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:	Letterkenny University Hospital
Address of Healthcare Service:	Kilmacrennan Rd, Ballyboe Glencar, Letterkenny, Co. Donegal. F92 AE81
Type of Inspection:	Announced
Date(s) of Inspection:	16 and 17 November 2022
Healthcare Service ID:	OSV-0001039
Fieldwork ID:	NSSBH_0017

About the healthcare service

The following information describes the services the hospital provides:

Model of Hospital and Profile

Letterkenny University Hospital (LUH) is a model 3* public acute general hospital and is one of the seven acute hospitals within the Saolta Hospital Group. It provides 24/7 undifferentiated care and services to the population of Donegal.

The hospital provides a range of acute services on an outpatient, day case and in-patient basis. Services include emergency department, intensive care, coronary care, general medicine, geriatric care, renal dialysis, general surgery, urology, obstetrics and gynaecology, paediatrics and neonatology, orthopaedics, oncology and haematology. The Hospital has a directorate structure and it also has two managed clinical academic networks (MCAN). The four directorates are Medicine, Perioperative, Radiology and Pathology. The two MCANs are the Cancer MCAN and the Women and Children's MCAN. It has a range of clinical and non-clinical support services available on site including four main theatres, central sterile services department (CSSD), pathology and laboratory department and a pharmacy department. Part of the Letterkenny University Hospital building includes an acute psychiatric inpatient unit. It is a teaching hospital with links to the National University Galway, the Royal College of Surgeons Ireland (RCSI) and the Letterkenny Institute of Technology (LIT).

The following information outlines some additional data on this healthcare service.

Model of Hospital:	Model 3
Number of beds:	365 plus 13 escalation beds available

* The National Acute Medicine Programme's model of hospitals describes four levels of hospitals as follows:
Model 1 hospitals: are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
Model 2 hospitals: can provide the majority of hospital activity including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.
Model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care.
Model 4 hospitals: are tertiary hospitals and are similar to Model-3 hospitals but also provide tertiary care and in certain locations, supra-regional care.

How we inspect

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

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service:

This section describes the governance, leadership and management arrangements in place in Letterkenny University Hospital. It considers how effective they are in ensuring that a good quality and safe service is being sustainably provided. It outlines how people who work in the service are managed and supported through education and training, and whether there is appropriate oversight and assurance arrangements in place to ensure high quality and safe delivery of care.

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

2. Quality and safety of the service:

This section describes the experiences, care and support people receive on a day-to-day basis. It is a check on whether the service is of a good quality and is a caring one that is both person centred and safe. It includes information about the environment in which they are cared for.

A full list of all standards reviewed as part of this inspection by themes and dimension and the resulting compliance judgments are listed in Appendix 1**.**

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance has been made under each standard monitored on how the service performed. We include our monitoring judgments in the inspection report and where we identify partial or non-compliance with the standards, we will issue a compliance plan. It is the healthcare service provider's responsibility to ensure that it implements the actions in the compliance plan within the set time frames.

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.

This inspection was carried out during the following times:

Dates	Times of Inspection	Inspectors	Roles
16 November 2022 17 November 2022	09.00hrs -17.30hrs 09.00hrs -16.30hrs	Patricia Hughes Emma Cooke Lisa Corrigan Nora O' Mahony John Tuffy	Lead Inspector Support Inspector Support Inspector Support Inspector Support Inspector

Information about this inspection

This announced inspection of compliance against national standards was undertaken on 16 and 17 November 2022 with a focus on four areas of known healthcare risk:

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

Previous inspections of the hospital undertaken by HIQA included Medication Safety in 2017 and 2018 and Maternity Care in 2019. HIQA also conducted a targeted assurance review of the governance arrangements of gynaecology services at Letterkenny University Hospital in 2021 following concerns about the quality of the service and safety of women accessing it. A number of actions had been taken in response to HIQA's findings from this review, including the appointment of an external clinical director for gynaecology services for a six-month period from September 2022, and progress with actions was assessed through this inspection.

The following clinical areas were visited as part of this inspection:

- emergency department
- medical 2 ward
- gynaecology ward.

The inspection team met with representatives of the following:

- the Hospital's Executive Board (HEB) comprising the Hospital Manager, Assistant Director of Nursing (ADON) deputising for the Director of Nursing, Assistant Director of Midwifery (ADOM) deputising for the Director of Midwifery, Associate Clinical Directors (ACD) for medicine including emergency medicine, perioperative directorate, radiology directorate representatives and the Facilities Manager.
- quality and patient safety including complaints management
- non-consultant hospital doctors (NCHDs)
- Human Resource Manager and Medical Manpower Manager
- Representatives or leads for: infection prevention and control, medication safety, the deteriorating patient and transitions of care.
- external Clinical Director for gynaecology services.

Acknowledgements

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

What people who use the emergency department told inspectors and what inspectors observed in the department

As part of this inspection, inspectors visited the emergency department on the first day of inspection and the respiratory response unit (RRU) on the second day.

The emergency department provides care for undifferentiated adult, maternity and paediatric patients with acute and urgent illness or injuries. Attendees to the emergency department at Letterkenny University Hospital presented by ambulance, were referred directly by their general practitioner (GP) or self-referred. The RRU had previously operated as the Acute Medical Assessment Unit (AMAU) prior to COVID-19 and at the time of inspection was being used to provide assessment and care for patients presenting to the emergency department with reported respiratory symptoms, irrespective of other presenting complaints.

On arrival at the emergency department, patients were promptly assessed for signs of COVID-19 in line with best practice guidelines. Inspectors noted that there was signage on walls and doors advising patients to declare any symptoms suggestive of COVID-19. Those with symptoms were directed to the RRU (colour coded red) and those without were directed into the emergency department (colour coded yellow). Inspectors were told that that there was a member of staff based at a desk located at the main entrance to the emergency department who streamed patients into either zone depending upon declaration of symptoms. The desk was not attended when inspectors first entered the building but was attended at all other times when observed by inspectors. The two zones were separated by the use of see-through partition panels. Each zone had its own waiting area. In addition, each had access to a further designated waiting area, 'red pod' or 'yellow pod', situated outside of the front door. These were reported to be used for overflow for up to six additional patients in each pod from their respective waiting rooms when required. Inspectors were told that there was inclusion and exclusion criteria to guide who may be suitable to wait in these external zone facilities.

The non-COVID-19 zone had a registration desk where people registered their attendance with clerical staff and then took a seat in the adjacent waiting area until called into the department for an initial assessment and triage. The waiting area comprised 23 seats. Inspectors observed that the minimum physical spacing of one metre was not being maintained. The waiting area in the COVID-19 zone comprised 18 seats. There was one person waiting there at the time of inspection.

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‡ The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the HSE. Early Warning Systems (EWS) improve recognition and response to signs of patient deterioration. A number of EWS designed to address individual patient needs are in place in acute hospitals.

§ Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

** Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016

Access to the emergency department was via a security fob. The emergency department had capacity for a total of 12 patients using the eight single cubicles and four single rooms. The RRU had capacity for a further 11 patients using its eight single cubicles and three single rooms. Inspectors were told that staff could 'surge up' its physical capacity from 25 (emergency department and RRU) to 32 patients if needed, using alternative spaces within the emergency department.

Inspectors observed that the main emergency department (non-COVID-19 zone) comprised:

- one triage room
- eight cubicles
- four single rooms (two of which had en-suite toilets). One of these single rooms was designated for use with children and had its own small waiting area. There was no audio-visual separation between this area and the areas where adults were being treated. Audio-visual separation is recommended in the national model of care for paediatric healthcare services.[††]
- a minor injuries area - 'purple pathway' and designated area for a 'plaster of paris' (POP) room
- one resuscitation room (two trolleys)
- two toilets for patients use (in addition to the two en-suite toilets listed above)
- one shower room in the emergency department.

There was a central nurses station, a clinical room, clean and dirty utility spaces, a relatives room, an ambulance bay, an ambulance utility room, an ambulance base office for the Hospital Ambulance Liaison Person (HALP), and various office spaces for nursing and medical staff contained within the emergency department. There was a Major Emergency Plan board on display. There was a security base office within the main emergency department from which security personnel provided a physical presence in the department at night from 8pm to 8 am. Access during the day shift was via a bleep system to security personnel who were working in various locations throughout the hospital campus.

The RRU (used for suspected and or COVID-19 patients) had:

- one triage room with two trolleys
- eight single cubicles
- three single rooms (one with negative pressure)
- one shower
- one resuscitation room (two trolleys)
- two toilets.

[††] National Model of Care for Paediatric Healthcare (HSE). https://www.hse.ie/eng/about/who/cspd/ncps/paediatrics-neonatology/moc/chapters/

Wall-mounted alcohol based hand sanitiser dispensers were strategically located. Hand hygiene signage was clearly displayed throughout the department. Staff were observed wearing appropriate personal protective equipment (PPE) in line with current public health guidelines and were 'bare below the elbow' in line with national guidance when not wearing PPE.

Inspectors observed staff actively engaging with patients in a respectful and kind way. Staff took the time to talk and listen to patients and encouraged them to let them know if they felt unwell while waiting to be reviewed.

Inspectors spoke with a number of people using the emergency department services to hear about their experiences of care received. Patients who spoke with inspectors were waiting from two to 34 hours in the department from time of registration at the hospital. A range of views were provided to inspectors relating to their experiences so far. All patients spoken with said that they had received some food and drinks although some said that they had had to ask for it and on more than one occasion. Each person said that they could get to the toilet themselves. The following comments were made in response to questions about what has been good about the service they had experienced so far and what areas did they think required improvements:

- *'Appears quieter here today but still very busy…happy so far, I would just like to know when I can get home'*
- *'Too many people here… waiting for a bed … here since 8 am yesterday, nurses are helpful, they check in with you regularly'*
- *'Arrived here at 4 pm yesterday, chair and pillow provided, no bed…, trying to get in contact with family to bring in supplies, had to ask staff for food. I am diabetic. Told to elevate leg, how can I do this while sitting on a chair? I would want to change everything I have experienced so far'*
- *'In the waiting room most of the night, came in yesterday afternoon, tried to rest on those hard chairs overnight, no pillow, no bed, no food or drink until I asked for it, the two vending machines were not working….'*

When asked, patients were aware of how to make a complaint if they needed to, however inspectors were also told that staff were doing their best and that they (the patients) would be reluctant to complain. One person said that they had no complaints.

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

Inspectors visited two ward areas, medical 2 and the gynaecology ward.

Medical 2 was a 16-bedded ward which specialised in the care of older patients, all in single rooms. Access to the ward was via a security fob. At the time of inspection, the ward was full and it also accommodated three additional patients on trolleys. Two patients were placed along the corridor and one was placed in the treatment room. All patients on this ward including those on trolleys had a means to call for assistance.

The gynaecology ward was an 11-bedded ward comprising a six-bedded bay, a three-bedded bay and two single rooms. At the time of inspection, all beds were full. The ward provides gynaecology care as well as care for women with early pregnancy complications including pregnancy loss. Inspectors were told that during periods of peak activity, the ward also accommodated patients receiving medical, surgical, and orthopaedic or oncology care.

Inspectors observed that staff interactions with people using the services on both wards were kind, respectful and attentive to patient needs. Curtains or screens were drawn around patients for privacy at appropriate times including those on trolleys on the corridor on Medical 2.

When asked to describe what had been good about their stay in the hospital, people who were using the services said:

- *'very attentive, transferred here late last night* (from another hospital), *it is very quiet and nice here. I have my own room although there is no toilet in this room'*
- *'everything very good, staff always ask before doing your blood pressure and say call if you need anything'*
- *'nurses here are very approachable.. definitely feel listened to… caring staff'*
- *'cleaner was in today and cleaned everywhere'*
- *'food has been nice'*
- *'Can't fault anything, they are doing their best'*

When asked what could be improved about the service or care they received, some patients responded saying:

- *'the mattress is very uncomfortable'*
- *'they are so busy and when people come in, they have to put them somewhere'*
- *'the waiting time when I came in was long and I was on a trolley in the treatment room'*
- *'access to doctors, it's slow, when they do come, I feel heard'*
- *'toilet space on gynae ward is tiny, door opens into both wards, better if it didn't'*

People who spoke with inspectors knew how to raise a complaint, if required. The leaflets on how to make a complaint, concern or give a compliment, HSE *'Your Service Your Say'* were made available in the display area in medical 2 ward (which inspectors noted was initially empty and refilled before the end of the inspection). The HSE *'Your Service Your Say'* poster was on display at the entrance to the gynaecology ward but the leaflets were not on display.

There was a large sign in the lobby of the main entrance to the hospital providing information on the HSE advocacy services. There was no information on advocacy services on display at ward level in either clinical area inspected. There was also prominent signage in the lobby of the main entrance to the hospital indicating how people using the service could identify staff disciplines by their uniforms.

Capacity and Capability Dimension

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

Inspection findings from the emergency department related to the capacity and capability dimension are presented under national standard 6.1 from the theme of workforce.

Inspection findings from the wider hospital and clinical areas visited and related to the capacity and capability dimension, are then presented under national standard 5.8 from the theme of leadership, governance and management.

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

Letterkenny University Hospital had defined corporate and clinical governance arrangements. Notwithstanding this, inspectors found that while these were working to some extent, they were not as effective as they should be. Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management, and hospital management's reporting arrangements to the Chief Executive Officer of the Saolta Hospital Group. This was largely consistent with what inspectors found on inspection. At executive level, the hospital had defined lines of responsibility and accountability for the governance and management of services. The General Manager had overall responsibility for governance and management of the hospital and reported to the Chief Executive Officer (CEO) of the Saolta Hospital Group.

Hospital Executive Board (HEB)

The hospital executive board (HEB) was the main governance structure with responsibility for governance and oversight of the hospital's healthcare services. The HEB, chaired by the General Manager, met twice a month in line with its terms of reference. Membership of the HEB comprised the DON, the director of midwifery, the associate clinical directors (ACD) from the directorates and managed clinical academic networks (MCANs), the quality and patient safety (QPS) manager, and representation from finance, facilities and human resources. Minutes of HEB meetings submitted to HIQA showed that the meetings followed a structured format, were action oriented and progress in implementation of actions was monitored from meeting to meeting. One meeting per month focused on reports from the clinical directorates and the second meeting per month focused on support services. Attendance as recorded on the minutes of meetings reviewed by inspectors could be improved. At the time of inspection, a number of longstanding items including communication between medical teams at the hospital and implementation of the clinical handover policy (between specialty consultants) had yet to be resolved.

The HEB reported monthly to the Saolta Executive Team and met with the Saolta Hospital Group executive and the group clinical directors for performance meetings six times per year where items such as finance, workforce, quality and safety, access to scheduled and unscheduled care and activity were reviewed and discussed. Inspectors were satisfied that these were well attended and that actions were progressed over time. The latest minutes provided to HIQA for inspection were dated March 2022, eight months prior to inspection.

There was a directorate structure lead by associate clinical directors (ACD) who were members of the HEB. The ACD's were members of key committees such as the QPS, and the Hospital Infection Prevention and Control Committee (HIPCC),. Risk and incident management was integrated within each directorate.

The external clinical director to the gynaecology service who had been appointed for a six-month period in September 2022 to provide support and oversight of the implementation of recommendations arising from the HIQA review in 2021 reported to the clinical director for the Saolta Women and Children's Managed Clinical Academic Network. This is discussed further under national standard 3.1.

In September 2022, the Saolta Hospital Group had also advertised a 12-month post for a senior change manager role at general manager grade. The purpose of the post as stated in the job description was to lead, co-ordinate, monitor and oversee the implementation of a change plan at Letterkenny University Hospital. The manager would be responsible for co-ordinating and supporting work streams to deliver on agreed strategic priorities for both Letterkenny University Hospital and the Saolta Hospital Group. Inspectors were told that it was expected that the postholder was due to take up post in February 2023. The job description indicated that the postholder would be based in Letterkenny University Hospital for at least 50% of the time.

Quality and Patient Safety (QPS)

The QPS committee was assigned with responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. The QPS committee was chaired by the DON and met monthly. It reported and was accountable to the HEB. It had responsibility for maintenance and oversight of the hospital risk register. A number of hospital committees reported into the QPS committee, including the Hospital Infection Prevention and Control Committee (HIPCC), Drugs and Therapeutics (DPC) and the Deteriorating Patient Committee (DPC). The QPS committee had multidisciplinary membership comprising medical staff including the associate clinical directors, representatives from nursing, midwifery, pharmacy, infection prevention and control, facilities, general management, patient services, consumer services manager, human resources and administrative support. Minutes and an updated log of actions were viewed by inspectors. Inspectors noted that not all subcommittees had been reporting into the QPS committee in line with their terms of reference. This needs to be addressed at hospital level to ensure that there is effective and integrated communication around quality and patient safety.

The hospital's quality and patient safety (QPS) department was led by the QPS manager who reported to the DON and at Saolta hospital group level to the Group QPS manager. The QPS department were also responsible for the management of the complaints processes for the hospital. The QPS department had undergone and was continuing to undergo changes due to recent and ongoing recruitment of staff. Risk and incident management were integrated within the directorate structures and directorate meetings were attended by quality and patient safety staff.

HIQA viewed an internal audit report titled 'Compliance with the Risk Management Policy' conducted by the HSE Internal Audit Department and dated 10 October 2022. It concluded that the level of assurance that may be provided to management about the adequacy and effectiveness of governance, risk management and internal control system in the area reviewed was limited. The report made seven recommendations around revision and maintenance of hospital and department risk registers. This is discussed further under national standard 3.1.

The hospital had a Clinical Audit Governance committee and a clinical audit facilitator. Inspectors viewed evidence of a range audit activity across the hospital year to date.

Hospital Infection Prevention and Control Committee (HIPCC)

The hospital had elements of the structures and systems in place to support the delivery of the infection prevention and control (IPC) programme. Only one of the 2.5 whole-time equivalent (WTE) consultant microbiology posts had been filled although these posts had been sanctioned a number of years previously. Inspectors were told that recruitment efforts to date have been unsuccessful. The hospital did not have an antimicrobial stewardship (AMS) committee or an AMS programme in place. The hospital needs to address these deficits and ensure that there are adequate formalised arrangements in place to support antimicrobial stewardship in the interests of patient safety at the hospital. The HIPCC, chaired by the Assistant General Manager (with the General Manager attending and chairing at least 2 meetings per annum), was responsible for

the governance of IPC in the hospital. It met monthly and reported and provided monthly written reports to the quality and patient safety committee. The ADON for IPC was a member of the QPS committee. The QPS committee reported to the HEB. Inspectors viewed the HIPCC updated action log dated October 2022.

The HIPCC provided support in terms of education, guidance and oversight of IPC matters to hospital staff and its subgroups, the decontamination committee and the outbreak management committee. Inspectors were told that the 2019 terms of reference for the HIPCC were undergoing review at the time of inspection. Membership of the HIPCC included the consultant microbiologist, ADON for IPC, clinical nurse specialists in IPC, antimicrobial pharmacist (who was on leave at time of the inspection, and inspectors were told that efforts to recruit a replacement had been unsuccessful to date), surveillance scientist, quality and patient safety manager, facilities manager, DON, director of midwifery, associate clinical directors, occupational health physician, bed manager and administrative support.

