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:	UPMC Aut Even Hospital
Centre ID:	OSV-0008824
Address of healthcare service:	Freshford Road, Kilkenny R95 D370
Type of Inspection:	Announced
Date of Inspection:	29 and 30 April 2025
Inspection ID:	NS_0144

About the healthcare service

Model of hospital and profile

The UPMC Aut Even Hospital is part of the UPMC Hospital Network.[1] The hospital was founded in 1915 and joined UPMC Hospital Network in March 2021. Services provided by the hospital include:

- general surgery
- urology
- ophthalmology
- pain medicine
- gastroenterology
- endocrinology
- general medical admissions and assessment
- diagnostic services
- outpatient cardiology service
- outpatient care.

The hospital is an elective hospital and has externally contracted services for laboratory services which includes the provision of blood and blood products.

The hospital has a service level agreement with the Health Service Executive (HSE) for the provision of a total of 11 patient rooms in which a HSE led and delivered medical oncology service is provided. UPMC Aut Even Hospital participates in the HSE's 'Multi-Party Framework Agreement for the Provision of Private Hospital Capacity to Support Urgent and Emergency Care' by providing five inpatient beds.

The following information outlines some additional data on the hospital

Number of beds	71 inpatient beds 24 day case beds

[1] The UPMC Hospital Network comprises four hospitals – UPMC Sports Surgery Clinic, UPMC Aut Even Hospital, UPMC Kildare Hospital and UPMC Whitfield Hospital.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024 (national standards)* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

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

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection

[†]Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.
[‡] Unsolicited information is information not requested by HIQA but is received by HIQA from people who use services, their relatives, and staff in the service or any member of the public.

are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
29 April 2025	09.00 – 17.15hrs	Eileen O'Toole	Emma Cooke Cathy Sexton Sara McAvoy
30 April 2025	08.45 – 13.15hrs	Eileen O'Toole	Emma Cooke Cathy Sexton Sara McAvoy

Information about this inspection

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

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

The inspection team visited two clinical areas:

- Surgical inpatient ward (25-bedded adult and paediatric inpatient surgical ward)
- Medical inpatient ward (23-bedded adult medical inpatient ward).

During this inspection, the inspection team spoke with hospital staff from a variety of professions and disciplines in the clinical areas visited during this inspection. Inspectors also spoke with the following staff at the hospital:

- Representatives of the hospital's senior management team, quality risk and patient safety team, human resources team and non-consultant hospital doctor team.
- A representative from the:
  - Infection Prevention and Control Committee
  - Medication Management and Use Working Group
  - Deteriorating Patient Improvement Committee
  - Patient Flow Department.

Acknowledgements

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

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[**] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

During this inspection inspectors visited the surgical and medical inpatient wards. Inspectors spoke with a number of patients about their experience of the care received in the hospital. Patients were complimentary about the staff and the care received, commenting that *"staff were very helpful"* and that *"everything was excellent"*.

When asked what was good about their stay in hospital patients commented that they *"would not have anything bad to say"* that they found *"the place very good"*. Inspectors observed effective communication between staff and patients which was supported by patients who said *"staff are very approachable"* and that the "*doctor explained everything*". When asked if there was anything that could be improved, patients who spoke with inspectors commented – *"can't think of anything"* and "*nothing really"*.

The majority of patients said they had not received information about the hospital's complaints process but if they wanted to make a complaint or had concerns about the care they received, that they found staff very approachable and would talk to them.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards (5.2, 5.5 and 5.8) related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes compliance with one standard (6.1) related to workforce. The service was found to be substantially compliant with the four national standards (5.2, 5.5, 5.8 and 6.1) assessed under this dimension. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

The general manager (GM) was the accountable officer with overall responsibility and accountability for the governance of healthcare services provided in the hospital. At UPMC network level, the GM reported into the managing director of UPMC Ireland.

Operational performance meetings between the hospital and UPMC Ireland were monthly and were attended by members of the UPMC Ireland executive team, the GM and the director of nursing (DON). These meetings had a standing agenda which included access, clinical activity and quality and patient safety. The purpose of these meetings, as detailed in the terms of reference, were to provide support, oversight and guidance to the hospital from the UPMC Ireland executive team.

UPMC Ireland network provided shared services to the four hospitals within their network. These positions included an assistant chief nursing officer (ACNO) in infection prevention and control, a director of pharmacy, a chief pharmacist for antimicrobial stewardship, chief pharmacist for medicines information and medication safety and lead pharmacy technician for procurement and technical services integration.

Within UPMC Aut Even Hospital, the GM identified the current senior management team (SMT) as the GM, the DON and the facilities manager. Inspectors were informed that the vacant position of director of quality and continuous improvement manager will also form part of the SMT when that position is filled.

The hospital's medical director (MD) had responsibility for clinical services at the hospital and chaired the Medical Advisory Committee (MAC). The MD was line manager for the lead non-consultant hospital doctor (NCHD) who, in turn, provided line management for the team of NCHDs that were direct hospital employees. The NCHDs were professionally accountable to the lead NCHD. The DON was responsible for the organisation and management of nursing services at the hospital and also had line management responsibility for the quality team.

The MD, GM and the DON met every two weeks at a quality and safety meeting. This was an information sharing meeting where updates were given and clinical governance issues were discussed. Clinical metrics such as deaths, unplanned transfer, and unplanned return to theatre were shared as were updates from working groups within the hospital.

