hospital participated in the National Sepsis Audit in 2024 which showed compliance at 86%, a QIP was developed with a plan to report the outcome to the DPC in March 2025. In 2024 sepsis specific simulation training was introduced with 80% of staff surveyed finding it more beneficial than that of an oral presentation. In one clinical area inspectors observed a sepsis pack, The sealed pack contained the sepsis form and equipment to initiate sepsis management on a patient. It is evident the hospital were proactive in highlighting the importance of sepsis management. In 2023, 39 sepsis screenings were initiated with the sepsis form. This increased to 107 sepsis screenings in 2024.

Transitions in care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's performance data indicators. [§§§§§§] The hospital reported on the number of inpatient

[‡‡‡‡‡‡] Nursing and midwifery quality care-metrics (QCM) provide an indication of the quality of the fundamental of nursing and midwifery care consist of a core suite of quality indicators across seven care groups, including: patient monitoring and surveillance and medication safety, medication storages and safety. 2018. Available on line from: Quality care-metrics in nursing and midwifery - healthservice.ie

[§§§§§§] HSE Performance data. Available on line from: https://www.hse.ie/eng/services/publications/performancereports/

discharges and, number of beds subjected to delayed transfer of care. The hospital collated data on patient transfers from the hospital to other hospitals, this was reviewed quarterly to inform further developments and improvements. The hospital also collected data on the numbers of paediatric emergency admissions and readmissions.

In the 2024 NIES results the hospital scored 90% on questions related to discharge or transfer. This was higher than the 2022 survey of 86% and above the 2024 national average of 72%.

In summary, inspectors were satisfied that the hospital systematically monitored and evaluated healthcare services.

Judgment: Compliant

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

The CGQSC was assigned with responsibility to review and manage risks that impact on the quality and safety of healthcare services at the hospital. Risks that could not be managed at hospital level were escalated to the SSWHG.

Risk Management

Risks were recorded on the hospitals corporate risk register with existing controls and the additional controls required to manage and reduce the risks. At the time of inspection there were 27 risks recorded on the risk register all rated high. The risk register was last reviewed in January 2025 and included risks related to: infrastructure, lack of capacity to meet demand, infection, prevention and control across a number of risks, medication reconciliation and staff recruitment-particularly for specialist posts. There were no high risks recorded related to the deteriorating patient or transitions in care. The previous 2023 HIQA inspection report outlined the ongoing challenges posed by the infrastructure of an old building (the hospital was first built in 1762) that was outdated and was not in line with recommended specifications and standards of a modern patient care facility.

Infection, Prevention and Control

The IPC ADON and QSR manager reviewed the IPC risks monthly and reported to the CGQSC. The highest rated risks were related to infrastructure and included toilet facilities and the nightingale-style wards*******. It was evident from talking to staff that IPC was a daily and ongoing focus in the hospital. Inspectors were satisfied that the hospital

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

screened all patients for multi-drug resistant organisms (MDROs) on admission in line with national guidance. Screening included MRSA, CPE and VRE. Patients with communicable infections were isolated as per national guidance, when available isolation facilities allowed. This was in keeping with what staff told inspectors about the pre-admission screening process and patient isolation management. Legionella testing was conducted on a quarterly basis and measures were implemented to address report findings. A legionella risk assessment from December 2024 was viewed by inspectors and this was an ongoing risk for the hospital and was recorded on the hospitals safety statement. In January 2025 the hospital had an outbreak of influenza A. Inspectors reviewed a comprehensive outbreak report, which showed a multidisciplinary team was convened to oversee the management of the outbreak in line with national guidance. The report identified areas for improvement that were for consideration at the next IPCC meeting.

At the time of inspection there were building works underway in a section of the out patients department. The hospital had in place an SOP titled: Prevention of Nosocomial Invasive Aspergillosis during building work in the South Infirmary Victoria University Hospital. The purpose of the SOP was to act as guidance for staff/contractors to ensure that construction/renovation activities in the hospital was undertaken in a safe and appropriate manner to reduce the risk of infection to patients at risk. Inspectors were provided with evidence of two risk assessments and a construction permit as outlined in the SOP, completed and signed by the maintenance manager and the IPC ADON prior to the works commencing.