The decontamination committee, which had been suspended during COVID-19 and re-established in April 2022, was chaired by the ADON for IPC. It reported into the HIPCC. The hospital had an outbreak control team which was responsible for managing outbreaks and for the compilation and sharing of reports at the end of an outbreak. Membership of this team included members of general management, DON or ADON, IPC ADON, consultant microbiologist, a representative from the affected clinical area(s), public health and occupational health although it was noted that attendance at outbreak team meetings was variable. The hospital needs to ensure that the requisite quorum attends such meetings. The outbreak control team reported to the HIPCC. Inspectors viewed a range of IPC policies, procedures and guidelines in use including the HSE policy document on prioritisation of patients for single room isolation in the event of competing demands for these facilities.

The hospital should review its formalised governance arrangements particularly in relation to an antimicrobial stewardship programme and AMS practices at the hospital.

Medication Safety

The hospital had an established Drugs and Therapeutics Committee (DTC) in place which met monthly to support the delivery of medication safety. This committee reported to the QPS committee who in turn reported to the HEB. According to QPS minutes reviewed by inspectors, the DTC had not submitted a report since April 2022. Inspectors were told that there had been verbal reports provided but that written reports would now recommence. The DTC terms of reference, dated 2017 were said to be under review at the time of inspection. The DTC was chaired by a consultant anaesthetist and membership included the chief pharmacist, general manager, quality and patient safety manager, director of nursing, director of midwifery, consultant microbiologist, antimicrobial pharmacist, consultants and nurse representation from the various directorates, NCHD representation and administrative support. The DTC also reported to the Saolta Group Drugs and Therapeutics Committee but inspectors were told that the Saolta committee had not met in several months.

The current and ongoing deficits in pharmacy staffing both from unfilled posts and long-term leave were impacting on the hospital's ability to provide a comprehensive clinical pharmacy service across all areas of the hospital plus the 10 to 11-bedded Donegal hospice. There was no assigned clinical pharmacist for the perioperative department which included ICU and theatre.

HIQA had previously conducted medication safety inspections at Letterkenny University Hospital in 2017 and 2018. Among the findings in these reports, HIQA noted the lack of sustained clinical pharmacy services which remain an issue to date.

The hospital should review its formalised governance arrangements particularly in relation to internal formal communications between the DTC and the QPS committee and in relation to the hospital's approach to pharmacy workforce planning, hospital wide pharmacy cover arrangements including antimicrobial pharmacy support.

The Deteriorating Patient

The hospital had a Deteriorating Patient Committee (DPC) in place to support the identification and management of the deteriorating patient. This committee provided a local governance structure to support the implementation and ongoing evaluation of the early warning systems (EWS) and the national clinical guideline on the management of the deteriorating patient. Inspectors were told that the original terms of reference dated July 2021 were under review and that the committee had been meeting monthly. The DPC reported to the QPS committee. The DPC was chaired by a consultant physician and membership included the general manager, DON, director of midwifery, the quality and patient safety manager, resuscitation officer, a selection of nurses and midwives representing various services across the hospital including emergency department, wards, maternity, paediatrics, practice development and IPC, consultants from medicine, emergency medicine, anaesthetics, geriatrics, microbiology, the NCHD lead and the medical education director. Inspectors noted that attendance from the proposed membership at the DPC meetings was variable. Inspectors were told that while associate clinical directors may not attend the DPC, they were also members of the QPS committee and the HEB to which the DPC reported. The resuscitation committee was a subcommittee of the DPC.

Transitions of Care

The hospital had a number of personnel and established committees to support transitions of care of people requiring admission into hospital and their subsequent transfers or discharge from the hospital. These included the monthly meeting of the Unscheduled Care Governance Group, the weekly meeting of the Integrated Care for Older Persons (ICPOP), the joint Community Health Organisation One (CHO1)[‡‡] and Letterkenny University Hospital Liaison forum, and the monthly meeting of the National Ambulance Service and Letterkenny University

[‡‡] Community Health Organisation Area One (CHO1) is one of nine geographically based organisations which are the HSE governing organisation for community healthcare services. Community healthcare services comprise the broad range of services that are provided outside of the acute hospital system and include primary care, social care, mental health and health and well-being. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.

Hospital Liaison forum. The hospital had a bed manager, a discharge co-ordinator and patient flow co-ordinators in post. There was a member of the patient flow team on duty seven days per week until 8.30pm and an on-site senior nurse manager on duty out-of-hours for the hospital.

The Unscheduled Care Governance Group (USCGG) was responsible for reviewing and improving the flow and experience of patients attending for emergency care at Letterkenny University Hospital and outward into the community. It was chaired by the hospital's general manager or assistant general manager and co-chaired by the lead consultant in emergency medicine. According to its terms of reference, it was to meet monthly. It reported and was accountable to the HEB. Membership included the DON, associate clinical directors (ACDs) and assistant directors of nursing (ADONs) from the medical and perioperative directorates, radiology, CNM3 (ED), representation from patient flow, discharge liaison, primary care, national ambulance service, IPC and Saolta Group for unscheduled care. Inspectors viewed a sample of minutes from meetings held at monthly or two monthly intervals. Items discussed included key performance indicators, the patient journey (inflow, throughput and egress), Winter Plan updates, integration with community services, ambulance turnaround times and vaccination updates. Minutes of the meetings were action focused and there was evidence of monitoring of progress.

In summary, while there was evidence of many of the elements of formalised governance arrangements being in place, there were also significant deficits in a number of key areas. These included the absence of an antimicrobial stewardship committee and programme, significant deficits in the overall provision of pharmacists (including an anti-microbial pharmacist) and consultant microbiologists, the ratio of locum posts to substantive posts among consultants in gynaecology), the over-reliance on locum consultant staff over prolonged periods of time and suboptimal attendance at some committee meetings (needs to be in line with terms of reference). HIQA found that more work is required on the governance arrangements to assure the delivery of high quality, safe and reliable healthcare.

Judgment: Partially compliant

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

Findings relating to the emergency department

The hospital's emergency department had an average of 140 patients presenting per 24-hour day (ranging from 86-188 attendances per day over the two months prior to inspection). This equated to a 10% approximately increase on 2019 (pre-pandemic) activity levels.

The draft Hospital and Community Integrated Winter Plan 2022/2023 dated September 2022 stated its aim as one of 'enhancing site specific services, improving the patient experience and facilitating flow throughout the system'. In particular, it identified where the hospital was underperforming year to date compared to national key performance indicators (KPIs) such as:

- the 24-hour patient experience time (PET) for the over 75 year olds (96.1% compared to HSE target of 99%),
- the 12th highest delayed transfer of care (DTOC) in the country averaging 14 per day (no HSE target),
- average trolley count at 8am (9.6 compared to HSE target of 8 or less) and
- percentage of compliance with national ambulance turnaround time of 30 minutes from time of arrival at the hospital to when the ambulance crew declare the readiness of the ambulance to accept another call (7.7% compared to HSE target of greater than 80%).

Among the initiatives identified in the plan, inspectors were told that approval had now been received for an additional four WTE[§§] consultants in emergency medicine bringing the approved complement to eight WTE.

Inspectors were informed of longstanding difficulties in accessing diagnostic tests such as computed tomography scans (CT), magnetic resonance imaging (MRI) and cardiac echo investigations for people who presented to the emergency department. There were protected slots for vascular and general ultrasounds for specific pathways of care however inspectors were informed that a CT scanner was not in use due to difficulties in staffing the unit. Inspectors were told that these delays were resulting in the admission of patients while waiting on access to such tests as inpatients. An external company had been contracted to provide some radiology service support out-of-hours.

On the first day of inspection, inspectors were told that the hospital' inpatient occupancy rate was over 100% and hospital management had enacted the full escalation protocol.[***] Planned procedures were being cancelled with input from a clinical decision maker as to which cases would still need to proceed. All consultants were contacted by bleep after the 9am hub to advise them of the bed status and to request timely discharges of patients ready to go home. Ward managers were asked to escalate any delay in access to diagnostic tests to both the hub and to the general manager's office so that this could be escalated for resolution. Thirteen escalation beds were opened by postponing some appointments and relocating ambulatory urology and infusion services to the day services unit and patients using the day services unit were cared for in the day surgery unit. In line with the HSE full capacity protocol, the hospital had transferred up to three patients on trolleys into full wards around the hospital to alleviate pressures within

[§§] WTE = whole time equivalent. This is based on the nationally approved contract for that discipline, for example, 1 WTE nurse, midwife, healthcare assistant =37.5 hours per week. 1 WTE administrative staff = 35 hours per week.

[***] Full capacity protocol is the final step in hospitals' escalation plans where extra beds are placed in inpatient wards and corridors of hospitals as a measure to address emergency department overcrowding. 'In level black' is the highest level of escalation within the protocol.

the emergency department. The discharge liaison co-ordinator was reviewing the 17 delayed discharges. The hospital had COVID-19, RSV[†††] and CPE[‡‡‡] outbreaks at the time of the inspection.

Inspectors were told that the Acute Medical Assessment Unit (AMAU) had not operated as an AMAU in recent months as it was being used instead as a pathway of care for patients with undifferentiated care needs who were either COVID-19 positive on presentation or who had respiratory and or other symptoms suggestive of COVID-19. This unit was referred to as the Respiratory Response Unit (RRU). Inspectors were told about a virtual AMAU run by the AMAU consultant and registrar for a selected group of patients based on specific criteria, Monday to Friday, 8.30am to 5pm. Due to short notice leave, this was not in place on the second day of inspection. Inspectors were told that when the facility was functioning as intended, between 30-40% of patients who presented to the emergency department were being seen in the AMAU. Inspectors were told that that approximately 50% of patients were admitted to the hospital from the RRU and between 30-40% from the emergency department (conversion rates) and that this reflected an older population who were geographically more isolated.

Inspectors noted that the clinical and operational governance arrangements in place to manage and oversee the performance and quality of unscheduled and emergency care at the hospital were not fully integrated. While nursing staff from the emergency department were used to staff the RRU and they reported to the clinical nurse manager 3 (CNM3) in the emergency department through their CNM2, inspectors found that the two pathways for undifferentiated emergency care were under separate medical teams with separate governance arrangements. Those in the non-COVID-19 pathway were under the care of the emergency medicine team while those with respiratory symptoms presenting for emergency care irrespective of other presenting complaints (undifferentiated care needs) were being assessed and managed under the medical team. Inspectors found that patients who were triaged and assessed in the COVID-19 pathway were not routinely reviewed by a member of the emergency medicine team and were not under the governance of the emergency medical team. This was not in line with national guidance.[§§§] The medical team present on duty in the RRU on the second day of inspection comprised one senior house officer from the medical team. This is discussed in greater detail under national standard 6.1. The split in oversight and governance of

[†††] Respiratory Synctial Virus (RSV): is a common contagious virus that usually causes mild, cold- like symptoms but can be serious in infants and older

[‡‡‡] Carbapenemase Producing Enterobacter ales (CPE) / [‡‡‡]Carbapenem Resistant Enterobacteriaceae (CRE) are a particular variant of gut bacteria that have become resistant to a critical group of antibiotics, the carbapenemens and are often also resistant to many other antibiotics. Detection of asymptomatic colonisation with CPE is of benefit to the wider community because it supports measures to control the spread of CPE in the acute hospital setting. A screening programme for CPE is offered on the basis that people are entitle to decline testing without prejudice to their access to care, HSE, HSPC (2019) requirement for screening for Carbapenemase Producing Enterobacterales.

[§§§] A Strategy to Improve Safety, Quality, Access and Value in Emergency Medicine in Ireland (2012). The National Emergency Medicine Programme. https://www.hse.ie/eng/about/who/cspd/ncps/emp/moc/

undifferentiated care and the medical cover on duty and present in the RRU was a concern to HIQA. This was raised with hospital management both on the day and following the inspection.

On the day of inspection, the emergency department appeared calm and organised and corridors were clear. Inspectors were told that it would usually be much busier in the department. This was supported by a review of published information derived from the HSE Special Delivery Unit (SDU) about numbers of patients on trolleys on a daily basis.

At 11.00am on the first day of inspection, there were 50 patients registered (on the hospital's electronic management system) across both the emergency department and the RRU. Of these, 24% had arrived via ambulance, 56% had been referred by their GP and 20% had self-referred. Sixteen of the 50 attendees were over 75 years of age (32%). Staff told inspectors that patients frequently reported difficulties in accessing a GP. The ambulance and hospital had instituted the 'Fit to Sit'[****] initiative in line with national guidance. Fourteen patients (28%) had been admitted and were on trolleys either in the emergency department or in the RRU waiting for a bed space at ward level. The minimum one metre physical spacing between trolleys (sides and end to end) was maintained. Delays in the patient journey from registration to triage, assessment and decision-making regarding admission and ultimate placement in a ward based bed or discharge home increases the risk to that patient and to others seeking to use the services. Such delays have the potential to hamper efforts to maintain a safe environment for both patients and staff. Hospital management had implemented measures to improve the issue of patient flow by placing up to three trolleys in a number of ward areas until such time as beds became available in line with the hospital's full capacity protocol. The practice of retaining admitted patients in the emergency department impacts on a service's ability to maintain, promote and protect the patients' dignity, privacy and confidentiality, and a human rights based approach to care.

Patients aged 16 years old or more were triaged and assigned to the relevant prioritisation category levels 1-5 in line with the Manchester Triage System.[††††] Staff could view the status of all patients in the department — their prioritisation category levels and waiting times — via the hospital's electronic patient management system. Those under the age of 16 were triaged using a paediatric triage system.

On the first day of HIQA's inspection:

- the waiting time from registration to triage ranged from 10 to 20 minutes, with an average wait time of 15 minutes
- the waiting time from triage to medical review ranged from five to 40 minutes, with an average wait time of 25 minutes

[****] Fit to Sit is the term assigned to an assessment by ambulance personnel of a patient's suitability to sit on a chair rather than require a stretcher.

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

- the waiting time from medical assessment to decision to decision to admit ranged from three to six hours with an average wait time of four hours
- the waiting time from decision to admit to admission to a bed on an inpatient ward ranged from one to seven hours in the emergency department and two to 34 hours in the RRU, averaging at four hours in the emergency department and 12 hours and 44 minutes in the RRU.

On the second day of inspection, inspectors re-visited the emergency department and found it to be overcrowded with people waiting on chairs placed on the side of the corridors. Some were provided with pillows and people were using these to prop against the wall to try to rest against them. Inspectors spoke with patients who reported long waiting times of up to 18 hours and poor conditions such as no access to a trolley, bed or designated space and having to request food and drinks.

Inspectors also visited the RRU and were told that due to leave, there was only one Senior House Officer (SHO)[‡‡‡‡] on duty and present in the RRU. The RRU had 100% occupancy with 11 patients present. The whiteboard on display had contact details for the Red team (SHO, Registrar and Consultant on Call) who could be called on for additional support. Inspectors were told that this team would ordinarily be doing their rounds at ward level. The level of available medical cover present in the RRU at the time providing assessment and treatment of patients with respiratory symptoms and possible undifferentiated care which was outside of the governance of the emergency medicine team was a concern to inspectors. This was brought to the attention of hospital management on the day and in a high risk letter to the hospital the day after the inspection.

Inspectors noted that there was a detailed Clinical Handover Policy in the hospital covering handover between various staff groups. Inspectors were told that it was not being universally implemented. This failure in implementation had been noted on the HSE performance minutes between the Saolta Hospital Group and the hospital management dated January 2022 and more recently in minutes of the HEB and Quality Patient Safety committee (QPS) in September and October 2022 where it was evident that a resolution had yet to be reached by the time of inspection. Inspectors raised this matter with the general manager during the inspection. The hospital needs to ensure that the policy on clinical handover is implemented without further delay and ensure that its use is regularly audited.

Examples of good practice observed by inspectors within the emergency department was the 'Team Roles' initiative. A series of colour coded sticky labels on rolls were located close to the PPE station where staff could apply the label signalling their discipline or grade, for example nurse, doctor, healthcare assistant, consultant. This is especially important in the scenario of resuscitation and where personnel are wearing full PPE. An education and training board listing a schedule of on-site teaching sessions was on display in the emergency department and a training session attended by members of the MDT was observed to be in progress on the first day of inspection. Audits and quality improvements plans (QIP) were also on display in the staff

[‡‡‡‡] The SHO grade is a non-consultant hospital doctor whose work is supervised by consultants and their registrars.

resource room in the emergency department. The Hospital Ambulance Liaison Person (HALP), a paramedic, was based in the emergency department daily. The role of this person was to assess calls from people who call an ambulance and to guide them on options that may be more appropriate to them than a visit to the emergency department. Staff had real-time visibility of incoming ambulance referrals via an electronic screen placed close to the central nurse's station. Inspectors were told that where two patients are transferred to hospital by ambulance at the same time, an assessment is undertaken to determine if they can be cohorted by one ambulance crew and if so, freeing up the second crew to be available for other calls.

Findings related the wider hospital and two inpatient clinical areas inspected

On the day of inspection, inspectors were satisfied that the available staffing on both inspected wards was in line with the ward rosters. Medical 2 had a full complement of nurses and healthcare assistants plus an extra healthcare assistant on duty on the day of inspection. One staff nurse was later deployed to another busier area. A review of the rostered versus actual staffing levels for this ward for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses had been met 90% of the time on day duty and 99% of the time on night duty. Full cover of healthcare assistants had been met 100% of the time on day duty and 95% of the time on night duty. The gynaecology ward had its full complement of staff on duty on the day of inspection (nurses and healthcare assistants). Review of the rostered versus actual staffing levels for the gynaecology ward for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses had only been met 77% of the time on day duty and 90% of the time on night duty. Full cover of healthcare assistants had been met 97% of the time on day duty and 100% of the time on night duty. Inspectors were told that the ward managers escalated staff shortages to the directorate ADON and out-of-hours to the on-site nurse manager. In such cases, the shortage may be covered by staff working additional shifts or by redeployment of staff from less busy areas. Ward staff meetings with the CNM2 were scheduled to take place every four weeks. These had been stopped during COVID-19 but had recommenced this year. Staff confirmed that they had direct access to the Employment Assistance Programme and occupational health services.

Workforce

The hospital was working in conjunction with the Saolta Hospital Group's overall HR policy on workforce planning and management. The hospital's approved whole-time equivalent (WTE) in 2022 was 2,085 WTE. This included 94 vacancies (4.5%). Most of the vacancies (n=35) were within nursing and midwifery. Only one of the sanctioned 2.5 WTE consultant microbiologist posts was filled. Inspectors were told that efforts to fill the remaining 1.5 WTE posts were unsuccessful to date. Inspectors were told that the recent approval of four additional consultants in emergency medicine will require significant recruitment efforts to fill those vacancies in a timely manner. Inspectors noted that one of the four existing consultant posts in emergency medicine and three of the four consultant posts in obstetrics and gynaecology were filled on a locum basis at the time of inspection, partly due to recent or impending retirements.

Inspectors were told that there was 74 consultants in post at the hospital and that eight of these were not on the Specialist Register of the Irish Medical Council. The hospital confirmed

that it has arrangements in place by their respective Associate Clinical Directors in line with national guidance for support, oversight and supervision of consultants not yet on the register. The consultants were operationally accountable and reported to the General Manager.

Inspectors were told that the number of pharmacists in post had increased from 21.05 WTE to 32.02 WTE in the last three years but that there were still six WTE senior grade pharmacists (requiring three years' experience in line with national guidance) and three WTE basic grade pharmacists posts to be filled. This reflected a 28% shortfall in the 32 WTE approved and funded posts. Inspectors were told of the difficulties in recruiting pharmacists and in particular the senior grade pharmacists who are required to have at least three years' experience although more interviews were planned to take place by January 2023. This situation mirrored findings from other hospitals inspected by HIQA. At the time of the inspection, there was no replacement in place for the hospital's antimicrobial pharmacist who was on leave. The hospital had 20 WTE pharmacy technicians in post.

Staffing levels and absenteeism rates were tracked and trended by the department and reviewed and reported at HEB meetings and at monthly performance meetings with the Saolta Hospital Group. The absenteeism rate prior to the inspection was noted to be 8.6 % overall including absences (1.8%) associated with COVID-19. The overall absence rate had fallen from a high of 13.6% in January 2022. The national target for absenteeism is 4% or less.

Induction programmes were in place for new staff starting every six months and since COVID-19, these were mostly provided online.

Inspectors were told that overall, staffing levels had improved recently although more was needed to be done to ensure all vacancies were filled. The hospital had access to an occupational health service and an employee assistance programme. There was a health promotion officer in post.

Staff training

HIQA noted that staff training had been listed on the hospital's risk register. There was notable deficits in the compliance by hospital staff (all relevant disciplines and grades) with attendance at staff training according to the hospital's training records. Attendance at hand hygiene training or completion of the HSELand online training for all staff was up from 65% at the beginning of the year to 81% by the time of inspection. There was room for further improvement noted among consultant and administrative staff. In particular, while the hospital demonstrated good overall compliance with up to date training in the use of the Irish Maternity Early Warning System (IMEWS) and the Paediatric Early Warning System (PEWS) at 100% by midwives, nurses and healthcare assistants, figures for these systems were 10.5 % and 0% for medical staff respectively. Mandatory training in the Irish National Early Warning System2 (INEWS2) also needs to be improved across all staff groups as it averaged 45.6% across all staff groups (HSE target 85%). There was low compliance across all relevant staff groupings with an average attendance level of 16.2% at up-to-date training in standard based and transmission based precautions, 42% in basic life support, 48.5% in medication safety (medication safety training data for nurses and midwives only), less than one per cent with training on the national

clinical handover guidance and three per cent in complaints training. The hospital needs to address these deficits and ensure that its staff maintain up-to-date mandatory training in line with national guidance.

Quality and Patient Safety (QPS)

Risk and incident management was integrated within the Directorate structures and Directorate meetings. The QPS committee had responsibility and oversight of the hospital risk register. The hospital register listed department risks related to overall capacity, infrastructural deficits, lack of isolation rooms, replacement of old equipment, waiting lists, access to diagnostics, staffing (pharmacy, consultants, administration, sexual assault trauma unit staffing, lack of QPS support for the Women and Children's MCAN), lack of electronic tracking of healthcare records, lack of dedicated combined HDU, fire safety issues, staff training and education, operating theatre capacity for back to back emergencies, delayed discharges, staff care, and data protection.

The hospital had developed quality improvement plans to respond to the findings of the National Inpatient Experience Survey 2021 and many of these were ongoing at the time of the inspection. Actions included the development of care pathways in the emergency department to help improve patient experience times, the availability of comfort packs (toothbrush, socks, t-shirts and aids for sleeping to improve the dignity of patients) and the use of a designated nurses to care for admitted patients in the emergency department awaiting transfer to a ward bed. Other more general actions included the introduction of the Model ward (discussed under national standard 3.1), protected mealtimes, colour coded catering trays to discretely indicate which patients required assistance at mealtimes, commencement of a patient survey and use of suggestion / comment card boxes (due to commence in December 2022), recruitment of a Patient Advice and Liaison Officer (PALS) who commenced in September 2022 and second PALS officer to be recruited, training in communication (incorporated into the MAGNET[§§§§] project-due to commence in February 2023), increased use of interpreters and sign language, use of patient information leaflets, executive walkabout to commence in January 2023, and facilitation of compassionate visiting including during times of restricted visiting.

Review of the 2022 National Inpatient Experience Survey showed that 84% of the respondents said they had a good or very good overall experience, compared to 82% nationally. 'Admissions' and 'care' on the ward were the highest rated stages of care. The hospital scored above the national average for questions on admissions. 'Discharge or transfer' was the lowest rated stage of care. Rating for all stages of care were about the same in 2022 as in 2021. Positive elements of experience included cleanliness of room or ward, quality of food, and privacy when being examined or treated. Areas for improvement included clear answers from a doctor, time to discuss care and treatment with a doctor, and a clear explanation of a diagnosis.

[§§§§] The MAGNET Project at Letterkenny University Hospital is a part of a wider Magnet4 Europe interventional study in which several Irish hospitals are participating. Its' stated aim is 'to improve the mental health and wellbeing of staff, creating an empowered and engaged workforce leading to improved patient outcomes'

Infection prevention and control (IPC)

The hospital had declared 32 outbreaks of COVID-19 among other less frequent infection outbreaks during the period January to November 2022. All but three of the 32 had been closed off by the first week in November 2022. Inspectors viewed a sample of outbreak reports completed at the end of each outbreak. At the time of inspection, the hospital was dealing with COVID-19, Carbapenemase Producing *Enterobacterales* (CPE) and Respiratory Synctial Virus (RSV) outbreaks of infection. Although the hospital had opted to offer targeted CPE screening in line with national guidance, as opposed to universal screening, the uptake of targeted screening within 24 hours of admission was 51% up to the end of Q3, 2022. The hospital had sought to increase this by holding a CPE awareness day in June 2022, specific in-service training sessions, circulation of a CPE checklist, and daily reminders to the wards regarding CPE screening and regular audits. The nursing documentation included a specific 'Prevention and Control of Infection' page which incorporated prompts for screening for Carbapenem Resistant Enterobacteriaceae (CRE). Inspectors were told that uptake of the screening test among the targeted population was high in some wards and not in others. Inspectors found that there was a lack of awareness among staff spoken with in the clinical areas as to the criteria of patient that ought to be offered CPE screening. This was discussed with hospital management at the time of inspection and afterwards in a high risk letter issued to the hospital. In response, HIQA was informed that the hospital will continue to monitor compliance levels across the hospital and that if there was not an improvement to a satisfactory level of compliance within a defined period of time, the hospital may consider alternative approaches.

Inspectors viewed and were satisfied with a range of IPC policies, procedures and guidelines in use including the HSE policy document on prioritisation of patients for single room isolation in the event of competing demands for these facilities. IPC risks and incidents were tracked and trended at the hospital. The IPC committee were consulted if there were specific hospital complaints relating to IPC.

Inspectors were satisfied with evidence of audit in IPC across the hospital. Hand hygiene audits were being carried out monthly year to date with some exceptions during the summer months. Results for compliance with standards for hand hygiene in the clinical areas ranged from 87% to 100% (HSE target: greater than 90%). Monthly audits were also being conducted at ward level around compliance with care bundles for urinary catheters, intravenous lines and ventilators (in ICU). Inspectors were informed of and viewed a draft transfer documentation sheet which was proposed for approval at the upcoming HIPCC meeting. It was based on an updated version of the information retained on the hospital's electronic management system and was to be used to formally communicate the infection status of people transferring to residential care. Inspectors noted on random audit of charts that this was an area for improvement at the hospital.

Inspectors were satisfied that the hospital had self-assessed and rated their overall performance against national standards for infection prevention and control and had outlined actions to be taken to address deficits. It also measured its progress in compliance with standards over the last two years. This showed some improvement in a small number of areas but most of the

areas listed as partially or non-compliant in 2021 remained the same in 2022. The hospital should consider how it can best address these non-compliances in a timely manner.

HIQA inspectors were told that the volume of work including the maintenance of databases is proving difficult for existing staff within the IPC team and that a business case was submitted to the Saolta hospital group to seek administrative support. At the time of inspection, approval had not been sanctioned. HIQA had previously conducted an infection prevention and control inspection at Letterkenny University Hospital in October 2020. Among its findings, it reported insufficient IPC resources and limited progress with an antimicrobial stewardship programme. These issues had yet to be resolved at the time of this most recent inspection. The hospital should review the management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Medication Safety

The hospital had management arrangements in place to support the delivery of medication safety however inspectors were told that significant deficits in the available pharmacy resources compared to the approved and funded posts were impacting on the provision of a comprehensive pharmacy service. Inspectors were told that there was a focus on prioritising medicine reconciliation on admission on medical wards including renal, stroke and paediatrics however, there was no assigned clinical pharmacist for the perioperative department which included ICU and critical care, operating theatres and surgical wards. The hospital had no replacement cover for the antimicrobial pharmacist on leave. It was noted that the staffing issue has been escalated to hospital management and has been recorded on the hospitals' risk register. Further work is required to strengthen the hospital's ability to ensure medication safety throughout the hospital.

There was evidence of risk reduction strategies in place at the hospital such as the use of automated medication dispensing systems, a high risk medicine list with reduction strategies, APINCH[*****] lists and SALAD[†††††] lists. The HSE leaflets '*Know, Check, Ask'*[‡‡‡‡‡] were noted to be on display in the emergency department. The hospital did not have a formulary and inspectors were told that the pharmacy controls new additions to stock as approved through the Drugs and Therapeutics Committee. In relation to alerts, recalls and recommendations from the Health Products Regulatory Authority (HPRA), these were received by both the chief pharmacist and the general manager who then disseminated them to the wards. Medication safety risks and incidents were tracked and trended. Risks were also escalated to Saolta hospital group level where indicated. Incidents are reported directly onto the National Incident Management System (NIMS).

The Deteriorating Patient

[*****] APINCH list: acronym for high risk medicines including **a**nti-infective agents, anti-psychotics, **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy, **h**eparin and other anticoagulants
[†††††] SALAD list: **S**ounds **A**like, **L**ooks **A**like **D**rugs
[‡‡‡‡‡] The 'Know, Check, Ask' is a campaign led by the HSE, aimed at encouraging health care professionals to discuss medication and empowering people to become more informed about their medication and its use.

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. There was an Early Warning System (EWS) and Deteriorating Patient Committee (DPC) in place. The hospital had implemented the following early warning systems, INEWS, IMEWS, PEWS and EMEWS in place. The HSE Adult Sepsis Form was in use at the hospital. The escalation protocols were in line with national guidance. There were posters on display in the medical ward relating to the INEWS version 2. There were assigned nurse leads for each of the early warning systems. Inspectors noted evidence of monitoring compliance with the use of warning systems and corrective actions being taken. Risks and incidents associated with the deteriorating patient were tracked and trended. The QPS department provided feedback on incidents to the DPC for discussion. Feedback and learning on DPC matters was shared at daily safety huddle meetings. Inspectors were told and they noted in QPS minutes that the digital INEWS had been introduced on one ward which has been visited by the national team with responsibility for this digital system. The system is used to record the observation findings and calculate the early warning score. Inspectors found gaps in compliance with the use of the early warning systems and escalation protocol from a random chart review. Inspectors noted that this continues to be an area requiring significant improvement by the hospital.

At the time of inspection, inspectors were told that a reconfiguration of critical care beds had taken place during the pandemic. The four-bedded high dependency unit (HDU) was relocated to a room (previously a six-bedded inpatient ward) adjacent to ICU B. ICU A had had four beds plus one isolation room and ICU B had 3 beds. Inspectors heard and noted documentation relating to concerns for patient care where patients requiring a higher level of surveillance would be best cared for in a high dependency unit setting where there would also be a higher staff to patient ratio. The hospital subsequently developed a standard operating procedure to guide staff on prioritisation of use of critical care beds in the event of competing demands. The hospital should seek to ensure that there sufficient capacity in an appropriate designated area, staffed and equipped to provide safe quality care to the category of patients requiring high dependency care.

Transitions of Care

The hospital had management arrangements in place to support internal and external transitions of care. The average length of stay (AvLOS) for both medical and surgical patients at the hospital year to date was 4.7 days compared to 5.4 days in 2021. The AvLOS for medical patients was 7.2 days (slightly above the HSE national target of 7 days) and AvLOS for surgical patients was 3.6 days (within the HSE national target of 5.2 days).

On the day of inspection, inspectors were told that 17 people were discharged and ready to go but could not go that day for various reasons. Inspectors noted that the daily average of delayed transfers of care is 14. To manage this situation, the discharge co-ordinators liaise with internal hospital staff and community services at several points during the day to plan for expected discharges and assist in resolving complex discharges.

Hospital staff spoke about the recent introduction of the 'Model ward', an initiative being rolled out across the Saolta hospital group including the medical wards at Letterkenny University

Hospital to date. It includes the routine planning of a predicted discharge date (PDD) at the time of admission which provides a focus on discharge to enable provision of timely care as required and helps avoid prolonged hospital stay unless necessary.

In relation to discharge home or transfer to residential care, inspectors were told that the hospital provides discharge letters to all patients discharged home to give to their GPs and that for people transferring to residential care, a discharge letter is provided plus an additional nurse transfer sheet is completed and sent with the person's prescription sheet to the nursing home in advance of the transfer.

Inspectors viewed a range of policies, procedures and guidelines developed to support patient flow at the hospital. These included guidance for integrated discharge rounds, safety flow huddles, a system wide framework and escalation procedure, and an admission, discharge, transfer and escalation policy. A standard operating procedure relating to the use of predicted discharge dates based on the nine steps for effective discharge planning and transfer from hospital as set out in the HSE Integrated Care Guidance document (2014), was in draft form and was due for review in December 2022. The nursing documentation included a specific Discharge Planning Risk Assessment page which incorporated a predicted date of discharge.

The discharge co-ordinator liaised with the wider multidisciplinary team (occupational therapist, physiotherapists, public health nurse liaison, and homecare coordinators) in relation to supporting people who have complex discharge needs.

Communication

Inspectors were told that communication boards, diaries and social media messaging groups including an internal hospital electronic communication tool are used widely. Inspectors noted that the most recent staff meeting in one of the inspected areas was held in May 2022. Inspectors noted that although there was a lot of activity and change going on, and while it may have been recorded in directorate and other hospital meetings, staff were not always aware of proposed or actual changes relating to the hospital. The hospital should ensure that there is effective two-way communication between hospital management and staff.

Conclusion

In summary, while inspectors noted the engagement with community services, additional posts, meeting and exceeding some HSE targets for KPIs, inspectors were not assured by the level of overcrowding, difficulties in access to diagnostic tests, increased patient experience times (reported by patients) and the lack of effective patient flow (witnessed on the second day of inspection). These conditions and experiences undermine patient dignity and respect notwithstanding the efforts of staff to mitigate against this. Inspectors were concerned to note that the clinical handover policy has yet to be implemented by all staff groups caring for patients. HIQA was concerned with the governance and staffing of the RRU which, although under the medical directorate, provided undifferentiated care for patients presenting with respiratory symptoms and with other possible complaints. The level of cover of medical staffing of the RRU as found on the second day of inspection and that which was rostered for the unit out of hours was a concern. This was raised with hospital management on the day and after the

inspection by issuing of a high risk letter to the hospital and the Saolta Hospital Group. In relation to the inspected wards and wider hospital, inspectors noted and were told of several initiatives taking place to help improve the delivery of high quality, safe and reliable healthcare services. These included good evidence of audit of IPC issues, addressing issues raised in the National Inpatient Experience Survey 2021, the commencement of the Model ward and the participation in the MAGNET project. HIQA, however, was concerned to note that ongoing issues in staffing in pharmacy and IPC have yet to be resolved. CPE screening was not being offered in line with national guidance for the targeted population. Inspectors found evidence of gaps in compliance with the use of the early warning systems and escalation protocol from review of a random selection of charts. These were also noted to be factors identified in relation to review of serious incidents. Overall, several of the deficits outlined either on their own or collectively represent a significant risk to people using the service and need to be addressed to bring the hospital into compliance with this standard.

Judgment: Non-compliant

Inspection findings relating to the Emergency Department

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

For a service to achieve high quality, safe and reliable healthcare it needs to have sufficient staff with the required skill-mix and competencies to respond to the needs of the population it serves. Inspectors were informed that the hospital was not an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine which was barrier to recruit and retain staff.

At the time of inspection, the emergency department at Letterkenny University Hospital had:

- 8 WTE approved posts for consultants in emergency medicine (four WTE posts had been approved in the weeks prior to inspection and the recruitment process had yet to commence). Of the remaining four WTE posts (which were being covered by five consultants), three WTE were filled on a permanent basis and one WTE was filled on a locum basis. A fifth locum consultant was in place covering leave of one of the permanent consultants. Some of the consultants were on the Specialist register of the Irish Medical Council, this was discussed under national standard 5.2. A senior clinical decision-maker[§§§§§] at consultant level was on-site in the hospital's emergency department each day.

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

- 10 WTE approved posts for registrars for emergency medicine (One WTE post had been approved in recent weeks). Of the remaining nine WTE, all were filled.
- 9 WTE approved posts for senior house officers for emergency medicine. Ten WTE were in post.

Inspectors were told that there was one consultant for emergency medicine on duty from 8am to 6pm per day and one on-call outside of those hours. There were two to three registrars and one to two SHOs on duty during the day and a minimum of one of each on duty at night and out-of-hours in the emergency department.

The RRU provided undifferentiated emergency care for patients who presented with respiratory symptoms and those who presented for other reasons but who also had respiratory symptoms. The RRU was staffed by staff from the medical directorate separate to emergency department medical staffing. It was staffed as follows:

- It was led by one WTE AMAU consultant physician, Monday to Friday during core hours.
- There was also one registrar and one SHO rostered on duty in the RRU seven days a week for the RRU from 9am to 9.30pm hours with on-call support from the Medical registrar and SHO assigned to ward duties.
- Out-of-hours, the RRU and medical wards throughout the hospital were staffed by one registrar and SHO from 9.30pm to 9am with on-call support from the Consultant Physician.

Inspectors found that while staffing levels in the main emergency department were maintained at planned levels, staffing levels for medical staff in the RRU were not being maintained at a level to support the provision of 24/7 undifferentiated emergency care of patients with respiratory symptoms. On the second day of the inspection, inspectors found that this unit was at full occupancy and was staffed by a Senior House Officer (SHO) where the consultant and registrar were on short-notice leave. The staffing levels and the clinical governance of this unit was a concern to HIQA which was raised with the management team at the hospital and also communicated in a high risk letter issued to the hospital the day after the inspection.

Hospital management advised that the approved nursing staff complement for the emergency department was 59 WTE. Inspectors were told that recruitment was ongoing to fill the nurse complement exclusive of the CNM3, specialist and advanced posts to bring it to 68 WTE to reflect the outputs of the Safe Staffing Framework (DOH 2022)[******]. The RRU was staffed from the emergency department complement of staff unlike the medical staffing of the RRU.

The approved nursing complement for the emergency department (and in post) by the end of October 2022 included:

[******] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

- 1 WTE ADON
- 1 WTE CNM3
- 10.02 WTE CNM2
- 5.37 WTE CNM1
- 1.81 WTE Advanced Nurse Practitioners (ANP)
- 1 WTE Clinical Nurse Specialist (CNS)
- 49 WTE Nurses
- 10.67 Healthcare Assistants (HCA).

