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:	Bantry General Hospital
Address of healthcare service:	Carrignagat Bantry Cork P75 DX93
Type of inspection:	Announced
Date(s) of inspection:	04 and 05 September 2024
Healthcare Service ID:	OSV-0001005
Fieldwork ID:	NS_0093

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

Bantry General Hospital is a Model 2* hospital providing services to the population of the area encompassing West Cork and South Kerry. It is a Health Service Executive (HSE) funded hospital managed by the South South West Hospital Group (SSWHG).† Services provided by the hospital include:

- acute medical in-patient and day patient services
- day service surgery
- endoscopy services
- a medical assessment unit
- a local injury unit
- a high dependency unit
- outpatient services including
    - Outreach Gynaecology
    - Outreach Obstetrics
    - Outreach Paediatrics
- diagnostic services

There was an onsite Designated Centre for Older Persons under the governance of Bantry General Hospital, which was not within the scope of this inspection.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	50 inpatient beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess

*A Model 2 hospital provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, 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.

† At the time of the inspection, the South South West Hospital Group comprised eight hospitals — Cork University Hospital, Cork University Maternity Hospital, University Hospital Kerry, Mercy University Hospital, Tipperary University Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital and Mallow General Hospital. The hospital group's academic partner was University College Cork.

compliance with the National Standards for Safer Better Healthcare as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of 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 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

[‡] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
04 September 2024 05 September 2024	13:30 – 18:00hrs 09:00 – 15:35hrs	Robert McConkey	Lead
		Patricia Hughes	Support
		Mary Flavin	Support
		Eilish Browne	Support

Information about this inspection

An announced inspection of Bantry General Hospital was conducted on 04 and 05 September 2024.

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

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

The inspection team visited three clinical areas:

- Local Injuries Unit
- Medical Assessment Unit
- Medical Ward

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

- Representatives of the hospital's Executive Management Board (EMB)
- Hospital Manager

[§] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
** Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
†† Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Director of Nursing
- Clinical Lead
- Quality, Risk and Patient Safety Manager
- Complaints Officer
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager (Hospital Manager)
- A representative from each of the following hospital committees:
    - Infection Control Committee (Decontamination and Hygiene)
    - Medication Management Committee
    - Deteriorating Patient Committee
    - Delayed Discharge and Bed Management team.

Acknowledgements

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

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

The local injury unit (LIU) and the medical assessment unit (MAU) were within the urgent care centre of the hospital.

The LIU was operational seven days a week from 8am to 8pm. It operated on a set of inclusion and exclusion criteria as set out in an approved standard operating procedure. Attendees to the LIU may present by themselves, or by referral by their General Practitioner (GP) or SouthDoc[‡‡]. The LIU comprised four assessment/treatment bays, three of which were single capacity and one double capacity.

The MAU is open Monday to Friday from 9am to 4.30pm and patients may self-refer to the MAU during these hours or be referred by their GP or Southdoc for urgent assessment or treatment. Outside of these hours patients with medical conditions could still be referred to the MAU 24 hours a day, seven days a week, by their GP or SouthDoc. Patients presenting with medical conditions could receive first line treatment in the MAU and may be discharged, admitted to the hospital, or transferred to other hospitals for ongoing treatment. The medical assessment unit had nine single assessment pods with no en-suite facilities. There were two showers and two toilets available for use by patients in the MAU.

[‡‡] SouthDoc is an out of hours family doctor service for urgent medical needs

The Medical ward was a 33-bedded ward consisting of six four-bedded rooms, one three-bedded room, one two-bedded room and four single rooms. The single rooms had en-suite shower and toilet facilities. At the time of inspection, 32 beds were occupied.

Inspectors observed effective communication between staff and patients. Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to patients.

On the day of inspection, inspectors spoke with a number of patients about their experience of care. Overall, patients were complimentary about the staff and the care they had received, commenting that they were 'happy with the care and the staff are kind', 'staff are outstanding and very patient', 'make you feel at home.' When asked to describe what was good about their experience, patients outlined that 'staff help me with the bathroom', 'assistance walking with the frame and getting in and out of bed ', 'Good food, staff very good, place is very clean.' When asked if anything could be improved about the service or care, the majority outlined that everything was satisfactory. One patient did outline that 'the rails at each side of the toilet are too far apart for me to stand up on my own'.

Most of the patients who spoke with inspectors were not aware of the hospital's official complaints process, but all outlined that they would talk to a nurse or someone senior if they had an issue. One patient commented they were aware of the poster outlining how to make a complaint that was on display in the ward.

Patients' experiences recounted on the day of inspection were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey. Ninety one percent of patients who completed the survey reported that they had a 'good' or 'very good' overall experience in the hospital, which was above the national average of 82%.

Overall, there was consistency with what inspectors observed in the clinical areas visited, what patients told inspectors about their experiences of receiving care in those areas and the findings from the 2022 National Inpatient Experience Survey.

Capacity and Capability Dimension

Key inspection findings and judgements from national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and national standard 6.1 from the theme of workforce are described in the followings sections.

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

Bantry General Hospital had formalised corporate and clinical governance arrangements in place. The reporting arrangement for hospital management and oversight committees was clearly outlined in documentation reviewed, and evident to inspectors during the inspection. The reporting structures and accountability relationships to the SSWHG was also clearly outlined.

Bantry General Hospital is part of the Cork University Hospital (CUH) Group, which also includes Cork University Hospital and Mallow General Hospital. The CUH Group operates under the SSWHG, managed by the HSE. The hospital was governed and managed by the Hospital Manager supported by the EMB which was chaired by the Chief Executive Officer (CEO) of the CUH Group. The Hospital Manager reported directly to the CEO of the CUH Group and upwards to the SSWHG Leadership Team.

There was devolved responsibility and accountability from the Clinical Director in CUH to the Clinical Lead in Bantry General Hospital who provided clinical oversight and leadership for medicine at the hospital. The clinical lead, along with a second consultant physician and consultant representative for surgery were members of the hospital's EMB. Members of the EMB attended the Performance Management meetings with the SSWHG.

The Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital and reported to the CEO of the CUH Group and to the Chief DON of the SSWHG.

Hospital Management Team

Bantry General Hospital's EMB was responsible for the governance and oversight of healthcare services at the hospital. The EMB met monthly and was chaired by the CEO of the CUH Group. The membership was appropriate to the size and scope of the hospital and there was good attendance at meetings. The EMB had oversight of the hospital's activities and performance of quality and safety indicators, and provided effective governance and oversight for the healthcare services in the hospital.

Meetings followed a structured format. Issues raised were progressed from meeting to meeting. However, while meeting actions were clearly outlined with an assigned responsible person, time frames to complete the actions were not always set.