Surgical theatres at UPMC Aut Even Hospital operated Monday to Friday. The relevant consultant anaesthesiologist was responsible for all perioperative care related to anaesthesia and for the first 24 hours post surgery for their respective patients. Inspectors were informed that if patients experienced any complications, then the admitting surgical consultant would be the first point of contact. Communication would then be between surgical consultant and consultant anaesthesiologist if a return to surgery was required. UPMC Aut Even Hospital had a service agreement with Critical Care Partners to provide anaesthesiology service to patients attending their hospital. This service consisted of a core group of consultant anaesthesiologists who were registered on the specialist register of the Irish Medical Council (IMC) and held privileges[§§] granted by the hospital. This agreement included arrangements to allow for regular scheduled surgical services, a named consultant anaesthesiologist out-of-hours on-call roster Monday to Friday (5pm to 7am) and a nominated consultant anaesthesiologist contactable throughout the weekend for anaesthesiology requirements.

UPMC Aut Even Hospital had a national framework agreement with the HSE for the provision of private hospital beds to support urgent and emergency care since November 2023. At the time of inspection, the number of beds that formed part of this agreement was limited to five, three of which were utilised on the medical ward. The hospital from which these patients were transferred from, continued to be medically responsible for their patients with any sudden or unexpected deterioration in condition being dealt with by UPMC Aut Even Hospital staff.

[§§] Privileges are the regulations set out by a hospital which will govern the use of the hospital facilities by independent non-salaried consultant level medical practitioners.

Surgical services were provided to a limited cohort of paediatric patients aged five years and over. The exception was the minor ear, nose and throat surgery which was carried out as a day case for patients aged two years and above, and this exception was clearly defined in a hospital policy. Hospital management reported that there was an appointed clinical lead for paediatric surgery and paediatric anaesthesiology but no formalised access to a named paediatric consultant with acute care responsibilities. Inspectors were informed that when there were paediatric inpatients on-site following surgery that their surgeon would remain onsite until all patients were discharged the following day.

The Clinical Governance Committee standing agenda included audit of clinical outcomes, clinical incident reviews, review of risk register, unplanned transfer of patients and quality of patient care. The committee was chaired by the medical director and was attended by the GM and the DON. Minutes reviewed demonstrated that agenda items were discussed as outlined above. The committee invited the specific accountable consultant to present both case reviews and unplanned transfers to committee members. Updates from Infection Prevention and Control Committee (IPCC) and Medication Management and Use Working Group (MMUWG) were presented at this forum. This committee reported into the Clinical Governance Committee in the UPMC network. On review of minutes, inspectors noted that actions were assigned to individuals but were not time bound.

The hospital's Quality and Patient Safety Committee met monthly, was chaired by the GM or the DON, had appropriate membership and reported into the Clinical Governance Committee. Minutes reviewed demonstrated that incidents, patient feedback, complaints, mandatory training, quality improvement plans and risk register updates were discussed. The meetings were action focused, with actions clearly outlined, assigned to a responsible person and time bound.

Operational Leader Committee meetings were weekly and in the main were information sharing sessions, for department heads to meet, receive information and share updates from their own department. This meeting met in line with their terms of reference and was chaired by the GM. Mandatory training attendance was discussed at these meetings.

The Medical Advisory Committee (MAC) was chaired by the medical director and was attended by the GM, DON, hospital consultants and UPMC network chief compliance officer vis-à-vis UPMC network director of governance and met in line with their terms of reference. From minutes reviewed by inspectors, there was evidence that unplanned transfers, returns to theatre, patient complaints, hand hygiene and incidents including medication incidents were presented at the MAC. The GM provided an update at each of the meetings and minutes reviewed detailed consultant privileges approved and upcoming privileges for review.

The Infection Prevention and Control Committee (IPCC) had responsibility for co-coordinating an infection prevention and control (IPC) programme. The DON was the chairperson of the IPCC and the committee met quarterly in line with their terms of reference. Inspectors were informed that the IPCC reported into the Quality and Patient Safety Committee as per their terms of reference which was inconsistent to that detailed on the hospital's organisational chart. From the UPMC network, three consultant microbiologists provided a consultant microbiologist service to the hospital on a rotational basis and attended the IPCC meetings. The assistant chief nursing officer in IPCC and the chief pharmacist for antimicrobial stewardship from UPMC network also attended. From evidence provided during this inspection, it was clear that the hospital had effective oversight and governance arrangements in place for the hospital's infection prevention and control programme.

The Medication Management and Use Working Group (MMUWG) was assigned responsibility to assure and improve the quality and safety of medication use in UPMC Aut Even Hospital. The MMUWG reported into the local Clinical Governance Committee and into the Drugs and Therapeutics Committee at UPMC network level. This committee was chaired by a medical consultant and had appropriate membership from both UPMC Aut Even Hospital and UPMC network. Medication incidents, audit and antimicrobial stewardship was discussed at this forum but minutes reviewed showed that minutes were action focused but not assigned to a responsible person and there were no timelines assigned for completion of actions. The UPMC Ireland, Drugs and Therapeutics Committee reported into the UPMC network Clinical Governance Committee.

The hospital had a newly formed Deteriorating Patient Committee which held its inaugural meeting in February 2025. This committee, which had evolved from the code blue and emergency response working group, was responsible for reviewing the response and management of the deteriorating patient within the hospital. At the inaugural meeting the terms of reference, committee membership and standing agenda was agreed. The agenda indicated that this committee, which was newly formed would include incidents, audit of Irish National Early Warning System (INEWS), the Irish Paediatric Early Warning Systems (IPEWS), sepsis and mandatory training.

The hospital accepted planned elective care and had a process for managing any issues in relation to transition of care. The bed management working group met weekly to discuss the scheduled cases for the coming week and used this time to identify any issues that needed attention or follow up with housekeeping, catering or staffing. Unplanned transfers of patients out to other facilities were logged as clinical incidents and discussed at the Clinical Governance Committee.

Overall, services within the hospital had integrated corporate and clinical governance arrangements in place for assuring the quality and safety of the healthcare services provided with regular review of information relating to the quality and safety of

outcomes for people using the service. However, the hospital did not have formalised access to a paediatric consultant with acute care responsibilities. The hospital organisational chart had some inconsistencies detailing reporting structures of some of the committees. Timelines for completion of actions were not always time bound nor assigned to an individual within the minutes of meetings.

Judgment: Substantially Compliant

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

The hospital had effective management arrangements in place to support and promote the delivery of safe, high-quality healthcare services in relation to the four areas of known harm which were the focus of this inspection — infection prevention and control, medication safety, deteriorating patients and transitions of care.

The hospital's Infection Prevention and Control Team (IPCT), had developed an annual programme for 2025. The programme set out the purpose, objectives and priorities which was approved by the IPCC. The IPCT had developed an annual report for 2024 which outlined how the hospital performed in relation to the monitoring of surveillance and compliance with infection prevention and control practices, audit results, training provided and quality improvement projects undertaken. A consultant microbiologist was not available on-site at the hospital, however staff had access to dedicated microbiologist advice on a 24/7 basis. The chief antimicrobial pharmacist from UPMC network supported the hospital's antimicrobial stewardship programme and provided updates at the IPCC.

The hospital had a pharmacy service and this was led by the chief pharmacist. As part of the network wide medication safety programme for UPMC hospitals, a medication safety strategy for 2025 to 2027 was developed with the aim of promoting medication safety and ensuring the safest possible environment for patients at all stages of the medication use process. A UPMC network medication safety programme work plan for 2025 was also developed which included, governance, leadership and compliance, education, training and capacity building, clinical pharmacy, medicines information, digital health and automation, audit, data insights and continuous quality improvement. Both documents were in draft format and awaiting final approval.

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. UPMC Aut Even Hospital had the following early warning systems (EWS) in place to support the recognition, escalation and

response to the deteriorating patient - INEWS and IPEWS. There was no designated consultant lead for each of the early warning systems used in the hospital. As discussed in national standard 5.2, the hospital had a newly formed Deteriorating Patient Committee and their terms of reference clearly stated that the group was responsible for the implementation of the deteriorating patient programme. The EWS hospital policies were aligned to national guidelines.

A bed management working group met weekly and reviewed upcoming scheduled care. Unplanned re-admissions, unplanned transfers and unplanned return to theatre were tracked and trended and discussed at the Clinical Governance Committee and the MAC.

It was evident to inspectors that there were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four key areas of harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, the service would benefit by identifying a designated consultant lead for each of the early warning systems used in the hospital. Both the medication safety strategy and medication safety programme work plan for 2025 were both in draft format and so require further action. Formalised management arrangements for the deteriorating patient at the time of inspection was at the development stage and was not yet embedded.

Judgment: Substantially Compliant

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

There were systematic monitoring arrangements in place at UPMC Aut Even Hospital to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital produced a quarterly quality overview report which detailed patient safety incidents, complaints, healthcare associated infections, unplanned patient transfers and patient feedback. The overview data was discussed at the relevant committees within UPMC Aut Even Hospital and at committee meetings with the UPMC network.

There were formalised risk management structures and processes in place to proactively manage and minimise risks at the hospital. The GM and the DON had governance and oversight of the corporate risk register. Risks were escalated through local governance structures and were escalated to the quality and safety meeting that was held between the MD, GM and the DON. Risks assessments reviewed at local level did not always contain additional controls or actions and was identified as an

opportunity for improvement. Identified ward based risks, which had been highlighted during the course of inspection, that had additional controls that could not be managed at local level were not always placed on the corporate risk register such as a lack of accessible bathrooms. The management of reported risks related to the four areas of known harm — infection prevention and control, medication safety, deteriorating patients and transitions of care is discussed further in national standard 3.1.

The IPCT demonstrated risk management structures and had developed an infection prevention control risk assessment and plan for 2025. On review, the risk assessment had existing measures, additional measures for roll out during 2025 and a review of their compliance rate and/or issues that had occurred in 2024. From review of IPCC minutes inspectors saw evidence that risk assessment updates were provided within this forum.

The hospital had systems and processes in place to manage sentinel events,[***] notifiable incidents and adverse events. All incidents were reported into the quality department and tracking and trending of incidents were reported to heads of department. There was a process to convene an independent team as required if a sentinel event occurred. Inspectors saw evidence that a rootcause analysis (RCA) was undertaken if a review was undertaken.

The hospital had an agreed annual plan for audit and evidence was provided of audit and monitoring in the areas that were the focus of this inspection (infection prevention and control, medication safety, the deteriorating patient and transitions of care) relevant to the size and scope of the hospital. Examples of audit and monitoring activities were provided to inspectors, however, quality improvement plans for audits which fell below set targets were not consistently developed.

Information from patient feedback and complaints were shared with staff and the hospital had a system in place which provided oversight of this process. The patient feedback response rate for quarter one in 2025 was between 4% and 7.1% which was low and did not reach the hospital target of 50%. Efforts to improve the response rated included; introduction of quick response (QR)[†††] code, re-introduction of paper based response and clinical staff speaking with between five and 10 patients weekly. Hospital management acknowledged that despite their improvement efforts there had been no improvement from the 2024 response rate.

Overall, it was clear that the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and

[***] A sentinel event is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reach the patient and results in any of the following: death, permanent harm or severe temporary harm.
[†††] A quick response (QR) code is **a** type of barcode that stores information and can be read by a digital device, such as a cell phone.

reliability of healthcare services. The identification and management of risk management processes requires review in order to ensure that all risk assessments have additional controls and actions and that all risks that cannot be managed locally are placed on the corporate risk register. The hospital should continue with their efforts to improve the rates of patient feedback. Furthermore, the hospital should ensure that all data collected is used to improve the quality and safety of the service and that there is responsiveness to non-compliant audit activity.

