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:	Nenagh Hospital
Address of healthcare service:	Tyone Nenagh Co. Tipperary E45 PT86
Type of inspection:	Announced
Date(s) of inspection:	26 and 27 September 2023
Healthcare Service ID:	OSV-0001066
Fieldwork ID:	NS_0057

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Nenagh Hospital is a Model 2* hospital managed by the University Limerick Hospitals Group (ULHG)† on behalf of the Health Service Executive (HSE). ULHG operate a hub-and-spoke model, across six hospital sites and six clinical directorates —

- cancer service directorate
- medicine directorate
- perioperative directorate
- diagnostics directorate
- urgent and emergency care (UEC) directorate
- maternal and child health directorate.

Within this model, University Hospital Limerick (UHL) is the 'hub' with key services, such as critical care services provided there. The other Model 2 hospitals within ULHG provide a range of services and have defined reporting arrangements to ULHG's executive management team through the clinical directorate structure. Hospital management at Nenagh Hospital report on the hospital's performance and compliance with defined quality and safety indicators at ULHG level, through four of the six clinical directorates, namely the medical; perioperative; diagnostic and UEC directorates. Nenagh Hospital provides the following care and services to medical and surgical patients from the catchment area of the Midwest region of Ireland:

- acute medical inpatient and day patient services
- day service surgery
- endoscopy services
- a medical assessment unit
- a local injury unit
- ophthalmology unit
- ambulatory gynaecological services
- outpatient care and diagnostic services.

The following information outlines some additional data on the hospital.

Model of Hospital	2

* A Model 2 hospital provides the majority of hospital activities 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.

† The University Limerick Hospitals Group comprises six hospitals - University Hospital Limerick, University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St. John's Hospital. The hospital group's academic partner is the University of Limerick.

Number of beds	52 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 two-day announced inspection of Nenagh Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better 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 services in Nenagh Hospital to ascertain their experiences of receiving care in the hospital
- 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 Nenagh hospital
- observed care being delivered, interactions with people receiving care in Nenagh Hospital and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection.

About the inspection report

A summary of the findings and a description of how Nenagh Hospital performed in relation to compliance with the 11 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 at a particular point in time — before, during and after the inspection.

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

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

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 healthcare service is being sustainably provided in Nenagh 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 the safe delivery of high-quality care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare services in Nenagh Hospital receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care. A full list of the 11 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
26 September 2023	13:30hrs to 18:15hrs	Danielle Bracken	Lead
		Denise Lawler	Support
27 September 2023	08:45hrs to 15:45hrs	Aoife O'Brien	Support

Information about this inspection

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

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

[**] 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 improves 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

The inspection team visited the following clinical areas:

- the Medical Assessment Unit (MAU)
- the Local Injury Unit (LIU)
- Medical 1 (general medical ward)
- Medical 2 (general medical ward).

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

- representatives of the hospital's site operational team:
    - Assistant Director of Nursing (ADON) — who represented the Operational Director of Nursing (DON) on the days of inspection
    - Business Manager
    - Consultant physician and deteriorating patient lead — who represented the associate clinical director on the days of inspection
- a representative for the non-consultant hospital doctors (NCHDs)
- patient flow representatives from Nenagh Hospital
- complaints officer from Nenagh Hospital
- Director of Quality and Patient Safety for ULHG
- Human Resource manager from ULHG
- a representative from the local Medication Safety Committee (MSC), Nenagh Hospital
- a representative from each of the following ULHG committees:
    - Infection Prevention and Control Committee (IPCC)
    - Drugs and Therapeutics Committee (DTC)
    - Deteriorating Patient Steering Committee (DPSC).

Acknowledgements

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

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

On the days of inspection, inspectors visited the LIU, MAU, Medical 1 and Medical 2 wards.

The MAU and LIU were co-located with a shared waiting room containing 12 seats. The MAU consisted of a treatment area with four bays partitioned by curtains and three

isolation rooms one of which had en-suite toilet and shower facilities. There was an additional wheelchair accessible toilet for patient use in this area. The LIU consisted of a treatment area with three bays, and two rooms which could be used by an Advanced Nurse Practitioner (ANP)[§§] or for patients returning for follow-up review.

Patients in MAU who spoke with inspectors described how they had been seen very quickly and that tests had been completed promptly. They described staff as *'excellent'*, *'kind'*, *'very efficient'* and *'lovely'*.

Medical 1 was a 26-bedded general medical ward, consisting of five double-occupancy rooms and 16 single rooms all of which had en-suite shower and toilet facilities.

Medical 2 was a 26-bedded general medical ward consisting of four four-bedded rooms, one three-bedded room, two double-occupancy rooms, and three single rooms all with en-suite shower and toilet facilities.

Patients who spoke with inspectors in the clinical areas visited during inspection described staff as *'all very nice'*, *'second to none'* and *'can't fault the service'*. It was expressed to inspectors that patients felt very well monitored and attended to by staff and that they were kept informed of care plans and progress, telling inspectors that they were *'in the best hands'*. The environment of the clinical areas was described as *'quiet'* and satisfaction with the level of cleanliness was high, with a number of patients describing the clinical areas as *'spotless'.*

Most patients who spoke with inspectors in the clinical areas visited said they had no complaints about the service but felt that they could approach staff if they had concerns and or wanted to make a complaint. Patients described how sometimes the *'tea had gone cold by the time it reached them'* and how this is an area that could be improved. Inspectors observed posters and information leaflets on how to make a complaint displayed in clinical areas visited.

Patients' experiences recounted during inspection, were consistent with Nenagh Hospital's overall findings from the 2022 National Inpatient Experience Survey,[***] where 88% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, this 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 Nenagh Hospital during the inspection and the findings from the 2022 National Inpatient Experience Survey.

[§§] Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

[***] The National Inpatient Experience Survey (NIES) is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the NIES are available at: https://yourexperience.ie/inpatient/national-results/.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the two themes of leadership, governance and management and workforce. Nenagh Hospital was found to be compliant with one national standard (5.5), substantially compliant with two national standards (5.2, 5.8) and partially compliant with one national standard assessed (6.1). Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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

Integrated corporate and clinical governance arrangements were in place at Nenagh Hospital. Management in Nenagh Hospital who spoke with inspectors clearly outlined the defined roles, accountability and responsibilities that were in place at the hospital for assuring the quality and safety of healthcare services provided there.

Nenagh Hospital was governed and managed by the Chief Executive Officer (CEO) of ULHG supported by ULHG's Executive Management Team (EMT), which was in keeping with the hub-and-spoke configuration of ULHG. The CEO of ULHG reported to and was accountable to the HSE's National Director of Acute Operations. Governance of day-to-day operations in Nenagh Hospital was provided by the hospital's operational DON supported by the hospital's business manager. The business manager for Nenagh Hospital reported upwards to the manager for scheduled care at ULHG. An associate clinical director, who was the local clinical lead was in place at Nenagh Hospital at the time of inspection. Additionally, a consultant clinical lead for Model 2 hospitals in ULHG provided clinical governance and leadership and represented the Model 2 hospitals at meetings of ULHG's EMT.

Organisational charts provided to inspectors clearly outlined lines of accountability and responsibility at Nenagh Hospital. Corporate and clinical reporting structures to the operational DON of Nenagh Hospital and from Nenagh Hospital to ULHG were also detailed. The reporting relationships to ULHG's chief director of nursing and midwifery were outlined in the organisational charts. These reporting arrangements were consistent with what inspectors found during inspection.

Nenagh Hospital had a senior management team in place who were members of the Hospital Management Committee, which was the main decision-making forum at the hospital. Operationally, there were two main governance structures at Nenagh Hospital, these were the Operational Site Steering Committee and the Medicine Clinical Operational Governance (COG) Group.

Hospital Management Committee

This committee was tasked with providing strategic leadership, management and oversight of the hospital, setting key priorities, goals and objectives. The committee, chaired by the associate clinical director, met quarterly in line with its terms of reference. From a review of minutes of committee meetings, inspectors noted that this committee functioned well in relation to service requirements for Nenagh Hospital and had effective oversight of staff recruitment, staff training, service performance, and service expansion at the hospital. In September 2023, the committee revised how it recorded minutes of meetings and had added a dedicated section for clearly defined time-bound actions, each with an action owner. This was a notable improvement from the minutes of committee meetings recorded in January and April 2023, which showed limited evidence of assigned time-bound actions, although issues discussed and agreed at meetings were progressed between meetings.

Operational Site Steering Committee

This committee had effective oversight of operational issues that affected the effective functioning of Nenagh Hospital. Chaired by the operational DON, the committee met quarterly in line with its terms of reference. Committee membership comprised hospital, and departmental management and clinical nurse managers (CNMs) throughout Nenagh Hospital. Meetings of the committee followed a comprehensive agenda. Minutes of committee meetings reviewed by inspectors were comprehensive and showed that the committee was action-oriented, and had appropriate oversight of the quality and safety of services in Nenagh hospital, including infection prevention and control practices, medication safety and the management of risks and complaints. The committee revised how it recorded minutes of meetings in September 2023 and had added a dedicated section for time-bound actions, each had an action owner and this improved the tracking of the progress in implementing actions from meeting to meeting. This was an improvement on minutes of committee meetings reviewed from March and June 2023 which had assigned actions, but these were not time-bound.

Performance Meetings

Monthly performance meetings between the EMT of ULHG and the HSE took place where compliance with quality and safety key performance indicators (KPIs) for were reviewed. This included data from the Hospital Patient Safety Indicator Reports (HPSIR) for each hospital in ULHG. A HPSIR report was produced for Nenagh Hospital each month. Every second month, the hospital group held performance meetings with each clinical directorate's management team where quality and safety priorities and actions agreed were discussed to ensure the quality of healthcare services at Nenagh Hospital.

Clinical Directorate Structure

Clinical services at Nenagh Hospital were delivered under the leadership and governance of four of the six ULHG clinical directorates — medicine, perioperative, diagnostics and UEC directorates. The clinical directorates were responsible for the operational functioning and management of the quality and safety and identified risks for the healthcare services under their remit. Each clinical directorate comprised a management team consisting of a clinical director, general manager and directorate DON. The UEC directorate was established in June 2023 and was tasked with overseeing performance in relation to patient flow including performance and activity in the MAU and LIU of Model 2 hospitals, including in Nenagh Hospital. The medicine, perioperative, diagnostics and UEC directorates had defined reporting arrangements to ULHG's EMT and the clinical director for each clinical directorate also reported to the chief clinical director of ULHG. Each directorate also reported formally on the quality and safety of services under their remit, including those in Nenagh Hospital, to ULHG's Quality and Safety Committee (QUALSEC).

Quality and Safety Committee

Nenagh Hospital did not have a local Quality and Safety Committee, they were represented on ULHG's QUALSEC by the operational DON. Each clinical directorate reported on the quality and safety of the services under their remit to QUALSEC using a standardised report template every three months. Clinical directorates' reports to QUALSEC reviewed by inspectors were comprehensive, informative and showed Copies of directorate reports submitted to QUALSEC showed that clinical directorates had effective oversight of the quality and safety of healthcare services in Nenagh Hospital, which included patient-safety incidents, complaints and quality improvements.

Medicine Clinical Operational Governance (COG) Group

Nenagh Hospital's medicine COG group, chaired by the associate clinical director, was responsible for the quality and safety of care and for ensuring services provided in the hospital were delivered in line with clinical need. The group had oversight of operational services, compliance with KPIs and the quality and safety of healthcare services provided in the hospital. Membership of the medicine COG group included the associate clinical director for Nenagh Hospital, ULHG's clinical lead for the Model 2 hospitals and the general manager of the medicine directorate. From a review of minutes of a meeting of the group in September 2023, inspectors noted that although operational services were discussed, compliance with KPIs and quality and safety issues were not discussed. It was therefore unclear to inspectors if this group had adequate oversight of the quality and safety of services provided in Nenagh Hospital. There were no actions recorded from meetings of the group and no evidence that the progress of implementation of agreed actions were monitored meeting to meeting.

Infection Prevention and Control Committee

Nenagh Hospital had a local IPCC, chaired by the operational DON which was attended by a member of the infection prevention and control team from UHL. The hospital was represented by the operational DON on ULHG's IPCC. This multidisciplinary committee, was responsible for the governance and oversight of infection prevention and control practices, which included the oversight of the implementation of ULHG's infection prevention and control programme[†††] across the six clinical directorates and for each hospital within ULHG. The IPCC was chaired by a clinical director and met quarterly in line with its terms of reference. It was clear from documentation reviewed by inspectors and meetings with staff during inspection that reports from Nenagh Hospital detailing performance with infection prevention and control practices at the hospital were submitted to each meeting of the IPCC. ULHG's infection prevention and control team also submitted an annual report, which contained information on the infection prevention and control practices at Nenagh Hospital in 2022 to the ULHG's IPCC.

Medication Safety Committee

Nenagh Hospital had a MSC who had oversight of the medication safety practices in the hospital. This included compliance with medication safety metrics and KPIs, audit findings, medication patient-safety incidents and medication related risks recorded on the hospital's risk register. The multidisciplinary MSC was chaired by Nenagh Hospital's pharmacist in charge and met approximately every two months, with the aim of having nine meetings a year as per their terms of reference. Minutes of MSC meetings reviewed by inspectors were comprehensive and showed that meetings were action oriented with a focus on performance and shared learning. Nenagh Hospital's MSC reported to ULHG's Drugs and Therapeutics Committee (DTC). ULHG's DTC promoted medication safety practices across the hospitals in ULHG and had developed a medication safety strategy to be implemented across the hospital group. Nenagh Hospital was represented on ULHG's DTC by the hospital's pharmacist in charge who provided verbal updates at meetings to ULHG's DTC.

Deteriorating Patient Committee

Nenagh Hospital did not have a Deteriorating Patient Committee. The hospital was represented by the operational DON on ULHG's Deteriorating Patient Steering Committee (DPSC). The objective of the committee was to provide governance and oversight of the implementation of national guidance on sepsis management and national early warning systems such as the Irish National Early Warning System (INEWS)[‡‡‡] version 2. The committee, chaired by the chief clinical director, aimed to meet every two months but had last met in June 2023, which was not in line with its terms of reference. Membership of the committee included senior clinical leadership and representatives from across ULHG.

[†††] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

[‡‡‡] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.

Minutes of meetings of ULHG's DPSC reviewed by inspectors did not provide information about the implementation of the deteriorating patient programme at Nenagh Hospital. The operational DON at Nenagh Hospital had oversight of the hospital's INEWS audit findings. Audit results will be discussed in more detail in national standards 5.8 and 2.8.

Unscheduled Care Committee

Nenagh Hospital did not have an Unscheduled Care Committee, but the hospital's operational DON represented the hospital on the University of Limerick Hospitals and Mid-West Community Healthcare Organisation Integrated Unscheduled Care Committee who facilitated patient's timely access to care in the most appropriate care setting. This committee was co-chaired by ULHG's chief operations officer and the head of service for older person's services. Membership was multidisciplinary and comprised key personnel throughout ULHG and the wider community services. Minutes of committee meetings reviewed by inspectors showed the committee had effective oversight of factors that could impact on efficient patient flow in Nenagh Hospital such as patient experience times (PETs), delayed transfers of care (DTOC), average length of stay (ALOS).