The EMB reported to the SSWHG Executive at Performance Management meetings. Inspectors were informed that the Terms of Reference (TOR) for the hospital's local performance management meetings were aligned with the HSE Accountability Framework. However, the document submitted by the hospital to HIQA, which was a chapter of the HSE Accountability Framework, did not include a TOR for the performance management meetings, and the frequency of meetings outlined in the document was not related to local performance management meetings. Only four local performance management meetings appear to have occurred since February 2023, with only one meeting having taken place in 2024 (April). Inspectors were informed that the Hospital Manager, the DON, and the Clinical Lead had formal and informal meetings with their reporting

counterparts in the SSWHG. The Clinical Lead held these meetings monthly, while the Hospital Manager met weekly. Inspectors were further informed that these meetings provided opportunities to raise issues of concern.

Quality and Safety Committee

The Quality and Safety Committee (QSC) was the main committee assigned with overall responsibility for the governance and oversight of quality and safety in the hospital. All of the hospital committees including the medication management committee, the infection control committee (decontamination and hygiene) and the deteriorating patient and sepsis committee reported to the QSC which in turn reported to the EMB. Terms of reference for the QSC were 'pending approval 2023' and outlined that meetings were scheduled to take place at least quarterly. However, the committee met only three times in the previous 12 months and only once in 2024. The committee was chaired by the Clinical Lead. There was good attendance by the required members. The committee provides a twice yearly report to the CUH Executive Quality and Safety Committee. However, implementation of actions from meeting to meeting was not clearly monitored as per national guidance.[§§]

The QSC's responsibilities included the monitoring of hospital risks and reviewing the hospital's risk register, monitoring patient-safety incidents and complaints, the implementation and monitoring of clinical audit, clinical guidelines and protocols, and performance monitoring related to key quality and safety indicators. The committee also provided oversight for the implementation of patient-safety quality improvements. The committee appeared to be effective in its oversight of the quality and safety of healthcare services at the hospital.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control Committee (IPCC) was responsible for the governance and oversight of infection prevention and control at the hospital. The committee was chaired by the Hospital Manager, it met monthly and reported quarterly to the QSC who in turn report to the EMB. The IPCC had a number of groups and committees reporting into it, including representatives from the four clinical directorates, the infection prevention and control team, and a medical scientist representative. The CNM2 for endoscopy reported on endoscopy-specific decontamination issues to the IPCC.

One day after the hospital inspection, on 06 September 2024, a media article came to the attention of HIQA regarding a Point Prevalence Survey conducted by the Health Protection Surveillance Centre (HPSC) in May 2023. The survey reported that Bantry General Hospital had the highest rate of Hospital Acquired Infections (HAI) in the country at the time the survey was conducted. In response to this, HIQA inspectors convened a follow-

[§§] Quality and Safety Committee Guidance and Resources. 2016. Available online from Quality and Safety Committee - HSE.ie

up meeting with the Hospital Manager and members of the IPC team to discuss the report's content. Hospital management informed HIQA that the request for data from the HPSC was misinterpreted by the hospital and the information provided, while accurate in its own right, it did not correctly align with what was requested. Inspectors were informed that the corrected data would show that the HAI rate at Bantry General Hospital was essentially in line with the national average. Inspectors were subsequently provided with documentation of communication between the hospital and the HPSC, acknowledging the error and agreeing to revise and reissue the report. HIQA was satisfied with the governance, management and oversight of infection prevention and control practices and infection outbreaks at the hospital.

Medication Management Committee

The hospital's Medication Management Committee (MMC) had assigned responsibility from the CUH Group Drugs and Therapeutics Committee (DTC) for the governance and oversight of medication safety at the hospital. The committee was co-chaired by the Senior Pharmacist and a Consultant Physician and met quarterly. There was good attendance at meetings by the multidisciplinary members. Meetings were action orientated, with actions assigned to a responsible person and the status of each action clearly monitored from meeting to meeting. The committee reported relevant issues to the CUHG DTC and Bantry General Hospitals QSC.

Deteriorating Patient and Sepsis Committee

The hospital's Deteriorating Patient and Sepsis Committee was responsible for ensuring that relevant national clinical guidelines[***] were implemented to support best practices in managing deteriorating patients and emergency events. Chaired by a consultant physician, this committee reported to the QSC and met quarterly, with meetings well attended by the members.

Inspectors reviewed the committee meeting minutes and noted discussions on the appropriateness of using the Paediatric Early Warning System (PEWS) in Bantry General Hospital. This was in the context of recent, but infrequent presentations of acutely unwell paediatric patients to the hospital where it was noted that the PEWS was not used. HIQA inspectors raised this issue during meetings with relevant committees and the EMB. During the meeting with management, inspectors were shown folders containing PEWS documentation catering to the different age groups of children, along with associated staff training records, and were told that the folders were located on the wards. Similarly, inspectors enquired whether the Irish Maternity Early Warning System (IMEWS) charts were used in line with national clinical guidelines when maternity patients present to the hospital. Inspectors were presented with an IMEWS folder containing the assessment

[***] Irish National Early Warning System (INEWS) Version 2, Paediatric Early Warning System (PEWS) and Sepsis Management National Clinical Guidelines and adherence to Irish Heart Foundation (IHF) and American Heart Association (AHA) guidance.

charts, which they were told were located on the wards. Additionally, inspectors were shown the staff training records on how to use IMEWS.

However, inspectors found inconsistencies in ward staff's knowledge regarding the availability and utilisation of PEWS and IMEWS when clinically appropriate. This is discussed further in Standard 3.1.

The committee was otherwise effective in its oversight of the deteriorating patient programme at the hospital.

Discharge planning

The hospital had systems and processes in place to manage transitions of care. A discharge planning team had responsibility for overseeing and implementing discharge planning within the hospital. This team included two discharge coordinators filling 1.5 whole-time equivalent (WTE) posts, was supported by the Assistant Director of Nursing (ADON), and reported issues to the DON and the Hospital Manager.

The discharge planning team had input from various disciplines and discussed all medical patients' progress and planned discharge dates. The team had established links to the community to facilitate supports for patients following discharge.

In summary, the hospital had formalised corporate and clinical governance arrangements in place as appropriate to the size and scope of the hospital. Details outlined in organisational charts, terms of reference and minutes of meetings reviewed by inspectors were reflected in discussions with lead representatives during this inspection. The senior management team had oversight and management of the relevant issues that impacted on or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital.

The MMC meeting minutes clearly outlined actions arising from meetings, with persons responsible and timeframes afforded to actions which were monitored from meeting to meeting. This was not replicated in all minutes reviewed. Minutes from meetings should clearly outline the actions arising from the meetings, the person responsible and timeframes for each action identified. Progress on implementation of actions should be monitored from meeting to meeting. The frequency of occurrence of meetings should align with the committee's TOR. It was noted that the QSC had only met once in 2024, which is a critical pathway for escalating issues to the EMB.

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.

The hospital had management arrangements in place in relation to the four areas of known harm[†††] which were the focus of this inspection and these are discussed in more detail below.

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Infection, prevention and control

The IPCC supported and oversaw the implementation of the hospitals infection prevention and control programme. Both the infection prevention and control and antimicrobial team developed an annual work plan that set out the objectives to be achieved in relation to infection prevention and control and antimicrobial stewardship[‡‡‡] in 2024. The IPC objectives for 2024 included hand hygiene, education, audit, surveillance and development and revision of infection prevention and control policies, procedure and guidelines. It was clear from documents reviewed by inspectors that the infection prevention and control team were meeting the objectives outlined in their annual work plan, and reporting on same through the hospital's monthly performance reports, with quarterly reports to the hospital QSC committee.

Medication safety

The hospital had a clinical pharmacy service,[§§§] led by the hospital's senior pharmacist and supported by a clinical pharmacist and a pharmacy technician. Inspectors were informed that, due to staffing levels, medication reconciliation was conducted on a prioritisation basis only. However, the absence of a comprehensive medication reconciliation programme was not recorded on the hospital risk register. Medication safety was supported by a consultant microbiologist with dedicated hours assigned to Bantry General Hospital and by an antimicrobial stewardship programme[****] led by a consultant medical physician. Inspectors were informed of good working relationships, links, and support from the CUH Group DTC, clinical pharmacy resources in CUH, and with local GPs and community pharmacists.

Deteriorating patient and Early Warning System

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

[§§§] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[****] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

Inspectors met with the chairperson of the committee, a consultant physician who oversaw the control and direction of the deteriorating patient and sepsis committee, and with members of the wider committee including the ADON Practice Development Coordinator. The committee had oversight of the INEWS, PEWS, IMEWS and sepsis management guidelines at the hospital. However, as discussed elsewhere in this report, familiarity of staff with the application of the appropriate early warning systems in paediatric and maternity patient presentations to the hospital was not effective. This was despite evidence of training records seen by inspectors where staff were supported with education and training.

The hospital had protocols in place for the management of the deteriorating patient onsite and for the emergency inter-hospital transfer[††††] of patients requiring a higher-level of time-critical care. Patient transfers from and to CUH were underpinned by a policy that detailed all of the requirements that had to be fulfilled to ensure the safe transfer of patients between hospitals. While the policy was out of date, which was recorded on the risk register, it was under review at CUH Group level and had been escalated to the SSWHG. Bantry General Hospital EMB informed inspectors that they were assured that they had effective processes in place and were clear about the management of patients attending the hospital with conditions outside of their scope.

The hospital was part of the National Ambulance Service (NAS) bypass protocol which ensures that patients with urgent medical needs outside the scope of the hospital are transported directly to CUH, which is better equipped to provide the necessary specialised care.

Transitions of care

It was evident to inspectors that the hospital had effective arrangements in place to monitor issues impacting safe transitions of care. The hospital's discharge team and patient flow coordinator proactively discussed and addressed issues contributing to delayed discharges. The discharge coordinators informed inspectors that they collaborated daily with others involved in patient flow activities and the DON held weekly meetings with the hospital Community Health Organisation 4[‡‡‡‡] (CHO). They effectively managed patient discharges and transfers in a patient-centred manner.

At the time of inspection, inspectors were told that the average length of stay for patients on the medical ward ranged from nine to 23 days, with longer average stays being recorded in the rehabilitation unit. This was above the HSE's target of seven days or less. At the time of this inspection, ten patients had delays in transfers of care. This included

[††††] The Emergency Inter-Hospital Transfer Policy Protocol 37 had been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.
[‡‡‡‡] Community Health Organisation services are a range of healthcare services that are provided outside of acute hospitals, such as primary care, social care, mental health and health and well-being services.

patients with complex discharge needs, for example inspectors were told by managers that patients have experienced waits of up to three months for a home care package to be available to them.

Inspectors reviewed documentation and the discharge team informed inspectors that audits were completed on the hospital discharge planning checklist. These audits captured data on communication with families, the provision of discharge information, and documentation of the predicted date of discharge. Compliance with audit measures was reported as 80% in 2022 and 60% in 2023.

Although there was no medical social worker onsite at Bantry General Hospital to support transitions of care, progress was achieved by the discharge team through various initiatives. These included the early establishment of a predicted date of discharge (PDD), linking with patients, their families, the community medical social worker, GPs and public health nurses (PHNs), coordinating with nursing homes regarding patient needs, attending medical handovers, meeting with homecare support managers, participating in MDT meetings, and presenting the patient Common Summary Assessment Reports[§§§§] (CSAR) weekly. The discharge planning team worked effectively despite challenges associated with the loss of local community beds. Inspectors were informed that all hospitals in the CUH group are competing for community beds and that overall the community bed stock had been reduced due to nursing home closures.

In summary, inspectors found that Bantry General Hospital was functioning well and as intended. Bantry General Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare with some areas for improvement identified. Ensuring enhanced staff familiarity with early warning systems, addressing staffing levels for medication reconciliation, updating inter-hospital transfer policies, and reducing delays in patient discharges could improve the capability and capacity to deliver quality and safe healthcare.

Judgment: Substantially compliant

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

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

[§§§§] Combined assessment information from various sources, thereby creating a single, permanent and transferable record of the information relevant to a decision on an individual's care needs at a given point in time.

Risk management

There were risk management structures in place to proactively identify, manage and minimise risks. The hospital maintained a risk register of identified hospital risks. The existing controls in place and the additional controls required to minimise these risks were outlined to inspectors. The risk register was reviewed quarterly by the QSC and raised monthly at the EMB, with updates provided at Performance Management meetings with the SSWHG. All risks on the risk register related to the four areas of known harm, which were the focus of this inspection, were outlined by staff on the day of inspection. Evidence of existing controls in place was provided during the inspection, and additional controls to mitigate the risks were advanced where possible. These risks are outlined further in national standard 3.1.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported monthly for the HSE's Hospital Patient Safety Indicator Report (HPSIR) and the HSE's management data report. Performance and activity data was reviewed at the QSC and EMB meetings, and at group Performance Management meetings.

Audit activity

The hospital had a programme of audit for infection prevention control, medication safety, clinical handover using Identify, Situation, Background, Assessment and Recommendation (ISBAR) and the early warning systems. Audit reports were reviewed by the relevant governing committee such as the IPCC, the DTC and the Deteriorating Patient and Sepsis committee. Audits were also reviewed at the QSC and EMB meetings. Examples of action plans and re-audit for areas of poor compliance were seen in documentation reviewed by inspectors. However, not all audits reviewed had time-bound actions plans for the implementation of recommendations following audits. On the day of inspection, staff who spoke with inspectors outlined the action plans and time frames for implementation of audit recommendations.

Management of patient-safety incidents

The hospital proactively identified, documented and monitored patient-safety incidents. Patient-safety incidents were reported to the National Incident Management System[*****] (NIMS), in line with the HSE's Incident Management Framework.[†††††] For the four quarters from Q3 2023 to Q2 2024, the percentage of incidents reported on the NIMS system

[*****] 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).
[†††††] HSE –Incident Management Framework and Guidance. 2020. Available online from: Incident management - HSE.ie

within 30 days of notification were 84.4%, 73.2%, 85.3%, and 95.0%, respectively. The average for this period was 84.3%, above the HSE's national target of at least 70%. Additionally, the year-to-date figures for January to July 2024 averaged 89.7%, indicating the hospital is consistently improving in timely incident reporting.

The hospital was in the process of implementing the electronic point of entry (ePOE)[‡‡‡‡‡] NIMS, a paperless system which would facilitate staff to enter incidents directly onto the NIMS. Although at the early stage of implementation, the proposed benefits of the ePOE system include the elimination of duplication, availability of real-time data on incidents or near misses and provision of prompts to review and commence risk mitigation processes.

Patient-safety incidents in relation to IPC and medication management were tracked and trended. These were collated in the hospital's monthly performance reports which were presented at the QSC and the EMB meetings. Inspectors were informed that incidents relating to the deteriorating patient, EWS and sepsis were tracked on an excel spreadsheet but were not trended. A monthly NIMS report was also provided to the hospital by the SSWHG.

There were processes in place to share learning from patient-safety incidents through daily safety huddles and the distribution of the hospital's performance reports through committees, and through line managers. Patient safety incidents were discussed at governance committee meetings such as the DTC and the IPCC. The SSWHG Serious Incident Management Team (SIMT) provided oversight and management for serious reportable events and serious incidents which occurred within the SSWHG including Bantry General Hospital. Findings from the National Inpatient Experience Survey were reviewed at meetings of the EMB with QIPs developed focussing on improved communication with patients.

Overall, the hospital had monitoring arrangements to identify and act on opportunities for continually improving the quality, safety, and reliability of healthcare services in the four areas of known harm relevant to this inspection. Tracking and trending all incident categories, and ensuring that recommendations and actions developed for QIPs are time-bound with a designated accountable person for implementation and follow-up, would enhance quality improvement.

Judgment: Substantially compliant

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

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

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

The hospital manager had overall responsibility for managing HR requirements onsite with support from the DON. The hospital manager reports to the CEO of the CUH group and attends weekly EMB meetings where human resource and medical manpower issues are discussed. The hospital manager had access to the CUH Group's HR manager and medical manpower, although inspectors were told that the latter post was vacant at the time of inspection. The lack of both a human resource manager and medical manpower on site in Bantry General Hospital was recorded on the hospital risk register and escalated to the group risk register.

The hospital's total complement of staff (all staff) in post in September 2024 was 332 WTEs which is 5.6 WTE above the approved complement. Although nursing staffing levels had increased by 11.5 WTEs arising from recommendations of the Safe Staffing Framework, at the time of inspection, there were 17.5 WTE unfilled temporary posts due to various types of leave including maternity leave, parental leave and unpaid leave. 14 of these vacant WTEs were in nursing and midwifery, accounting for approximately 10% of the nursing and midwifery workforce, and 3.5 WTEs were across allied health professionals (AHP). Under the Safe Staffing Framework, an additional 12 WTE Healthcare Assistant (HCA) - Multitask Attendant (MTA) posts were recommended. At the time of inspection, four of these posts were filled, a further two had been approved and recruitment was in progress. Inspectors were told that although Bantry General Hospital had approval to fill maternity leave posts, recruitment was challenging due to the remote and rural location of the hospital.

Inspectors were informed by management that all of the consultants employed at the hospital were on the relevant Specialist Division of the Register of the Irish Medical Council.

The hospital had adequate workforce arrangements in place to support and promote the delivery of day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. Monthly key performance indicators (KPIs) for attendance were reported to the SSWHG HR, and to the hospital EMB monthly, and to the CUH Group EMB every six weeks.

Injury unit

The hospital's injury unit operated seven days a week from 8am to 8pm. Patients self-referring, or referred by the GP or Southdoc with minor injuries were accepted in line with the LIU inclusion criteria set out in the Management of Local Injuries (LIU) policy. The

policy was last revised in October 2022. The unit had a nurse staffing complement of 5.21 WTEs, which included one WTE CNM2, one WTE CNM1, and 3.21 WTE staff nurses.

There were three WTE registrars assigned to the unit. From Monday to Friday, the injury unit was staffed by a registrar, two staff nurses, and a MTA. On Saturdays and Sundays, the staffing was reduced to one registrar and one staff nurse.

A senior clinical decision-maker at registrar level was present on-site in the unit whenever it was operational. Clinical governance was provided around the clock by a consultant in emergency medicine located at CUH.

Medical assessment unit

The medical assessment unit (MAU) operated between 9am to 4.30pm Monday to Friday and accepted self referrals and GP or Southdoc referrals for patients within the MAU's agreed admission criteria. GPs could also admit patients with medical conditions directly to the Hospital 24/7, if necessary. The MAU had four staff at CNM2 grade. Two Advanced Nurse Practitioners (ANP) and one candidate ANP also worked in the MAU. A consultant was present in the MAU Monday – Friday from 9am to 5pm and on Saturday and Sunday from 9am – 12pm. Outside of these hours, non-consultant hospital doctors (NCHDs) were present in the MAU with consultant on-call cover. There were three patients in the MAU at the time of the inspection and all were admitted to the hospital.

Medical ward

The medical ward rostered a CNM2 and six staff nurses daily from 8am to 8pm. Three nurses and one HCA were rostered on nights. At the time of inspection, inspectors were informed that there were 1.9 WTE nursing posts vacant. In addition, inspectors were told that six nurses were on maternity leave. As previously discussed, although approval to fill those posts was in place, recruitment was challenging due to the remote and rural location of the hospital.

Medication safety

The hospital had 1.5 WTE pharmacists, which included one WTE senior pharmacist and 0.5 WTE clinical pharmacist. There was also one WTE pharmacy technician on the staff. All of these posts were filled, but cover was not provided for leave. A Monday to Friday clinical pharmacy service was provided to the wards and medication safety training and education was provided to staff.

Infection prevention and control

The hospital had an infection prevention and control team comprising 2.0 WTE IPC clinical nurse specialists (CNS's) and 0.33 WTE microbiologist. A surveillance scientist and an antimicrobial pharmacist are two key posts currently unfilled in Bantry General Hospital. These posts were recorded on the hospital risk register and escalated to CUH Group and SSWHG level. Notwithstanding such vacancies, support from a surveillance scientist was

being provided from CUH, and the hospital's own senior pharmacist and a pharmacy technician both have a special interest in antimicrobial pharmacy. Additionally, an antimicrobial stewardship programme was in place overseen by a consultant medical physician.

Mandatory and essential staff training

It was evident from staff training records reviewed by inspectors that nursing staff in the hospital undertook multidisciplinary team training appropriate to their scope of practice. The hospital had a system in place to monitor and record staff attendance at mandatory and essential training. Monitoring of attendance at training was overseen by the CNM2 in the clinical area or unit.

Training records from the clinical areas visited on the day of inspection were reviewed. There was close to full compliance rates for mandatory and essential training related to infection prevention and control, the Irish National Early Warning System, basic life support (BLS) and training of national guidance on clinical handover with ISBAR for the nursing and healthcare assistant staff as relevant. However, training records related to PEWS and or IMEWS were not available in the clinical areas inspected. Senior hospital management provided evidence to inspectors that training had been provided in PEWS and IMEWS.

Inspectors also reviewed training records for mandatory and essential training relevant to infection prevention and control, deteriorating patient, medication safety and complaints for all hospital nurses, doctors, healthcare assistants and health and social care professionals (HPSC). Overall, attendance and uptake at training for all these disciplines were satisfactory, but some areas could be improved.

Compliance with required training for hospital staff varied across disciplines, with the following ranges observed:

- 94% of nurses to 65% of doctors were up to date with infection prevention and control training
- 93% of nurses to 91% of doctors were compliant with hand hygiene training (HSE's target of 90%)
- 91% of doctors and 82% of nurses to 37% of HSCPs were up to date in BLS training
- 100% of HCAs and 99% of nurses to 84% of doctors were up to date with training on the Irish National Early Warning System
- 100% of nurses to 84% of doctors were up to date on communication and clinical handover training.

Overall, inspectors found that hospital management were planning, organising and managing their nursing, medical and support staff in the injury unit, the medical assessment unit and the medical ward to support the provision of high-quality, safe healthcare.

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. Although challenged with pharmacist resources in the past, the hospital's pharmacy resources have increased since the Medication Safety Inspection in 2019, but staff reported ongoing challenges with medication reconciliation due to staff resources.

There were systems in place for staff to access the occupational health services and the employee assistance programme (EAP). Posters to promote awareness of the EAP were visible on notice boards in areas frequented by staff. However, some of the medical staff who spoke with inspectors were not aware of the EAP or how to access these services.

Training records reviewed by inspectors for the clinical areas visited on the day of inspection demonstrated good compliance with attendance at mandatory and essential training for nursing and healthcare assistants. However, attendance at mandatory and essential training for the overall staff in the hospital could be improved in areas relevant to the focus of this inspection. As discussed elsewhere in this report, there were discrepancies between the information provided by hospital management and the feedback from staff regarding the use of and training in PEWS and IMEWS. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. Additionally, it is important that staff complete any training mandated by local policies or arrangements to ensure compliance and consistency across all departments.

Judgment: Substantially compliant

Quality and Safety Dimension

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

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

It was evident through observation of care provided, and through discussions with both staff members and patients that staff in the clinical areas visited were aware of the need

to respect and promote patients' dignity, privacy and autonomy. In all three clinical areas visited during the course of the inspection, staff were observed using privacy curtains when providing assistance and personal care to patients.

Staff working in the hospital were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring when engaging with patients and to be responsive to their individual needs. Information was provided to patients in a clear and comprehensive manner. In addition, information was accessible to patients' in their native languages. Inspectors were told translation services were also used to support effective communication with non-English speaking patients.

In two of the clinical areas visited during the inspection, patient's personal information was observed by inspectors to be protected and stored appropriately. However, patient's personal information was observed not to be protected on a white board in the medical assessment unit. This was brought to the attention of the clinical nurse manager in the clinical area and to members of the EMB.

In general, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. However, staff were challenged to maintain privacy and dignity in the medical assessment unit due to the lack of single rooms with en-suite toilet and shower facilities. Patients that required isolation and or while awaiting confirmatory test results for infectious diseases were required to attend to personal hygiene and use commodes at the bed side, which impacted on their privacy and dignity.

Overall, there was evidence that hospital management and staff were committed to ensuring that patient's dignity, privacy and autonomy was respected and promoted in the hospital. This is consistent with the human rights-based approach to care promoted by HIQA. However, areas for improvement were identified, including the need to protect and store patients' personal information appropriately, and the lack of single rooms with en-suite toilet and shower facilities to ensure patients' privacy and dignity while in isolation.

Judgment: Substantially Compliant

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

Inspectors observed that a culture of kindness and consideration was actively promoted by all staff in the clinical areas visited by inspectors. Staff were observed to communicate and engage with patients in an open, caring, sensitive and respectful manner. This was validated by patients who expressed their satisfaction with the care provided by the staff and commended the staff for their kindness. For example patients stated that 'staff are

lovely, friendly', and 'kind' and 'explain what tablets I am on'. Each patient had access to a call bell at their bedside ensuring they could access assistance from staff as needed.

The hospital welcomed feedback from people using the service and it was evident that patients spoken with were comfortable raising any issues or concerns with staff. Posters outlining the procedure for making a complaint were prominently displayed in the clinical areas. In addition, posters displayed in the clinical areas visited also provided information about how to access patient advocacy services. Two patients outlined that if they had a concern or wanted to make a complaint they would 'talk to a nurse'.

Overall, it was evident 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.

The Quality, Patient Safety and Risk Manager was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints in Bantry General Hospital. The complaints officer sits on the EMB and provides monthly updates on complaints. There was evidence of a culture of complaints resolution in the clinical areas visited.

Where possible, complaints were resolved locally by the CNM. Complaints that could not be resolved locally were escalated to the quality and patient safety manager and the Director of Nursing (DON). Feedback on complaints was provided by the CNM to staff during safety huddle meetings in the clinical area where the complaint originated.

The hospital had a complaints management system§§§§§ (CMS) and inspectors were informed that the hospital used the HSE's complaints management policy, 'Your Service Your Say'****** (YSYS). However, it was noted that the hospital did not fully adhere to this policy as they did not use the YSYS HSE point of contact resolution and escalation form. The hospital informed inspectors that they had trialled this two years ago, but discontinued its use because patients did not like having to sign it. YSYS posters were displayed and leaflets were available, providing patients with information and access to the YSYS service. There was a comments box at the front of the hospital for patients to submit feedback. Additionally, documentation reviewed by inspectors included a local complaints policy dated June 2019 and evidence that the hospital tracked and trended complaints reported since 2022.

In response to the National Inpatient Experience Survey 2022, the hospital produced three time-bound quality improvement plan (QIPs) and implemented actions to improve communication with patients and improve the discharge process. Inspectors also reviewed recommendations that were implemented in 2023 & 2024 as a result of patients' complaints recorded on the hospital CMS. For example, not all patients requiring dressing packs were receiving them on discharge, post-surgery. To address this, relevant staff received education on the appropriate provision of these supplies to patients.

The hospital formally reported on the number and type of complaints, verbal and written, received annually, along with the percentages of complaints resolved within 35 days. The CMS report for 2022 showed that eight formal complaints were received and seven (87.5%) of them were resolved within 35 working days. In 2023, nine formal complaints were received and six (67%) of them were resolved within 35 working days. However, it should be noted that the national policy KPI is to resolve at least 75% of complaints within 30 days, rather than 35 days, as reported by the hospital.

The QSC and risk manager had oversight of the effectiveness of the hospital's complaints management process. Written complaints were tracked and trended to identify the emerging themes and categories involved. Collated data and information on the hospital's compliance with national guidance and standards on complaints management was submitted to the EMB and to the SSWHG performance management meetings.