<u>Medication Safety</u>

The hospital had a limited clinical pharmacy service available to clinical areas. As a result pharmacist-led medication reconciliation was conducted on a priority basis from Monday to Friday and this was recorded as a high rated risk on the corporate risk register. There was a dedicated anti-microbial pharmacist in the hospital supported by a consultant microbiologist who attended the hospital two days per week and staff could access advice from an on-call consultant or NCHD microbiologist. The hospital had a list of high risk medications, with a number of initiatives in place to manage these drugs in a safe way. One initiative was described as the 'red box' whereby a high risk medication was stored individually in a red box with all relevant information and instructions for use. The hospital had developed a list of sound-alike look-alike medications (SALADs). Both lists were on display in medication preparation areas. Inspectors were informed the pharmacy service had recently received HSE funding which was being utilised in making 10 short medication safety information videos for patients about various high risk medications. Wards had a pharmacy technician service for medication stock control. Inspectors were informed by staff that pharmacists were available for advice and support by telephone and in person.

Deteriorating Patient

The hospital had systems in place to manage the deteriorating patient. This included the INEWS and PEWS observation charts. The clinical communication tool, ISBAR was also in use and it was evident that this tool was being used to support communication between staff in relation to patient care. The hospital offered monthly training on INEWS and PEWS. Monthly training on the Irish Maternity Early Warning System (IMEWS) was also offered, the hospital managed zero to two obstetric cases per year for non-obstetric related conditions. Inspectors reviewed the out of hours and on-call arrangements for medical staff, which demonstrated effective cover across all specialities. All paediatric care was consultant led. NCHDs were required to escalate concerns regarding deteriorating children to the anaesthesiologist NCHD and consultant anaesthesiologist on call in the first instance.

Healthcare staff attended scenario-based simulation training to enhance their skills, knowledge and confidence to manage the deteriorating adult and child. In addition the hospital offered targeted multidisciplinary Paediatric Advanced Life Support (PALS) and Acute Events, Life Threatening, Recognition And Treatment (ALERT) training. The hospital had an anticipatory care plan in place. This care plan offered clinical guidance to staff as to immediate actions to take in the event of an acute deterioration of a patient. The hospital had an emergency room near the main entrance. This was staffed 24 hours a day, seven days a week. Emergency presentations triggered an escalation response pathway. The hospital had access to the National Ambulance Service (NAS) protocol 37 which ensures that patients with urgent medical needs outside the scope of the hospital are transported directly to CUH or other hospitals, which offer specialised clinical care. In 2024, 35 patients were transferred to other hospitals which represented 0.08% of inpatient admissions for the year.

Transitions of Care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services to support safe and effective discharge planning and other transitions of care. At the time of inspection, the hospital had SOP's in place for the management of unscheduled presentations, admissions to, transfers within, and transfers from the hospital. The hospital had a number of transfer and discharge templates to facilitate safe transitions of care. Transfer and discharge templates recorded the patient's infection status. Inspectors were informed of a recent initiative is the recording of the patient's pressure areas on transfer documentation for patients transferring from CUH for orthopaedic rehabilitation.

All scheduled patients underwent preassessment prior to admission. For paediatric admissions detailed guidelines, produced by the Department of Anaesthesiology outlined the care pathway for routine paediatric admissions and for complex paediatric admissions. Paediatric patients from 12 to 16 years were managed in the day surgical unit also. During admission to the unit paediatric patients had a dedicated admission

area, dedicated trolley spaces, dedicated morning admissions, and parents or guardians accompanied the child at all times, except when the child was in the operating theatre. Staff Nurses on the unit were all trained in PEWS, and the CNM was trained in PALS, BLS training covered paediatric life support. Inspectors were informed that the resuscitation trolleys in the clinical areas carried the full range of clinical equipment sizes in the event of a child requiring resuscitation. Inspectors were informed that the clinical communication tool, ISBAR was used for nursing handovers in the clinical areas.

The hospitals IPC guidelines supported scheduled admissions and alerts were also recorded on the electronic inpatient management system (IPMs).

The hospital had a range of patient information leaflets given to patients prior to discharge, that included information on general recovery, particular to their clinical condition and follow-up instructions.

Policies, Procedures, Protocols and Guidelines (PPPGs)
The hospital had a suite of up-to-date infection prevention and control PPPGs dated February 2025 based on national guidelines which included policies on standard and transmission based precautions, outbreak management, managements of patients in isolation and equipment decontamination. The hospital also had a suite of up-to-date medication safety PPPGs which included guidelines on prescribing and administration of medication, high alert medicines and sound alike look alike drugs. Prescribing guidelines could be accessed by staff at the point of care through desktop computers. At the time of inspection the hospital were commencing the use of a mobile application (app) to access clinical guidelines, protocols and essential resources on antimicrobial prescribing.
All PPPG's were accessible to staff via the hospitals intranet. The hospital did not have a document management system in place for document management and PPPG's.
In summary, the hospital had systems in place to identify and manage potential risk of harm to people associated with the four areas of harm. Areas for improvement include:

- address the risk posed by the lack of hospital wide pharmacy-led medication reconciliation.