Rostering was planned to provide a core nursing staff complement of 10 nurses including a CNM2 for the emergency department and a CNM1 for the RRU throughout the 24 hour cycle. These postholders rotated their placement in the RRU on alternate days. There was also one healthcare assistant on duty 24/7. The staffing levels were rostered to increase to 13 nurses from mid-morning to 2am seven days a week. The twilight[††††††] shift was covered by the use of bank or agency staff. On the day of inspection, the actual nursing staff complement in the emergency department was one nurse short of the rostered number of 10 nurses on the day shift.

In addition to this complement of nurse staffing on duty during the inspection, there was one WTE CNM3 on-duty for core hours Monday-Friday and 1.73 WTE Advanced Nurse Practitioners covering the minor injuries area for 5-6 days per week.

Review of the rostered versus actual staffing levels for emergency department for the four weeks prior to the week of the inspection demonstrated that full cover of rostered nurses and healthcare assistants was not always achieved and that overall there was an average of a 9% shortfall in nurses during the day and 1% at night. There was an average shortfall of 12% of HCAs on day duty and 23% on night duty over the month. Inspectors were told that although there had been a recent uplift of 20 WTE of nurses in the approved WTE for nursing in the emergency department that recruitment was ongoing and that staff also continue to leave to travel and or pursue career progression.

An ADON had overall nursing responsibility for the emergency department, ambulatory care and cancer services. There was a ward clerk on duty in the emergency department 8am to 2am Monday to Thursday and 8am to 8pm Friday to Sunday. Staff in the department had access to an infection prevention and control nurse who visited the department a few times per week and was accessible via a bleep at other times. There was a pharmacy technician who reviewed the medication stock control daily (Monday to Friday) and a clinical pharmacist who prioritised medicine reconciliation where there was polypharmacy. The hospital had no replacement for the antimicrobial pharmacist who was on leave.

[††††††] Twilight shift is a term used in nursing to described a shift worked between 18.00-20.00hrs.

Attendees to the emergency department were assigned to the emergency medicine consultant-on-call until admitted. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

Uptake of mandatory and essential staff training

HIQA found that the percentage of staff attendance and uptake at mandatory and essential training needs to be improved by all staff grades particularly in the use of INEWS and EMEWS, basic life support and infection prevention and control practices. The data for hospital staff as a whole are presented under national standard 5.2 of this report.

In summary, while nursing staff levels on the day of inspection were largely aligned to the planned roster, review of the rosters over the month prior to inspection indicate that there had been ongoing deficits as outlined above on the day of inspection. The hospital need to address this ongoing deficit and particularly in the context of a chronically overcrowded department. It is acknowledged that improvements had taken place and are taking place both in relation to nursing and to emergency medical staffing at consultant and registrar levels despite ongoing turnover of staff. The hospital should ensure that all consultant staff are or are working towards accreditation on the specialist register with the Irish Medical Council. Finally, the staffing levels and the clinical governance in the RRR unit was a particular concern to HIQA. This was raised with the management team at the hospital on inspection and issued a high risk letter to the hospital the day after inspection which was later escalated to the Saolta hospital group CEO. Subsequent assurances were received in relation to reconfiguration plans for the service but this needs to implemented by hospital management.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings from the emergency department related to the quality and safety dimension are presented under national standards 1.6 and 3.1 from the themes of person-centred care and safe care respectively.

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[‡‡‡‡‡‡] Person-centred care and support

[‡‡‡‡‡‡] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs. The environment in which care is delivered should also promote and protect the patient's dignity and privacy, and protect the personal information of people who use the service.

At 11am on the first day of inspection, there were 50 patients in the department across the emergency department and the RRU. This exceeded the planned capacity of 23 (12 in the emergency department and 11 in the RRU). Fourteen patients in the emergency department and or RRU were admitted and were boarding in one or either area while awaiting an inpatient bed. Inspectors noted that patients were accommodated in cubicles cordoned off by curtains or in single rooms. The confidentiality, dignity and respect of patients was promoted and protected.

On the second day of inspection, when inspectors revisited the emergency department, they found it to be very overcrowded with patients who had been in the department for up to 18 hours, seated on chairs or wheelchairs placed along the corridor. The boarding of admitted patients in the department directly contributed to crowding of the department and the privacy and dignity could not be protected in the same way for these patients. Maintenance of confidentiality was a challenge. Inspectors observed clinical consultations and the exchange of information being undertaken on the corridor. People (patients, visitors and staff) using the corridor could overhear patient-clinician conversations and personal information being exchanged between patients, medical and nursing staff. This was not in line with the human rights-based approach to healthcare as promoted and supported by HIQA.

Hospital management had developed a quality improvement plan to address findings of the previous year's National Inpatient Experience Survey (2021) relevant to the emergency department and had included initiatives which were continuing throughout 2022 and into 2023. These were outlined under national standard 5.5. There was evidence that the hospital was engaging with community services to implement measures to support and improve patient flow in the emergency department.

It was clear from speaking with and observing staff working in the hospital's emergency department that they were committed and dedicated to promoting person-centred care. Staff were observed to be kind and caring towards patients in the department, and tried to respond to their individual needs, which was challenging in an overcrowded department.

In summary, inspectors were satisfied with evidence on the first day of inspection that patients' dignity, privacy and autonomy were respected and promoted, however this was in contrast to findings on the second day on inspection together with feedback from patients using the service where the emergency department environment posed a risk to the quality of healthcare provided and to the health and welfare of patients. Notwithstanding the initiatives implemented and the findings as noted on the first day of inspection, the practice of boarding admitted patients in the emergency department contributed to overcrowding of the department. In such a setting, it was impossible to maintain, promote and protect patients' dignity, privacy and

confidentiality, which impacted on the meaningful promotion of the patient's human rights especially those accommodated in trolleys on corridors.

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.

To protect people who use the service from the risk of harm associated with the design and delivery of healthcare, services must proactively monitor, analyse and respond to information relevant to the provision of care.

Letterkenny University Hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times. Collated performance data and compliance with relevant national key performance indicators was reviewed at meetings of the hospital's executive board and performance meetings with the Saolta University Health Care Group.

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at department level with oversight of the process assigned to the clinical nurse manager grade three (CNM3). Risks related to the emergency department were recorded on the hospital's corporate risk register. The HEB had oversight of the risks recorded on this register. The effectiveness of actions and controls implemented to manage and mitigate risks were reviewed and updated at monthly meetings of the QPS Committee and the HEB. Risks not manageable at hospital level were escalated to the Saolta University Health Care Group. Staff outlined examples of the reporting processes followed in the identification of risk.

Performance data on the patient experience time collected on the first day of HIQA's inspection showed that for patients in the emergency department at 11am (data from the RRU was not supplied):

- Ten of the 38 (26%) attendees to the emergency department were in the department for more than six hours after registration. This was within the national target, which requires that at least 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- Ten of the 38 (26%) attendees to the emergency department were in the department for more than nine hours after registration. This was not in line with the national target,

which requires that 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.

- On the first day of inspection, the hospital was in line with the HSE national target of ensuring that at least 97% of attendees are admitted to a hospital bed or discharged within 24 hours of registration.
- Five attendees to the emergency department aged 75 years or over remained within the emergency department nine hours after registration, which was not in line with the national target of 99% of 75 year olds and over being admitted, discharged or transferred within 9 hours of first registration.
- One attendee to the emergency department aged 75 years or over remained within the emergency department 24 hours or more following registration.

Inspectors were told that the number of patients in the emergency department was usually higher that what it was when inspectors visited the department on the first day of inspection. This was consistent with a review of Trolleygar, the published data by the HSE on numbers of admitted patients waiting on trolleys for a bed.

The hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In 2021, 92.3% of the ambulances who attended the emergency department did not meet the turnaround time interval of less than 30 minutes. This partially demonstrates how insufficient capacity and or ineffective patient flow in the department affects the timely offload and review of patients in the emergency department.

Inspectors were told of specific improvements in patient-centred care. These included the recent appointment of a Patient Advocacy and Liaison person, the procurement of additional pressure relieving mattresses, development of specific care pathways (chest pain, upper gastro-intestinal including Glasgow coma scale, cellulitis, deep vein thrombosis (DVT) pathway (Monday to Friday) among others to help towards admission avoidance.

Inspectors viewed an internal audit report on 'Compliance with the Risk Management Policy' provided by the HSE Internal Audit Department and dated 10 October 2022. It concluded that its 'audit findings indicate that the level of assurance that may be provided to management about the adequacy and effectiveness of governance, risk management and internal control system in the area reviewed is limited'. The auditor made seven recommendations around revision and maintenance of hospital and department risk registers.

Infection Prevention and Control

A COVID-19 management pathway was in operation in the emergency department via the RRU. Inspectors found that patients presenting to the emergency department were streamed for COVID-19 on arrival at the hospital with one exception, where there was no staff member at the desk when inspectors entered the building on the first day of inspection. A staff member was at the desk at all other times when observed by inspectors over the two day inspection. Staff

confirmed that terminal cleaning§§§§§§ of the triage room was carried out following suspected or confirmed cases of COVID-19. Minimum physical spacing of one metre, in line with national guidance was not being maintained in the waiting area. It was also not maintained in the main emergency department during the second day of inspection when there was significant overcrowding of patients being cared for on the corridor.

Staff reported having access to the IPC Link Clinical Nurse Specialist. There was evidence of regular hand hygiene audits being conducted and results on display. Eighty-one per cent of staff had up-to date training in hand hygiene. As previously stated, the hospital did not have an antimicrobial stewardship (AMS) committee or programme in place.

Medication safety

At the time of inspection, inspectors were told that medicine reconciliation by a pharmacist was not routinely undertaken on all patients in the emergency department due to pharmacy staff shortages but that the pharmacist reviews the medication of patients who have been prescribed multiple medications (polypharmacy) and those who had been in the emergency department overnight or who were prescribed time critical medicines. There was evidence of a range of audit activity by pharmacy staff over the last 12 months for example the pharmacist had undertaken an audit of omitted medicines in the emergency department and had developed a quality improvement plan to respond to its findings including a plan to re-audit. Individualised patient medication transfer packs to assist in continuity of medicine administration when a patient was transferred to a ward were provided by pharmacy. A pharmacy technician reviewed and topped up stock levels in the emergency department (Monday to Friday). Monographs for intravenous medicines, SALAD and high risk medicine lists plus 'medication safety minutes' were on display in the clinical room. There was no replacement cover for the hospital anti-microbial pharmacist.

Deteriorating patient

The hospital had implemented the national early warning system to support the recognition and response to a deteriorating patient in the emergency department. The INEWS, IMEWS, PEWS and EMEWS were in use at the hospital and the escalation protocol was in line with national guidance. The paediatric triage system was used for paediatric patients, aged less than 16 years. The Identify, Situation, Background, Assessment, Recommendation (ISBAR)******* communication tool was used when requesting reviews of patients. Stickers were in use in patient charts to formally record escalation of care. Inspectors were told of the risk of delay in communicating critical results from the laboratory to the medical team caring for patients. This was escalated as a risk and was documented in QPS and HEB meeting minutes. At the time of inspection it had yet to be formally resolved. A further issue that had been discussed at DPC

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

******* Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

level was the delay in accessing input from other specialities for patients in the emergency department. Inspectors were told that in the event of a delay, nurses escalate the delay to the ADON/ out of hours nurse manager who then contacts the relevant team.

Transitions of care

Inspectors were told that emergency department consultants conducted rounds from 6am daily and an operational report was then sent by the CNM3 to the general manager, DON and the Saolta Hospital Group by email. A nursing handover took place twice a day at 8am and 8pm in line with national guidance. The ISBAR communication tool was used for internal and external patient transfers. The hospital had a clinical handover policy although there were documented discussions in Saolta Performance, HEB and QPS minutes in relation to it not being in use by medical teams in the transition of care from one specialty to another. This was ongoing at the time of inspection and should be addressed as a matter of priority. Safety huddles were conducted at 8.30am and 3pm daily with consultants. Consultant ward rounds were conducted at 8:35am and 4pm. A hub was held with the general manager, DON, bed manager, consultant in emergency medicine and CNM2 at 2pm daily (Monday to Friday).

Overall, based on the composite of evidence relating to inspection findings over two days in the emergency department and RRU, inspectors found that while a lot of work and effort is underway to protect service users from harm, inspectors were concerned with a range of risks not yet fully controlled. These included overcrowding associated with delays in assessment and treatment of patients and the risk of cross-infection. Medicine reconciliation had to be prioritised to patients on multiple medications due to staffing constraints. There were ongoing documented risks of delay in communicating time critical laboratory results and concerns relating to non-compliance with the clinical handover policy both of which remained unresolved at the time of inspection. The risk for patients of being placed in the RRU when their presenting condition(s) warranted care and oversight from emergency medicine personnel was a concern to HIQA. Hospital management need to ensure early and sustainable improvements in these areas to protect service users from harm particularly in the context of learning from previous serious incidents.

Judgment: Non-compliant

The findings from the inspected areas and wider hospital

Capacity and Capability Dimension

Inspection findings from the wider hospital and clinical areas visited and related to the capacity and capability dimension, are presented under national standard 5.8 from the theme of leadership, governance and management, and workforce.

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

The hospital had monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. At the time of inspection, Letterkenny University Hospital had systematic monitoring arrangements to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided.

Monitoring of Service 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 each month for the HSE's hospital patient safety indicator report. Collated performance data relating to finance, workforce, quality and safety and access to scheduled and unscheduled care was reviewed at meetings of the hospital executive board and meetings between the hospital and the Saolta hospital group.

The complaints process was being developed in line with national guidance. This is discussed further under national standard 1.8. Learning from complaints was shared via the QPS, directorate, line manager structures and daily safety huddles.

Risk Management

There was evidence that the hospital was developing formalised risk management structures and hospital wide processes in line with national guidance following review by the HSE internal audit department. Risks were currently tracked and trended in the hospital's risk register which was maintained and reviewed at QPS level and used to inform the HEB and the directorate structures. Work was in progress to establish department based risk registers which would be owned and managed at local level and would be used to feed into the overall hospital risk register. High-rated risks not managed at hospital level were escalated to the Saolta Hospital Group. Management of risks related to the four areas of known harm is discussed further under national standard 3.1.

Audit Activity

The hospital had a clinical audit governance committee in place and a clinical audit facilitator who had oversight of clinical audit activity and provided support for audit and or the implementation of quality improvement plans arising from audit findings across the hospital. Inspectors viewed a series of audits conducted as they related to the four areas of focus of this inspection and found evidence that audit was being used to bring about improvements in those areas.

Management of Serious Reportable Events and Patient Safety Incidents

The hospital's QPS team were responsible for ensuring that all serious reportable events were managed in line with national guidance and serious incidents were managed in line with the National Incident Management Framework (2020). Serious reportable events and serious incidents were reviewed, tracked and trended by the quality and patient safety department each month. The hospital executive board had governance and oversight of all serious reportable events and serious incidents that occurred at the hospital. Notwithstanding this, HIQA was concerned with the level of input from key personnel such as consultants from the relevant speciality based on review of a selection of anonymised completed preliminary assessment reviews (PARs) prepared and submitted to the Serious Incident Management Team (SIMT) and supplied to HIQA on request at the end of the inspection. HIQA was concerned with the potential for delay in implementing the learning and recommendations from previous serious reportable events and serious incidents.

Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System (NIMS),[†††††††] in line with the HSE's Incident Management Framework. The hospital executive board and the QPS committee had governance and oversight of reported patient-safety incidents. Patient-safety incidents were also discussed at performance meetings with the Saolta Hospital Group. Patient-safety incidents related to the four areas of known harm are discussed further in national standard 3.3.

The hospital began direct reporting of clinical incidents to NIMS in November 2022.

Feedback from People Using the Service

Findings from National Inpatient Experience Surveys were reviewed at meetings of the Quality and Patient Safety Committee and updates were provided to the hospital executive board. The hospital was working to implement quality improvement initiatives, in response to the National Inpatient Experience Survey findings (2021). The quality improvement plans focused on:

- development of care pathways in the emergency department to help improve patient experience times
- provision of comfort packs (toothbrush, socks, t-shirts and aids for sleeping to improve the dignity of patients)
- designated nurses to care for admitted patients in the emergency department awaiting transfer to a ward bed

[†††††††] 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).

- introduction of the Model ward, protected mealtimes, colour coded catering trays to discretely indicate which patients required assistance at mealtimes,
- commencement of a patient survey and use of suggestion/ comment card boxes (due to commence in December 2022),
- recruitment of a Patient Advice and Liaison Officer (PALS) who commenced in September 2022 and second PALS officer to be recruited,
- training in communication (incorporated into the Magnet project-due to commence in February 2023),
- increased use of interpreters and sign language, use of patient information leaflets,
- executive walkabout to commence in January 2023,
- facilitation of compassionate visiting including during times of restricted visiting.

Overall, while the hospital had elements of systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services and were developing their complaints and risk management systems in line with national guidance following recent external reviews, HIQA was concerned that the approach to patient safety incidents and serious reportable events was not yet as effective as it ought to be. HIQA found limited evidence of early multidisciplinary input from relevant and senior disciplines being used to guide immediate remedial actions and ensure prompt learning followed by timely implementation of recommendations to support patient safety at the hospital.

Judgment: Partially compliant

Quality and Safety Dimension

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

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted in hospital.[‡‡‡‡‡‡‡] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who

[‡‡‡‡‡‡‡] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs. The environment in which care is delivered should also promote and protect the person's dignity and privacy, and protect the personal information of people who use the service.

It was clear from speaking with and observing staff working in both Medical 2 ward and in the gynaecology ward that they were committed and dedicated to promoting person-centred care and ensuring the dignity, privacy and autonomy of patients. Staff were observed orientating patients, familiarising them with their surroundings and offering to assist them.

In addition to previously described quality improvement plans arising from the findings of the 2021 National Inpatient Experience Survey, a further example of an initiative used to respect and promote one's dignity was the 'Get Up, Get Dressed, Get Moving' §§§§§§§that was in use at the hospital.

There were challenges related to the respect and promotion of privacy, dignity and autonomy of people using the service when in line with the hospitals' full capacity protocol, three additional patients were placed on the 16-bedded medical ward which was already full. One patient was placed in a bed in the treatment room and two were placed on beds along the corridor. Although the additional three patients had access to toilet facilities, they did not have access to shower facilities. Care and attention was taken to ensure privacy at ward level for people being cared for in beds on corridors. Despite best efforts by staff, protection and promotion of privacy for patients was more challenging when on the corridor. While there was reasonable access to toilet facilities for patients on the gynaecology ward, inspectors noted that access to shower facilities was reduced in one of the shower areas due to storage of inappropriate items.

Eighty-four per cent of Letterkenny University Hospital respondents to the National Inpatient Experience Survey said they had a good or very good overall experience, compared to 82% nationally. When asked, if overall they were felt treated with dignity and respect while in the hospital, the hospital had scored 9.1 (above the national average 8.9). This was an improvement on 2021 data when the hospital had scored 8.9 (below the national average of 9.0). When asked if they were given enough privacy while in the hospital, Letterkenny University Hospital scored 8.4 (national average 8.7).