Judgment: Substantially Compliant

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

Workforce arrangements at the hospital were planned, organised and managed to ensure high-quality, safe and reliable healthcare. The human resources department (HR) had overall responsibility for the key performance indicators (KPIs) related to workforce. At the time of inspection, inspectors were informed that the hospital had a total of 240 whole time equivalent (WTE) employees with 29 vacancies which were, in the main, new posts. The reported turnover rate was 10%. Absenteeism rate was 3.2% which was commendable. Annual staff planning was carried out with the HR department, the GM and the DON. There were no reported risks related to staffing at the hospital at the time of inspection.

Consultants working at the hospital were not employed directly by the hospital. There was a formalised process to grant privileges for consultants to use the hospital facilities. This process was supported by a suite of hospital policies to set out the application process for credentialing, the granting of clinical privileges, the maintenance of privileges and the procedure for ongoing practice evaluation of all medical practitioners with admitting privileges. The application process included submission of evidence of registration on the speciality division of the Irish Medical Council. Inspectors were informed that an annual professional practice evaluation of all medical practitioners was undertaken by the hospital.

Inspectors were informed that there were seven NCHDs employed by the hospital. One of the seven NCHDs was employed at a medical registrar level and was delegated responsibility of line management to the remaining NCHDs. The MD had overall clinical responsibility for the NCHD team.

Should there be any instance of matters relating to patient care, the relevant consultant for the patient was contacted during and outside core working hours. The medical

registrar was on-site Monday to Friday during core hours and had clinical responsibility for medical patients only. The surgical patients were cared for by a surgical NCHD. During the out-of-hours period there was one NCHD that was on-site and available for medical review of patients. There were a total of four NCHDs who covered the out-of-hours period, all of whom were trained in both advanced cardiovascular life support (ACLS) and paediatric advanced life support (PALS) which was a prerequisite for on-call cover. There were formalised arrangements in place if there was a need to open theatre out-of-hours.

The clinical areas visited at the time of inspection had their rostered complement of nursing and health care assistant (HCA) staff. The clinical nurse managers (CNM), grade two reported into the two nurse service managers (CNM3) who reported into the DON. The hospital employed a total of five nurses with a paediatric qualification and efforts were made to ensure that these nurses were on duty and available to care for the paediatric patients on the days that they received surgery. Mandatory training for inpatient nurses included paediatric emergency assessment, recognition and stabilisation (PEARS)[‡‡‡]. The wards had continuous professional development folders and clinical facilitators were allocated to inpatient wards to support staff with training.

Corporate induction was provided to all new staff on commencement of employment. Training compliance was reported on at the monthly quality and patient safety committee. In the clinical areas inspected good compliance with mandatory training was evidenced. An opportunity for improvement was identified in the surgical ward where 77% of nurses had completed medication safety education and 77% had completed INEWS training. Eighty one per cent of inpatient nursing staff had completed PEARS.

At the time of inspection, 100% of NCHDs had completed basic life support. Compliance with both ACLS and PALS needed improvement but there was a time bound plan in place to ensure that all eligible NCHDs received both ACLS and PALS education. An opportunity for improvement was also noted in NCHD training in relation to standard based precautions, transmission based precautions, donning and doffing personal protective equipment and hand hygiene where the compliance rate was 71.4%. Through discussion with SMT, it was unclear to inspectors who had oversight of the uptake of mandatory training by NCHDs and if this had been assigned to an accountable person.

As discussed in national standard 5.2, the UPMC Ireland network provided shared services to the four hospitals within their network. These positions included a director of pharmacy and a chief pharmacist for antimicrobial stewardship. The chief pharmacist

[‡‡‡] The Paediatric Emergency Assessment, Recognition and Stabilization (PEARS) Provider Course is designed to increase the paediatric healthcare provider's knowledge and skills necessary to assess early signs of respiratory failure and shock, provide early emergent interventions, and alert the appropriate Advanced Life Support (ALS) response team.

located at the hospital was a shared position with another hospital within the network and UPMC Aut Even Hospital received 0.6 WTE of this position and reported into the director of pharmacy and the GM. Inspectors were informed that there had been an overall increase in relation to pharmacy resourcing across all UPMC sites but there were no current vacancies in pharmacy staff.

Within the hospital, a 0.8 WTE clinical nurse specialist in IPC was supported by a lead IPC assistant chief nursing officer from UPMC Ireland network.

In summary, the hospital planned, organised and managed their workforce to provide quality, safe and reliable healthcare. The hospital had low vacancy rates across all staff disciplines which is to be commended. However, appropriate oversight of and improvement with compliance of mandatory training within the NCHD group needs improvement.

Judgment: Substantially Compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. UPMC Aut Even Hospital was found to be compliant in three national standards (1.6, 1.7 and 3.3), substantially compliant with four national standards (1.8, 2.7, 2.8 and 3.1) assessed. 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.

Staff were aware of the requirement to respect and promote the dignity, privacy and autonomy of service-users. Staff were observed to be caring, kind and responsive to patient's individual needs in the clinical areas inspected. All the single rooms and multi-occupancy rooms in the clinical areas visited had en-suite bathroom facilities. The physical environment in the inpatient wards supported the delivery of care that respected and promoted the patient's dignity and privacy. Privacy curtains were used when providing care in multi-occupancy rooms.

Inspectors observed staff maintaining patient's privacy on the ward by knocking on their door and awaiting permission to enter. However, on the medical ward it was observed that the patients' healthcare records were not stored appropriately and this was brought to the attention of the CNM.

On review of minutes from the quality and patient safety committee from quarter one 2025, inspectors noted the emphasis placed on an observed trend of inpatient complaints in relation to respect and dignity issues. A quality improvement plan was in the planning phase to ensure that these experiences were not repeated.

Overall, there was consistency with what inspectors observed in the clinical areas visited and what patients told inspectors about their experiences of receiving care. There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital.