In summary, inspectors found there were integrated corporate and clinical governance arrangements in place at Nenagh Hospital. No actions were documented from meetings of the medicine COG group and there was no evidence that the implementation of agreed actions was monitored from meeting to meeting. It is important that the medicine COG group record agreed time-bound actions to improve the quality and safety of services provided at Nenagh Hospital and that progress of implementation of these actions is continually monitored. Changes to how minutes of meetings of other local governance structures are recorded, introduced at the time of inspection, will assist the medicine COG group to implement and monitor the effectiveness of agreed actions.

Judgment: Substantially compliant

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

Inspectors found that Nenagh Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare, appropriate for the size, scope and complexity of the service provided at the hospital.

Findings relating to the Medical Assessment Unit and Local Injury Unit

Inspectors were satisfied that there were defined lines of responsibility and accountability with devolved autonomy and decision-making in place for the management of the MAU and the LIU. Operationally, on the days of inspection these units were functioning well. There was evidence of strong medical and nursing leadership in both units. The MAU was consultant led. An emergency medicine consultant based in UHL attended the LIU once a

week. Operational oversight of day-to-day workings of the units was the responsibility of the onsite CNM 2, who reported to the ADON.

The MAU operated seven days a week and opened from 8am to 8pm, Monday to Friday and 8am to 6pm at the weekends and bank holidays. Inspectors were informed that the pathway for referral to the MAU was through the patient's general practitioner (GP) and from the emergency department in UHL through an appointment service and the national ambulance service.

Since February 2023, Nenagh Hospital accepted non-urgent 999 and 112 ambulance calls, with patients received through this pathway reviewed in the MAU. Defined criteria was in place for the referral of medical patients to Nenagh Hospital under this protocol. Since February, 53 patients had been directly transferred and reviewed in the hospital's MAU, of these, 26 (49%) were admitted to an inpatient bed in the main hospital.

At 11am on the first day of inspection:

- 10 patients were present in the MAU, with a total of 17 patients reviewed in the unit that day
- 17.64% of patients reviewed in MAU were admitted to an inpatient bed in Nenagh Hospital
- 90% of patients reviewed in MAU were admitted or discharged within six hours of registration, which was above the target of 75% set by the HSE.

When MAU activity in 2022 was compared to year to date in 2023, inspectors found:

- on average, 203 patients attended the MAU per month in 2022 and 319 patients per month year to date in 2023 — this represented a 57% increase in attendances to the MAU
- the average daily admission rate from MAU was 21.31% in 2022 and 22.9% year to date in 2023 — this represented a slight increase in patients requiring admission from MAU
- on average, 79.8 % of those attending MAU in 2022 were admitted or discharged within six hours, this figure reduced to 74.5% year to date in 2023 and is marginally below the HSE's target of 75%.

The LIU operated seven days a week from 8am to 8pm. There were defined inclusion and exclusion criteria for the LIU. On the first day of inspection:

- 10 patients were in the LIU at 11am, with a total of 46 patients reviewed in the unit that day
- none of the patients seen in LIU were admitted to an inpatient bed
- the average PET was 1 hour 23 minutes.

In relation to activity in the LIU in 2022 compared to year to date in 2023, inspectors found:

- a total of 12,449 patients attended LIU in 2022, which equated to an average attendance of 1,037 patients per month
- from January to September 2023, the average attendance to LIU per month was 1,198 patients, which represented an increase of 16% on 2022 attendances.

Staff in MAU told inspectors that access to diagnostics and the lack of access to the laboratory for blood results outside of core working hours and at weekends was challenging. During these times, blood samples were transported to UHL by taxi and turnaround times for results could be two to three hours. This was a risk recorded on the MAU's local risk register and as an interim mitigating measure, a business case for point of care testing in MAU had been submitted to ULHG.

Findings relating to the wider hospital and other clinical areas

In line with the hub-and-spoke arrangement of ULHG, some resources were centralised in UHL with an offsite allocation to the Model 2 hospitals in the hospital group. The quality and patient safety department was centralised at UHL and a designated risk advisor visited Nenagh Hospital regularly. Nenagh Hospital had management arrangements in place in relation to the four areas of known harm for the other clinical areas visited during inspection, these are discussed in more detail below.

Infection prevention and control

There was no dedicated infection prevention and control team or nurse for Nenagh Hospital. Staff at Nenagh Hospital were supported by the infection prevention and control team from UHL and a designated infection prevention and control nurse manager visited the hospital once a week. Outside of scheduled visits, staff at Nenagh Hospital could access the infection prevention and control team in UHL by telephone and email. Inspectors were told that infection prevention and control issues specific to Nenagh Hospital were raised at the weekly ULHG infection prevention and control team meeting. Staff in clinical areas that spoke with inspectors felt supported by the infection prevention and control team. Staff at Nenagh Hospital were supported by an antimicrobial stewardship (AMS) pharmacist, based at UHL that visited Nenagh Hospital approximately once a week. Staff in Nenagh Hospital had access to microbiology consultants 24/7.

Medication safety

Nenagh Hospital were approved and funded for one whole-time equivalent (WTE)[§§§] pharmacist and 1.5 WTE pharmacy technicians and all of these posts were filled. At the time of inspection, the lack of an on-site pharmacist outside core working hours was a

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

high-rated risk recorded on the hospital's risk register. When the pharmacist was on planned leave, pharmacist cover was provided by an agency pharmacist. A comprehensive clinical pharmacy service[****] was not available in Nenagh Hospital, and this was also a high-rated risk recorded on the hospital's risk register. Inspectors were told that NCHD-led medication reconciliation was carried out on an ad hoc basis. At the time of inspection, a business case for one WTE senior clinical pharmacist had been submitted to ULHG's diagnostics directorate for consideration.

Nenagh Hospital did not have a medication safety officer (MSO). Inspectors found evidence that medication practices at the hospital were supported by the MSOs based in UHL. The MSOs generated medication related patient-safety incident reports specific to Nenagh Hospital and attended meetings of Nenagh Hospital's MSC.

Deteriorating patient

The relevant early warning system — INEWS version 2 and Identify, Situation, Background, Assessment and Recommendation (ISBAR)[††††] communication tool were used in Nenagh Hospital. The operational DON attended meetings of ULHG's DPSC meetings and there was a consultant lead for the deteriorating patient in place at the hospital. There was a local deteriorating patient pathway in place at Nenagh Hospital that detailed the criteria for transferring patients from the hospital to UHL. Clinical staff reported that response times from medical staff to review a patient whose clinical condition was deteriorating were timely.

Transitions of care

Inspectors found that Nenagh Hospital had effective arrangements in place to monitor issues that impact the effective, safe transitions of care, including effective patient flow arrangements. The hospital had 2.0 WTE CNM 2s dedicated to bed management and patient flow and 1.0 WTE discharge co-ordinator. Inspectors were told that the patient flow CNMs liaised daily with MAU regarding admissions. The patient flow CNMs along with the discharge co-ordinator liaised daily with clinical areas and attended weekly delayed transfer of care meetings where issues impacting on the timely and safe discharge of patients were discussed.

In summary, inspectors found that the MAU and LIU in Nenagh Hospital were functioning well and as intended. Nenagh Hospital had effective management arrangements in place to support and promote the safe delivery of high-quality healthcare services at the hospital.

Judgment: Compliant

[****] 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.
[††††] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a structured way to transfer critical information between health professionals with the goal of improved communication and patient-safety.

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.

Inspectors found Nenagh Hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on compliance with a range of KPIs, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital.

Monitoring service's performance

Nenagh Hospital provided assurances in relation to service performance to four of the six clinical directorates governing and overseeing the delivery of clinical services across hospitals in ULHG. The directorates in turn provided assurances to ULHG's QUALSEC through quality and safety reports submitted quarterly. At Nenagh Hospital, data on a range of different clinical measurements related to the quality and safety of healthcare services was collected and collated in line with the national HSE reporting requirements. Collated performance data for unscheduled and scheduled care at the hospital, including data on MAU and LIU attendances and PETs, bed occupancy rate, ALOS of medical patients, ALOS of patients in the Clinical Recovery Support Unit (CRSU), and DTOC. This will be discussed in more detail in national standard 2.8.

Risk management

Inspectors found Nenagh Hospital had effective risk management structures and processes in place to proactively identify, manage and minimise risks in line with the HSE's integrated risk management policy. Risks were identified, managed and monitored locally at clinical area level, hospital level and clinical directorate level. Risks recorded on the local and hospital risk registers, had control measures in place to mitigate the actual and potential risks to patient safety and these measures were regularly reviewed and updated. Inspectors noted that some actions did not have due dates or responsible persons assigned to oversee the implementation. Risks that could not be fully managed at hospital level were escalated to the relevant clinical directorate. ULHG's QUALSEC had oversight of risks recorded on Nenagh Hospital's risk register. The management of actual and potential risks to patient safety are discussed further in national standard 3.1.

Audit activity

Nenagh Hospital had a local audit committee. The operational DON had oversight of the clinical audits carried out at Nenagh Hospital and the implementation of quality improvement plans developed in response to audit findings. There was evidence that audit activity and findings were reviewed at meetings of the Hospital Management Committee

and Operational Site Steering Committee. Audit activity will be discussed further in national standard 2.8.

Management of serious reportable events and patient-safety incidents

The operational DON at Nenagh Hospital and Serious Incident Management Team (SIMT) of each clinical directorate had oversight of serious reportable events (SREs) and patient-safety incidents that occurred in Nenagh Hospital. SREs and patient-safety incidents were reported to the National Incident Management System (NIMS),‡‡‡‡ in line with the HSE's Incident Management Framework.§§§§ With the exception of the hospital's MSC, there was limited evidence that SREs or patient-safety incidents that occurred in Nenagh Hospital were discussed at meetings of the hospital's local governance committees. ULHG's IPCC had oversight of all infection prevention and control patient-safety incidents that occurred across ULHG including at Nenagh Hospital. Patient-safety incidents related to the four areas of known harm will be discussed in more detail under national standard 3.3.

Feedback from people using the service

Inspectors found there was effective oversight of feedback from patients to inform improvements to healthcare services provided at Nenagh Hospital. The hospital had implemented three quality improvement measures as a result of findings from the National Inpatient Experience Survey 2022. These included:

- information about patient's clinical condition was provided in a way that they can understand
- patients were given time during medical ward rounds to discuss their care with the medical team
- patients were provided with information about the side-effects of medications and danger signals to watch out for on discharge from hospital.

Nenagh Hospital held its most recent Patient Experience Committee meeting in September 2023, this committee was responsible for enhancing patients' experience of healthcare services provided in the hospital. The committee, chaired by the operational DON planned to meet every quarter and reported to the ULHG's patient experience committee according to its terms of reference. The aim of the committee was to proactively identify areas for improvement and develop quality improvement plans to address these and monitor the progress in implementing these plans.

In summary, Nenagh Hospital had effective and systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety

‡‡‡‡ 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: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

and reliability of healthcare services with some areas for improvement noted. Some actions on the hospital risk register did not have due dates or responsible persons assigned. This is important to ensure progress with implementing agreed actions to reduce the actual and potential risks to patient safety. Patient-safety incidents were not discussed at key governance committees, such as the Operational Site Steering Committee and medicine COG group, tasked with improving the quality and safety of services at Nenagh Hospital. This is a missed opportunity for shared learning.

Judgment: Substantially compliant

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

Inspectors found that hospital management had effective arrangements in place to plan organise and manage their staffing levels to support the provision of high-quality, safe healthcare. Nenagh Hospital did not have an onsite human resources department, staff recruitment was coordinated through ULHG. Each clinical directorate had a human resources business manager and there was a designated link person in place to liaise with Nenagh Hospital. Staff vacancies and absenteeism were standing items on the agenda of clinical directorate performance meetings. There was evidence in minutes of meetings of the Hospital Management Committee, Operational Site Steering Committee and medicine COG group reviewed by inspectors, that staffing arrangements and the recruitment needs of Nenagh Hospital were reviewed and discussed.

Nenagh Hospital had adequate workforce management arrangements in place to support the day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, compliance with essential and mandatory training required improvement.

In September 2023, Nenagh Hospital had a total of 326 WTE staff across all professions and disciplines, when compared to December 2022, this represented an uplift of 32 staff (11%). The hospital had an approved complement of 167.26 WTE nurses (this included management grades). At the time of inspection, the actual number of nurses in position was 156.61 WTE, this represented a shortfall of 10.65 WTE (6.4%) nurses. Of this shortfall, five of these posts were new posts that had been approved in August 2023 to align with the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist*

Medical and Surgical Care Settings in Ireland.[*****] Inspectors were told that recruitment campaigns were underway at the time of inspection to fill these positions.

Nenagh Hospital was funded for 6.5 WTE medical consultants, with 6.0 WTE medical consultants in place at the time of inspection, this represented a shortfall of 0.5 WTE (7.7%) consultants. A consultant in emergency medicine from UHL visited the LIU in Nenagh Hospital once a week. The medical consultant staff were supported by a total of 19 NCHDs – 8.0 WTE at registrar grade and 10 WTE at senior house officer (SHO) grade and 1.0 WTE at intern grade. All NCHD positions were filled at the time of inspection. Inspectors were informed by hospital management that all consultants employed at the hospital were on the relevant specialist division of the register of the Irish Medical Council. Inspectors reviewed the hospital's risk register and noted that unfilled staffing positions that presented a risk to the effective functioning of Nenagh Hospital were being actively managed.

Inspectors noted that the clinical areas visited during inspection had some unfilled shifts due to short-term sick leave in the month before HIQA's inspection. Inspectors were told that these were usually filled by re-allocating staff or by staff taking extra shifts and agency staff. At the time of inspection, the absenteeism rate, year to date in 2023 at Nenagh Hospital was 7%. Of this, less than 1% was related to COVID-19 absence. The absence rate was above the HSE's target of 4% or less but the absenteeism rate had reduced when compared to the 2022 rate of 9.9%. Staff education on the hospital's attendance policy and the management of staff's return to work had taken place. Notwithstanding this, lowering the absenteeism rate should be an area of continued focus after this inspection.

Staff training

All new staff at Nenagh Hospital attended a corporate induction programme organised by the Learning and Development Unit at UHL, which took place several times a year. Specific induction programmes were also provided for new NCHDs and nursing staff. Staff who spoke with inspectors confirmed that they had attended induction when they commenced employment in Nenagh Hospital.

Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and the deteriorating patient. Training records for nurses and HCAs were overseen by the CNM 2 in each clinical area visited during inspection.

[*****] *The Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland* 2018, provides recommendations in relation to the number and type of nurses and healthcare assistants required within a ward based setting https://www.gov.ie/en/publication/2d1198-framework-for-safe-nurse-staffing-and-skill-mix-in-general-and-speci/

Medical staff attendance at and uptake of training was recorded in the National Employment Record (NER).[†††††]

Training records reviewed by inspectors demonstrated that there was evidence of high staff attendance at and uptake of mandatory and essential training in some of the clinical areas visited. However, attendance at and uptake of training in relation to standard and transmission-based precautions, infection outbreak management, basic life support (BLS), advanced cardiovascular life support (ACLS) could be improved for nursing and medical staff.

Inspectors had concerns in relation to the capacity of staff in Nenagh Hospital to respond outside of normal working hours to a rapidly deteriorating patient. This was a risk recorded on the hospital risk register and is discussed further under national standard 3.1. One of the mitigating controls in relation to this risk was that some nursing and medical staff were trained in ACLS.

Inspectors reviewed training records for medical and nursing staff and found that 81% of nurses and 52% of doctors were up-to-date with BLS training and 85% of nurses and 33% of doctors were up-to-date with ACLS training. Given this level of uptake of ACLS and BLS training, inspectors were not fully assured about the timelines of intervention for patients who may experience clinical deterioration, especially those requiring airway support. Hospital management confirmed to inspectors that ACLS training was to be provided to a further 10 doctors by year end (2023). BLS and ACLS scenario training, which included an audit of cardiopulmonary resuscitation (CPR) skills, was carried out in all clinical areas visited during inspection in 2022 and year to date in 2023. The delivery and increasing uptake of ACLS and BLS training should be an area of focused improvement after this inspection.

In summary, overall, inspectors found that hospital management had effective arrangements in place to plan, organise and manage their staffing levels to support the provision of high-quality, safe healthcare. However, compliance with BLS and ACLS training, especially among medical staff required significant improvement. This represented a risk to the timely response to patients whose clinical condition was deteriorating, especially those who may require airway support. Hospital management should 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.

Judgment: Partially compliant

[†††††] The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

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. Nenagh Hospital was found to be compliant with one national standard (1.7) and substantially compliant with six national standards (1.6, 1.8, 2.7, 2.8, 3.1, 3.3) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

For the most part, it was clear to inspectors that staff in all clinical areas visited during inspection promoted the privacy, dignity, confidentiality and autonomy of patients receiving care. Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. For example, patients told inspectors that staff responded promptly to call bells for assistance with toileting and getting out of bed when needed. Patients expressed that they felt very well monitored and that staff were very approachable. Staff were observed providing one-to-one assistance to patients and assisting patients to mobilise.

There was evidence that patients' autonomy and independence was promoted, for example, patients told inspectors that they were kept informed and updated about their plan of care. Inspectors observed patient information booklets in place in the clinical areas visited that provided information to patients about their care and services available within the hospital.

In general, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. However, the close proximity of cubicles in the LIU meant that private conversations could be overheard. Multi-occupancy rooms in the clinical areas visited, with shared en-suite bathroom facilities afforded less privacy than single rooms. However, patients in multi-occupancy rooms that spoke with inspectors felt they had enough privacy and this was consistent with the findings from the National Inpatient Experience Survey where the hospital's score of 9.2 was higher than the national average of 8.6.

Inspectors observed that the privacy and dignity of patients was promoted and protected by staff when providing care, through the use of privacy curtains for example. Inspectors observed that the glass viewing panels in doors to single rooms had blinds in place which could be closed for additional privacy. There was an end-of-life suite in one of the clinical areas visited to provide dignity to patients and families at the end of life.

Inspectors observed that patient's personal information was protected and stored appropriately in line with general data protection regulations.

Overall, there was evidence that hospital management and staff at Nenagh Hospital were aware of the need to respect and promote the dignity, privacy and autonomy of patients. However, the close proximity of cubicles in the LIU meant that private conversations could be overheard and multi-occupancy rooms in the clinical areas visited during inspection afforded less privacy than single rooms.

Judgment: Substantially Compliant

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

Inspectors observed staff in the clinical areas visited during inspection actively listening and effectively communicating with patients in an open and sensitive manner, in line with their needs and preferences. Inspectors found evidence of a person-centred approach to care, especially for vulnerable patients, such as patients with dementia.

Inspectors observed and staff told inspectors about initiatives introduced to make clinical areas more dementia-friendly. Inspectors observed 'what matters to me' boards in place, with details of things that were important to patients to help staff caring for them better understand their needs and preferences. Rooms were colour-coded to help patients more easily navigate along the corridors. In one clinical area visited a replica of a 'train station' had been created for patients to sit and relax in. A video showing scenery that would be expected to be seen from the 'train' window played continuously. Inspectors also observed a clock that showed the date and season to orient patients to time and place. A secure garden accessible only by swipe access was also available to patients.

Inspectors observed staff actively engaged with patients in a respectful and kind manner, taking time to talk and listen to patients and responding promptly to patients' needs. In particular, inspectors observed some kind and caring interactions with patients that had dementia. These observations were confirmed by patients who said they could talk to a nurse about their worries and concerns.

There was evidence of a good culture of kindness, consideration and respect in the way that staff engaged with and responded to feedback from people who use the healthcare services at Nenagh Hospital. This was aligned with the human rights-based approach to care promoted by HIQA.

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.
Inspectors found Nenagh Hospital had systems and processes in place to manage formal and informal complaints and to learn from and oversee the implementation of recommendations arising from review of complaints. The hospital had two designated complaints officers — the operational DON and business manager, who were assigned with responsibility for managing and overseeing the implementation of recommendations from complaints. Nenagh Hospital had implemented the HSE's complaints management policy '*Your Service Your Say*',[‡‡‡‡‡] and used the national complaints management system (CMS) to record, track and trend formal complaints using the HSE classification system. Hospital management at Nenagh Hospital supported and encouraged point of contact complaint resolution, with complaints managed at local clinical area level by the CNM. Staff in the clinical areas visited were knowledgeable about the complaints management process. Inspectors observed posters and leaflets on how to make a complaint displayed in all the clinical areas visited. The hospital's Operational Site Steering Committee and ULHG's Director of Quality and Patient Safety also had oversight of the effectiveness of the complaints management process at Nenagh Hospital. Complaints were reported to and reviewed at meetings of ULHG's QUALSEC. Additionally, there was a Complaints Steering Group in place at ULHG level and Nenagh Hospital was represented on this committee by the operational DON and business manager. Complaints data from Nenagh Hospital was provided at meetings of the Complaints Steering Group. Nenagh Hospital reported on the number and type of formal complaints received annually. The hospital received 30 formal complaints in 2022, 40% of these were resolved within 30 working days or less. Hospital management had received 37 formal complaints year to date in 2023, 68% of these were resolved within 30 working days, which is a marked improvement on 2022. However, further improvement is required to meet the HSE's target of 75% for resolution of complaints within 30 working days or less. In 2023, ULHG began measuring compliance with a new KPI on the number of recommendations arising from the complaints resolution process implemented within 65 working days or less. Data reviewed by inspectors for Nenagh Hospital for quarter 2 of 2023 showed that 80% of recommendations from complaints had been implemented within 65 working days or less.

[‡‡‡‡‡] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comments, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

Staff confirmed they received feedback and learning was shared from the complaints resolution process. Patients who spoke with inspectors knew that they could raise a concern with staff members if required. The hospital did not have a local Patient Advocacy Liaison Service (PALS),§§§§§ but an assigned PALS manager from UHL visited Nenagh Hospital once a week.

In summary, inspectors found Nenagh Hospital had efficient systems and processes in place to respond effectively to complaints and concerns raised by patients and or their families. Hospital management and ULHG should continue to ensure that complaints are resolved promptly, in line with HSE targets.

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.

The MAU was relocated in 2020 to a refurbished area on the ground floor. Inspectors observed that the environment in Medical 1 had been modernised following a complete refurbishment and patient rooms were spacious. Medical 2 had also undergone refurbishment although this was not fully completed, with floor coverings in parts of the ward due for replacement. Inspectors found a high level of cleanliness and maintenance of the physical environment in the clinical areas visited. CNMs who spoke with inspectors were satisfied with the timely response from the maintenance team. All clinical areas visited were secure and required swipe access to enter.

Hospital management at Nenagh Hospital had implemented processes to ensure the appropriate placement of patients requiring transmission-based precautions — the infection prevention and control team in UHL liaised with CNMs and bed management on patient placement daily. The MAU had three single rooms, one with en-suite toilet and shower facilities. Medical 1 had 16 single rooms, all with en-suite toilet and shower facilities. Medical 2 had three single rooms, all with en-suite toilet and shower facilities. Inspectors were told that at times, when there were no single rooms available, patients who required transmission-based precautions were cohorted****** on the advice of the infection prevention and control team in UHL and in line with clinical guidance.