Judgment: Substantially compliant

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

The hospital had patient safety incident management systems in place to identify, report, manage and respond to patient safety incidents in line with national legislation, and guidelines. As previously mentioned, the hospital had recently implemented the electronic point of entry (ePOE) NIMS, facilitating staff to enter all incidents directly onto the NIMS.

Staff who spoke with inspectors were knowledgeable about reporting systems in place for patient safety incidents. Staff training on the new system had been provided and was ongoing at the time of inspection. The new system allows department managers and line managers to track and trend incidents that occur in their areas and view on a dashboard format. Staff reported feedback on incidents was provided to individual staff and at departmental staff meetings or safety huddles. Staff were aware of the most common patient-safety incidents reported in their area and were knowledgeable on the appropriate escalation and management of patient safety incidents.

Patient safety incidents were reviewed in committee minutes of DTC and IPCC meetings reviewed by inspectors. Patient safety incidents related to the deteriorating patient and transitions in care were primarily reviewed at the IRCEG and also discussed at other committees depending on the issues of concern. The IRCEG was responsible for the ongoing management of patient safety incidents that occurred in the hospital. Minutes of meetings reviewed by inspectors showed that incidents were being managed appropriately with oversight from the CGQSC.

At the time of inspection, inspectors were informed that the QRM met with the SSWHG QPS manager every six weeks and as required and gave an update on risk management and QPS issues within the hospital.

In summary, inspectors were satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of harm which were the focus of this inspection. The hospital was reporting incident's related to the four areas and these incidents were reviewed at Board, EMC, CGQSC, DTC and IPPC. The new electronic point of entry (ePOE) NIMS will allow each department to track and trend incidents in their areas. Area for improvement include:

- formally minute patient safety incidents related to the deteriorating patient and transitions in care

Judgment: Substantially compliant

Conclusion

HIQA carried out a two day unannounced inspection of South Infirmary Victoria University Hospital to assess compliance with 11 national standards from the National Standards for Safer Better Healthcare. The inspection focused on four areas of known, infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was judged to be compliant with four national standards (5.8, 1.6, 1.7, 2.8) and substantially compliant with seven national standards (5.2, 5.5, 6.1, 1.8, 2.7, 3.1, 3.3)

Capacity and Capability

The hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare appropriate to the size and scope of the hospital. The hospitals formalised governance structures were documented and effectively communicated through senior management structures, reflecting a strong commitment to oversight and accountability. All committees should be clearly represented on organisational charts.

Areas for improvements were identified that included, risks posed due to the lack of a pharmacist-led medication reconciliation, and improving inter-hospital transfer policies which would further support the hospital's capacity to deliver safe and effective care.

Training records reviewed by inspectors for the clinical areas visited on the day of inspection demonstrated good compliance with attendance at mandatory and essential training for nursing and healthcare assistants. Attendance at mandatory and essential training for the overall hospital staff should be improved to ensure that all clinical staff have undertaken the necessary training appropriate to their scope of practice and at the required frequency, in line with local and or national standards, policies or guidelines.

Quality and Safety

The inspection at South Infirmary Victoria University Hospital demonstrated a strong commitment by all staff in respecting and promoting the dignity, privacy, and autonomy of patients. Hospital management and staff were dedicated to fostering a culture of kindness, consideration, and respect. While there were structures in place to manage patient feedback with a focus on continuous improvement, the patients that inspectors met were not aware of the formal hospital process, nor was the complaints process on view in the clinical areas visited. At the time of inspection the implementation of a quality improvement plan across the hospital was at an advanced stage.

The four clinical areas visited very clean and tidy, with some minor wear and tear. The physical infrastructure of the hospital continues to pose challenges in the upkeep and maintenance of the buildings, and is a daily focus for hospital management. Due to these

infrastructural constraints the hospital continues to share services between paediatric and adult patients in some clinical areas. Additional business cases had also been submitted to the SSWHG for capital funding to carry out infrastructural reconfiguration to remediate some of the ongoing risks.

The hospital had systems in place to monitor, evaluate and continuously improve services. While each area is conducting and following up on audits, at the time of inspection there was no dedicated clinical audit resource in the hospital.

Finally, the hospital had a system in place to identify, report, manage, and respond to patient-safety incidents, with oversight from the CGQSC and the EMC.

Overall, South Infirmary Victoria University Hospital demonstrates effective oversight in quality and safety, with areas for improvement to ensure the highest standards of patient care. HIQA will, as part of the monitoring activity, continue to monitor the progress in relation to compliance with the National Standards for Safer Better Healthcare.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the 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.	Substantially compliant
Standard 5.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved	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	Substantially 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.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant

Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant