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:	Roscommon University Hospital
Address of healthcare service:	Athlone Road, Ardsallagh More Roscommon F42 AX61
Type of inspection:	Announced
Date(s) of inspection:	02 March 2023
Healthcare Service ID:	OSV-0001035
Fieldwork ID:	NS_0028

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Roscommon University Hospital is a model 2 public acute hospital. It is a member of and is managed by the Saolta University Health Care Group.* Roscommon University Hospital serves a population of approximately 65,000 in County Roscommon and further populations in adjoining counties. Services provided by the hospital include:

- acute medical in-patient and day patient services
- elective inpatient and day service surgery
- endoscopy services
- urgent care centre incorporating:
  - an injury unit
  - medical assessment unit
  - medical day services
- ambulatory care and diagnostic services
- diagnostics
- outpatient care.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	66 Inpatient beds 34 day care beds

How we inspect

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

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

findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how the service performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national standards. These are defined as follows:

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
02 March 2023	09:00hrs – 17:40hrs	Nora O'Mahony	Lead
		Lisa Corrigan	Support
		Danielle Bracken	Support

Information about this inspection

An announced inspection of Roscommon University Hospital was conducted on 02 March 2023. This inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm:

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

The inspection team visited the following clinical areas:

- St Coman's medical ward
- the injury unit and the medical assessment unit.

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

- representatives of the hospital's Executive Management team:
  - General Manager
  - Director of Nursing
  - Associate Clinical Director Medicine
- the Quality and Risk Manager
- the Human Resource and Medical Manpower Manager
- a representative for the non-consultant hospital doctors (NCHD)
- representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Deteriorating Patient (incorporating national early warning systems and sepsis)
  - Discharge Planning.

Acknowledgements

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

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

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

The St Coman's ward was a 25-bedded ward consisting of two single rooms, two 2-bedded rooms, one 4-bedded rooms and three 5-bedded multi-occupancy rooms. There were no ensuite or adjoining toilet or showers facilities in the single or multi-occupancy rooms. There were five toilets on the ward corridor, three of these had shower facilities. Only two of the shower facilities were wheelchair accessible. At the time of inspection all beds were occupied.

The injury unit and the medical assessment unit were within the urgent care centre of the hospital. The injury unit comprised of two procedures rooms and the medical assessment unit had four cubicles and a single isolation room with no en-suite facilities.

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

On the day of inspection, inspectors spoke with a number of patients about their experience of care. Overall, patients were complimentary about the staff and the care they had received, commenting that '*nurses are very attentive'*, '*couldn't praise staff enough',* '*treatment is first class*.' When asked to describe what was good about their experience patients outlined that '*staff will bring you out for fresh air in a wheelchair',* '*staff are very good to check in on you',* '*staff take time to get to know you.*' When asked if anything could be improved about the service or care, the majority outlined that everything was satisfactory. One patient did outline that they were '*waiting for a homecare package',* another patient said that '*they would like a full emergency department here'* but did outline that the '*current service was fantastic'*. Patients who spoke with inspectors were not aware of the hospital's official complaints process, but outlined that they would talk to the nurse in charge or any staff member if they had an issue as '*it is easy to talk to staff'*.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 92% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, which was above the national average of 81.9%.

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

Capacity and Capability Dimension

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

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

Roscommon University Hospital had formalised corporate and clinical governance arrangements in place. The reporting arrangement for hospital management and oversight committees was clearly outlined in documentation reviewed, and evident to inspectors during the inspection. The reporting structures and accountability relationships to the Saolta University Health Care Group was also clearly outlined.

The hospital was governed and managed by the General Manager supported by the Hospital Management team (HMT). The General Manager reported directly to the Chief Operations Officer and upwards to the Chief Executive Officer of the Saolta University Healthcare Group.

The Associate Clinical Director (ACD) for medicine provided clinical oversight and leadership for medicine at the hospital. There was devolved responsibility and accountability according to clinical specialty, with a consultant representative for surgery and radiology. The ACD and consultant representative for surgery and radiology were members of the hospital's HMT and attended Performance Management meetings with the Saolta University Health Care Group Executives. However, at the time of inspection the consultant representative role for radiology was vacant.

The Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital and reported to the hospital's General Manager and the Chief DON of the Saolta University Health Care Group.

Hospital Management Team

Roscommon's Hospital Management Team (HMT) committee was responsible for the governance and oversight of healthcare services at the hospital. The HMT met monthly and was chaired by the hospital's General Manager. The membership was appropriate to the size and scope of the hospital and there was good attendance at meetings. The HMT had oversight of the hospital's activities and performance of quality and safety indicators, and provided effective governance and oversight for the healthcare services in the hospital.

Meetings followed a structured format with issues raised progressed from meeting to meeting. However, meeting actions were not clearly outlined with an assigned responsible person and time frames.

The HMT reported to the Saolta University Health Care Group Executives at Performance Management meetings. As per this committee's terms of reference, the hospital were to report to the Saolta University Health Care Group every second month (six meetings per year), yet only three meeting had taken place in 2022. No alternative meeting arrangements were put in place of the cancelled meetings, but inspectors were informed that the General Manager, the DON and the ACD had formal and informal monthly meetings with their reporting counterparts in the Saolta University Health Care Group where issues of concern could be raised. The hospital's monthly reported metrics were available on an information technology platform accessible by the Saolta Executive Management Team.

Quality and Safety Committee

The Quality and Safety Committee was the main committee assigned with overall responsibility for the governance and oversight of quality and safety in the hospital. The committee was chaired by the Quality and Risk Manager and met monthly. There was good attendance by the required members. However, implementation of actions from meeting to meeting was not clearly monitored as per national guidance.[††]

The Quality and Safety Committee's responsibilities included: the monitoring of hospital risks and reviewing the hospital's risk register, reporting on patient-safety incidents, review of complaints and compliments, the approval of hospital polices and the monitoring of key performance indicators and audits. The committee also provided oversight for the implementation of patient-safety quality improvements. The committee was effective in its oversight of the quality and safety of healthcare services at the hospital.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control at the hospital. The committee was chaired by the Director of Nursing, it met quarterly and reported to the HMT. The committee presented an annual report to the HMT. The committee had a number of sub-committees that reported into it, these included hygiene services, decontamination and environmental services. HIQA was satisfied with the governance and oversight of infection prevention and control practices and infection outbreaks at the hospital.