Where necessary, independent patient advocacy services are provided for by the national Patient Advocacy Service funded by the Department of Health.

§§§§§ The Complaints Management System is a national database management system developed to support the HSE's complaints management process and to enable the end-to-end management and tracking of complaints, investigations, outcomes and recommendations at local level.
****** HSE Managing Feedback within the Health Services. Your Service Your Say 2021. Available on line from: https://www.hse.ie/eng/about/who/complaints/ncglt/your-service-your-say-2021.pdf

Overall, inspectors found that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. Despite some deviations from the YSYS policy and a decline in resolution timeliness in 2023, the hospital demonstrated a commitment to continuous improvement by implementing targeted actions to address specific complaints and ensuring access to independent patient advocacy services.

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 the inspection, inspectors visited the LIU, the MAU and the Medical ward and observed that overall the hospital's physical environment was clean and well maintained with few exceptions.

The purpose-built LIU was opened in 2022 and comprised four assessment and treatment bays, three of which were single capacity and one double capacity. Each assessment and treatment bay contained a sink. There was one shower and one toilet available for use in the LIU. The unit was bright, well maintained and clean. The layout of the unit prioritised patient's privacy.

Inspectors were informed by staff that security in the LIU could be enhanced by the use of lone worker alarms. The risk had been documented in a risk assessment in the Health and Safety (H&S) folder within the LIU. An action log indicated that a request had been submitted to maintenance and had been reported to the QSC in 2022. At the time of inspection, this was not in place.

The medical assessment unit had nine single assessment pods without en-suite facilities. There were two showers and two toilets available for use in the MAU. Inspectors were informed that patients in isolation while awaiting confirmatory test results for infectious diseases, attended to their hygiene needs at their bedside and were provided with individual commodes for toileting. Representatives of the IPC committee informed inspectors that a risk assessment had been completed regarding the lack of single rooms with en-suite toilet and shower facilities. Although the hospital risk register reviewed by inspectors recorded risks related to isolation facilities in the HDU and Stroke Rehabilitation unit, it did not include an entry concerning the lack of isolation facilities in the MAU.

The hospital had processes in place to support the appropriate placement of patients. The infection prevention and control nurses liaised with staff daily to prioritise patients for single-room isolation when the number of available single rooms was insufficient to meet the demand for isolation. On the day of inspection, one single room on the medical ward

was in use for isolation purposes. Inspectors observed that there was appropriate isolation signage in place at the entrance to the rooms and the room doors were closed.

While the medical ward appeared visibly clean there was evidence of general wear and tear observed, with paint work and wood finishes chipped, this did not facilitate effective cleaning. In addition, the hospital had identified the need to replace the flooring in the medical ward. Renovation work had commenced, and at the time of inspection, three rooms had been completed.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) clearly displayed throughout the three clinical areas.

Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms in the medical ward. Infection prevention and control signage in relation to transmission based precautions was also observed in the clinical areas visited.

Environmental cleaning was carried out by dedicated MTAs. There was a green tagging system in place to identify patient equipment that had been cleaned. Inspectors observed patient equipment to be clean in all the clinical areas visited during inspection. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Inspectors observed that there was limited storage space for equipment in the medical ward with the storage of multiple commodes within the sluice room resulting in a cluttered environment.

Inspectors noted that all hand hygiene sinks observed conformed to recommended standards.[††††††]

In summary, inspectors found that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. There was areas for improvement identified in relation to the storage of medical equipment, general wear and tear including paintwork and wood finishes and the lack of single rooms with en-suite toilet and shower facilities in the MAU.

Judgment: Substantially compliant

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

[††††††] 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

Inspectors were satisfied that the hospital had effective systems and processes to monitor, evaluate, and respond to information from various sources. These systems helped improve services continuously and assured hospital management and the hospital group about the quality and safety of services. Inspectors found that the hospital had monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments and patient experience surveys.

Infection prevention and control monitoring

Inspectors were satisfied that the IPCC had oversight of monitoring of infection prevention practices in the hospital. Monthly environmental, equipment and hand hygiene audits were undertaken with a high level of compliance achieved by areas visited by inspectors on the day of inspection.

Documentation reviewed by inspectors for the period between 01 June 2024 and 01 September 2024 reported on environmental hygiene and patient equipment audit compliance. The compliance rates for the three clinical areas visited were above 91% for the AMU, above 93% for the medical ward, and above 98% for the LIU. Audit findings were shared with clinical staff during daily meetings and displayed on quality boards in the ward. Time-bound action plans were developed to address areas requiring improvement for some, but not all, monitoring and audit findings.

In June and July 2024, all areas were compliant with the HSE's target of 90% for hand hygiene practices. Inspectors were satisfied that the IPCC were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols.

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 a healthcare-associated infection surveillance report to the IPCC every month. These reports were also shared with and staff in clinical areas.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study in 2023, and reporting on compliance with antimicrobial stewardship KPIs every quarter. The hospital's KPIs were reviewed at the monthly IPCC meeting. Although monitoring and

[‡‡‡‡‡‡] 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

evaluation of antimicrobial stewardship was apparent in the hospital, action plans for areas not fully compliant to support improvement was not clearly evident to inspectors.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were carried out in medication safety, storage and custody metrics. Inspectors were informed that initiatives were introduced to improve medication safety practices at the hospital. For instance, recording of both the patient's weight and the minimum dose interval on prescription charts consistently scored low on medication safety audits. This led to the introduction of education sessions to improve compliance with practice. While medication metrics and audits were discussed at the MMC meetings, examples of action plans and re-audit in areas of poor compliance was not seen in documentation reviewed by inspectors. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital collated performance data through audits of INEWS observation charts and the quality care metrics in nursing and midwifery[§§§§§§] to monitor compliance against national guidance on INEWS. Some individual scores related to the INEWS escalation and response protocol audit on the medical ward in Q3 2024 were low. For example, for the question 'Were patients' INEWS scores or parameters adjusted', the compliance result was 37.5%, and 'Was the nurse in charge informed of the INEWS score', the result was 42.9%. While inspectors were informed that the ADON Practice Development and the ward CNM follow up low compliance scores with staff education sessions, no formal QIPs in relation to low compliance levels were evident in documents reviewed. The results, however, are displayed on the wards metrics board.

The use of the ISBAR communication tool was audited as part of the hospital's patient monitoring and surveillance metrics. Overall compliance with the use of ISBAR communication tool was consistently above 90% in documentation reviewed for Bantry General Hospital for 2023 and 2024.

National guidelines recommends that clinical handover practice be monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organisation to assure senior managers that any necessary continuous quality improvements were put in place.

Transitions of care monitoring

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

Performance in relation to transfers and discharges was monitored using the HSE's hospital patient safety indicators.[*******] The hospital reported on the number of inpatient discharges and the number of beds subjected to delayed transfer of care. Performance data in relation to patient transfers and discharges was reported and discussed at the EMB and by the delayed discharge and bed management team members. Out-of-hours presentations of patients with conditions outside the scope of the hospital are also audited and discussed at the EMB.

Overall, inspectors were satisfied that the hospital systematically monitored and evaluated healthcare services. However, there was an opportunity for improvement in the development and implementation of action plans in INEWS, medication safety and antimicrobial stewardship to support continuous 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 at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. The Quality and Patient Safety Committee was assigned the responsibility to review and manage risks that impact the quality and safety of healthcare services. Risks that could not be managed at hospital level were escalated to the SSWHG. Risks were recorded on the hospital's risk register with existing controls and additional required actions to manage and reduce these risks. High-rated risks on the hospital's risk register relevant to the areas of focus of this inspection are outlined below.

Infection prevention and control

Risks related to infection prevention and control were discussed monthly by the IPCC and were overseen by the Quality and Patient Safety Manager and documented in the hospital's corporate risk register. The lack of isolation rooms was identified as a high-rated risk in this context. This risk was expressed by staff and management on the day of inspection and observed by inspectors.

Audit of hand hygiene compliance was generally above the HSE National Standard of 90%, with high levels of attendance at hand hygiene training by all disciplines.

[*******] HSE Patient Safety Indicators. Available on line from: https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/hospital-patient-safety-indicators-rports/south-south-west-hospital-group/

Infection outbreak preparation and management

Inspectors noted that the hospital screened patients for multi-drug resistant organisms (MDRO) at point of entry. Patients with a confirmed infection were isolated within 24 hours of admission or diagnosis, in accordance with national guidance. However, the demand for isolation rooms often exceeded the availability. The hospital had an isolation prioritisation policy and patients were isolated in line with the hospital's infection prevention and control policy. A copy of the MDRO screening tool used in the hospital which identified the MRDOs to screen for (MRSA, CPE, and VRE) and the characteristics of patients to screen, were consistent with what inspectors were told by staff on the medical ward. However, inspectors found that not all staff on the ward were aware of the tool in use.

In 2023, the hospital had 4 outbreaks of COVID-19, and a further 4 outbreaks of COVID-19 in 2024. A multidisciplinary outbreak team was convened to advise and oversee the management of COVID-19 outbreaks. Inspectors noted that outbreak reports were comprehensive. The control measures taken to manage the outbreaks were consistent with what the IPC committee informed inspectors in relation to the management of an outbreak. Management of outbreaks was supported by a local policy.

Medication safety

Inspectors noted that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications. Inspectors observed the use of risk reduction strategies to support safe use of medicines in relation to anticoagulants, insulin and opioids. For example, a consultant physician and the diabetes ANP conducted an insulin round on every ward from Monday to Friday to identify and prescribe for any patients requiring insulin. Sound-Alike Look-Alike Drugs (SALAD) posters were visible on wards and stickers were placed on SALAD drugs to alert staff of the risk. Inspectors also observed the use of risk-reduction strategies to support safe use of medicines in relation to anticoagulants and insulin.

Medication reconciliation was undertaken on a prioritisation basis for new admissions from Monday to Friday by a clinical pharmacist. It was evident that clinical pharmacists were accessible to staff and visited clinical areas. Wards also had pharmacy technician services for medication stock control. The consultant microbiologist visited the hospital one day per week and the microbiology team in CUH were accessible to staff by phone 24/7.

Deteriorating patient

The hospital had systems in place to manage the deteriorating patient. This included the INEWS version 2 observation chart and an ISBAR communication tool which was used to communicate with doctors when patient reviews were required.

In addition, the hospital had developed both PEWS and IMEWS folders containing assessment charts for use with relevant populations presenting to Bantry General Hospital, and staff had received associated training on their use. However, inspectors found

inconsistencies in the ward staff's knowledge regarding the availability and utilisation of PEWS and IMEWS when clinically appropriate. Although it was acknowledged that presentations of acutely unwell paediatric or maternity patients are infrequent, inspectors were told that they are transferred to CUH as a matter of priority. It was apparent that the appropriate EWS was not always being used as per local guidance in the case of paediatric presentations, or in line with national guidance for pregnant or postnatal patients. This concern was particularly relevant for patients who were present for a short period while awaiting transfer to a higher level of care. This was an area in need of attention by the hospital.

The hospital's High Dependency Unit (HDU) comprised 4 beds for admissions and one assessment bed. The admission criteria for the HDU were outlined in the hospital's policy document, which was in draft form.

Depending on the level of assessed urgency, deteriorating patients requiring a higher level of care were transferred to CUH using an appropriate emergency inter-hospital transfer protocol, for example Protocol 37.[†††††††] The hospital had identified the presentation of 'out of scope or protocol' patients as a high risk to patient safety and this was recorded on the hospital's risk register. An audit of 'out of scope' presentations was seen by inspectors showing that out of 1158 hospital presentations in the three month period between May and July 2024, 26 (2.24%) were 'out of scope'. Out of scope presentations were discussed at the EMB. It was noted that the hospitals Mandatory Transfer policy was out of date since 2010 and inspectors were informed that the sign off of this policy was under ongoing discussion with the CUH group and had been escalated to the SSWHG.

While the hospital was part of the National Ambulance Service (NAS) bypass protocol, inspectors were informed of rare instances where the NAS deemed it clinically necessary and appropriate to stop at Bantry General Hospital after communicating with the hospital, to seek to stabilise a patient before continuing onwards to CUH. This data was captured in the 'out of scope audit' referenced previously.

Safe transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services to support safe and effective discharge planning and other transitions of care. At the time of inspection, the hospital had admission and transfer policies providing clear guidance on the admission criteria for the hospital, the injury unit and the MAU. Inspectors were informed that the ISBAR format was used during protected time for the nursing shift handover on the medical ward and inspectors were informed that safety huddles occur daily in the LIU. Nursing clinical handover was supported by an up-to-date policy.

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

The hospitals IPC guideline supported the transfer and discharge of patients with a suspected infection. A record of the patient's assessment of their infection status on admission was recorded on all documents reviewed by inspectors, but was not always recorded on the discharge documentation reviewed.

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 which included guidelines on prescribing and administration of medication, high alert medicines and sound alike look alike drugs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care through desktop computers.

All policies, procedures, protocols and guidelines were accessible to staff via the hospitals intranet. Bantry General Hospital were in the process of implementing the Q-Pulse system for document management and maintenance of their PPPGs.

Overall, inspectors found that the hospital had established systems to identify and manage potential risk of harm associated with the four areas of known harm - infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, there was evidence of inconsistencies in the knowledge regarding appropriate application of PEWS and IMEWS. Additionally, the hospital's Mandatory Transfer policy, which has been out of date since 2010, needs focus of attention. The quality and safety of transitions of care could be improved by including MDRO status on all discharge documentation.

Judgment: Partially Compliant

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

The hospital had patient safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Incidents were reported using the National Incident Report Form (NIRF). The hospital's average rate of reporting of clinical incidents into NIMS within 30 days was 84.3% for the four quarters from Q3 2023 – Q2 2024, which exceeded the HSE target of at least 70%.