The clinical areas visited during inspection had dedicated cleaning staff. CNMs were satisfied with the cleaning schedule. During core working hours cleaners were always

§§§§§ The Patient Advocacy and Liaison Service (PALS) team acts as a point of contact between patients, their families or carers and the hospital to assist in addressing concerns about any aspect of care or service in the hospital.
****** Cohorting is the practice of grouping patients infected or colonised with the same infection together to confine their care to one area and prevent contact with susceptible patients.

present and there was oversight of cleaning by the cleaning supervisor. Patients who spoke with inspectors described the environment as '*spotless*', which aligned with findings from the 2022 National Inpatient Experience Survey, where the hospital scored above the national average of 9.0 for cleanliness.

Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited. Staff were observed to be wearing appropriate personal protective equipment (PPE) in line with public health guidelines in place at the time of inspection. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available in clinical areas. Inspectors observed posters in relation to correct hand washing technique displayed and found hand hygiene sinks conformed to national requirements.[††††††]

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. Inspectors observed that waste, including hazardous waste and linen was segregated and stored appropriately and all sharps containers had the temporary closure mechanism in place. Inspectors observed that there were adequate storage facilities in clinical areas visited. Emergency equipment and supplies were in place and were checked daily and weekly in line with hospital policy.

In summary, the physical environment of the clinical areas visited during inspection was well designed and the infrastructure was modern — this supported the delivery of safe care that protected the health and welfare of patients. However, there were a limited number of single rooms in Medical 2, which sometimes resulted in patients requiring transmission-based precautions having to be cohorted when all the single rooms were in use.

Judgment: Substantially compliant

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

Inspectors found Nenagh Hospital had effective systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources to inform continuous improvement and provide hospital management and ULHG with assurances on the quality and safety of healthcare services provided at the hospital. Sources of information included audit findings, compliance with defined quality and safety performance metrics, patient-safety incident reviews, complaints, risk assessments and

[††††††] 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.

patient experience surveys. Inspectors observed that audits findings and compliance with metrics were displayed on notice boards in the clinical areas visited during inspection.

Infection prevention and control monitoring

ULHG's IPCC actively monitored and evaluated infection prevention and control practices in Nenagh Hospital. The committee had oversight of environmental, patient equipment and hand hygiene audit findings, and compliance with infection prevention and control guidelines and protocols. Inspectors reviewed Nenagh Hospital's annual report for 2022 which summarised infection prevention and control audit findings and the hospital's rates of healthcare-associated infection.[‡‡‡‡‡‡] Clinical staff who spoke with inspectors confirmed that audit findings were shared with them and time-bound action plans were developed to improve infection prevention and control practices across the hospital.

Monthly environmental and patient equipment hygiene audit findings reviewed by inspectors showed that all clinical areas visited during inspection performed well in this area. Environmental and patient equipment hygiene audit findings ranged from 91% to 100% for the three months (June, July and August) preceding HIQA's inspection. All the clinical areas visited also scored higher than the HSE's target of 90% for hand hygiene practices for the three months (June, July and August) preceding HIQA's inspection. Sluice and commode audits were carried out every three months. There was evidence that when infection prevention and control practices were below expected standards, quality improvement plans were put in place to improve the practices and re-audit occurred.

In line with the HSE's national reporting requirements as part of the HPSIR report, hospital management monitored and publically reported on rates of healthcare-associated infection. In 2022, Nenagh Hospital reported that:

- the rates of new cases of hospital-associated *Clostridioides difficile* infection was significantly greater than the HSE's target of less than or equal to 2 per 10,000 bed days for three months in 2022 – 12.8 in July 2022, 5.9 in November 2022 and 11.4 in December 2022
- the rate of new cases of hospital acquired *Staphylococcus aureus* blood stream infections was 5.7 in December 2022 which was significantly greater than the HSE's target of less than or equal to 0.8 per 10,000 bed days
- there were five new cases of *Carbapenemase-producing Enterobacterales* (CPE) in 2022.

A review into the increased incidence of *Clostridioides difficile* acquired infections in Nenagh Hospital in quarter 3 of 2022 was carried out. The review found two linked cases

[‡‡‡‡‡‡] 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.

of infection and a quality improvement plan was put in place to prevent reoccurrence. There was also evidence that a review was carried out and the review findings were discussed with the Serious Incident Management Team when a serious *Staphylococcus aureus* blood stream infection occurred in the hospital.

CPE screening compliance audits were carried out in Nenagh Hospital monthly and audit findings from 2022, reviewed by inspectors showed that compliance was variable, ranging from 70% to 100%. Quality improvement initiatives were introduced to improve CPE screening in the hospital, this will be discussed in more detail in national standard 3.1.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship (AMS) practices at Nenagh Hospital. The hospital did not have an AMS committee or AMS programme, but ULHG's IPPC and DTC had oversight of the hospital's AMS activity. Nenagh Hospital participated in the national antimicrobial point prevalence study[§§§§§§] and reported to ULHG's IPCC and DTC on compliance with antimicrobial stewardship KPIs every three months. AMS data for Nenagh Hospital for quarter 2 of 2023 reviewed by inspectors showed that improvement was needed in relation to documentation of indication and treatment duration, compliance with choice of agent and switching eligible patients to oral antibiotics. Quality improvement plans to improve AMS practices were in place at ULHG level which included audit, re-audit and targeted education and the implementation of these plans were overseen by the DTC and IPCC.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices in line with the hospital's medication safety audit plan 2023. Audits carried out included compliance with concentrated potassium use, Venous thromboembolism (VTE) prophylaxis[*******] prescribing and nurse prescribing audits. There was evidence that time-bound quality improvement plans were introduced when required to improve and ensure safe medication practices across Nenagh Hospital.

Deteriorating patient monitoring

Performance data through 'Test Your Care' nursing and midwifery metrics[†††††††] relating to the INEWS escalation and response protocol was collated at Nenagh Hospital. Audit of compliance with the INEWS escalation and response protocol including the use of the ISBAR tool was also carried out every three months and there was evidence that time-

§§§§§§ The national antimicrobial point prevalence study collects information on prescribing practices of antibiotics and other information relevant to treatment and management of infectious disease of hospitalised patients.

******* Venous thromboembolism (VTE) prophylaxis consists of pharmacological and non-pharmacological measures to diminish the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE).

††††††† Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

bound quality improvement plans were developed to bring the hospital into compliance with relevant national guidance.

Transitions of care monitoring

Compliance with defined KPIs in relation to transitions of care was monitored at Nenagh Hospital. The number of attendances to the LIU and MAU, ALOS of medical inpatients and DTOC were reported monthly as per HSE reporting requirements. This performance data was discussed at meetings of the UL Hospitals, Mid-West Community Health Organisation Integrated Unscheduled Care Committee, relevant clinical directorates and the Hospital Management Committee. At the time of inspection, the hospital's ALOS for medical inpatients was 4.6 days, this was a reduction when compared to the ALOS in 2022 (5.3 days). The ALOS for patients in the hospital's CRSU was also tracked. The CRSU admitted patients from UHL with complex recovery needs that had lengths of stay in excess of 30 days, such as patients that had amputation of a limb. Year to date in 2023, the ALOS for patients in CRSU was 22 days, an improvement on the 2022 figure of 36 days. At the time of inspection, Nenagh Hospital had three DTOC. Inspectors were told that there was an average of three DTOC per month, which was an improvement on the average of five DTOCs per month in 2022. The low numbers of DTOC indicates that there was good patient flow in Nenagh Hospital.

At the time of inspection, clinical handover was not audited in Nenagh Hospital but the use of the ISBAR communication tool was audited as part of INEWS audits.

In summary, inspectors found Nenagh Hospital had effective systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of healthcare services and ensure compliance with national guidance and standards. Clinical handover is an area that could benefit from being audited and quality improvements introduced where needed to ensure the effective exchange of clinical information.

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.
Inspectors found there were effective systems and processes in place at Nenagh Hospital to identify, evaluate and manage actual and potential risks to patients. It was evident from minutes of meetings reviewed by inspectors that the Hospital Management Committee and Operational Site Steering Committee had oversight of the management of identified risks to patient safety. Additionally, QUALSEC had oversight of the management of risks escalated to ULHG.

It was clear to inspectors that clinical staff took responsibility for managing risk in their clinical areas, in line with the HSE's integrated risk management policy. Local risk registers were maintained and reviewed by CNMs monthly and were discussed with senior management at Nenagh Hospital every three months. Inspectors were told that advice in relation to risk assessment was available when needed from a designated risk advisor in UHL. At the time of inspection, there were four high-rated risks recorded on the hospital's risk register, three of these related to medication safety and are discussed below. One of the four high-rated risks related to administrative staff vacancies, control measures in place to mitigate the risk included the conversion of agency posts and recruitment of staff to permanent positions. High-rated risks that could not be managed at Nenagh Hospital level were escalated to the relevant clinical directorate where they were documented on the directorate's risk register and escalated upwards to ULHG's EMT, if required. Risk registers reviewed by inspectors had control measures and time-bound actions assigned to the relevant executive manager, CNM or clinical directorate. Inspectors saw evidence of the mitigating measures in place during inspection to reduce the risk to patient safety.

Infection prevention and control

There was evidence that infection related risks were discussed as part of each clinical directorate's and individual hospital's updates to the ULHG's IPCC, although risk was not a standing agenda item for meetings of the committee.

On admission to Nenagh Hospital, patients were routinely screened for CPE and MRSA in line with defined criteria and for respiratory illnesses such as COVID-19 and influenza if symptomatic. Staff uptake of flu vaccination for nurses in Nenagh Hospital in 2022 was 56%, well below the HSE's target of 75%, this is an area that would benefit from improvement.

The hospital was following national guidance in relation to screening for CPE. To facilitate the screening process, an infection prevention and control admission screening record was included in nursing care documentation. The screening record contained clear instructions about screening patients for CPE and MRSA and had a designated section to record the dates that CPE and MRSA samples were taken.

It was evident that comprehensive surveillance reports relating to infection outbreaks were discussed at meetings of ULHG's IPCC every three months. There was also evidence that quality improvement plans were implemented to improve infection prevention and control practices across Nenagh Hospital. Inspectors noted from minutes of meetings of ULHG's IPCC that while infection outbreaks and patient-safety incidents were not a standing agenda item, they were a standard item on the reporting template used by each clinical directorate and individual hospital when reporting to the IPCC.

Inspectors reviewed a COVID-19 outbreak report from September 2023 and found it to be comprehensive with recommendations for the reduction of transmission made. The availability of single rooms for patients requiring transmission-based precautions was a

factor to assist in reducing transmission. A Legionella risk assessment, carried out in Nenagh Hospital in May 2023 did not identify any major risks and a quality improvement plan was developed to implement recommendations from the risk assessment.

Medication safety

There were three high-rated risks recorded on the hospital's risk register in relation to medication safety. Risks related to the lack of pharmacy cover outside of core working hours and the lack of clinical pharmacists to support medication reconciliation at Nenagh Hospital. There was evidence that control measures implemented to mitigate the actual and potential risks to patient safety were regularly monitored and updated where necessary by the pharmacist in charge with oversight from the MSC. Medication reconciliation practices were underpinned by a formalised up-to-date policy at ULHG level. There was an up-to-date policy in place regarding access to ULHG pharmacies out of hours and medication stock control in Nenagh Hospital was carried out by the pharmacy technician daily.

Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of prescribing and administration. Staff who spoke with inspectors in the clinical areas visited were aware of the medication safety resource folder on the hospital's intranet. Staff were aware of ULHG's first medication safety newsletter that was issued in September 2023. The newsletter introduced the three MSOs in ULHG, encouraged reporting of medication safety incidents, provided examples of learning from patient-safety incidents and outlined the risk of harm associated with paracetamol use in patients with risk factors.

Inspectors observed the use of risk reduction strategies to support safe medication practices, including segregated storage of pre-diluted potassium. The hospital had a list of high-risk medications that aligned with the APINCH[‡‡‡‡‡‡‡] classification and a list of sound-alike look-alike medications (SALADs) displayed as posters.

Deteriorating patient

There were a number of moderate or low-rated risks recorded on the hospital's risk register related to the deteriorating patient. One of these risks related to the ability to respond in a timely way to deteriorating patients outside of core working hours due to reduced NCHD medical cover outside core working hours. Staff and management who met with inspectors explained the control measures in place to mitigate this risk. Inspectors also requested additional information following inspection. This included the basic life support policy which was a ULHG policy, inspectors noted that this document was in draft format. Sign-off and ratification of this policy for use within ULHG should take place at the earliest opportunity following this inspection. Inspectors noted that not all

[‡‡‡‡‡‡‡] An acronym representing medicines known to be associated with high potential for medication-related harm: Antimicrobials, Potassium and other electrolytes, Insulin, Narcotics (opioids) and other sedatives, chemotherapeutic agents, heparin and other anticoagulants.

controls outlined in relation to this risk were documented on the risk register, it is important that this risk and control measures to minimise the risk are regularly updated and accurately reflected. This is an area for improvement following inspection.

The potential for out of criteria patients to self-present to Nenagh Hospital for care and treatment was another moderate or low-rated risk recorded on the hospital's risk register. This risk was managed by having pathways in place to transfer patients to UHL that were underpinned by a formalised policy. Immediate transfers were reliant on the national ambulance service but ambulance response times were not within nationally agreed timeframes. This was a risk identified by hospital management and was recorded on the hospital's risk register but inspectors noted that control measures to mitigate this risk were not time-bound or assigned to a named individual, this needs to be remedied and requires close monitoring following inspection.

Transitions of care

The hospital had effective systems and processes in place to reduce the risk of harm associated with patient transfer in and from Nenagh Hospital and to support safe and effective discharge planning. Inspectors observed a number of transfer forms used to ensure important patient information was shared and exchanged on transfer. These forms included a patient transfer handover form for patients being transferred from UHL that aligned with ISBAR. Inter-hospital transfers within ULHG were underpinned by a formalised policy. For patients admitted through MAU, a detailed admission form was complete in MAU and this accompanied the patient when admitted to an inpatient bed in the main hospital or another hospital.

Daily safety huddles took place in the clinical areas visited and a script to guide the discussion at safety pauses and huddles had recently been introduced across Nenagh Hospital. This script included patient safety concerns and discussion of vulnerable patients and patients at risk, such as those with elevated INEWS scores or those at risk of falling, those with delirium and or at end of life. Actions arising out of these meetings were documented on an action log and implemented thereafter.

Nursing documentation reviewed by inspectors contained a very comprehensive discharge planning section, which included requirements for complex discharge. Discharge summaries were completed, although staff who spoke with inspectors indicated that sometimes there were delays in completing discharge summaries. This was an area being monitored at ULHG level by the medicine directorate and at local hospital level by the Hospital Management Committee.

Policies, Procedures, Protocols and Guidelines

Nenagh Hospital had a number of policies, procedures, protocols and guidelines (PPPGs) in place in relation to infection prevention and control, medication safety, deteriorating patient and transitions of care. Most of these PPPGs were group level PPPGs ratified for use for the hospitals within the group and were up-to-date. All policies, procedures,

protocols and guidelines were available electronically for staff through a shared folder on the hospital intranet on computers in clinical areas.

In summary, inspectors found there were effective systems and processes in place at Nenagh Hospital to identify, evaluate and manage immediate and potential risks to patients, with some areas for improvement identified. Not all control measures on the hospital's risk register were accurately reflected, time-bound or assigned to named individuals, a review of the risk register following inspection is required to remedy this. The timeliness of discharge summaries, although monitored, requires improvement and continuous monitoring.

Judgment: Substantially compliant

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

Inspectors found Nenagh Hospital had effective 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. Patient-safety incidents were reported to the NIMS, in line with the HSE's Incident Management Framework. As discussed in national standard 5.8, within ULHG, there were SIMTs at clinical directorate and at ULHG levels, who had oversight for ensuring that reported patient-safety incidents were effectively managed in line with national guidance. ULHG's performance meetings with the HSE tracked the number of patient-safety incidents, and performance in relation to timeliness of reporting and completing patient-safety incident reviews. ULHG's director of quality and patient safety had oversight of implementation of recommendations from patient-safety incident reviews for all hospitals in ULHG.

Staff who spoke with inspectors were knowledgeable about the patient-safety incident reporting process in place in Nenagh Hospital and how to manage a patient safety incident. Learning from incidents was shared with clinical staff at ward meetings. Staff in clinical areas visited also had access to incident data through an electronic database and could see what incidents were closed and open with corrective measures in place. Nenagh Hospital performed well in relation to timely entry of patient-safety incidents reported to NIMS, in quarter 1 of 2023, it took an average of four days to report incidents onto this system, well within the set target.§§§§§§§

A patient-safety incident overview report specific to Nenagh Hospital was compiled on a yearly basis. This report tracked and trended patient-safety incidents for different clinical areas within the hospital. From a review of documentation, inspectors could see that the incident reporting rate for Nenagh Hospital in 2022 was lower than that of some model 2

§§§§§§§ Incident reporting target – 70% of reported incidents should be entered onto NIMS within 30 days of notification.

hospitals.******** This was recognised by management at ULHG who were encouraging incident and near miss or 'good catch' reporting through various means including the medication safety newsletter, safety pauses and safety walkabout visits to clinical areas.

In 2022 there were a total of 325 clinical patient-safety incidents reported. The most frequently reported patient-safety incidents (39%) in Nenagh Hospital in 2022 were slips, trips and falls. A total of 82 medication related patient-safety incidents (25% of total reported patient-safety incidents) were reported in total in 2022. Five patient-safety incidents were escalated to the medicine directorate SIMT in 2022. One of these met the criteria for an SRE and four patient-safety incidents were at category 2 level, which included one fall and one healthcare-acquired infection.

Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not specifically tracked or trended at Nenagh Hospital. There was evidence that issues identified through other means such as audit activity were discussed and there was evidence of some quality improvement plans to address these issues.

In summary, Nenagh Hospital had effective 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. However, there were some areas for improvement noted, such as the rate of reporting patient-safety incidents, which was below the average for model 2 hospitals and was an area of focus for ULHG.

Judgment: Substantially compliant

Conclusion

HIQA carried out a two-day announced inspection of Nenagh 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 two national standards assessed (5.5; 1.7)
- substantially compliant with eight national standards assessed (5.2; 5.8; 1.6; 1.8; 2.7; 2.8; 3.1; 3.3)
- partially compliant with one national standard assessed (6.1).

Capacity and Capability

******** South Infirmary Victoria University Hospital, St. Michael's Hospital, St. John's Hospital, Bantry General Hospital, Tipperary University Hospital, Mallow General Hospital.

Nenagh Hospital had effective, formalised, integrated corporate and clinical governance arrangements in place. The revised structure for recording minutes of governance meetings with a dedicated section for time-bound actions in use at the hospital improved the tracking of progress in implementing actions. Hospital management at Nenagh Hospital should ensure that progress in implementing actions is tracked for all governance committees to ensure greater oversight in relation to areas requiring improvement and the effectiveness of actions to improve healthcare services.

Nenagh Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare. Operationally, on the days of inspection the MAU and LIU were functioning well and were compliant with HSE targets related to PETs. There was evidence of good patient flow through the hospital with effective oversight by the hospital's management team and at ULHG level.

In general there were effective systematic monitoring arrangements in place in Nenagh Hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. However, some actions on the hospital's risk register did not have due dates or responsible persons assigned and this is something that should be remedied. Discussion of patient-safety incidents at local committees such as the Operational Site Steering Committee and medicine COG group could be improved.

Staffing levels to support the provision of high-quality, safe healthcare at Nenagh Hospital were effectively managed. The capacity of adequately trained staff to respond to patients whose clinical condition had or was deteriorating is an area for immediate response following inspection. Lack of up-to-date BLS and ACLS training for staff is an area of risk identified by inspectors which could lead to some risk for patients whose clinical condition may deteriorate, especially those requiring airway support.

Quality and Safety

Staff and hospital management at Nenagh Hospital promoted the privacy, dignity, confidentiality and autonomy of patients receiving care. There was evidence of a good culture of kindness, consideration and respect in the way that staff engaged with and responded to feedback from people who use the services. The ability to hold private conversations with patients in the LIU and multi-occupancy rooms in clinical areas was challenging and is an area for consideration following this inspection.

Inspectors were satisfied that Nenagh Hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. Hospital management with the support of and oversight by ULHG, should continue to ensure that complaints are resolved promptly, in line with HSE targets.

For the most part, the physical infrastructure in Nenagh hospital was well designed, although at times there were not enough single rooms available and cohorting of patients

with the same infection was necessary when transmission-based precautions were required.

Inspectors found evidence of effective systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services. This included audit activity, however, clinical handover is an area that was not audited in Nenagh Hospital.

The management of immediate and potential risks to people using the healthcare services at the hospital although generally effective, required some improvement. All control measures on the hospital's risk register should be accurately reflected, time-bound and assigned to named individuals.

Staff who spoke with inspectors were knowledgeable about the patient-safety incident reporting process in place in Nenagh Hospital and how to manage a patient safety incident. The reporting of patient-safety incidents should continue to be encouraged at Nenagh Hospital.

Overall, inspectors found a high level of compliance in Nenagh Hospital with the 11 national standards assessed during this inspection. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the implementation of actions employed to bring Nenagh Hospital into full 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 at Nenagh Hospital was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a 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	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, 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
Quality and Safety Dimension	
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Compliance Plan for Nenagh Hospital

Inspection ID: NS_0057

Date of inspection: 26 and 27 September 2023

Compliance Plan

Compliance Plan Service Provider's Response

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

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

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

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

Short Terms actions:

<u>Mandatory training</u>

- **To ensure that all relevant Nursing and Medical staff have received training in Standard and transmission-based precautions**

Update on Implementation:

- This training is being delivered to staff via online HSEland & onsite by the IPC department in person. Hospital ODON & Clinical Lead monitoring same to ensure all relevant nursing & medical staff receive the training. This is ongoing since date of inspection.

Responsible persons: Site ODON & Clinical Lead
Date for Completion February 28th 2024

- **To ensure that all relevant nursing and Medical staff have received training in infection outbreak management.**

Update on Implementation:

- This training is delivered to staff via online HSEland & onsite by IPC department in person. Hospital ODON & Clinical Lead monitoring same to ensure all relevant nursing & medical staff received the training. This is ongoing since inspection date

Responsible persons: Site ODON & Clinical Lead
Date for Completion February 28th 2024

- **To ensure that all relevant Nursing and Medical staff have received training in basic life support.**

Update on Implementation:

Training is ongoing and is being offered/ provided to all relevant staff. 84% of the Doctors will have their training completed by the middle of February 2024. Nursing is currently at 95% compliance.

-

Responsible persons: Site ODON & Clinical Lead

Date for Completion April 31st 2024

- **To ensure that all relevant Nursing and Medical staff have received advanced cardiovascular life support (ACLS) training.**

Update on Implementation:

- Training continues to be provided. Ten extra medical staff have received training since inspection. 84% of the Doctors will have their training completed by the middle of February 2024. There is a specific ACLS roster with 50 nurses on same. 86% of the staff on this roster are ACLS trained.

Responsible persons: Site ODON & Clinical Lead
Date for Completion September end 2024

Timescale:**To be completed by September End 2024**