Drugs and Therapeutics Committee

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

The hospital's Drugs and Therapeutics Committee had assigned responsibility for the governance and oversight of medication safety at the hospital. The committee was chaired by the Associate Clinical Director for medicine and met six times a year. There was good attendance at meeting by the multidisciplinary members. Meetings were action orientated, with actions assigned to a responsible person and the status of each action clearly monitored from meeting to meeting. The committee was operationally accountable and reported relevant issues to the Hospital Management Team.

Deteriorating Committee

The hospital's Deteriorating Patient and Resuscitation Committee was responsible for ensuring that relevant national clinical guidelines[‡‡] were implemented to support best practice in managing the deteriorating patient and emergency events. This committee, was chaired by a consultant anaesthetist and reported to the HMT. The committee met quarterly. Meetings were well attended by the required members. The committee was effective in its oversight of the deteriorating patient programme at the hospital.

Discharge planning

The hospital's Discharge Planning Forum had responsibility for the oversight and implementation of discharge planning within the hospital. This forum was chaired by the Discharge Coordinator, met weekly and reported to the hospital's General Manager.

The Discharge Planning Forum had input from various disciplines and discussed all medical patient's progress and planned discharge dates. A representative from the community intervention team[§§] attended this forum to facilitate community supports for patients following discharge.

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

The Drugs and Therapeutic meeting minutes clearly outlined actions arising from meetings, persons responsible and timeframes afforded to actions which were monitored from meeting to meeting, this was not replicated in all minutes reviewed. Minutes from

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

[§§] A Community Intervention Team (CIT) is a specialist, health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services/acute intervention for a defined short period of time at home, in a residential setting or in the community, thereby avoiding acute hospital attendance or admission, or facilitating early discharge.

meetings should clearly outline the actions arising from the meetings, the person responsible and timeframes for each action identified. Progress on implementation of actions should be monitored from meeting to meeting.

Judgment: Substantially compliant

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

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

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

Infection, prevention and control

The hospital had an infection control programme in line with national guidance.[†††] The infection prevention and control and antimicrobial team developed an annual work plan that set out the objectives to be achieved in relation to infection prevention and control and antimicrobial stewardship[‡‡‡] in 2023. The IPC objectives for 2023 included hand hygiene, education, audit, surveillance and development and revision of infection prevention and control policies, procedure and guidelines. It was clear from documents reviewed by inspectors that the infection prevention and control team were implementing the objectives outlined in their annual work plan, and reporting on same through the hospital's monthly performance reports.

The committee also produced a comprehensive annual report for 2022 which detailed the achievements, surveillance, education, policies reviewed, audits undertaken, outbreak reports completed and quality improvements implemented to minimise the transmission of healthcare-associated infections.

Medication safety

[***] Infection prevention and control, medication safety, the deteriorating patient (including sepsis) and transitions of care.
[†††] National Clinical Effectiveness Committee. National Clinical Guidelines. Draft Guidance on Infection Prevention and Control. 2022. Available on line from: ncec-ipc-guideline-2022-for-consultation.pdf (hse.ie)
[‡‡‡] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

Up to recently, the hospital had 1.4 whole time equivalent[§§§] (WTE) senior pharmacist, who mainly provided a medicines dispensing service Monday to Friday. The hospital had recently recruited 0.8 WTE pharmacists, which provided the resources to introduce a clinical pharmacy service for inpatients. The clinical pharmacists also completed medicine reconciliation for new patients. The hospital planned to expand this service further with an additional 0.6 WTE pharmacist.

Deteriorating patient

Inspectors were informed that the hospital's resuscitation officer was the designated lead for the implementation of the Irish National Early Warning Systems (INEWS).[§§§] A clinical nurse manager (CNM) 2 was the assigned lead for the monitoring of sepsis, in addition to their role as a unit CNM2. The resuscitation officer and the CNM2 were supported in their lead roles by the Assistant Director of Nursing (ADON) for medicine, a consultant anaesthetist and the Deteriorating Patient and Resuscitation Committee. The hospital had implemented the INEWS Version 2 in line with national clinical guidelines.

The hospital had protocols in place for the management of the deteriorating patient onsite and for the emergency inter-hospital transfer[****] of patients requiring a higher-level of time-critical care. The hospital had protocols in place for the care of patients presenting to the hospital with symptoms or conditions outside the treatment criteria of the hospital's injury unit or the medical assessment unit (out of protocol). These protocols were supported by regular staff education and training.

Transitions of care

The hospital's discharge coordinator and bed manager were responsible for the daily operations of the hospital's admissions and discharges. The bed manager was responsible for the inter-hospital admissions. The discharge coordinator was responsible for discharges to nursing homes and provided assistance for patients with complex discharges, liaising with staff, patients and families.

At the time of inspection, the average length of stay for medical patients was 10.8 days, which was above the HSE's target of seven days or less. The average length of stay for surgical patients was 1-2 days which was compliant with the HSE's target of 5.2 days or less.

Two patients had delays in transfers of care, one patient was due for transfer the next day and the other patient was awaiting transfer to a long-term care facility. The hospital

[§§§] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.
[****] The Emergency Inter-Hospital Transfer Policy Protocol 37 had been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

was in the catchment area of the Community Health Organisation1[††††] (CHO) and CHO2. Inspector were informed that recently there had been difficulties accessing carers in the community and accessing nursing home beds. This impacted on patient's discharge and transfer plans on occasions. The CHOs held weekly meeting to discuss the services available in the community. The hospital did not always attend the meetings, but inspectors were informed that the hospital liaised regularly with the CHO's.

In summary, HIQA was assured that the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm which were the focus of this inspection.

Judgment: Compliant

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

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

Risk Management

There were risk management structures in place to proactively identify, manage and minimise risks. The hospital maintained a risk register of all identified hospital risks. The existing control in place and the additional controls required to minimise these risks were outlined. The risk register was reviewed monthly by the Quality and Safety Committee and the HMT, with updates provided at Performance Management meetings with the Saolta University Health Care Group.