In summary, there was good evidence that dignity, privacy and autonomy was respected and promoted at ward level where there was no extra beds or trollies on the ward. It is acknowledged that additional beds on wards is part of the full capacity protocol in use in hospitals to minimise risk however this practice does not fulfil the standards required to meet the personal needs or human rights to dignity, privacy and autonomy. The hospital in conjunction with the Saolta hospital group and the HSE should focus on ensuring that all patients using the hospital services are afforded dignity, privacy and autonomy.

§§§§§§§ 'Get Up, Get Dressed, Get Moving' is an initiative within the national HSE campaign, used to promote independence and embed the concept of early and ongoing movement, into the culture and practice of health and social care.

Judgment: Substantially compliant

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

Inspectors observed staff to be kind, caring, respectful and responsive towards patients in the two inpatient areas inspected. Call-bells were answered in a timely manner. Staff were observed offering help to patients. However, some patients in the emergency department who had been waiting overnight expressed disappointment with the availability of snacks and drinks when the vending machines were out of order during the night.

There was prominent signage at the main entrance to the hospital which helped identify the various staff disciplines by uniform colour. Inspectors considered this to be good practice as it respects the needs of patients to be able to easily identify the various disciplines of staff.

Inspectors observed and heard about a number of initiatives either underway or in progress at the hospital that indicated a hospital wide approach of kindness, consideration and respect. These included the provision of comfort packs in the emergency department to those in need, cushioning of the hard seats in the emergency department waiting area, compassionate visiting arrangements and discrete use of colour coded trays indicating which patients required mealtime assistance among others. A further example of promotion of a culture of kindness, consideration and respect was observed on medical 2 ward, where there was a practice of offering paired red hearts for people and their families at the end of their lives. When a person was approaching the end of their life, one heart was given to the person and the other to their family. When the patient died, the family were invited to swap back the red heart with that which had been with the deceased person.

HIQA note the findings from the 2022 National Inpatient Experience Survey, where people who used the services at Letterkenny University Hospital scored their overall experience as 8.2 out of 10 compared to the national average of 8.1 out of 10.

In summary, there was evidence that the hospital promotes a culture of kindness, consideration and respect. Listening to and acting on patient experience as outlined in patient feedback to inspectors is an area identified for continuous attention and improvement following this inspection.

Judgment: Substantially 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.

On inspection, inspectors found that the hospital was continuing to develop its systems to respond to complaints and concerns in line with national guidance. The delegated complaints officer was a member of the QPS team. Complaints in terms of numbers, themes and recommended time frames for acknowledgment and resolution were tracked and trended by QPS staff. According to the HSE's National Complaints and Governance Learning Team (NCGLT) 2021 report of '*Your Service Your Say'* 146 complaints were received by Letterkenny University Hospital in 2021, the majority of which related to safe and effective care, and communication and information. HIQA noted that 28% of these complaints were resolved within the recommended 30-day timeframe.

Leaflets on how to make a complaint, HSE *'Your Service Your Say'* were made available in the display area in Medical 2 ward which inspectors noted was initially empty but refilled before the end of the inspection. The HSE *'Your Service Your Say'* poster was on display at the entrance to the gynaecology ward but the leaflets were not on display "*due to COVID-19"* and were instead reported to be "*provided by the CNM2".* There was a large sign in the lobby of the main entrance to the hospital providing information on the HSE advocacy services. The hospital had employed a Patient Advocacy Liaison officer in September 2022.

Inspectors noted that both consultants and nurse managers were involved in complaint investigation and resolution and that complaint logs were maintained at department level. Feedback was provided from the QPS department via the Directorate structure and via the ACD and ADON network. Inspectors were told that all staff had been asked to undertake the complaints training module in HSELanD. Whole hospital statistics indicated that by the time of inspection only 3% of staff had undertaken training in complaints. Verbal complaints were not yet routinely recorded. This represents a missed opportunity for sustained learning and change. The hospital was reported to be considering how it might capture such complaints and bring about sustained service improvements.

The HSE National Complaints and Governance Learning Team (NCGLT) had, within the last 12 months, audited the complaints processes at Letterkenny University Hospital. The purpose of the audit was to ensure that the recommendations in the 'Learning to Get Better' report********, were being actively implemented at all levels in the hospital. The NCGLT had reported its findings in March 2022, stating that based on its findings, the audit assurance level was 'Unsatisfactory'. Of the 23 recommendations in the report, HIQA noted that 11 had been implemented by the time of the inspection, eleven were in progress and one was applicable to the Saolta Hospital Group as opposed to the hospital. Those in progress included: delegation orders for additional staff in complaints management, training for complaints officers, introduction of modes of communication with people who make a complaint, commencement of use of YSYS feedback boxes, recruitment of a second PALS officer, development of a complaints policy statement and use of the NCGLT Learning Notification Form / Learning Summary Casebook to share learning. Inspectors were advised that the delegation order was completed

******** 'Learning to Get Better' An investigation by the Ombudsman into how public hospitals handle complaints (Office of the Ombudsman 2015) https://www.ombudsman.ie/publications/reports/learning-to-get-better/

on 8 November 2022 for the delegated complaints officer and three other staff including the director of Nursing but that at the time of inspection this had not yet been updated on the action tracker.

In summary, inspectors found that while the hospital was developing structures and processes in place to manage complaints, there was evidence that timelines were exceeded in recent months. Implementation of recommendations as set out by the HSE NCGLT were ongoing at the time of inspection. The hospital needs to ensure that it is managing complaints in line with national guidance and that staff are trained in complaints management.

Judgment: Partially compliant

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

Two wards were inspected, medical 2 and the gynaecology ward. Medical 2 was a 16-bedded ward which specialised in the care of older people. The ward comprised 16 single en-suite rooms, four of which had negative pressure facilities. At the time of inspection they were not being specifically used for infection prevention and control. The ward was full and it also accommodated three people on trolleys in line with the hospital's full capacity protocol set out to accommodate a surge in admitted patients. Two patients were placed in beds along the corridor and one was placed in a bed in the treatment room. All patients on this ward including the extra patients had a means to call for assistance.

The gynaecology ward was an 11-bedded ward comprising a six-bedded bay, a three-bedded bay and two single rooms. At the time of inspection, all beds were full. The ward provides gynaecology care as well as care for women with early pregnancy complications including pregnancy loss. Inspectors were told that during period of peak activity, the ward also accommodated patients receiving medical surgical, orthopaedic or oncology care. During this inspection, there was at least one patient present for each of those reasons. There were no additional beds or trolleys on this ward. Inspectors noted that both wards appeared calm and controlled. Overall the wards were noted to be clean, with some exceptions which were brought to the attention of the ward manager (CNM). Inspectors were informed that wards had adequate cleaning resources and that cleaning was supervised by cleaning supervisor. Equipment seen by inspectors appeared clean on visual inspection. Clean equipment ready for use was denoted by the use of green stickers on both wards.

Inspectors found that there was inappropriate storage of equipment on the floor of the shower room of the gynaecology ward. This resulted in reduced space and access to the shower. This

was brought to the attention of the ward manager. Handwashing sinks in both wards were not compliant with HBN[††††††††] standards.

Inspectors reviewed documentation relating to water testing for legionella and were satisfied on discussion with hospital staff that the risk was mitigated in line with recommended practice.

In summary, the physical environment based on inspection of two ward areas (with minor exceptions as discussed with ward managers) was largely maintained to support the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

Judgment: Substantially compliant

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

Hospital management monitored and reviewed information from multiple sources, including:

- quality and safety performance metrics
- findings from audit activity
- risk assessments
- quality nursing and midwifery metrics
- patient-safety incident reviews
- complaints
- national inpatient patient experience surveys.

Infection Prevention and Control Monitoring

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.[‡‡‡‡‡‡‡‡] The infection prevention and control team submitted an infection control report to the Infection Prevention and Control Committee annually.

Every month the hospital monitored and publically reported on rates of:

- *Clostridioides difficile* infection
- Carbapenemase producing *Enterobacterales* (CPE)

[††††††††] Health Building Notes (HBN) provides evidence based guidance on standards of building and physical infrastructure for healthcare facilities (from the UK) approved for use in hospitals in Ireland by HSE Estates.

[‡‡‡‡‡‡‡‡] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf

- hospital acquired *Staphylococcus aureus* blood stream infections
- hospital acquired COVID-19 and outbreaks.

From January 2022 to the time of the inspection, the hospital's rate of new cases of:

- hospital-associated *Clostridioides difficile* infection rates ranged from 1.1 (April) to 5 (July), which was above the national HSE's target of less than 2 per 10, 000 bed days.
- hospital-acquired *Staphylococcus aureus* blood stream infection rates ranged from 0 (February and April 2022) to 3.8 (September 22), which is significantly above the national HSE's target of less than 0.8 per 10,000 bed days.

Inspectors were unclear what action(s) had been introduced at the hospital in response to high rates of *Clostridioides difficile and* hospital-acquired *Staphylococcus aureus*.

The hospital had opted to offer CPE screening to a targeted population but inspectors were told that application of the screening approach varied between clinical areas. Although the IPC team had made a number of approaches to raise awareness of the value of CPE screening, the variance in uptake continued. At the time of inspection 51% of the targeted population had been screened year to date. The hospital had four cases of carbapenemase-producing enterobacterales year to date in 2022 (two cases in January, one in May and one in August). HIQA was not assured by the hospital's compliance with targeted screening for CPE and a high risk letter was issued to the hospital and the Saolta hospital group.

Monthly environment, equipment and hand hygiene audits were undertaken at the hospital using a standardised approach. The last three environmental hygiene audits were reviewed in respect of the three inspected areas. The frequency of the audits was irregular with a range of 3-15 month gaps between audits. Compliance rates for the three clinical areas visited during inspection showed that the clinical areas were not compliant with the national HSE target of 90% for environmental hygiene in the earlier audits but were all compliant by their most recent audits carried out in April 22, August 22 and October 22 respectively. Findings from hand hygiene audits carried out in 2022 showed that the hospital scored an average monthly result of 75.7% compliance which was below the HSE target of 90%. Attendance at hand hygiene training by staff had increased from 65% at the beginning of the year to 81% by the time of the inspection.

Medication Safety Monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication audits carried out 2020-2022 included:

- medical reconciliation on admission (2020)
- missed dose audit in the emergency department (February 2022)
- medication safety – monthly nurse metrics

Quality improvement initiatives were identified at the end of each audit report with time-bound quality improvement plans developed to implement these initiatives. Inspectors were told of plans to re-audit 'missed doses' within the coming months.

Antimicrobial Stewardship Monitoring

The hospital did not have an antimicrobial stewardship committee or programme. There was no replacement for the antimicrobial pharmacist (following recruitment efforts).

Deteriorating Patient Monitoring

Performance data relating to the escalation and response of the deteriorating patient was collated monthly through test your care metrics. High levels of compliance were noted (greater than 90% on nine of the 11 months year to date). On inspection of a range of charts by inspectors however, breaches in compliance with use of the INEWS and escalation of care were noted and brought to the attention of the ward manager.

Transitions of Care Monitoring

The hospital tracked the number of new attendances to the emergency department, patient experience times, the average length of stay of a medical and surgical patient and the rate of delayed transfer or discharge every month. At the time of inspection, 17 patient transfers were delayed.

There was evidence of auditing compliance with national guidance on clinical handover in nursing. National guidelines recommend that clinical handover be monitored and audited regularly to assure senior managers that any necessary continuous quality improvements are put in place to ensure compliance with national guidance.

Staff in all three clinical areas visited demonstrated awareness of hospital's findings from the National Inpatient Experience Survey and could provide examples of quality improvement plans are being progressed to improve the patient experience.

In summary, while the hospital had several systems in place to monitor and evaluate healthcare services provided at the hospital, HIQA was not assured by the continued absence of an antimicrobial stewardship programme at the hospital or the hospital's approach to CPE screening which had been escalated to the hospital following inspection. The hospital needs to ensure that arrangements are in place to provide effective antimicrobial stewardship.

Judgment: Non-compliant

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

The hospital had systems and processes in place to proactively identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. Risks were identified and managed at clinical area level and risks not managed at that level, were escalated to senior management and recorded on the hospital's corporate risk register. The Quality and Patient Safety Committee and the hospital executive board had oversight of the risks on the hospital's corporate risk register and the effectiveness of corrective actions or controls in place to mitigate the risks to patient safety.

The hospital had a risk register in place. This was reviewed by the QPS committee on a monthly basis. Unscheduled care, COVID-19 and waiting lists featured as the highest rated risks. Issues impacting on medication safety, the deteriorating patient and transitions of care were also itemised. The risk register was forwarded to the Saolta hospital group every two months. Risks requiring assistance to control were escalated to the Saolta hospital group for example, limited critical care capacity. Inspectors were told that work was taking place across the Saolta hospital group to align the risk management processes and that it would be under the remit of the incoming senior change manager scheduled to take up post in February 2023. Risks identified at ward level were escalated to the ADON and the QPS department. Risks were also raised at ward-based safety huddles and at the patient flow meetings as relevant.

Inspectors viewed an internal audit report dated 10 October 2022, conducted by the HSE Internal Audit Department on 'Compliance with the Risk Management Policy'. The auditor made seven recommendations around revision and maintenance of hospital and department risk registers. Inspectors noted that the hospital had adopted the HSE approved risk register template for all risk registers. Other recommendations included review of the hospital risk register to ensure capture of all risks, de-escalation as appropriate to department based risk registers, determination of appropriate risk rating, oversight and review of risk registers at ward or department level and staff training. Inspectors viewed the hospital's implementation plan which indicated that all recommendations were due to be implemented by end of December 2022.

Oversight of Gynaecology Services

Inspectors met with external Clinical Director for the gynaecology services who had been appointed on a six-month contract from Sept 2022 following HIQA's targeted assurance review of gynaecology services in 2021. The external Clinical Director reported to the Group Clinical Director for the Women and Children's MCAN. The external Clinical Director was on-site three days per week at the hospital and had oversight of the processes and outcomes of the gynaecology services and was providing support to staff. Staff reported positive changes taking place in the service as a result of this external support such as the recent configuration of teams of junior doctors aligned to a named consultant.

Inspectors were informed that a report would be submitted by the external clinical director to the Group Clinical Director for the Women and Children's MCAN on completion of the contract. Inspectors were told that while there were four approved and funded posts for consultant obstetricians and gynaecologists, at the time of inspection, only one was filled on a permanent basis and three posts were filled on a locum basis. Delays in access to diagnostic tests was

raised as a risk impacting the gynaecology service. The lack of capacity at Saolta group level was said to be a factor in continuing to transfer women for gynae-oncology and urogynaecology cases to Dublin. The hospital and Saolta hospital group need to address these outstanding issues so that services are safe and sustained.

Inspectors reviewed the ambulatory gynaecology key performance indicators for the management of post-menopausal bleeding as measured by the percentage of women who were seen within 28 days of referral. This averaged at 93.9% over the period March to October 2022 with a range of 87.7% in March to 98.1% in August 2022 (target 100%). The data for women receiving a diagnosis and test results within 28 days of being seen in the clinic averaged 95.4% over the period March to October 2022 with a range of 87.5% in May 2022 to 100% (on three of the eight months). The target is 90% within 56 days. The percentage of women who were seen and received histological confirmation within 12 weeks of referral averaged 99.2 % over the period March to October. It was 100% in seven of the eight months and 93.8% in May 2022 (target 100%).

A patient satisfaction survey of all women attending the ambulatory gynaecology and post-menopausal clinic had been conducted between November and December 2021. There was a 62.6% response rate and high levels of overall satisfaction were expressed by women using the service with one score of 80% and all others expressing between 90-100% satisfaction. HIQA were satisfied that this service has seen significant improvements however, this will need to be monitored carefully to ensure that the improvements are sustained over the medium and long term and beyond the period of the appointment of external supports.

Infection Outbreak Preparation and Management

The hospital had opted to follow national guidance in relation to selective screening of patients for multi drug resistant organisms (MDRO). However, not all patients were screened on admission for carbapenemase-producing enterobacterales. The hospital had a system in place to identify patients with communicable infectious diseases (CID). There was a trigger on the integrated patient management system (IPMS) for multi-drug resistant organisms (MDROs) status for patients who had previously attended the hospital but this was not available for patients who came from other hospitals or nursing home. While the MDRO status was recorded on the IPMS, it was not documented on the charts audited by inspectors on one of the two inspected wards. This division in the source of information is a risk which needs to be addressed by the hospital to ensure continuity and safe care. Inspectors found no evidence on chart review, of MDRO status being recorded on letters to GP's from the inspected wards. These practices need to be addressed to reduce potential patient safety risk.

By the time of inspection, the hospital had reported 32 outbreaks of COVID-19 since the beginning of the year. Multidisciplinary outbreak teams were convened to advise and oversee the management of the outbreaks. Inspectors were told that attendance at such team meetings could be improved. The sample of summary reports from outbreaks, submitted to HIQA were comprehensive and outlined control measures, potential contributing factors and recommendations to reduce reoccurrence of outbreaks. Staff described the management of infection outbreaks. This was in line with required standards (outbreak team, daily meetings,

isolation, contacts cohorted, surveillance, PPE, including FFP2). Staff reported good access to the IPC nurse for advice and support at ward level. The minimum one metre separation was observed to be in place in the inspected wards. Hand hygiene audits results displayed on the Gynaecology ward showed that there was a 93% compliance rate observed among staff in October 2022.

Medication Safety

Medication reconciliation by a pharmacist was not undertaken on all patients. A clinical pharmacist was assigned to the emergency department and the remaining areas inspected had pharmacy technicians assigned to them who reviewed stock control on a weekly basis.

HIQA was satisfied that risk reduction strategies for high-risk medicines were used in the hospital. The hospital had a list of high-risk medications that included the core high-risk medications represented by the acronym 'APINCH'. Inspectors observed the use of risk reduction strategies to support the safe use of anticoagulant, insulin and opioid medicines. These included safety alerts (such as weight based doses, drug interactions, skin staining following IV iron infusion), medication incidents reporting pathway and the use of medication safety minutes on use of Fentanyl, Oxycodone, Vancomycin and direct oral anticoagulants. The hospital had a list of sound-alike look-alike medications (SALADs). There was information available in hard copy on high risk medicines and SALADs on display in the clinical rooms. Inspectors noted that although prescribing guidelines and medication information were available to staff via the hospital's intranet, there was no access to the intranet within the clinical rooms where medications are prepared in the inspected areas. This should be addressed by the hospital. Medication fridge temperatures were noted to be monitored electronically on both wards with inbuilt alarm systems in case of deviation.

Health Products Regulatory Authority (HPRA) alerts, recalls and recommendations were received by both the chief pharmacist and the hospital general manager who then disseminated them to the wards. Medication safety risks and incidents were tracked and trended. Risks were also escalated to Saolta hospital group level where indicated. Incidents were reported directly onto the National Incident Management System (NIMS).

Deteriorating Patient

The hospital had implemented all four of the approved early warning systems at the hospital, INEWS2, IMEWS, PEWS and EMEWS. Staff in the clinical areas visited were knowledgeable about the INEWS2 escalation process for the deteriorating patient. Staff informed inspectors that ISBAR (**I**dentify, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) was being used for escalation of raised early warning scores and or when requesting patient review. Inspectors reviewed a sample of healthcare record and found that INEWS charts were not always completed correctly, INEWS scores were not always calculated correctly or escalated in line with national and local guidance. Inspectors escalated and discussed these issues with the clinical nurse manager on the day of inspection.