In 2023, the average rate of incidents per 1000 bed days reported by the hospital to NIMS was 22.6. From January to April 2024, this rate decreased to 20.1, which was just below the HSE expected national average of 21.7 incidents per 1000 bed days, as indicated by the Hospital Patient Safety Indicator reports[‡‡‡‡‡‡‡] reviewed by inspectors.

Staff who spoke with inspectors were knowledgeable about how to report a patient-safety incident and reported to be comfortable and supported in doing so. The hospitals QSC tracked and trended patient-safety incidents in relation to infection prevention and control and medication incidents, as well as health and safety incidents, and a monthly incident summary report was provided to the Hospital by the SSWHG. The QSC representative reported on patient safety incidents monthly to the EMB and to the CUH Group every 6 months.

Patient-safety incidents were reviewed in committee minutes of meetings related to three of the four areas of harm seen by inspectors. Staff responsible for transitions of care and patient discharges informed inspectors that any incident related to delayed discharges or length of stay are discussed daily with senior management and at the EMB. The Quality, Patient Safety and Risk manager provided individual reports of incidents tracked and trended for the IPCC and the MMC. While the deteriorating patient and sepsis committee reported patient safety incident data on the deteriorating patient, trending of this data was not occurring.

In general, feedback to staff in clinical areas was provided informally by clinical nurse managers, clinical pharmacists, the infection prevention and control team, and the deteriorating patient team. Incidents were also discussed at staff huddles, at ward meetings, recorded in the communication book and an annual report of incidents including trending was provided to the CNM of the ward to share with staff.
Overall, inspectors were satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm. The hospital were tracking and trending infection prevention and control patient-safety incidents, medication incidents and incidents related to transitions of care. However, the deteriorating patient was not a specific category where incidents were trended. There was evidence that the QSC had oversight of the management of incidents and that the EMB had oversight of serious incidents and reportable events.

Judgment: Substantially Compliant

‡‡‡‡‡‡‡ The Hospital Patient Safety Indicator Report (HPSIR) is a monthly report that collates a range of patient safety indicators. The purpose of the HPSIR is to assure the public that the indicators selected and published in this report are monitored by senior management of both the hospital and hospital group on a monthly basis, as a key component of clinical governance.

Conclusion

HIQA carried out a two-day announced inspection of Bantry General Hospital to assess compliance with 11 national standards from the National Standards for Safer Better Healthcare. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Overall, the hospital was judged to be:

- Compliant with one national standard (1.7)
- Substantially compliant with eight national standards (1.6, 5.5, 5.8, 6.1, 1.8, 2.7, 2.8, 3.3)
- Partially compliant with two national standards (5.2, 3.1)

Capacity and Capability

The hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare appropriate to the size and scope of the hospital. The hospital's formalised governance structures are well-documented and effectively communicated among senior management, reflecting a strong commitment to oversight and accountability. However, it was noted that the QSC did not meet as frequently as outlined in its terms of reference. This could present a delay in the escalation and two-way communication of issues, as all committees dealing with the four key areas of harm report to the QSC, which in turn reports to the EMB.

There were areas identified for improvement. Enhancing the documentation of meeting minutes to include clear actions, responsible persons, and timeframes would strengthen the hospital's governance processes. Additionally, addressing staffing levels, particularly for medication reconciliation, and improving inter-hospital transfer policies would further support the hospital's capacity to deliver safe and effective care.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety, and reliability of healthcare services. Tracking and trending all incident categories and ensuring that recommendations and actions developed for quality improvement plans are time-bound with a designated accountable person for implementation and follow-up would enhance quality improvement.

Training records reviewed by inspectors for the clinical areas visited on the day of inspection demonstrated good compliance with attendance at mandatory and essential training for nursing and healthcare assistants. However, attendance at mandatory and essential training for the overall hospital staff should be improved to ensure that all clinical staff have undertaken the necessary training appropriate to their scope of practice

and at the required frequency, in line with local and or national standards, policies or guidelines.

Quality and Safety

The inspection of Bantry General Hospital demonstrated a strong commitment to respecting and promoting the dignity, privacy, and autonomy of patients. Hospital management and staff were dedicated to fostering a culture of kindness, consideration, and respect. Systems were in place to respond promptly and effectively to complaints and concerns, with a focus on continuous improvement and patient advocacy.

The physical environment of the hospital generally supported the delivery of high-quality, safe, and reliable care. However, there was scope for improvement in the provision of storage facilities for medical equipment, maintenance of facilities, and provision of single rooms with en-suite facilities to enhance infection control measures and ensure patient privacy and dignity, particularly for those in isolation.

The hospital systematically monitored and evaluated healthcare services, but there was scope for further development and implementation of action plans in areas such as INEWS, medication safety, and antimicrobial stewardship to support continuous improvement.

The hospital had established systems to identify and manage potential risks of harm, particularly in infection prevention and control, medication safety, the deteriorating patient, and transitions of care. However, inconsistencies in the use of PEWS and IMEWS, and compliance with INEWS escalation protocols need to be addressed to enhance patient safety. Including MDRO status on all discharge documentation would improve the quality and safety of transitions of care.

Finally, the hospital had a system in place to identify, report, manage, and respond to patient-safety incidents, with oversight from the QSC and the EMB. While tracking and trending of incidents were generally effective, the category of deteriorating patient incidents requires more focused attention.

Overall, Bantry General Hospital demonstrates a solid foundation in quality and safety, with clear areas for improvement to ensure the highest standards of patient care. Following this inspection, HIQA will, through the compliance plan submitted by hospital management (see Appendix 2), as part of the monitoring activity, continue to monitor the progress in relation to compliance with the National Standards for Safer Better Healthcare.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Overall Governance	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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.	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	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**

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

Appendix 2

Compliance Plan

Bantry General Hospital 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

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

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

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

(a)

1. It was identified that all minutes from meetings should clearly outline the actions arising from the meetings, the person responsible and timeframes for each action. In order to fulfil this requirement the hospital has introduced an 'Action tracker' document and the implementation and use of this will be monitored by the QSC.
2. The frequency of occurrence of the QSC will align with the TOR and national recommended frequency (minimum of four times per year) in 2025. This will be monitored by the EMB.

(b) Not applicable

Timescale: End of Q1 2025

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

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

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

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

(a)

1. To address the inconsistent use of IMEWS and PEWS across the hospital, PEWS and IMEWS training is scheduled for the 9th January 2025 for all relevant nursing and medical staff.
2. Following the inspection the Nursing discharge documentation has been updated to include MDRO status.

(b)

It was identified that the hospital needs to review and update the mandatory Transfer Policy. This is a combined Cork University hospital group policy and will require input and agreement from all three sites. The hospital provides assurance that this will be progressed by the Risk Manager to the SSWHG Quality, Risk and Patient Safety Lead.

Timescale: End of Q2 2025