All risks on the risk register related to the four areas of known harm, which were the focus of this inspection, were outlined by staff on the day of inspection. Evidence of existing controls in place was provided during the inspection, and additional controls to mitigate the risks were advance where possible.

The hospital's Infection Prevention and control (IPC) team maintained a risk register on which all IPC related risks were identified. Risks outside the control of the IPC team were escalated to the hospital's risk register. This is discussed in more detail under standard 3.1.

[††††] Community Health Organisation services are a range of healthcare services that are provided outside of acute hospitals, such as primary care, social care, mental health and health and well-being services.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported by month for the HSE's hospital patient safety indicator report (HPSIR) and the HSE's management data report. Performance and activity data was reviewed at the Quality and Safety Committee and Hospital Management Team meetings and at group Performance Management meetings.

Audit activity

The hospital had a programme of audit for infection prevention control, medication safety audit and the early warning systems. Audit reports were reviewed by the relevant governing committee such as the Infection Control and Prevention Committee, the Drugs and Therapeutics Committee and the Deteriorating Patient Committee. All infection prevention and control audits were also incorporated into the monthly performance report reviewed at the Quality and Safety and HMT meetings. Examples of action plans and re-audit for areas of poor compliance were seen in documentation reviewed by inspectors. However, not all audits reviewed had time-bound actions plans for the implementation of recommendations following audits. On the day of inspection, staff who spoke with inspectors outlined the action plans and time frames for implementation of audit recommendation.

Patient-safety incidents

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

Patient-safety incidents were tracked and trended and collated in the hospital's monthly performance reports which was presented at meeting of the Quality and Safety Committee and the HMT. There were processes in place to share learning from patient-safety incidents through daily safety huddles and the distribution of the hospital's

[‡‡‡‡] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
[§§§§] HSE –*Incident Management Framework and Guidance*. 2020. Available online from: Incident management - HSE.ie
[*****] The electronic point of entry (ePOE) reporting is where frontline line staff enter incidents directly onto the National Incident Management Framework System eliminating the need for paper reporting.

performance reports through committees, such as the Head of Departments and through line managers. Patient-safety incidents were discussed at governance committee such as the Drugs and Therapeutics and Infection Prevention and Control committees.

The Saolta University Health Care Group Serious Incident Management Team (SIMT) provided oversight and management for serious reportable events and serious incidents which occurred within the Saolta University Health Care Group including Roscommon University Hospital.

Findings from the National Inpatient Experience Survey were reviewed at meetings of the Hospital Management Team.

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

Judgment: Compliant

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

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

The hospital's Human Resources and Medical Manpower Manager reported to the General Manager. The Human Resources and Medical Manpower Manager was a member of Hospital Management Team and reported at monthly meetings on human resource and medical manpower issues.

The hospital's total approved complement of staff (all staff) in January 2023 was 429 WTEs with 34.3 (8%) vacant posts across all disciplines and staff grades. There were two vacant consultant posts, one in radiology and one in anaesthetist with two vacant non-consultant hospital doctors (NCHD) posts. Other vacant posts included two staff nurse posts, a senior pharmacist post and four healthcare assistant posts. Recruitment for all vacant posts was in progress at the time of inspection, with many at an advanced stage.

The vacant radiology position was identified as a risk by the hospital and recorded on the hospital's risk register. Inspectors were informed that a second radiologist was due to commence employment in the hospital in the coming months and in the intervening period locum cover had been secured.

Inspectors were informed by management that one consultant employed at the hospital was not on the relevant Specialist Division of the Register of the Irish Medical Council. Senior hospital management had discussed the requirements to register on the Specialist Register with the consultant in question, and appropriate supports and clinical and corporate oversights were in place.

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

The absenteeism rate was monitored by the HMT. In January 2023 the hospital's absenteeism rate was 5.4% which was above the HSE's target of 4% or less.

Injury unit and medical assessment unit

The injury unit and medical assessment unit (MAU) had an approved nurse staffing level of 17.05 WTEs. The unit had its full complement of staff at the time of inspection. On review of the nursing rosters for the four weeks preceding the inspection, the unit was fully staffed, apart from one unfilled shift.

Injury unit

The hospital's injury unit operated 24/7 from 8am to 8pm. A senior clinical decision-maker[†††††] at registrar or RANP level was on-site in the unit when the department was operational. Clinical governance was provided by a consultant in emergency medicine located at Galway University Hospital (GUH) and this was an interim arrangement. The lack of a long-term sustainable governance arrangement for the injury unit was identified as a risk by the hospital, recorded on the hospital's risk register and escalated to group level. It was proposed that governance would be established through more long-term sustainable arrangements once there was an increase in the level of consultants in emergency medicine in GUH.

The injury unit managed patients with minor injuries under strict criteria and accepted general practitioner (GP) referrals or self-referrals. The injury unit was staffed by a registrar in emergency medicine, four registered advanced nurse practitioners (RANP)[‡‡‡‡‡] and three candidate advanced nurse practitioners.[§§§§§]

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

[‡‡‡‡‡] 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. Registered advanced nurse practitioners (RANP) have met the criteria for registration to enter the Advanced Practice Division of the Nursing

[§§§§§] A candidate advance nurse practitioner is undertaking the academic preparation and develop the clinical and leadership skills, competencies and knowledge required to meet the criteria to be registered as a registered ANP with the Nursing and Midwifery Board of Ireland.

From Monday to Friday, there was a registrar in emergency medicine on duty during core hours with a RANP, a candidate ANP and two staff nurses on duty 8am to 8pm. At weekends the unit was staffed by a RANP, surgical NCHD at senior house officer or registrar level and two staff nurses. Clinical governance was provided by a consultant in emergency medicine at GUH 24/7.

In 2022 there were 12,733 attendees to the injury unit. This was a 35% increase on 2021 attendees of 9338. Attendee figures year to date in 2023 are similar to those of 2022 at approximately 1,078 per month.

Medical assessment unit

The medical assessment unit (MAU) was opened 9am to 5pm Monday to Friday and accepted GP referrals for patients within the MAU's admission criteria. The MAU had one WTE registrar in general medicine and a RANP in acute medicine. The medical on-call consultant had overall clinical governance for the unit and visited the unit to review the patients. The unit was staffed daily by a medical registrar, a RANP and two staff nurses.