Transitions of Care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer between healthcare services and to support safe and effective discharge planning. The hospital had a bed manager and a discharge co-ordinator to facilitate effective discharge planning from the hospital. The hospital had a number of transfer and discharge forms to facilitate safe transitions of care. All patients were provided with copies of the discharge summaries to give to their GP on discharge. Notwithstanding this, HIQA found evidence of omission of key information such as record of MDRO (including CPE status).

Hospital staff spoke about the recent introduction of the 'Model ward', a Saolta hospital group initiative being rolled out in all medical wards at the hospital and aimed at standardising elements of structures and processes at ward level for example the standardised use and maintenance of a white board and integrated alert system for patient care. It focused on individualised patient centred care. Inspectors heard of plans to roll out the initiative in the surgical wards. The model ward included the routine planning of a predicted discharge date (PDD) at the time of admission and a focus on discharge to enable provision of timely care as required to avoid prolonged hospital stay unless necessary.

The hospital had a detailed and evidence-based clinical guideline for clinical handover dated July 2019. It contained a standard operating procedure for handover between medical staff and one for nursing staff. It included an algorithm for the ISBAR 3 (**I**dentify, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation) technique when transferring and or communicating escalation of patient care between healthcare professionals. It included guidance on the Safety Pause and the Safety Huddle and an audit tool for clinical handover. At the time of inspection, inspectors noted that there were numerous documented discussions at hospital and Saolta hospital group level spanning a period of almost a year relating to the fact that this policy was not being used in practice and that this posed a patient safety risk. The hospital should seek to resolve this matter without delay.

Safety Pauses and Safety Huddles were held twice daily and inspectors viewed signed documentation relating to the safety pause held on the gynaecology ward. It highlighted aspects including numbers of patients with the same surname, those at known risk of falls, pressure sores, increased early warning scores, staffing issues or commitments to meetings, equipment issues, and alerts to patterns of near misses and or safety issues among others.

Policies, Procedures and Guidelines

The hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and 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 policies, procedures, protocols and guidelines.

Uptake of Mandatory and Essential Training

There was evidence that CNMs and clinical skills facilitators were responsible for maintaining a record and had oversight of the uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection

prevention and control, medication safety and INEWS on the HSE's online learning and training portal (HSELanD). Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training.

Staff uptake of mandatory training in hand hygiene in the last two years was 81%, (HSE target of 90%). Staff uptake of mandatory training in standard and transmission-based precautions in the last two years averaged 16.5% across all relevant staff groups. Overall the staff uptake of mandatory training at the hospital was sub-optimal and requires significant improvement. This is detailed under national standard 5.2.

It is essential that hospital management ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

In summary, inspectors noted that the hospital is working to strengthen the management of risk through improvements being made to the risk management system. However, apparent weakness as well as breaches in existing systems that ought to be working effectively were found on inspection and during examination of records. Attendance at mandatory staff training requires urgent and ongoing attention to ensure that it is maintained at least at national targets. CPE screening should be carried out in line with national guidance, MDRO status should be recorded on patient charts in the interests of continuity of care and safety and it should be communicated in writing to the GP and or the residential care facility. Current medication safety policies and procedures should be available at the point of preparation. Ongoing monitoring of the performance of the gynaecology services plus attention to the ratio of substantive to locum posts and access to diagnostics needs to be continually monitored at hospital and Saolta hospital group level. Finally, the hospital should ensure that it has an approved clinical handover policy in place, communicated to all relevant staff and ensure that compliance is maintained and regularly audited.

Judgment: Partially compliant

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

Higher reporting rates of clinical incidents generally indicate a good reporting culture and greater visibility of risk at the hospital, which are key determinants for safer healthcare services. Reports to the National Incident Management System (NIMS)§§§§§§§§ in 2022 was incomplete in relation to monthly reporting of the number of clinical incidents per 1000 bed days. Information was publicly available for two months, January and May 2022 prior to the inspection (HSE HPSIR 2022). On both months, the value provided was 27. The hospital provided their monthly data for each of the 10 months on request and the average number of clinical incidents per

§§§§§§§§ The National Incident Management System is the single designated system for reporting of all incidents in the public healthcare system.

1000 bed days per month from January to October inclusive was reported to be 29.8. The HSE expected average is 14.88.

Inspectors were told that incidents at ward level were until recently, reported to the QPS team using an electronic management system and were also escalated to the CNM3 and ADON. The QPS staff sought additional information if required, to prepare reports for the QPS meetings where they were then reviewed. The hospital had recently implemented a direct reporting mechanism to the National Incident Management System (NIMS). The hospital had instituted direct reporting of incidents onto the NIMS in the weeks prior to the inspection and inspectors heard from staff and observed that this was available to them on their ward computers both to report an incident and to have access to what they had reported to date. The hospital provided data on incidents reported which included falls, medication errors and escalation of care issues. The implementation of recommendations from reviews of patient-safety incidents was monitored by the hospital's quality and patient safety department. Updates on the progress of implementation of recommendations were provided to the relevant governance committees.

According to published HSE data, Letterkenny University Hospital had reported serious reportable events in line with national policy. Inspectors were told by staff that the directorates are provided with monthly Excel sheets on the overview of incidents per department and the aggregated data.

Staff who spoke with HIQA were knowledgeable about what and how to report a patient-safety incident and were aware of the most common patient-safety incidents reported, which were falls. The quality and patient safety department tracked and trended patient-safety incidents in relation to the four key areas of known harm. The Quality and Patient Safety Committee, Serious Incident Management Team, hospital executive board and Saolta Hospital Group had oversight of the numbers and categories of reported patient-safety incidents. Information relating to and feedback on patient-safety incidents was shared with staff in clinical areas informally by clinical nurse managers. Safety huddles were the mechanism used to share learning from patient-safety incidents and discuss operational issues that could impact on patient safety. A formal standardised system in place to facilitate the sharing of learning from patient-safety incidents at the safety huddle was viewed by inspectors.

Anonymised preliminary assessment reviews (PARs) conducted on three recent serious incidents were submitted on request to HIQA at the end of the inspection. Inspectors were concerned to note that there was an absence of documented input on the PARs from personnel such as consultants from the relevant specialties. The hospital had a Local Incident Management Team (LIMT) which would review the completed PAR before consideration by the Saolta Serious Incident Management Team (SIMT). In relation to PARs reviewed by inspectors, there was no evidence on the forms that these had further input or were reviewed (after completion by the QPS member of staff and ADON) by the LIMT. The forms were then submitted to the SIMT. HIQA was concerned that the hospital was not following its own processes, and that there were apparent delays in implementing the learning and recommendations from serious reportable events and serious incidents. HIQA issued a high risk letter to the hospital after the inspection seeking assurance that it was compliant with the guidance of the HSE Incident Management Framework (2020). In response, the Saolta hospital group advised that PARs have been

submitted to the SIMT at the request of the Saolta Group SIMT if their meeting date predates the LIMT meeting.

In summary, while HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were more recently being reported directly to the NIMS in line with the HSE's incident management framework, HIQA found limited evidence that the processes in place to manage and respond to incidents were functioning as effectively as they ought or that sufficient or timely learning was being shared. HIQA issued a high risk letter to the hospital with subsequent escalation to the Saolta Hospital Group related to these findings.

Judgment: Non-compliant

Conclusion

This inspection was carried out at Letterkenny University Hospital on 16 and 17 November 2022 against the *National Standards for Safer Better Healthcare* under the revised monitoring programme using a core set of standards. It involved:

- An overall assessment of compliance of the effectiveness of governance under the national standards 5.2 and 5.5
- Compliance with three national standards (6.1 from the dimension of Capacity and Capability and NS 1.6 and 3.1 from the dimension of Quality and Safety) as assessed in the emergency department.
- Compliance with one national standard from the dimension of Capacity and Capability (5.8) and seven national standards from the dimension of Quality and Safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) as assessed on 'Medical 2' ward and the gynaecology ward.

Capacity and Capability

Overall, inspectors found that Letterkenny University Hospital was partially compliant or non-compliant in four national standards (5.2 PC, 5.5 NC, 5.8 PC, and 6.1 PC).

In terms of its capacity and capability, inspectors found that Letterkenny University Hospital was partially compliant with national standard (5.2). While some formalised governance arrangements were in place, HIQA found that more work is required on the governance arrangements and processes around incident management, risk management, complaints management, infection prevention and control, medication safety and staff training to assure the delivery of high quality, safe and reliable healthcare. Deficits in some of these areas had also been noted through recent external audits by the HSE National Complaints and Governance Learning Team (NCGLT) and the HSE Internal Audit team.

Inspectors found some evidence of effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. These included engagement with community services, sanction for additional posts, meeting and exceeding some HSE KPIs targets related to performance within the emergency department. Inspectors, however were not assured by the level of overcrowding, the increased patient experience times as reported by patients to inspectors and the lack of effective patient flow in the emergency department as witnessed on the second day of inspection. HIQA was not assured by the level of staffing in place for the RRU as found on the second day of inspection and particularly given the scope of work that was being undertaken there. The hospital was found to be non-compliant with national standard 5.5 and these issues were raised with hospital management on the day and after the inspection by issuing of a high risk letter to the hospital. Assurances in relation to reconfiguration of the unit was provided to HIQA following the inspection.

Further work is required to fill vacancies relating to consultant microbiologists and pharmacists, ensure that there is an antimicrobial stewardship (AMS) programme in place, ensure that the targeted CPE screening is offered to all eligible people in line with national guidance, address the outstanding issues on the hospital's self-assessment against national IPC standards and the need for clinical pharmacy services and medicine reconciliation. There was no access to an antimicrobial pharmacist for hospital staff. Attendance at mandatory and essential training in line with national standards requires attention. These areas should represent a key focus for early improvements following this inspection. It is acknowledged that improvements have been noted in staffing levels in nursing and in emergency medical staffing at consultant and registrar levels despite ongoing turnover of staff.

Inspectors found that Letterkenny University Hospital was partially compliant with national standard 5.8. While the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services and were developing their complaints and risk management systems in line with national guidance, HIQA was concerned that the approach to patient safety incidents and serious reportable events was not as effective as it ought to be. HIQA found limited evidence of effective response and management of incidents being used to guide immediate remedial actions and ensure prompt learning associated with serious reportable events and patient-safety incidents followed by timely implementation of recommendations to support patient safety at the hospital.

Inspectors found that Letterkenny University Hospital was partially compliant with national standard 6.1. While nursing staff levels on the day of inspection were largely aligned to the planned roster, review of the rosters over the month prior to inspection indicate that there had been ongoing deficits. The hospital needs to address this particularly in the context of a chronically overcrowded department. It is acknowledged that improvements had taken place and are taking place both in relation to nursing and to emergency medical staffing at consultant and registrar levels despite ongoing turnover of staff. The hospital should ensure that all consultant staff are or are working towards accreditation on the specialist register with the Irish Medical Council. Finally, the staffing levels and the clinical governance in the RRU was a particular concern to HIQA which was raised with the management team at the hospital on inspection. A high risk letter was issued to the hospital the day after inspection which was later

escalated to the Saolta Hospital Group CEO. Subsequent assurances were received in relation to reconfiguration plans for the service but this needs to implemented by hospital management.

Quality and Safety

Overall, inspectors found that Letterkenny University Hospital was compliant or substantially compliant in three national standards (1.6 SC, 1.7 SC and 2.7 SC in the wards,) and partially compliant or non-compliant in six national standards (1.6 PC in the emergency department, 1.8 PC, 2.8 NC, 3.1 NC in the emergency department, 3.1 PC in wards and 3.3 NC).

Inspectors found that Letterkenny University Hospital was partially compliant with national standard 1.6 in the emergency department,. The environment posed a significant risk to the quality of healthcare provided and to the health and welfare of patients attending the emergency department as found on the second day of inspection. Notwithstanding the initiatives implemented, the practice of boarding admitted patients in the emergency department contributed to overcrowding of the department. In such settings, it was impossible to maintain, promote and protect patients' dignity, privacy and confidentiality, which impacted on the meaningful promotion of the patient's human rights especially those accommodated in trolleys on corridors. Inspectors did not find sufficient evidence that actions taken by management sufficiently addressed deficits of service users' dignity, privacy and autonomy as noted on the second day of the inspection.

Inspectors found that Letterkenny University Hospital was substantially compliant with national standard 1.6 in the inspected wards. While there was evidence that dignity, privacy and autonomy was respected and promoted, the hospital needs to ensure appropriate storage of items away from patient toilet and shower facilities. It is acknowledged that the placement of additional beds on wards is part of the full capacity protocol but it is noted that this practice does not fulfil the standards required to meet the personal needs or human rights to dignity, privacy and autonomy. The hospital in conjunction with the Saolta hospital group and the HSE should focus on ensuring that all patients using the hospital services are afforded dignity, privacy and autonomy.

Inspectors found that Letterkenny University Hospital was substantially compliant with national standard 1.7. There was evidence that the hospital promotes a culture of kindness, consideration and respect. Listening to and acting on patient experience as outlined in patient feedback to inspectors is an area identified for continuous attention and improvement following this inspection.

Inspectors found that Letterkenny University Hospital was partially compliant with national standard 1.8 relating to the management of complaints. While the hospital was found to have structures and processes in place to manage complaints and notwithstanding the fact that implementation of recommendations as set out by the HSE NCGLT were ongoing at the time of inspection, there was evidence that the hospital was not meetings its targets for complaint resolution and timelines were being exceeded in the majority of complaints.

Inspectors found that Letterkenny University Hospital was substantially compliant with national standard 2.7. In summary, the physical environment based on inspection of two ward areas

(with minor exceptions as discussed with ward managers) was largely maintained to support the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

Inspectors found that Letterkenny University Hospital was non-compliant with national standard 2.8. While the hospital had several systems in place to monitor and evaluate healthcare services provided at the hospital, HIQA was not assured by the continued absence of an antimicrobial stewardship programme at the hospital or the hospital's approach to CPE screening. HIQA issued a high risk letter to the hospital following inspection. In relation to follow-up of the HIQA 2021 Gynaecology Assurance Review, inspectors found there is a need to progress from a reliance on locum consultants within the gynaecology service. There was good evidence from audit, from patient satisfaction surveys and from feedback from the external clinical director that improvements have been made to the gynaecology service and are having a positive impact on quality and safety of gynaecology services. These will continue to need close monitoring to ensure that they are sustained beyond the support of short-term external supports.

Inspectors found that Letterkenny University Hospital was partially compliant with national standard 3.1 in relation to risk management. Improvements were being made to the risk management system following the HSE internal audit however, apparent weaknesses as well as breaches in existing systems that ought to be working effectively were found on inspection and during examination of records. The hospital should ensure that MDRO status is recorded on patient charts as well as in the integrated patient management systems in the interests of continuity of care and safety and that it is also communicated in writing to the GP and or the residential care facility.

Inspectors found that Letterkenny University Hospital was non-compliant with national standard 3.3 in relation to management of incidents. HIQA was satisfied that patient-safety incidents and serious reportable events were now being reported directly onto the National Incident Management System in line with the HSE's incident management framework. However, HIQA found limited evidence that the processes in place to manage and respond to incidents were functioning as effectively as they ought or that sufficient or timely learning was shared. HIQA issued a high risk letter to the hospital with subsequent escalation to the Saolta Hospital Group related to these findings.

Overall, on the day of inspection, HIQA acknowledges the hospital management's efforts to address the issues identified. There is evidence of considerable work in progress and the hospital is meeting and exceeding some key performance indicators. More work is required however to ensure that care delivered in the hospital complies with the National Standards for Safer Better Healthcare and that changes made are sustainable. Although some of the challenges faced in the emergency department reflect recent findings in other emergency departments, measures are required to address overcrowding, staffing issues affecting pharmacy and microbiology in particular, patient flow issues and timely access to diagnostics. This warrants a concerted proactive short, medium and long-term approach by the hospital, in conjunction with the Saolta Hospital Group and the HSE to address these issues.

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

Compliance classifications

An assessment of compliance with the national standards assessed during this inspection at Letterkenny University Hospital 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 non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management sets out the actions taken or planned in order for the healthcare service to come into compliance with the national standards judged to be non-compliant. It is the responsibility of the healthcare service provider to ensure that it implements the actions in the compliance plan within the set time frames to fully comply with the national standards.

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

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

Capacity and Capability Dimension	
Overall Governance	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	**Partially compliant**
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	**Non-compliant**
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	**Partially compliant**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Partially compliant**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Non-compliant**

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
National Standard	**Judgment**

Theme 5: Leadership, Governance and Management	
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**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Substantially compliant**
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	**Substantially compliant**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Partially compliant**
Theme 2: Effective Care and Support	
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.	**Non-compliant**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Partially compliant**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	**Non-compliant**

Compliance Plan
Compliance Plan Service Provider's Response

National Standard		Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare		Partially compliant
Issues NS 5.2:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Implementation of Clinical Handover Policy	The Clinical Handover Policy has been finalised and will be presented for ratification at Quality and Patient Safety (QPS) Committee February 2023 As of Jan 2023 communication related incidents are also being monitored through the QPS report presented at QPS Committee and HEB.	Plan to roll out the National Healthcare Communication Programme to provide education on communication and handover. Facilitators are currently being identified and trained to roll out this programme. (Q2 2023) Compliance with the Clinical Handover Policy will be audited in Q3 2023
Not all sub committees had been reporting into the QPS committee in line with their terms of reference	A programme of work to strengthen governance within Letterkenny University Hospital (LUH) has been identified as part of the EY workshop series held in 2022. A Senior Change Manager has been appointed and will take up post mid February 2023. The EY Steering Group (Saolta & LUH membership) are currently grouping and prioritising the specific actions across 5 themes. This will be completed and agreed in early March 2023.	The LUH Hospital Executive Board (HEB) and the QPS service, working with the Change Implementation Manager and Saolta Executive will agree and implement changes to the governance structure at LUH to include updated terms of reference; membership; and reporting relationships. A key component of this process will include enhanced interface with the Saolta governance structure. Process to commence in February 2023 and be delivered over a 12 month period. (Q1 2024)

Consultant attendance at key committee meetings	The review of the governance structures as outlined above will also ensure a stronger role for Clinical Directorates/ Managed Clinical & Academic Networks (MCAN) and to this end strengthen participation in and membership of key governance committees.	On-going work within Saolta to strengthen the Clinical Directorate /MCAN model will also enhance integration between the Clinical Directorates/ MCANS across the Group over the next six months. (Q3 2023)
Governance of Respiratory Receiving Unit (RRU)	Effective from 10th January 2023 the Emergency Department/RRU division was formally reconfigured as Green and Red Emergency Pathways. The Emergency Medicine Consultants have overall governance of both pathways and the Emergency Medicine Doctors assess and treat patients in the Red Pathway referring to Speciality Teams where appropriate. General Medicine accepts direct presentations for Triage categories 3, 4 and 5	The Acute Medical Assessment Unit (AMAU) will be restored to assess and treat stable GP referral patients with senior clinical leadership provided by an AMAU Consultant supported by the on call Consultant Physician (20th Feb 2023) LUH are revisiting proposals with HSE Estates to provide a modular building to relocate non-clinical functions in the Emergency Department and convert the non-clinical accommodation into additional patient treatment areas for patients with potential transmissible infections.
Implementation of Recommendations of Risk Register Internal Audit	Ongoing work is being done to meet the recommendations of the audit of compliance with the risk management policy. To date 4 of the 7 of the recommendations are fully implemented and the QIP for the remaining 3 recommendations are well advanced and scheduled for completion for late Quarter 2 2023	The QPS team are being supported by the National Risk Management team to meet the remaining final recommendations. (Q2 2023)

	Risk register meetings have from 4 times per year to monthly to ensure the timely implementation of all recommendations.	
Anti Microbial Stewardship (AMS)	LUH are progressing the appointment of a locum consultant to cover clinical work one day a week to free up time for antimicrobial stewardship pending the filling of the 2nd Consultant Microbiologist post The issue of lack of antimicrobial stewardship is in the process of being added to the risk register (Feb.2023). LUH Infection Prevention and Control Committee (HIPCC) has always incorporated their antimicrobial stewardship committee (the name of the committee was changed in the terms of reference (TOR) in 2022 to reflect this). Antimicrobial concerns are also discussed at the Drugs and Therapeutics committee.	**Antimicrobial Stewardship (AMS) Programme:** The antimicrobial stewardship programme is paused as a result of ongoing unsuccessful recruitment of a replacement antimicrobial pharmacist and unfilled Consultant Microbiology posts. Both posts continue to be advertised. The Chief Pharmacist is reviewing available resources within the Pharmacy Department to support an antimicrobial stewardship programme. (Feb 2023) When the antimicrobial pharmacist returns from leave (late Q2 2023) they will recommence the programme development work initiated in 2022 for adoption and implementation. Both unfilled Consultant Microbiologist 1.5 WTE and unfilled 1 WTE antimicrobial pharmacist posts continue to be advertised and all attempts to develop more targeted recruitment will be explored. LUH and CHO1 have also received funding for a shared Consultant

		Microbiologist to enhance IPCT and AMS in both services and the interface between the services. It is hoped to fill this post in 2023.
Medication Safety	LUH HR Department has carried out significant recruitment over the last number of years for the Pharmacy Department at LUH, with an increase of 12 WTE (pharmacists and technicians) approved for LUH in the last 2 years. There is a national shortage of Senior Pharmacists throughout the country and every effort is being made to continually recruit. LUH has rolling recruitment campaigns in place for both Basic & Senior grade Pharmacists. A further round of interviews were held in January with a 3 successful candidates emerging from this. The first of these candidates is due to commence employment in April of this year.	A thorough Pharmacy workforce planning process has commenced with LUH HR and the Pharmacy Department in an attempt to forecast service needs in the medium/long term and the potential requirement for additional Pharmacy staffing. (Q2 2023)

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.		Non-compliant
Issues NS 5.5:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Implementation of Clinical Handover Policy	The Clinical Handover Policy has been finalised and will be presented for ratification at Quality and Patient Safety (QPS) Committee February 2023. As of Jan 2023 commuication related incidents are also being monitored through the QPS report presented at QPS Committee and HEB.	Plan to roll out the National Healthcare Communication Programme to provide education on communication and handover. Facilitators are currently being identified and trained to roll out this programme. (Q2 2023) Compliance with the Clinical Handover Policy will be audited in Q3 2023
Access to diagnostics	A policy has been drafted for Radiographer Practitioners to vet specific CT examinations from ED & AMAU to ensure a more productive workflow. This is being presented to the next RadiationSafety Committee (May 2023). When staffing permits, a third Radiographer is allocated to work in MRI to improve the workflow. The MRI scanner in LUH is scheduled for replacement in Q4 2023 as part of the National Equipment Replacement Programme. The new scanner will increase both functionality and speed within the service. The second CT scanner will be operational (9-5) (Mon-Fri) by the end of February with protected slots for AMAU in morning and afternoon.	Business cases have been submitted to Saolta for approval of extra staff for MRI, 1 Radiographer and 1 HCA. LUH has been accepted as one of the national pilot sites for Advanced Practice Radiography Sonography Reporting (training commenced March 2023). This development will enhance the hospital's capability for timely reporting of US scans.

	LUH also has a rolling recruitment campaign for cardiac physiologist vacancies including 2 new posts approved in 2022.	
Absenteeism rate 8.6% National target 4%	There is continuing focus of LUH Management in relation to absence rates in the hospital. Absence data is monitored on a monthly basis via Saolta and is also presented as part of the HEB report.	LUH Management recognise the importance of ongoing monitoring of absenteeism in the hospital. This includes both covid and non-covid rates. A schedule of refresher training for 2023 is in place for all line managers to focus on absence management in the hospital and in line with Managing Attendance Policy and Procedures. Targeted interventions will be undertaken in areas with a pattern of high absence (Q3 2023).
Recruitment	Staffing levels have improved significantly at LUH over the last number of years with an increase of 490 WTE since December 2019 taking into account significant recruitment across all grades of staff. WTE is monitored both at Saolta level and on a monthly basis at local hospital level. Monthly WTE monitoring is included as part of the monthly HR HEB report. Number of vacancies and recruitment campaigns are also included as part of the report.	Recruitment is a top priority for LUH HR Department. LUH HR Department continues to work with Heads of Services regarding succession and workforce planning and filling of vacancies. A new Electronic Employment Control Tracker (replacing the existing Recruit Log spreadsheet systems) will be implemented to streamline the recruitment process between LUH and Saolta (Q2 2023).

Staff Training	Review has commenced re staff training compliance at LUH and initial discussions have commenced with line managers. (Dec 2022). Discussions have also taken place at Saolta HR level with particular focus on staff training utilising HSEland; links with Learning & Development Unit and also monitoring of Health & Safety mandatory training. Compliance with mandatory training for nursing staff is effectively monitored by the erostering system (HealthRoster) which provides detailed reports for managers.	Work in relation to monitoring of staff training and recording of same is resource dependent and the need for a central repository has been identified. This work will involve liaising with line managers, engaging with the Learning & Development Unit and link in with Saolta group. SAP has been identified as the system to provide the central repository of staff training. Training records for HSCP's will be recorded on SAP by Quarter 3 2023 and subsequently rolled out for other staff groups.
No assigned clinical Pharmacist for the peri-operative directorate (inc. ICU & Theatre)	The Intensive Care Unit is a priority for provision of clinical Pharmacy service due to the vulnerable patient population, high usage volume of high risk medicines & the impending rollout of the electronic Clinical Information System in this area. One of our existing Senior Pharmacists is undertaking additional training in order to assume this role when additional Pharmacist staff commence working here (Q2 2023).	Provision of clinical Pharmacy services to the Peri-Operative directorate will be considered as part of the aforementioned workforce planning process.
Medicine reconciliation had to be prioritised to patients on multiple medications due to staffing constraints	Prioritisation of patients is standard practice with clinical Pharmacy services and is necessary to ensure best use of existing resources. This practice will continue in order to ensure that Pharmacist resources are more effectively targeted towards more vulnerable patients and high risk medicines use.	The aforementioned workforce planning process (Q2 2023) will take into account staffing requirements to provide consistent, high quality provision of clinical Pharmacy services to all in-

	As a whole-hospital approach to risk-stratification of patients on admission is not feasible within our current staffing resources, so this process will continue on a ward-level basis where Pharmacists are allocated to these areas.	patients in LUH.
National Inpatient Experience Survey	There are a total of 36 Quality Improvement Initiatives identified from the 2021 National Inpatient Experience Survey. 26/36 recommendations have been completely implemented. 8/36 recommendations are in progress and will be fully implemented by Q3 2023. 2/36 recommendations are to be implemented.	Work is ongoing implementing the quality improvement plan from the national inpatient experience survey to complete the 8 actions in progress and the 2 outstanding are on the agenda to be addressed through the Nutrition and Hydration Committee.
CPE Screening Compliance	Issues of non compliance are discussed at monthly LUH Hospital Infection Prevention and Control Committee (HIPCC). A CPE sticker was developed successfully in the Gynae ward and has been circulated to all the wards hospital wide for use to identify patients for screening. This is placed on the IPC page of the nursing assessment and care plan (currently being updated by NPDU) and to support the CPE screening checklist. A quarterly audit of compliance of CPE screening in line with local and national guidelines continues. This is carried out by the IPCT and findings are circulated to service ADONs and ward CNM/CMMs highlighting non-compliances and requesting a QIP to address non compliances at ward level. This report is discussed at HIPCC, QPS and by ADONs at CNM meetings. Ongoing education of the need for CPE screening and circulation of CPE screening requirements on the wards. Ongoing support by IPCT on daily rounds. All requirements	A monthly ward led audit to monitor compliance with CPE guidelines (to support the IPCT quarterly audit) will be implemented from Q3 2023. Results from the audits will guide targeted interventions at ward level. Ongoing issue with difficulty identifying if a patient has been in another hospital in the past 12 months. This is an issue Nationwide and will be partially addressed when there are connected patient information systems – work ongoing including the ICNET system that will link the hospitals of the Saolta group. LUH will revisit the issue of moving from targeted to universal CPE screening based on the data received from the monthly

	for CPE screening checklist are available in the ward IPC folders and are laminated for display on wards. This is supported by additional information on nursing team sheets printed from IPMS identifying patients that have been in LUH in the past year (automatically meet criteria for CPE screening). There are regular discussions at safety flow huddles twice daily. IPC attend and highlight examples of non-compliance with CPE screening and the consequences for other patients and the service as a whole. Increased focus on highlighting the importance of including patient CPE screening requirements on "patient status at a glance board" and discussion at handovers. This is a process that works well on some wards and that can be easily replicated. We are currently in the process of rolling out the Model Wards hospital wide. This includes the model ward board (which replaces the patient status at a glance boards) that has a specific section to highlight CPE and other IPC screening. This was designed as an action and measure to tackle the issue of poor CPE screening compliance.	and quarterly audits of compliance. (Q3 2023).
Lack of effective patient flow on 2nd day of inspection	Appointment of 2nd ADON ED Patient Flow on 27th February will allow for more effective cover. LUH (with support from Saolta) undertook a Bed Utilisation Survey (Dec.2022) the analysis of which was completed in January 2023 and will inform further improvements to the management of patient flow within the hospital.	The recommendations from the Bed Utilisation Study will be implemented (Q2 2023). LUH will be reinstating its AMAU facility and patient stream on the 20th February 2023. The Health Performance Visualisation Platform (HPVP) is available in LUH and is currently being rolled out. Reports from

		HPVP will be utilised to enhance our data driven approach to the management of patient flow within the hospital, including the trending of KPIs. Work is continuing with HSE Estates to identify a suitable location to reinstate the Discharge Lounge. (Q3 2023)
Pharmacy staffing	WTE is monitored both at Saolta level and on a monthly basis at local hospital level. Monthly WTE monitoring is included as part the monthly HR HEB report. Number of vacancies and recruitment campaigns are also included as part of the report. Owing to the recruitment difficulties outlined, combined with the significant training resources required to equip a new candidate to performing a specialist role such as antimicrobial stewardship. We have not to date received any interest from suitable candidates in taking on temporary positions of any grade. The necessity for additional training in advance of commencement compounds this. Proposal considered to establish development programme for pharmacists to recruit Senior Pharmacists. LUH HR Department has carried out significant recruitment over the last number of years for the Pharmacy Department at LUH, with an increase of 12 WTE (pharmacists and technicians) approved for LUH in the last 2 years. There is a national shortage of Senior Pharmacists throughout the country and every effort is being made to continually recruit. LUH has rolling recruitment campaigns in	A thorough workforce planning/review process has begun with the LUH HR department in an attempt to forecast service needs in the medium/long term and the potential requirement for additional Pharmacy staffing. Full implementation of the Pharmacy career structure review and clarification over potential progression for new candidates is imperative for attracting new staff as well as retaining existing staff. This process is ongoing between HSE & union representatives.

	place for both Basic & Senior grade Pharmacists. A further round of interviews were held in January with a 3 successful candidates emerging from this. The first of these candidates is due to commence employment here in April of this year. The recent agreement to implement the long-planned Pharmacy career structure review has hopefully improved the attractiveness of hospital Pharmacy as a career path, particularly with the more favourable salary terms for newly-qualified Pharmacists. The issue of shortage of suitable candidates for Pharmacy positions is affecting all segments of the profession nationwide.	

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
Issues NS 6.1:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Poor uptake of mandatory and essential staff training INEWS, ENEWS,	A review has commenced re staff training compliance at LUH and initial discussions has commenced with line managers. Discussions have also taken place at Saolta HR level with particular focus on staff training on INEWS and ENEWS. This is audited and results are discussed at deteriorating patient committee.	We are currently exploring the use of SAP as a central repository and reporting system for mandatory training in conjunction with HealthRoster. (Q2 2023)
Ongoing deficits in nurse staffing rosters	Our electronic roster system (HealthRoster) provides accurate and contemporaneous data on the nursing workforce. This allows us to be proactive in recruiting staff as vacancies arise. This also provides indepth reports to	We are engaged in the Magnet accreditation programme and the outputs of this programme will lead to better retention of staff.

	nurse managers giving them the data to support workforce planning. We are currently implementing the ED Safer Staffing recommendations which ensure we are compliant with National Standards for our Emergency Department anticpated completion Q3 2023. We have engaged in an international nurse recruitment programme over the last year and we have employed 60 nurses throughout this programme.	We are engaged in discussions with our third level colleges to increase the number of our undergraduate student nurses commencing the nursing degree programme. (Q4 2024)
Consultants on Specialist Register	At time of inspection there were 7 Consultants out of a total of 73 Consultants who were not on the Specialist Register. As a consequence of ongoing consultant recruitment by the end of Q1 of 2023 LUH will have reduced this number to 4 Consultants who are not on the Specialist Register of the IMC. Since inspection 5 WTE permanent posts have been advertised by Public Appointment Service as of 3/2/23. Meetings with post holders who are not on the Specialist Register of the IMC will continue to take place and formal approval will continue to be sought from National Director of Acute Operations as per standard procedure.	It is envisaged that by the end of 2023 LUH will further reduce Consultants not on the Specialist Register by 2. For all other remaining Consultants in Post LUH will continue to advertise permanent posts and are currently working with HBS Recruit Special Projects Co-ordinator to advertise specific Consultant posts to a wider audience to fill the posts with candidates on the Specialist Register.

National Standard		Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. **EMERGENCY DEPARTMENT**		Partially compliant
Issues NS 1.6:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Patients on chairs/ wheelchairs in corridors. **Boarded patients in ED**	We have appointed a CNM2 with responsibility for the care provided to patients who are boarding in ED whilst awaiting an inpatient bed. We also have approval for 6.3 WTE nurses to support the care of boarded patients. All boarded patients are offered comfort packs to improve their comfort while awaiting a bed. A recent audit was undertaken in all emergency departments in the Saolta group. This audit looked specifically at the care and documentation of all boarded inpatients. We are now working to implemement the recommendations of the audit. Recent initiatives to reduce the number of boarded inpatients by admission avoidance include appointment of a FIT team, introduction of the purple pathway and introduction of an enhanced care programme. LUH has received funding to employ four additional Consultants in Emergency Medicine. This will allow us to improve the availability of Senior Clinical Decision makers within the Emergency Department and extend our onsite presence.	LUH are revisiting proposals with HSE Estates to provide a modular building to relocate non clinical functions in the Emergency Department and convert the non-clinical accommodation into additional patient treatment areas for patients with potential transmissible infections. We will implement the recommendations from the Bed Utilisation Study (Q2 2023) Reinstatement of AMAU (20 February 2023).

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 - **EMERGENCY DEPARTMENT**		Non-compliant
Issues NS 3.1:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Ambulance Turnaround times	Appointment of 2nd ADON ED Patient Flow on 27th February will allow more effective cover. An ambulance liason officer is based in the ED to support the nursing staff in caring for patients in ambulances. LUH has received funding to employ four additional Consultants in Emergency Medicine. This will allow us to improve the availability of Senior Clinical Decision makers within the Emergency Department and extend our onsite presence.	Pathfinder project will commence in April 2023 to support admission avoidance by providing assessment and treatment at home. LUH are revisiting proposals with HSE Estates to provide a modular building to relocate non clinical functions in the Emergency Department and convert the non-clinical accommodation into additional patient treatment areas for patients with potential transmissible infections. (Q4 2023) Recommendations from the Bed Utilisation Study will be implemented to enhance patient flow in order to reduce the PET times and board of patients in the Emergency Department, reducing delay in access to treatment cubicles for ambulance handover.
Implementation of Recommendations of Risk Register Internal Audit	Ongoing work is being done to meet the recommendations of the audit of compliance with the risk management policy. To date 4 of the 7 of the recommendations are fully implemented and the QIP for the remaining 3 recommendations are well advanced and scheduled for completion for late Quarter 2 2023	The QPS team are being supported by the National Risk Management team to meet the remaining final recommendations. (Q2 2023)

	Risk register meetings have from 4 times per year to monthly to ensure the timely implementation of all recommendations.	
Communication of Critical Results from Lab	The Medical Scientist now contacts the ward extension twice with an interval of 5 mins between calls. If no reply then they activate telemetry bleep system, if no reply from bleep, they ring the Registrar/Consultant responsible for the patient immediately to ensure there is no delay in relaying critical results.	
Delay in accessing specialty advice in ED	Appointment of PALS officer ensures that patients receive communication and access to advice as required. A number of clinical pathways for presenting conditions have been developed and implemented between Emergency Medicine and specialty services. LUH has received funding to employ four additional Consultants in Emergency Medicine. This will allow us to improve the availability of Senior Clinical Decision makers within the Emergency Department and extend our onsite presence.	Appointment of a 2nd PALS officer is being progressed and will be appointed by (Q2 2023) Work is ongoing to extend the range of patient pathways available for patients presenting at the Emergency Department (Q4 2023). The Acute Medical Assessment Unit (AMAU) will be reinstated to assess and treat stable GP referral patients with senior clinical leadership provided by an AMAU Consultant supported by the on call Consultant Physician (20th Feb 2023)
Delays in assessing and Treating patients in ED	3rd ANP minor injuries has been appointed. (Jan 2023).	A panel has been formed to appoint a 4th ANP in Minor injuries.

	A Purple Pathway stream has been developed to fast track patients presenting with minor injuries through the Emergency Department. LUH has received funding to employ four additional Consultants in Emergency Medicine. This will allow us to improve the availability of Senior Clinical Decision makers within the Emergency Department and extend our onsite presence.	As noted above the AMAU will be reinstated from 20th Feb 2023. A Frailty Intervention Team (FIT) and Community Intervention Team (CIT) have been established in 2022 and there is ongoing work to integrate their service within the Emergency Department.
Medication Reconciliation for patients on multiple medications	There has been an appointment of an ED clinical pharmacist. This allows prioritisation of patients who require medication reconciliation in ED when the Clinical Pharmacist is on duty. The Clinical Pharmacist also supports medication reconciliation within the ED through the provision of education, support and advice.	A whole-hospital approach to risk-stratification of patients on admission is currently not feasible within our staffing resources. The roll out of clinical pharmacists in all clinical areas will continue as resources allow.

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
Issues NS 5.8:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Implementation of the Complaints Audit recommendations	Work is ongoing to meet the recommendations of the Complaints Process Review.	Progressing appointment of a 2nd PALS officer.

	Delegated complaints officer, plus a delegation of 3 existing members of staff to cover absence and training has been provided (Nov 2022). National KPI's are monitored monthly in the QPS report and at HEB. Staff Inductions to include education sessions on incident management and complaints handling (From Jan 2023) Implementation of Service User Feedback forms since Dec 2022. Feedback is collated and disseminated to the wards by QPS team and also included in the QPS report and directorate/ MCAN reports. PALS Service Sept 2022 Implementation of the Stage 1 Point of Occurrence report forms to capture the Stage 1 service user feedback. This is collated and included in the QPS and HEB reports and directorate reports. National Complaints Management system is in use to allow timely and effective tracking of implementation of recommendations and compliance with National KPI's. This is communicatied in the QPS and HEB reports and also communicated in the Directorate reports. There is ongoing engagement with the Ombudsman and the National Complaints Governance Learning Team to ensure that all recommendations are being met from the Learning to get better report.	Work is in progress to establish a Patient and Family Engagement Forum (Q3 2023) LUH will continue to liaise with the recently appointed Saolta Lead for Complaints Manangement in the ongoing development in our complaints and patient feedback processes.

Level of input from key personnel (Consultants) into QPS and Incident Management	A new algorithm has been designed to streamline processes for reporting of incidents, ensure timely multi- disciplinary involvement in incident reviews and facilitate effective and timely open disclosure following a patient safety incident. This will be presented for agreement and ratification at February 2023 QPS meeting. This will then be for immediate implementation and QPS is currently implementing an audit of reviews to ensure continuous improvement in the quality of the reviews undertaken. Quality and Patient Safety Ward visits are in place to support staff in all areas of Quality and Patient Safety including but not limited to: • Effective Complaints Handling • Incident Reporting • Open Disclosure • Data Protection GDPR • National Patient Safety Strategy Commitments • National Standards for safer better healthcare self assessment • Service User Feedback • Risk Assessment and maintaining risk register	Clinical Director/ MCAN input into risk and quality management will constitute a key workstream within the roll out of EY project recommendations. (Q1- Q4 2023)

National Standard		**Judgment**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.		Partially compliant
Issues NS 1.8:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**

Implementation of the Complaints Audit recommendations	Work is ongoing to meet the recommendations of the Complaints Process Review. Delegated complaints officer, plus a delegation of 3 existing members of staff to cover absence and training has been provided (Nov 2022). National KPI's are monitored monthly in the QPS report and at HEB. Staff Inductions to include education sessions on incident management and complaints handling (From Jan 2023) Implementation of Service User Feedback forms since Dec 2022. Feedback is collated and disseminated to the wards by QPS team and also included in the QPS report and directorate/ MCAN reports. PALS Service Sept 2022 Implementation of the Stage 1 Point of Occurrence report forms to capture the Stage 1 service user feedback. This is collated and included in the QPS and HEB reports and directorate reports. National Complaints Management system is in use to allow timely and effective tracking of implementation of recommendations and compliance with National KPI's. This is communicatied in the QPS and HEB reports and also communicated in the Directorate reports. There is ongoing engagement with the Ombudsman and the National Complaints Governance Learning Team to ensure	Progressing appointment of a 2nd PALS officer. Work is in progress to establish a Patient and Family Engagement Forum (Q3 2023)

	that all recommendations are being met from the Learning to get better report.	

National Standard		Judgment
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.		Non-compliant
Issues NS 2.8:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Lack of Clarity re: Actions introduced in response to high levels of C. Difficile	LUH are progressing locum consultant covers clinical work on one day a week to free up time for antimicrobial stewardship. The issue of lack of antimicrobial stewardship is in the process of being added to the risk register. (Feb, 2023)	Both unfilled Consultant Microbiologist 1.5 WTE and unfilled 1 WTE antimicrobial pharmacist posts continue to be advertised. When the antimicrobial pharmacist returns from leave (late Q2 2023) they will recommence the programme development work initiated in 2022 for adoption and implementation. The Chief Pharmacist is reviewing available resources within the Pharmacy Department to support an antimicrobial stewardship programme. (Feb 2023)
Variance in CPE Screening between Clinical Areas Compliance with Targeted Screening for CPE	Issues of non compliance are discussed at monthly LUH Hospital Infection Prevention and Control Committee (HIPCC). A CPE sticker was developed successfully in the Gynae ward and has been circulated to all the wards hospital wide for use to identify patients for screening. This is placed on the IPC	A monthly ward led audit to monitor compliance with CPE guidelines (to support the IPCT quarterly audit) will be implemented from Q3 2023. Results from the audits will guide targeted interventions at ward level.

	page of the nursing assessment and care plan (currently being updated by NPDU) and to support the CPE screening checklist. A quarterly audit of compliance of CPE screening in line with local and national guidelines continues. This is carried out by the IPCT and findings are circulated to service ADONs and ward CNM/CMMs highlighting non-compliances and requesting a QIP to address non compliances at ward level. This report is discussed at HIPCC, QPS and by ADONs at CNM meetings. Ongoing education of the need for CPE screening and circulation of CPE screening requirements on the wards. Ongoing support by IPCT on daily rounds. All requirements for CPE screening checklist are available in the ward IPC folders and are laminated for display on wards. This is supported by additional information on nursing team sheets printed from IPMS identifying patients that have been in LUH in the past year (automatically meet criteria for CPE screening). There are regular discussions at safety flow huddles twice daily. IPC attend and highlight examples of non-compliance with CPE screening and the consequences for other patients and the service as a whole. Increased focus on highlighting the importance of including patient CPE screening requirements on "patient status at a glance board" and discussion at handovers. This is a process that works well on some wards and that can be easily replicated. We are currently in the process of rolling out the Model Wards hospital wide. This includes the model ward board (which replaces the patient status at a glance boards) that has a specific section to highlight CPE and other IPC	Ongoing issue with difficulty identifying if a patient has been in another hospital in the past 12 months. This is an issue Nationwide and will be partially addressed when there are connected patient information systems – work ongoing including the ICNET system that will link the hospitals of the Saolta group. LUH will revisit the issue of moving from targeted to universal CPE screening based on the data received from the monthly and quarterly audits of compliance. (Q3 2023).

	screening. This was designed as an action and measure to tackle the issue of poor CPE screening compliance.	
Anti Microbial Stewardship (AMS)	LUH are progressing the appointment of a locum consultant to cover clinical work one day a week to free up time for antimicrobial stewardship pending the filling of the 2nd Consultant Microbiologist post The issue of lack of antimicrobial stewardship is in the process of being added to the risk register. (Feb, 2023) LUH Infection Prevention and Control Committee (HIPCC) has always incorporated their antimicrobial stewardship committee (the name of the committee was changed in the terms of reference (TOR) in 2022 to reflect this). Antimicrobial concerns are also discussed at the Drugs and Therapeutics committee.	**Antimicrobial Stewardship (AMS) Programme:** The antimicrobial stewardship programme is paused as a result of ongoing unsuccessful recruitment of a replacement antimicrobial pharmacist and unfilled Consultant Microbiology posts. Both posts continue to be advertised. The Chief Pharmacist is reviewing available resources within the Pharmacy Department to support an antimicrobial stewardship programme. (Feb 2023) When the antimicrobial pharmacist returns from leave (late Q2 2023) they will recommence the programme development work initiated in 2022 for adoption and implementation. Both unfilled Consultant Microbiologist 1.5 WTE and unfilled 1 WTE antimicrobial pharmacist posts continue to be advertised and all attempts to enhance recruitment will be explored. LUH and CHO1 have also received funding for a shared Consultant Microbiologist to enhance IPCT and AMS in both services and the interface

		between the services. It is hoped to fill this post in 2023.
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 - **WIDER HOSPITAL**		Partially compliant
Issues NS 3.1:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Implementation of Recommendations of Risk Register Internal Audit	Ongoing work is being done to meet the recommendations of the audit of compliance with the risk management policy. To date 4 of the 7 of the recommendations are fully implemented and the QIP for the remaining 3 recommendations are well advanced and scheduled for completion for late Quarter 2 2023 Risk register meetings have from 4 times per year to monthly to ensure the timely implementation of all recommendations.	The QPS team are being supported by the National Risk Management team to meet the remaining final recommendations. (Q2 2023)
Implementation of the Complaints Audit recommendations	Work is ongoing to meet the recommendations of the Complaints Process Review. Delegated complaints officer, plus a delegation of 3 existing members of staff to cover absence and training has been provided (Nov 2022). National KPI's are monitored monthly in the QPS report and at HEB. Staff Inductions to include education sessions on incident management and complaints handling (From Jan 2023)	Progressing appointment of a 2nd PALS officer. Work is in progress to establish a Patient and Family Engagement Forum (Q3 2023)

	Implementation of Service User Feedback forms since Dec 2022. Feedback is collated and disseminated to the wards by QPS team and also included in the QPS report and directorate/ MCAN reports. PALS Service Sept 2022 Implementation of the Stage 1 Point of Occurrence report forms to capture the Stage 1 service user feedback. This is collated and included in the QPS and HEB reports and directorate reports. National Complaints Management system is in use to allow timely and effective tracking of implementation of recommendations and compliance with National KPI's. This is communicated in the QPS and HEB reports and also communicated in the Directorate reports. There is ongoing engagement with the Ombudsman and the National Complaints Governance Learning Team to ensure that all recommendations are being met from the Learning to get better report.	
Implementation of Clinical Handover Policy	The Clinical Handover Policy has been finalised and will be presented for ratification at Quality and Patient Safety (QPS) Committee February 2023. As of Jan 2023 commuication related incidents are also being monitored through the QPS report presented at QPS Committee and HEB.	Plan to roll out the National Healthcare Communication Programme to provide education on communication and handover. Facilitators are currently being identified and trained to roll out this programme. (Q2 2023) Compliance with the Clinical Handover Policy will be audited in Q3 2023

Level of input from key personnel (Consultants) into QPS and Incident Management	A new algorithm has been designed to streamline processes for reporting of incidents, ensure timely multi- disciplinary involvement in incident reviews and facilitate effective and timely open disclosure following a patient safety incident. This will be presented for agreement and ratification at February 2023 QPS meeting. This will then be for immediate implementation and QPS is currently implementing an audit of reviews to ensure continuous improvement in the quality of the reviews undertaken. Quality and Patient Safety Ward visits are in place to support staff in all areas of Quality and Patient Safety including but not limited to: • Effective Complaints Handling • Incident Reporting • Open Disclosure • Data Protection GDPR • National Patient Safety Strategy Commitments • National Standards for safer better healthcare self assessment • Service User Feedback • Risk Assessment and maintaining risk register	Clinical Director/ MCAN input into risk and quality management will constitute a key workstream within the roll out of EY project recommendations. (Q1- Q4 2023)
Approved and Funded posts for Obstetricians and Gynaecologists (1 permanent and 3 locum)	Since the HIQA inspection, 2 permanent consultant obstetricians and gynaecologists have been appointed at LUH (recruitment for which was ongoing at time of inspection). One is in the substantive post and the second is currently working as a locum and once clearances are completed by PAS, will be appointed as substantive. Recruitment is ongoing for the remaining consultant vacancies.	It is planned that by end of 2023 all 5 WTE posts will be filled on a permanent basis.

Access to diagnostics	A policy has been drafted for Radiographer Practitioners to vet specific CT examinations from ED & AMAU to ensure a more productive workflow. This is being presented to the next Radiation Safety Committee (May 2023). When staffing permits, a third Radiographer is allocated to work in MRI to improve the workflow. The second CT scanner will be operational (9-5 Mon-Fri) by the end of February with protected slots for AMAU in morning and afternoon. LUH also has a rolling recruitment campaign for cardiac physiologist vacancies including 2 new posts approved in 2022.	Business cases have been submitted to Saolta for approval of extra staff for MRI, 1 Radiographer and 1 HCA. LUH has been accepted as one of the national pilot sites for Advanced Practice Radiography Sonography Reporting (training commenced March 2023). This development will enhance the hospital's capability for timely reporting of US scans.
Admission screening for CPE	Issues of non compliance are discussed at monthly LUH Hospital Infection Prevention and Control Committee (HIPCC). A CPE sticker was developed successfully in the Gynae ward and has been circulated to all the wards hospital wide for use to identify patients for screening. This is placed on the IPC page of the nursing assessment and care plan (currently being updated by NPDU) and to support the CPE screening checklist. A quarterly audit of compliance of CPE screening in line with local and national guidelines continues. This is carried out by the IPCT and findings are circulated to service ADONs and ward CNM/CMMs highlighting non-compliances and requesting a QIP to address non compliances at ward level. This report is discussed at HIPCC, QPS and by ADONs at CNM meetings.	A monthly ward led audit to monitor compliance with CPE guidelines (to support the IPCT quarterly audit) will be implemented from Q3 2023. Results from the audits will guide targeted interventions at ward level. Ongoing issue with difficulty identifying if a patient has been in another hospital in the past 12 months. This is an issue Nationwide and will be partially addressed when there are connected patient information systems – work ongoing including the ICNET system that will link the hospitals of the Saolta group. LUH will revisit the issue of moving from targeted to universal CPE screening based

	Ongoing education of the need for CPE screening and circulation of CPE screening requirements on the wards. Ongoing support by IPCT on daily rounds. All requirements for CPE screening checklist are available in the ward IPC folders and are laminated for display on wards. This is supported by additional information on nursing team sheets printed from IPMS identifying patients that have been in LUH in the past year (automatically meet criteria for CPE screening). There are regular discussions at safety flow huddles twice daily. IPC attend and highlight examples of non-compliance with CPE screening and the consequences for other patients and the service as a whole. Increased focus on highlighting the importance of including patient CPE screening requirements on "patient status at a glance board" and discussion at handovers. This is a process that works well on some wards and that can be easily replicated. We are currently in the process of rolling out the Model Wards hospital wide. This includes the model ward board (which replaces the patient status at a glance boards) that has a specific section to highlight CPE and other IPC screening. This was designed as an action and measure to tackle the issue of poor CPE screening compliance.	on the data received from the monthly and quarterly audits of compliance. (Q3 2023).
MDRO Status recorded on IPMS but not documented on charts.		The Infection Prevention and Control section in the Nursing Assessment and Care Plan document has been updated will be implemented with education to support the accurate completion of documentation. (Q3 2023).

MDRO status not recorded on letters to GPs	The Inter-Healthcare Facility Infection Control Healthcare Associated Infection (HCAI) Transfer/Discharge form has been updated on the IPMS (Jan 2023) and all wards directed that a printed copy must be given to the patient on discharge and a copy retained in the patient notes. This document contains details of MDRO (including CPE status) and vaccination status and is now being used by all hospitals in the Saolta group to ensure consistent communication.	Going forward a copy of the Inter-Healthcare Facility Infection Control Healthcare Associated Infection (HCAI) Transfer/Discharge form will be sent to GPs on patient discharge which will contain essential MDRO and vaccination information. (Q2 2023).
No access to internet within clinical rooms where medications are prepared.	Since the inspection, a pilot has been commenced in AMAU of having a wall mounted PC in the drug preparation area.	Discussions are underway with ICT department to evaluate the pilot and commence a roll out to all wards. (Q2 2023)
INEWS chart not always completed correctly on sample of healthcare records reviewed	LUH is engaged in the National roll out if the digital INEWS system. We are piloting this system on Medical 3 and this pilot will inform the national recommendation re roll out. A review has commenced re staff training compliance at LUH and initial discussions has commenced with line managers. Discussions have also taken place at Saolta HR level with particular focus on staff training on INEWS and ENEWS. This is audited and results are discussed at deteriorating patient committee. Review of all Irish National Early Warning Scores (INEWS) ≥ 7,review of Emergency Medicine Early Warning System (EMEWS) that trigger "Red", review of patients requiring higher levels of care, is included in the SOP which has been developed on performing the "Safety Pause" in ED, at 8.30am, 15.00hrs, 23.00hrs and 6.00hrs.	

Sub Optimal uptake of mandatory training	Review has commenced re staff training compliance at LUH and initial discussions have commenced with line managers. (Dec 2022). Discussions have also taken place at Saolta HR level with particular focus on staff training utilising HSEland; links with Learning & Development Unit and also monitoring of Health & Safety mandatory training. Compliance with mandatory training for nursing staff is effectively monitored by the erostering system (HealthRoster) which provides detailed reports for managers.	Work in relation to monitoring of staff training and recording of same is resource dependent and the need for a central repository has been identified. This work will involve liaising with line managers, engaging with the Learning & Development Unit as well as link in with Saolta group. We are currently exploring the use of SAP as a central repository and reporting system for mandatory training in conjunction with healthroster. (Q2 2023)

National Standard		**Judgment**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.		Non-compliant
Issues NS 3.3:	**(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.**	**(b) where applicable, long-term plans requiring investment to come into compliance with the standard**
Absence of documented input on PARS from personnel such as Consultants from the relevant specialties	A new algorithm has been designed to streamline processes for reporting of incidents, ensure timely multi- disciplinary involvement in incident reviews and facilitate effective and timely open disclosure following a patient safety incident. This will be presented for agreement and ratification at February 2023 QPS meeting. This will then be for immediate implementation and QPS is currently implementing an audit of reviews to ensure	Clinical Director/ MCAN input into risk and quality management will constitute a key workstream within the roll out of EY project recommendations. (Q1- Q4 2023)

	continuous improvement in the quality of the reviews undertaken. Quality and Patient Safety Ward visits are in place to support staff in all areas of Quality and Patient Safety including but not limited to: • Effective Complaints Handling • Incident Reporting • Open Disclosure • Data Protection GDPR • National Patient Safety Strategy Commitments • National Standards for safer better healthcare self assessment • Service User Feedback Risk Assessment and maintaining risk register	
No evidence on the PARS that they had further input or were reviewed **Hospital not following own process- delays in implementing learning and recommendations from SRE (Serious Reportable Events)**	New process to streamline processes for reporting of incidents, multi- disciplinary involvement in incident reviews and facilitating effective and timely open disclosure following a patient safety incident have been designed for agreement and ratification at February 2023 QPS meeting and then for immediate implementation and QPS currently implementing an audit of reviews to ensure continuous improvement in the quality of the reviews undertaken. PARS are updated during and after the LIMT and SIMT process and are uploaded to be attached to the incident and the review screen updated on completion with recommendations communicated in the relevant reports to the clinical directorates and QPS meetings for action.	The format of the QPS report is being updated (February 2023) to include follow-up from SIMT and implementation status of recommendations. This will also be presented to HEB and the relevant directorate reports. This action log will be monitored through QPS and HEB. The effectiveness of these changes will be reviewed as part of the implementation of EY recommendations in respect of Quality and Patient Safety (Q3 2023)
Limited evidence that the process in place to manage and respond to	A historical backlog of reviews due to staffing in QPS is now addressed. Ongoing monitoring of compliance with 125 day	Ongoing work on the monitoring of the quality of patient incident reviews by auditing the compliance with National

incidents were functioning as effectively as they ought or that timely learning was being shared	KPI for the review of SRE's and Serious Incidents and working towards compliance. All reviews on completion are currently uploaded and attached to the incident on NIMS (review screen) with the SIMT outcomes.	timelines and also auditing the quality of the reviews. (Q1 2023)