Judgment: Compliant

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

Staff were committed and dedicated to promoting a person-centred approach to care. It was evident that a culture of kindness was actively promoted by staff and management. Staff were observed providing care with kindness, consideration and respect. Inspectors witnessed call bells being answered promptly. This was validated by a patient who told inspectors that staff were "*very approachable*" and that "*staff are lovely*". Patients who spoke with inspectors outlined that there was a *"lovely banter between staff*" and *"a friendly atmosphere*" on the ward.

Patients were offered opportunities to raise issues relevant to their care. This was evidenced by a patient who spoke with inspectors about the difficulties they were experiencing with the lack of an accessible bathroom and how they had raised this issue with ward staff. Inspectors were informed that this issue was being progressed.

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

Judgment: Compliant

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

There were effective processes in place at the hospital to respond to feedback and complaints received from patients and or their families.

The GM, as the overall accountable person for the hospital was responsible for the management of complaints. At the time of inspection, there was a coordinated response to complaints from the GM, the DON and the quality coordinator.

The hospital's complaints policy guided the management of complaints at the hospital and set out the process and timelines for acknowledging and responding to complaints. The hospital received a total of 21 complaints in 2024, of which 86% were resolved within the 30 day designated timeframe. The hospital received seven complaints in quarter one of 2025 which were trended into four categories of clinical, environmental, patient management and relationships. Complaints were discussed at Quality and Patient Safety Committee, Clinical Governance Committee, MAC and were also escalated to the UPMC network. The hospital risk rated all complaints into major which was a reportable event, moderate which involved a process change and had possible business impact and minor which had no impact to the business.

Inspectors did not observe any information on how to make a complaint or access independent advocacy services in the clinical areas inspected. Complaints were resolved at point-of-care where possible. Inspectors were informed that the shared learning from complaints was brought back to the ward level by the CNM2 and were shared at the safety brief.

Overall, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families. However, information on how to make a complaint or access independent advocacy services was not clearly displayed in the clinical areas inspected.

Judgment: Substantially Compliant

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

During this inspection, inspectors visited the medical and the surgical ward. The medical ward received admissions from general practitioners or outpatient clinics and the patients were then under the care of the consultants who had privileges within the hospital. The ward areas comprised of single rooms in the main with some two-bedded and three-bedded multi-occupancy rooms. All rooms had en-suite toilet and shower facilities. Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms visited by inspectors. There was evidence of stained floor surfaces in both wards and the cleaning staff advised that effort to address this was not successful. There was also evidence of wear and tear in the patient rooms. Inspectors were informed that there was a rolling plan for renovation which was ongoing.

The CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place. Cleaning staff confirmed they had received relevant training and were knowledgeable about their role and cleaning processes. Inspectors were informed by the cleaning staff that when a patient was discharged a terminal[§§§] clean was completed by the cleaning staff and/or the HCAs. Cleaning schedules were updated and monitored by the cleaning supervisor daily. Patient equipment was cleaned by nursing staff and/or HCAs and there was a system to indicate the equipment was cleaned. Equipment observed in the clinical areas was clean. Environmental and equipment audits were completed monthly and this will be discussed further in national standard 2.8.

Hazardous waste was observed to be safely and securely stored. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Inspectors observed that not all hand hygiene sinks throughout the medical ward conformed to national requirements.[****] When the inspectors discussed this with senior members of the hospital, they were told that the organisation had an ongoing programme of refurbishment, which included replacing hand hygiene sinks and repair of damaged surfaces.

There was evidence of appropriate placement of patients requiring transmission-based precautions. Patients were isolated in single rooms with appropriate signage in place and the doors were closed. All patients that transferred from acute hospitals were isolated for three days and if asymptomatic then isolation precautions were lifted.

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

[****] Department of Health, United Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

Inpatient paediatric patients were cared for on an identified wing on the surgical floor only and were admitted to a single room. This arrangement meant that they were cared for in an environment that potentially had mixed adults and paediatric patients. Best practice indicates that children should be cared for in a designated paediatric ward. There was a hospital policy which stated that a parent or guardian must remain with the child for the duration of their stay. A child protection and welfare policy also detailed identified risks for the paediatric patient with the procedures in place to manage the risk. At the time of inspection, there were no paediatric patients admitted in the hospital.

During this inspection, inspectors observed the security and maintenance arrangements for the physical environment. On both wards visited, the exit doors to the wards were recently replaced and inspectors were informed that swipe access was due to be installed. The CNM advised that the exit doors are locked at night to avoid unauthorised access. Risk assessments had been completed in relation to lack of swipe access.

The hospital had only one patient bed lift to the third floor where the medical ward was located, which was identified as a risk on the corporate risk register. This posed a risk if the lift failed and patients required emergency transfer. The lack of accessible bathrooms and the difficulty encountered for patients was also highlighted during this inspection and was also identified as a risk by ward staff. These issues will be further discussed in national standard 3.1.

In summary, the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. Whilst there was no paediatric patients in the hospital at the time of inspection, paediatric patients were cared for in an environment that potentially had mixed adults and paediatric patients. The following areas needed improvements, acknowledging that remedial work was underway:

- not all hand hygiene sinks throughout the medical ward conformed to national requirements
- exit doors on both wards inspected was awaiting installation of swipe access
- one patient lift to third floor
- lack of accessible bathrooms.

Judgment: Substantially Compliant

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

The inspectors found that there were assurance systems in place at UPMC Aut Even Hospital to monitor, evaluate and continuously improve the quality and safety of care provided.

The quality department reported on clinical metrics quarterly for inpatients and included reportable deaths, inpatient deaths, unplanned transfers, unplanned returns to theatre, unplanned readmissions, incidents, reportable incidents and patient complaints. These metrics were reported to the Clinical Governance Committee, the Quality and Patient Safety Committee and escalated to the UPMC network at operational performance meetings. There was benchmarking performed between sites across the network in AMS auditing and medication incident reporting, further benchmarking across the network is an opportunity for improvement.