In 2022, 856 patients were reviewed in the MAU. This was a decrease of 12% on 2021 attendees of 973. On average 25% of MUA attendees were admitted to the hospital.

In January 2023, the National Ambulance Service (NAS) and Roscommon University Hospital (RUH) agreed a programme that allowed patients within the MAU admission criteria, to be transferred directly to the hospital's MAU between 9am and 3pm. At the time of inspection, approximately one patient per week had been transferred to the MAU by ambulance.

St Coman's ward

St Comans ward had an approved nursing compliment of 20.4 WTE. All nursing posts were filled at the time of inspection. The ward currently had a vacant healthcare assistant post and inspectors were informed that this post was in the process of recruitment. On review of the nursing rosters for the four weeks preceding the inspection the unit was fully staffed. This level of cover was achieved by replacement of short-term absences by agency staff or reallocation of staff from other areas of the hospital.

Medication safety

The hospital currently had one WTE senior grade supervising pharmacist, one WTE pharmacy technician and two part-time (1.4 WTE) clinical pharmacists in place, with an additional 0.8 WTE clinical pharmacist due to commence shortly. With the increase in pharmacy staffing levels the hospital planned to provide a 5/7 clinical pharmacy service and medication safety education for staff.

Infection prevention and control

The hospital had an infection prevention and control team comprising two infection control nurses (1.8 WTE), providing cover 5/7. An antimicrobial stewardship pharmacist visited the hospital weekly and undertook clinical patient reviews and audits. There was currently only 0.15 WTE consultant microbiologist cover for the hospital, therefore onsite visits were infrequent but a consultant microbiologist was available off site 7/7. Support and advice was available by telephone 24/7 from the Galway University Hospital on-call microbiology consultant or specialist registrar in microbiology.

An infection prevention and control Assistant Director of Nursing (ADON) was a shared post between Roscommon, Galway and Portiuncla University hospitals. The ADON provided advice and support for the onsite infection prevention and control team and also visited the hospital periodically.

There were systems in place for staff to access the occupational health services and the employee assistance programme. Staff who spoke with inspectors were aware of how to access these services. Posters to promote awareness of the employee assistance programme were clearly visible on notice boards in areas frequented by staff.

Mandatory and essential staff training

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

Training records from the clinical areas visited on the day of inspection were reviewed. There was almost full compliance rates for mandatory and essential training related to infection prevention and control, the Irish National Early Warning System, basic life support (BLS) and training of national guidance on clinical handover with ISBAR for the St Coman's ward, the injury unit and the MUA nursing and healthcare assistant staff as relevant .

In additional to the above, staff in the injury unit and medical assessment unit, and ADONs who worked out of hours, undertook additional training to care for the deteriorating patient or the 'out of protocol'****** patient who might attend the hospital. This included training in advanced cardiac life support (ACLS) and paediatrics emergency assessment, recognition and stabilisation (PEARS).

To support staff clinical skills, knowledge and confidence in managing an acutely deteriorating patient staff nurses from all wards and units attended practical case scenario sessions and simulation training. These sessions were based on acute emergency conditions such as myocardial infraction, bradycardia simulation, major bleed, sepsis and anaphylaxis and were provided by a clinical facilitator, an ACLS and BLS instructor and

****** Patients presenting to the hospital with symptoms or conditions outside the treatment criteria of the hospital's injury unit or the medical assessment unit (out of protocol).

nurse practice development staff. The hospital's provision and uptake of these additional training courses to provide care for the deteriorating and 'out of protocol' patient was commendable.

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

Compliance with required training for hospital staff varied across disciplines with a range as outlined below:

- from 76% of nurses to 37% of HPSCs were up to date with infection prevention and control training
- from 91% of nurses to 64% of doctors were compliant with hand hygiene training (HSE's target of 90%)
- from 81% of nurses to 52% of doctors were up to date in BLS training
- from 51% of nurses to 42% of doctors were up to date with training on the Irish National Early Warning System
- from 45% of healthcare assistants to 35% of nurses were up to date in training on complaints management (No data for doctors, household staff or HPSCs was provided).

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the injury unit , the medical assessment unit and St Coman's ward to support the provision of high-quality, safe healthcare. All clinical areas visited on the day of inspection had their full complement of nursing staff, with short terms absences back filled with agency or reallocation of staff, with some minor exceptions.

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, the deteriorating patient and transitions of care. Although challenged with pharmacist resources in the past the hospital's pharmacy resources had been recently increased to support medication safety.

The vacant radiology consultant position was highlighted as a risk by the hospital. The hospital should progress the filling of this position in a permanent capacity as a priority. Governance of the injury unit was also identified as a risk and should be formalised through more long-term sustainable arrangements.

Training records reviewed by inspectors for the clinical areas visited on the day of inspection demonstrated good compliance with attendance at all mandatory and essential training for nursing and healthcare assistants. However, attendance at mandatory and essential training for the overall staff in the hospital could be improved in all areas relevant to the focus of this inspection.

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

Judgment: Substantially compliant

Quality and Safety Dimension

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

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

Staff in the clinical areas visited by inspectors demonstrated a person-centred approach to care and made every effort to maintain their patient's dignity, privacy and autonomy. Staff were observed drawing privacy curtains, speaking in lowered tones and providing patients with information on their plan of care. All staff communicated with patients in a manner that respected their dignity.

The design of the physical environment on St Coman's ward did not fully protect the dignity and privacy of patients on that ward. The single and multi-occupancy room in St Coman's ward did not have ensuite or adjoining toilet and shower facilities, also not all shower facilities available were wheelchair accessible. Patients in isolation in single rooms had to use commodes in the absence of ensuite facilities and did not have access to shower facilities while in isolation. The proximity of beds in the five-bedded multi-occupancy rooms on this ward was such that it created an environment in which it was difficult for staff to meaningfully maintain patients' privacy and dignity. However, inspectors were informed that patient would be brought to an office space for private conversation and the breaking of bad news if needed and when possible.

The MAU and injury unit consisted of individual assessment cubicles with privacy curtains. The infrastructure in this modern department facilitated a more meaningful promotion of a human-rights based approach in the provision of dignity and respect.

In the clinical areas visited during the inspection, patient's personal information was observed by inspectors to be protected and stored appropriately. Patient's autonomy was

protected and promoted, and all patients who spoke with inspectors were aware and involved in their plan of care.

The findings of the National Inpatient Experience Survey demonstrated that patients who responded to this survey felt they were treated with dignity and respect while in Roscommon University Hospital. When patients were asked:

- if they were given enough privacy while on the ward, the hospital scored 8.9 which was above the national average of 8.6
- if staff treating and examining them introduce themselves, the hospital scored 8.7 which was the same as the national score of 8.7.
- if overall, they felt they were treated with respect and dignity, the hospital scored 9.4 which was higher the national score of 8.9.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. However, improvements to aspects of the physical environment in St Coman's ward, as outlined in standard 2.7, should be addressed to promote the privacy, dignity and confidentiality of patients receiving care.

Judgment: Substantially compliant

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

Inspectors witnessed examples of kindness and consideration during interactions between patients and staff. Staff were regularly checking on patients and attending to their needs.

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, this was validated by a patient who told inspectors that staff were *'easy to talk to'.*

Staff informed inspectors that they try to get to know patients so that they can talk to them about their interests. This was validated by a patient who told inspectors that '*they (staff) take time to get to know you'*.

Inspectors observed patient's expressed needs and preferences being accommodated by staff. By way of example, patients were allowed to have personal items of sentimental value with them. There was evidence that staff supported a person-centred approach to care, especially for vulnerable patients. A patient told inspectors that staff were very kind and brought them out in a wheelchair for fresh air. Another patient outlined that they mobilise independently, but that staff will always *'check in on you'.*

Overall, HIQA were assured that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The Quality and Risk Manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints.

The hospital used the HSE's complaints management policy 'Your Service Your Say.'[††††††] The hospital tracked and trended verbal and written complaints and compliments received by HSE category. Complaints and compliments were reported and reviewed at the hospital's Quality and Safety Committee and learning from complaints was used to help drive improvements at an organisational level.

Staff strived to resolve complaints received at first point of contact and the hospital had a system in place to document locally received complaints and compliments. The hospital's Patient Advocacy and Liaison Service (PALS) Coordinator[‡‡‡‡‡‡] assisted patients through the complaints process and also supported patients preparing for transfer to other organisations with advice and support. 'Your service your say' leaflets where available in the hospital.

At the time of inspection the hospital did not have a system in place to formally monitor the percentage of complaints resolved within 30 working days in line with national guidance. Although not quantifiable, inspectors were informed that the majority of complaints were managed within 30 working days. The hospital should have a system in place to formally monitor and report complaint resolution timeframes.

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

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

Inspectors were informed that staffing levels within the quality and safety department has been recently increased. In additional to the Quality and Safety Manager, the department now had a PALS Coordinator who commenced in October 2022, a 0.4 WTE clerical officer and one WTE grade 5 quality and safety officer. As a result of the increase in staff, the hospital informed inspectors that they now plan to commence using the National Complaints Management System§§§§§§ (CMS) to manage complaints and formally report on the number and type of complaints, verbal and written received. Once using the CMS, to manage data, Roscommon University Hospital would be included in the HSE 'Your Service Your Say' annual feedback reports******* going forward.

Feedback on complaints and compliments was provided to staff in the clinical area that were the subject of the complaint or compliment, and there was evidence of learning from complaints demonstrated to inspectors.

Overall, HIQA was assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. However, the hospital should ensure that the systems in place support the monitoring and reporting of national metrics to ensure the quality and safety of the hospital's complaints management's process. This should represent a key focus for early improvement efforts following HIQA's inspection.

Judgment: Partially compliant

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

On the day of inspection, inspectors visited St Coman's ward, the injury unit and the MAU. Inspectors observed that overall the physical environment was clean and well maintained with a few exceptions.

The hospital had processes in place to support appropriate placement of patients. The infection prevention and control nurses liaised with staff and bed management on the placement of patients.

On the day of inspection, the two single rooms on St Coman's ward were in use for isolation purposes. Neither room had en-suite facilities, which was not in line with best

§§§§§§ The Complaints Management System is a national database management system developed to support the HSE's complaints management process and to enable the end-to-end management and tracking of complaints, investigations, outcomes and recommendations at local level.

******* Health Service Executive. *Managing Feedback within the Health Service. 'Your Service Your Say'*; 2021. Available on line from: https://www.hse.ie/eng/about/who/complaints/ncglt/your-service-your-say-2021.pdf

practice in national guidelines.[†††††††] Inspectors were told that patients in isolation were provided with individual commodes. There was appropriate isolation signage in place at the entrance to the rooms and room doors were closed. The lack of appropriate isolation facilities was highlight by the staff as a risk on the day of inspection and included in the infection prevention and control and hospital risk registers.

Physical distancing of one metre between beds was not possible in the 5-bedded multi-occupancy rooms. The inappropriate bed spacing was identified by the hospital and recorded on the hospital's risk register. St Coman's ward was a thoroughfare for people accessing St Teresa's ward and although not an issue on the day of inspection, could raise issues during an outbreak of infection.

Environmental and terminal cleaning[‡‡‡‡‡‡‡] was carried out by hospital cleaning staff. The clinical areas visited had a dedicated cleaner. The cleaning supervisor and clinical nurse managers had oversight of the cleaning and cleaning schedules in the clinical areas visited, hospital staff were satisfied with the level of cleaning staff in place.

Cleaning of equipment was assigned to a dedicated staff member daily through the use of a checklist which was monitored by the cleaning supervisor. In clinical areas visited, the equipment was observed to be clean. The hospital had a system in place to record and identify clean equipment. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) clearly displayed throughout the clinical areas. Inspectors noted that not all hand hygiene sinks observed conformed to recommended standards.[§§§§§§]

Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited. Staff were also observed wearing appropriate personal protective equipment in line with current guidelines.

The hospital was secure with swipe access doors to wards and a security presence at the main entrance to the hospital.

In summary, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. A number of infrastructural issues on St

[†††††††] National Clinical Effectiveness Committee. National Clinical Guidelines. Draft Guidance on Infection Prevention and Control. 2022. Available on line from: ncec-ipc-guideline-2022-for-consultation.pdf (hse.ie)

[‡‡‡‡‡‡‡]Terminal cleaning is the thorough cleaning/disinfection of all surfaces including floors and re-useable equipment. This may be required following an outbreak or increased incidence of infection.

[§§§§§§] 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

Coman's ward had the potential to impact on infection prevention and control measures. For example, there was a lack of isolation rooms with en-suite facilities, not all hand-hygiene sinks conformed to recommend standards, there was a lack of physical distancing of one metre between beds in 5-bedded rooms and access to St Teresa's ward was through St Coman's ward.

Judgment: Partially compliant

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

HIQA was satisfied that the hospital had systems and processes in place to systematically monitor, evaluate and continuously improve the healthcare services provided. The quality and safety of care and its outcome was monitored using a variety of measures, including national performance indicators, relevant to the size and scope of the hospital.

The hospital collated activity and performance data for unscheduled and scheduled care in line with national metrics such as, average length of stay, admissions, discharges and delayed transfers of care and patient experience times for the MAU.

The hospital also collected and collated data relating, to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the Quality and Safety Committee and at Hospital Management Team meetings and at Performance Management meetings with the group. Information on activity, staffing, audits and incidents was also monitored and tracked monthly at ward level.

Infection prevention and control monitoring

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

In January 2023, environmental audit compliance in St Coman's ward was 94% with 96% compliance with cleaning. The urgent care centre was overall 91% compliant with environmental audits and 98% compliant with cleaning audits. Audit findings were shared with clinical staff. There were time-bound action plans developed to address areas requiring improvement for some but not all monitoring and audit findings. Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection, in line with

HSE's national reporting requirements.******** The infection prevention and control team submitted a healthcare-associated infection surveillance and audit report to the Infection Prevention and Control Committee at quarterly meetings. Infection prevention and control data was included the hospital's monthly performance report reviewed by the Quality and Safety Committee and HMT.

HIQA was satisfied that the hospital had appropriate infection prevention and control surveillance and monitoring in place. The hospital were taking appropriate actions based on findings as per national guidance and had shared the learning with staff to reduce the risk of recurrence.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study and reporting on compliance with antimicrobial stewardship key performance indicators every quarter. The hospitals' performance with key performance indicators were reviewed at the quarterly Infection Prevention and Control Committee and the HMT. Although comprehensive monitoring and evaluation of antimicrobial stewardship was apparent in the hospital, action plans for areas not fully compliant to support improvement was not provided to inspectors.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were carried out in medication safety metrics, sedation use, drugs-not-administered and the management of schedule 2 drugs. Examples of action plans and re-audit in areas of poor compliance was seen in documentation reviewed by inspectors. However, not all audits reviewed had time-bound actions plans for the implementation of recommendations following audits. Audit findings and learning from audits was shared with medical and nursing staff.

Deteriorating patient monitoring

The hospital collated performance data through audits of INEWS observation charts and the quality care metrics in nursing and midwifery†††††††† to monitor compliance against national guidance on INEWS. The use of the Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool was audited as part of the hospital's

******** 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

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

patient monitoring and surveillance metrics. Inspectors were provided with examples of action plans for areas of improvement from findings of patient monitoring and surveillance metrics.

Transitions of care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's performance data indicators.[‡‡‡‡‡‡‡‡] The hospital reported on the number of inpatient discharges, number of beds subjected to delayed transfer of care and the number of new attendances to the injury unit and MAU every month. Performance data in relation to patient admission and discharges was reported and discussed at the HMT and discharge planning meetings.

Overall, HIQA was satisfied that the hospital was systematically monitoring and evaluating the healthcare services provided appropriate to the size and scope of the hospital. Although examples of recommendations and action plans from monitoring and audit was seen by inspectors, the hospital must ensure that all noncompliance or areas for improvement identified through monitoring and audit is acted on to ensure improvements in the services provided.

Judgment: Substantially compliant

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

The Quality and Safety Committee was assigned with responsibility to review and manage risks that impact on the quality and safety of healthcare services at the hospital. Risks that could not be managed at hospital level were escalated to the Saolta University Health Care Group.

Risks were recorded on the hospital's corporate risk register with existing controls and actions in place to manage and reduce these risks. High-rated risks on the hospital's risk registered relevant to the areas of focus of this inspection are outlined below and discussed in the following sections:

- governance of the injury unit
- orthopaedic pathways for patient's treated in the injury unit with fractures or suspected fractures
- lack of appropriate isolation facilities and bed spacing
- hospital acquired infections

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

- Lack of clinical pharmacy service.

Injury unit and orthopaedic pathway

Governance of the injury unit and the orthopaedic pathways for patients treated in the injury unit with fractures or suspected fractures were areas of risk related to the injury unit. These risks were highlighted by the hospital staff, recorded on the hospital's risk register and escalated to group level. Existing controls and additional controls or action plans were outlined on the risk register. As previously outlined under national standard 6.1 interim governance arrangements were in place for the governance of the injury unit. Interim arrangements were also in place for follow-on care for patients with confirmed or suspected fractures. These controls outlined mitigated the risks outlined for now, but the hospital should continue to progress towards permanent sustainable arrangements.

Infection prevention and control

The infection prevention and control team maintained a local risk register of potential infection risks. The lack of appropriate isolation facilities and bed spacing in 5-bedded multi-occupancy rooms in St Comans ward were high-rated risks recorded on the local infection prevention and control risk register. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register.

The urgent care centre was the entry point for the entire hospital. On arrival at the hospital, patients and visitors were assessed for respiratory symptoms and risk of COVID-19 in line with national guidance. The hospital had streaming pathways in place for patients with confirmed or suspected COVID-19.

HIQA was satisfied that the hospital screened patients for multi-drug resistant organisms on admission to the hospital in line with national guidance and that patients with communicable infections were isolated as per national guidance, when available isolation facilities allowed.