The IPCT reported on rates of Meticillin-Resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. difficile) infection, Carbapenemase-Producing Enterobacterales (CPE) and Vancomycin Resistant Enterococci (VRE). Rates of healthcare-associated infections (HAI) were trended and each confirmed case had a RCA performed which was then discussed at the quarterly IPCC. The overall HAI rate was reported as 0.13% in 2024 which is commendable. In 2023, the national point prevalence survey[††††] demonstrated an overall HAI prevalence of 7.4%. There were no reported outbreaks since 2022. Compliance with screening for multi-drug resistance organism (MDRO) was monitored annually and 98% of patients that met the hospital screening criteria was screened appropriately in 2024. Transmission based precautions compliance was monitored against the hospital benchmark of 95%. Compliance ranged from 83% to 100% in 2024. Inspectors did not view any action plans performed when compliance fell below the hospital benchmark.

Environmental audits were carried out monthly across the hospital with a hospital benchmark of 80%. Results ranged from 72% to 94% in 2024. A responsible person had been identified to carry out the actions necessary for non-conformances but these actions were not time bound nor was there evidence supplied that re-audit had occurred or that a quality improvement plan was developed.

Patient equipment audits were carried out monthly in the hospital. Compliance rates ranged from 94.7% to 100% on the surgical ward and from 89.5% to 94.7% on the medical ward. In March 2025, the compliance rate for the hospital was 88.2% which was below the hospital benchmark of 90%. Areas of non-compliance were highlighted on the monthly audits but inspectors did not see any actions assigned to an individual or evidence of re-audit.

[††††] https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/surveillance/hospitalpointprevalencesurveys/2023/pps2023_NationalReport_20241104.pdf

Sharps management and waste management compliance was audited monthly. Poor compliance was noted in quarter two of 2024 and an analysis was carried out with good compliance levels achieved subsequently.

The IPC clinical nurse specialist (CNS) and link champions carried out monthly hand hygiene audits. In the three months preceding this inspection, the medical ward had an average compliance of 84.2% and the surgical ward had an average compliance of 70.6%. Both wards were not compliant with the hospital's hand hygiene standard of 90%. Inspectors did not see evidence of re-audit on the occasions when the compliance level fell below the expected standard but were informed that non-conformances were addressed at the time of audit. All audit results were discussed at the monthly clinical nurse manager meeting and at IPCC. Evidence of a quality improvement plan completed in 2024 in hand hygiene compliance was provided to inspectors. This was undertaken as the hospital wide compliance was below the hospital benchmark of 90%. The actions completed included an improvement in hand hygiene signage, increased number of local auditors and increased education sessions. Improvements in compliance was achieved in the latter end of the year in 2024. Hand hygiene non-compliances was identified as a risk within the hospital and will be discussed further in national standard 3.1. Hand hygiene should continue as a focus for sustained improvement.

Surgical site surveillance was discussed at quarterly IPCC meetings. Surgical site infections (SSI) were defined and benchmarked using international sources. The hospital carried out enhanced surveillance of both total knee and total hip replacements. Following an increase in SSI rates in 2024 a quality improvement plan was undertaken to eradicate Methicillin-Susceptible Staphylococcus aureus (MSSA), develop a surgical scrub audit, increase hygiene audits in operating theatres and develop and implement an SSI care bundle.[‡‡‡‡]

Compliance with care bundles for peripheral vascular cannulas maintenance, peripheral vascular insertion, urinary catheter maintenance, central venous access devices were monitored monthly with good compliance rates achieved in 2024 overall. Blood stream infections (BSI) surveillance was monitored with a 0.01% acquired in 2024.

Safe storage of medication and legal classification – controlled drugs audits were carried out quarterly across the hospital. The medical ward achieved 83.4% compliance and the surgical ward achieved 90.4% compliance in quarter four, 2024. Nursing medication safety was monitored through nursing and midwifery quality care metrics. Results from July to August 2024 were reviewed and demonstrated, in the main, good compliance. Medication safety in relation to prescribing pro re nata (PRN)[§§§§] medications was noted

[‡‡‡‡] A care bundle is a structured way of improving the processes of care and patient outcomes through the use of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

[§§§§] A type of medication can be prescribed as PRN, which means to be taken when required rather than a regular dose.

to achieve poor scores. An audit of PRN medications across the four hospitals in the UPMC network was undertaken in November 2024. Recommendations included the review and standardisation of the medicines prescription and administration record (MPAR) to support intended prescribing practices. A pilot of a revised MPAR was ongoing at the time of inspection at one of the UPMC hospital sites and was due for implementation in UPMC Aut Even Hospital in quarter three, 2025.

The UPMC network had an overarching AMS audit plan across their four hospital sites with agreed KPIs using the national AMS guidelines. The UPMC network chief pharmacist for antimicrobial stewardship undertook weekly rounds in the hospital to review antibiotic prescribing in UPMC Aut Even Hospital and presented an update on AMS KPIs at the quarterly IPCC.

The INEWS escalation and response was audited monthly by the hospital. In 2024, between 150 and 318 patient charts were assessed for compliance with performance indicators relating to the use of INEWS with minimal non-compliances reported. Inspectors did not see any evidence of actions in relation to the non-compliances. The IPEWS audit consisted of a review of all paediatric inpatient charts which was a total of 348 in 2024. Non-compliances were identified in the escalation process within the PEWS charts which resulted in "Tuesday Thoughts" which were education recordable sessions, re-education at safety huddles and simulation training. Inspectors were informed that these actions have resulted in an improvement in compliance. The hospital undertook an audit of patient charts (136) to review if the sepsis tool/form was initiated appropriately. All charts audited were compliant in that no patients were suspected to have sepsis and the sepsis tool was not initiated. On each occasion that a patient experienced a deterioration an incident was logged which then resulted in a review of the timelines and appropriateness of response after the deterioration was detected.