In 2022, the hospital had outbreaks of COVID-19 and outbreak of clostridium difficile. A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks in line with national guidance

In the latest published hospital data in December 2022, the hospital's rate of new cases of hospital associated clostridium difficile infection was 12.4 per 10,000 bed days, significantly higher than the national target of less than 2 cases per 10,000 bed days. The hospital was also a national outliner in relation to the number of new cases of hospital associated clostridium difficile infection.§§§§§§§ In response, the hospital has set up an outbreak management team and developed action plans to manage outbreaks. The hospital had an alert organism surveillance system in place and informed inspectors than

§§§§§§§ HSE Management Data Report. September 2022. Available online from. 2022 Performance Reports - HSE.ie

the cases of clostridium difficile infection between May to October 2022 were not epidemiologically linked. However, clostridium difficile cases between November 2022 and January 2023 were linked. Inspectors reviewed the outbreak action plan implemented early in February 2023 which included full ward terminal cleans. No new cases had been identified since the implementation of this action plan. The hospital needs to ensure continued surveillance and maintain prompt actions to mitigate the risks and reduce hospital acquired cases.

Medication safety

HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medicines and sound-alike look-alike medicines (SALADs). Inspectors observed the use of risk-reduction strategies to support safe use of medicines in relation to anticoagulants, insulin and opioids.

A clinical pharmacy service was a recent development in the hospital following an increase in pharmacy staffing levels, with a further 0.8 WTE pharmacist due to commence shortly. Medication reconciliation was also undertaken for new patients by clinical pharmacists. The hospital planned to have 5/7 clinical pharmacy services available, with medicine reconciliation to be completed for all patients on admission. It was evident that the available clinical pharmacists were accessible to staff. Wards also had a pharmacy technician service for medication stock control.

Deteriorating patient

The hospital had systems in place to manage the deteriorating patient. This included the INEWS version 2 observation chart and an ISBAR communication tool which was used to communicate with doctors when patient reviews were required. Nurses in clinical areas attended scenario-based simulation training to enhance their skills, knowledge and confidence to manage the deteriorating patient. Deteriorating patients requiring a higher level of care were transferred using the emergency inter-hospital transfer protocol. *********

Compliance with the INEWS and ISBAR standards was audited by the hospital. Compliance with use of ISBAR varied across monthly audits reviewed by inspectors which concurred with findings on the day of inspection. The hospital's audits reviewed by inspectors indicated good overall compliance with INEWS standards.

In 2022, 1877 service users (319 children and 1558 adults) presented to the hospital outside of the injury unit's treatment criteria†††††††††† (out of protocol). The hospital had

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

†††††††††† Injury unit treatment criteria at the time of inspection for adults and children of five years of age and older: Suspected broken bones to legs (from knees to toes), Suspected broken bones to arms (from collar bone to finger tips), All sprains and strains, Facial injuries (including nasal and oral injuries), Minor burns and scalds, Wounds, bites, cuts, grazes and scalp lacerations, Splinters and fish

identified the presentation of 'out of protocol' patients as a high risk to patient safety. However, this risk was not included in the hospital's risk register but existing controls to mitigate the risks were outlined to inspectors. Evidence of these controls implemented in practice were seen through evidence gathered on the day of inspection. By way of example, staff in the injury unit, the medical assessment unit and the out of hours ADONs had undertaken advanced cardiac life support (ACLS) and paediatrics emergency assessment, recognition and stabilisation (PEARS) and scenario-based simulation training to enhance their skills and knowledge. The 'out of protocol' patients were assessed by two staff members and advised on further medical management options based on hospital protocols. The MAU and on-call medical staff were also available to provide medical assistance if required. The hospital had placed electronic signs at the hospital indicating that they was no emergency department service in the hospital.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with patients transfer between healthcare services, and to support safe and effective discharge planning. At the time of inspection, the hospital had admission and transfer policies providing clear guidance on the admission criteria for the hospital, the injury unit and the MAU. The hospital had a number of transfer and discharge templates to facilitate safe transition of care. The patient's infection status was recorded on all admission documentation reviewed by inspectors. However, patient infection status was not recorded on the all transfer document reviewed by inspectors on the day of inspection. Inspectors were informed that a verbal handover was also provided when patient were transferring between organisations. This handover included details of the patient's infection control status. The hospital should ensure that necessary information is shared, including infection status, to facilitate safe transfer of care.

Policies, procedures and guidelines

The hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines which included policies on standard and transmission based precautions, outbreak management, managements of patients in isolation and equipment decontamination.

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of medication, high-risk medications and sound-alike look-alike drugs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff through the hospital's electronic document control system. However, medicines information was not accessible in the medicines preparation area.

hooks, Small abscesses and boils, Foreign bodies in eyes/ears/nose, Minor chest injuries, Minor head injuries (fully conscious patients, who did not experience loss of consciousness or vomit after the head injury) , Road Traffic Accidents—delayed presentations only. Change of Indwelling Urinary Catheter (adults only), Peg tubes re-insertion (adults only) and Dislocated shoulders (adults only).

All policies, procedures, protocols and guidelines were available to staff on the hospital's electronic document control system. However, on the day of inspection all staff could not easily access policies, procedures, protocols and guidelines on the hospital's electronic document control system.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk of harm associated infection prevention and control, medication safety, the deteriorating patient and transitions of care.

However, the hospital needs to ensure that medicines information is accessible to staff at the point of medicines preparation, and that staff can access policies, procedures and guidelines. The hospital also needs to ensure that permanent orthopaedic patient pathway are in place for all patients with confirmed or suspected fractures. The hospital needs to ensure continued surveillance and maintain prompt actions for outbreaks of infections and ensure patient observations are monitored in line with national guidance.

Judgment: Substantially compliant

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

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

Staff who spoke with HIQA were knowledgeable about reporting systems in place for patient-safety incidents. Staff training on the new system had been provided and was ongoing at the time of inspection. Staff were aware of the most common patient-safety incidents reported.

The hospital tracked and trended patient-safety incidents in relation to the four key areas of harm which were the focus of this inspection. An incident summary report was submitted to the Hospital Management Team and the Quality and Safety Committee.

Patient-safety incidents were a standing agenda items at the Drugs and Therapeutics and Infection Prevention and Control Committee meetings. Patient-safety incidents were reviewed in minutes of meetings seen by inspectors. However, the review of patient-safety incidents related to the deteriorating patient and transitions of care were not consistent in agendas or minutes of meetings reviewed by inspectors for these governing committee. None the less, committee representatives who spoke with inspector's were knowledgeable about incidents which had occurred in their area, and the Quality and Risk managers outlined that individual reports were being developed on the new ePOE NIMS, which would be available for all areas and committees going forward.

The rate of incidents reported to NIMS per 100 bed days was not reported nationally since February 2022, as per Hospital Patient Safety Indicator reports‡‡‡‡‡‡‡‡‡ reviewed by inspectors. The hospital should ensure clinical incident data is reported nationally in line with national requirement and available for review at group level.

In general, feedback to staff in clinical areas was provided informally by the Clinical Nurse Manager and the Quality and Risk Manager. Inspectors observed shared learning notices displayed. Inspectors noted patient-safety incidents data such as a patient safety cross§§§§§§§§§ displayed on clinical area noticeboards.

The Saolta Healthcare group Serious Incident Management Team (SIMT) provided oversight and the management of serious reportable events and serious incidents which occurred within Roscommon University Hospital. Preliminary Assessment Reports (PARs) were completed on serious incidents or Serious Reportable Events (SREs) which occurred in the hospital. PARs were reviewed by the SIMT for decision on ongoing management in line with the HSE's Incident Management Framework (2020).

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of harm which were the focus of this inspection. The hospital was reporting incident's related to these four areas and these incidents were reviewed at HMT, Quality and Safety, Drugs and Therapeutics and Infection Prevention and Control Committees. However, review of incidents were not consistently included in the meetings minutes seen by inspectors other governing committees relevant to the focus of this inspection.

The Senior Incident Management Team and the HMT had oversight of serious incidents and serious reportable events. However, the hospital should ensure clinical incident data is reported nationally in line with national requirements.

Judgment: Substiantially compliant

Conclusion

HIQA carried out an announced inspection of Roscommon University Hospital to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care.

‡‡‡‡‡‡‡‡‡ The Hospital Patient Safety Indicator Report (HPSIR) is a monthly report that collates a range of patient safety indicators. The purpose of the HPSIR is to assure the public that the indicators selected and published in this report are monitored by senior management of both the hospital and hospital group on a monthly basis, as a key component of clinical governance.
§§§§§§§§§ A safety cross is a visual data collection tool that we can use to identify areas for improvement.

Capacity and Capability

The hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare appropriate to the size and scope of the hospital. However, hospital Performance Management meeting with the the Saolta healthcare group, had not taken place in 2022 in line with the committee's terms of reference. Occurrence of these meeting should be supported by the Saolta University Health Care Group to ensure good governance arrangements.

The hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services in the four areas in the four areas of known harm which were the focus of this inspection.

HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the injury unit, the medical assessment unit and St Coman's ward to support the provision of high-quality, safe healthcare. The vacant radiology consultant position was highlighted as a risk by the hospital, and the filling of this positon in a permanent capacity should be progressed as a priority. Governance of the injury unit should also be formalised through more long-term sustainable arrangements.

Training records reviewed by inspectors for the clinical areas visited on the day of inspection demonstrated good compliance with attendance at all mandatory and essential training for staff. However, attendance at mandatory and essential training for the overall hospital staff should be improved.

Quality and Safety

The hospital staff promoted the dignity, privacy and autonomy of people receiving care at the hospital and this was consistent with the human rights-based approach to care promoted by HIQA. However, aspects of the physical environment in St Coman's ward, visited on the day of inspection did not fully promote the privacy, dignity and confidentiality of patients receiving care. Hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. People who spoke with inspectors were positive about their experience of care received in the hospital, and were complimentary about the staff.

The hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. However, the hospital should ensure that the systems in place support the monitoring and reporting of

national metrics. This should represent a key focus for early improvement efforts following HIQA's inspection.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. A number of infrastructural issues on St Coman's ward had the potential to impact on infection prevention and control measures in the hospital. For example, the lack of isolation rooms with en-suite facilities and the access to St Teresa's ward through St Coman's ward.

The hospital was systematically monitoring and evaluating healthcare services provided at the hospital appropriate to the size and scope of the hospital. Although examples of recommendation and action plans from monitoring and audits were seen by inspectors, the hospital must ensure that all areas of improvement identified through monitoring and audit is acted on to ensure continual improvements in the services provided.

The hospital had systems in place to identify and manage potential risks of harm associated with infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital should ensure continued surveillance and maintain prompt actions to reduce the risk of hospital acquired infections in line with national guidance. Patient-safety risks should be reviewed and managed by the relevant governing committees in the areas of infection prevention and control, medication safety, the deteriorating patient and transitions of care.

The hospital should ensure that clinical incident data is reported nationally in line with national requirement and available for review at group level. The hospital also needs to ensure that permanent orthopaedic patient pathways are in place for all patients with confirmed or suspected fractures.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the *National Standards for Safer Better Healthcare*.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
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.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2. Compliance Plan.

Roscommon University Hospital Response.

National Standard	Judgment
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially compliant
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. The hospital commenced using the National Complaints Management System in April 2023. (b) where applicable, long-term plans requiring investment to come into compliance with the standard N/A	
Timescale: Complete	

National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	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. The hospital applies for minor capital funding on an annual basis for replacement of non-compliant hand hygiene sinks e.g. in 2022 the hospital replaced seven sinks using minor capital funding which was approved for this purpose. A submission has been made for minor capital in 2023 for funding for replacement of all non-compliant hand hygiene sinks. A decision in relation to this funding application is awaited.	

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

A brief was submitted to HSE Capital Estates in 2016 for the replacement of St. Coman's and St. Teresa's Wards with a new 50 bedded medical ward block, which will provide all single occupancy rooms with en-suite facilities. The development of a replacement medical ward block is included in a briefing document for a revised Spatial Plan for the hospital, which was submitted to HSE West Capital Estates in 2022, and is awaiting progression by HSE West Capital Estates.

Timescale: Q4, 2023 (dependent on minor capital funding allocation)