The hospital collected data on all unplanned transfers out of hospital for clinically deteriorating patients, unplanned returns to theatre, average length of stay and re-admissions. In 2024, the hospital had a total of 17 unplanned transfers and in quarter one and up to the time of the inspection in 2025 the hospital had a total of four unplanned transfers, all transfers were to the local acute hospital. Each transfer was logged as an incident and there was then a process to undertake a review of each transfer. The patient's relevant consultant attended and presented to the clinical governance meetings following each unplanned transfer. On review of a paediatric patient re-admission at the clinical governance committee meeting a decision was taken that the hospital would not accept any further paediatric re-admissions due to the skill mix and planning required for this cohort of patient to return to theatre. This is a good example of when the hospital used information from monitoring and evaluation to inform decision making.

Audit of compliance with the clinical handover tool, ISBAR was carried out in 2024. Internal transfer of care and nursing end of shift handover was audited for compliance with following the ISBAR structure and that early warning scores formed part of the handover. There was no scoring system for this audit and there were no non-compliances identified in the three audits reviewed.

As discussed in national standard 5.8 patient feedback response rate was low for quarter one, 2025 which did not reach the hospital target of 50%. Continuous improvement was demonstrated with the 'you said, we did' initiative outlining actions taken as a result of patient feedback.

Laboratory services for UPMC Aut Even Hospital was outsourced to three laboratories, St. Luke's General Hospital, the Beacon Hospital and Biomnis medical laboratory. Inspectors were informed that the hospital was assured that turnaround times (TAT) were monitored and met requirements from these outsourced services.

Overall, the hospital had systems in place to systematically monitor and evaluate the services relevant to the size and scope of the hospital with many examples provided of audits completed to continuously improve practice and the quality and safety of the service. However, quality improvement plans were not consistently developed in response to audits where expected performance/targets had not been achieved. Furthermore, timeframes and the person responsible for quality improvement implementation was not always identified in audit reports. Hand hygiene compliance should continue as a sustained focus for improvement.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service.

The GM and the DON had oversight of the risks within the hospital and were responsible for maintaining, reviewing and updating the corporate risk register. Inspectors were informed that risks were escalated to the UPMC network at the operational performance meetings but minutes reviewed did not reflect this. Within the hospital, risks were reviewed at the clinical governance meeting and at the quality and safety committee. Risks were recorded on the corporate risk register with existing controls and additional actions required to manage and reduce these risks.

The hospital utilised a tiered escalation process at ward level where the CNM managed and outlined operational risks and escalated risks to the nurse service managers who maintained a local risk register at ward level. Inspectors were informed that local risk registers were reviewed annually and as required by the CNM and nurse service manager.

The hospital had only one patient bed lift to the third floor which was identified as a risk on the corporate risk register which posed a risk if the lift failed and patients required emergency transfer. A risk assessment had been completed which included implemented control measures of training for all personnel that would be involved in the use of evacuation aids and ensuring evacuation aids were serviceable. Additional measures on the corporate risk register included the plans for a second lift, due to be completed at the end of 2025. This risk was not contained on the local risk register on the third floor clinical area and at the time of inspection, staff on the clinical area reported to inspectors that they were not aware of the risk.

Lack of accessible bathrooms had been identified as a risk at a local level. Inspectors were informed that this risk had been escalated and actions agreed. On review of the risk assessment there were no additional controls or actions and no action owner. This risk had not been escalated to the corporate risk register.

Risks related to infection prevention and control of healthcare-associated infection were identified, monitored and reviewed at IPCC. Inpatients were screened at the pre-anaesthetic clinic and/or on admission to the hospital to identify if they were at risk of carrying an MDRO in line with hospital policy which set out clearly defined criteria and type of isolation required if positive. All inpatients that met the screening criteria were treated as positive until a result was returned, cared for in a single room and placed in contact precautions.

Day case patients were not screened for MDROs prior to procedure and an IPC departmental risk assessment had been carried out which identified that this could cause transmission of infection or a healthcare-associated infection. Implemented control measures included IPC policies, education and the use of a booking form used to verify the patients MDRO status prior to admission. If a day case patient had a history of an MDRO and this was disclosed at booking or on presentation for day case then that patient was cared for in a single room in contact precautions if available. Inspectors also saw evidence of a nursing admission assessment which captured history of the patient's MDRO status. IPC alerts were placed on the electronic health record for patients with a known MDRO.

The risk of healthcare-associated infections due to hand hygiene non-compliances was identified as a high-rated risk on the corporate risk register. Additional control measures included increased local auditor training, awareness days and promotion of hand hygiene at department head level. As discussed in national standard 2.8 hand hygiene compliance was identified as an ongoing issue at the time of inspection.

Inspectors noted that not all hand hygiene sinks throughout the medical ward conformed to national requirements. As discussed in national standard 2.7, inspectors were informed that the organisation had an ongoing programme of refurbishment, which included replacing hand hygiene sinks. This risk was not placed on the corporate risk register.

A comprehensive clinical pharmacy service[*****] was not provided for all patients and pharmacy-led medication reconciliation[†††††] was not undertaken for all patients. Pharmacist medication reconciliation was carried out on prioritised patients, in accordance with a defined prioritisation matrix on patient admission only and for inpatients only. The incomplete pharmacy service was identified as a high-rated risk on the corporate risk register and local pharmacy department risk register which identified that the risk was due to staffing constraints, nevertheless as discussed in national standard 6.1, there were no vacancies within the hospital pharmacy department. Additional control measures included the development of an alternative medicines management solution with the goal of enhancing the service delivery efficiency. At the time of inspection, this was still in progress.

The hospital had a list of high-alert medications and inspectors observed the use of risk reduction strategies to support the safe use of opioids, potassium and segregation of high risk medications into a red box. Forty five per cent of medication incidents were related to high-alert medications in quarter one, 2025. There was a list of sound alike look alike drugs (SALADs). Staff in the clinical areas inspected had access to medicines information on electronic tablets and through an application for smart mobile telephones. Up-to-date prescribing guidelines, antimicrobial guidelines and copies of British National Formulary (BNF) and BNF for children were available at the point of preparation. Alerts and recalls were managed through the pharmacy.

At the time of inspection, the location, size, design and security of the pharmacy had been outlined as a risk to inspectors and was on the local pharmacy department risk register. There were advanced works on site in the hospital and pharmacy would move in quarter two 2025. This risk was not on the corporate risk register.

[*****] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[†††††] Medication reconciliation: involves using a systematic process to obtain an accurate and complete list of all medications taken prior to admission.

The hospital was using the national early warning systems for the various cohorts of patients — INEWS and IPEWS to support the recognition, response and management of a deteriorating patient. The ISBAR communication tool was used for the escalation of the care of the deteriorating patient. Policies and procedures were in place to support the implemented early warning systems and staff were knowledgeable about escalation and response protocols.

Staff had access to a range of up-to-date policies, procedures, protocols and guidelines through the hospital's intranet.

Overall, arrangements were in place to ensure the identification and management of significant risks and the GM and the DON had good oversight of the risks in the hospital. However, further structured arrangements could be introduced to ensure that all ward level risks, which could not be managed at ward level, would be escalated to the corporate risk register. Also, relevant staff should have an awareness of the risks entered on the corporate risk register in relation to the area that they are working in. Not all risk assessments had additional controls completed to reduce the risk to an acceptable level and not all required actions were identified.

Judgment: Substantially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. This process was supported by hospital policies on risk management and sentinel event identification, documentation and notification.

The hospital had a system in place for the tracking and trending of patient safety incidents. Incidents were categorised into sentinel events, harm/no harm incidents and near miss reports. There was a total of 341 incidents reported in 2024 and a total of 41 in quarter one, 2025 none of which were classified as sentinel events. Inspectors were informed that there had been no sentinel events in the past three years. The quality department had oversight of incidents, reported incidents into the Quality and Safety Committee and presented to the department heads meeting. Staff who spoke with HIQA were knowledgeable about how to report a patient safety incident and what were the trends within the hospital. Shared learning from incidents was discussed at safety huddles on the ward.

A root cause analysis (RCA) was carried out when patient mortality and defined patient morbidity occurs such as unplanned transfers, surgical site infections and unexpected outcomes/surgical complications. The RCA was then reviewed by a multidisciplinary team and presented at the clinical governance committee. On review of a RCA undertaken, following a patient safety incident, inspectors noted that it included recommendations with the corrective and preventative actions taken.

Medication related patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. A medication incident analysis report was developed for quarter one, 2025 which detailed 77 medication incident reports per 1000 bed days, 3% related to NCC MERP category E or above‡‡‡‡‡ and 45% of incidents were related to high alert medications. A detailed review for incidents graded E and above was carried out. Inspectors reviewed an example of a review which included the patient outcome and suggested actions and recommendations with both the responsible person and the timeline included. In quarter one, 2025 91% of incidents were reported by pharmacists and 0% by doctors which is an opportunity for improvement.

Incidents in relation to infection prevention and control were monitored by the IPCT and discussed at meetings of the IPCC when they occurred. All unplanned transfers out of hospital for clinically deteriorating patients was logged as incidents, a RCA completed and reported into the quality and safety meeting between the MD, the GM and the DON, the clinical governance committee and the MAC. There were a total of 17 unplanned transfers in 2024 and four in quarter one, 2025.

The hospital effectively identified, managed, responded to and reported on patient-safety incidents. There was clear evidence of actions and recommendations implemented in response to incidents which resulted in positive outcomes for patients.

Judgment: Compliant

‡‡‡‡‡ Medication incidents which may have caused harm or death.

Conclusion

HIQA carried out an announced inspection of UMPC Aut Even Hospital to assess compliance with national standards from the National Standards for Safer Better Healthcare. The inspection focused on four areas of harm – infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

Services within the hospital had integrated corporate and clinical governance arrangements in place for assuring the quality and safety of healthcare services. Formalised management arrangements for the deteriorating patient had been initiated and was making good progress. The hospital also had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. Information from feedback and complaints from people who use the services was shared with staff and overall, it was clear that the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital planned, organised and managed their work force to provide quality, safe and reliable healthcare and the hospital had low vacancy rates across all staff disciplines which is to be commended.

Quality and Safety

During this inspection inspectors spoke with a number of patients about their experience of the care received in the hospital. Patients were complimentary about the staff and the care received. Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and promoted a culture of kindness and consideration.

There were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families. However, information on how to make a complaint or access independent advocacy services was not clearly displayed in the clinical areas inspected.

The physical environment within the hospital required improvements which were ongoing at the time of inspection and there was a plan in place for completion. Whilst there were no paediatric patients in the hospital at the time of inspection, paediatric patients were cared for in an environment that potentially had mixed adults and

paediatric patients. The overall reported hospital acquired infection rate was low and there were no reported outbreaks since 2022 which is commended.

The hospital had systems in place to systematically monitor and evaluate the services relevant to the size and scope of the hospital with many examples provided of audits completed to continuously improve practice and the quality and safety of the service. There were systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service. However, structured arrangements in place to minimise the risks could be improved.

The hospital effectively identified, managed, responded to and reported on patient-safety incidents. There was clear evidence of actions and recommendations implemented in response to incidents which resulted in positive outcomes for patients.

Overall, UPMC Aut Even Hospital demonstrates effective oversight in quality and safety for their patients with some actions required to demonstrate full compliance. HIQA will, as part of the monitoring activity, continue to monitor compliance with the *National Standards for Safer Better Healthcare.*

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

Compliance Classifications

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

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

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

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

safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially 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.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant