Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection against the *National Standards for Safer Better Healthcare*.

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| Name of healthcare service provider: | National Rehabilitation Hospital |
| Address of healthcare service: | Rochestown Avenue<br>Dún Laoghaire<br>Co. Dublin<br>A96E2H2 |
| Type of inspection: | Announced |
| Date of inspection: | 13 and 14 September 2023 |
| Healthcare Service ID: | OSV-0001475 |
| Fieldwork ID: | NS_0055 |

## About the healthcare service

The following information describes the services the hospital provides.

### 1.0 Model of Hospital and Profile

The National Rehabilitation Hospital (NRH) is a publicly funded Voluntary Hospital and is the national tertiary centre for complex rehabilitation. The hospital provides specialist rehabilitation services to adult and paediatric patients who, as a result of an accident, illness or injury, acquired a physical or cognitive disability and require specialist medical rehabilitation. Care is delivered by medical consultant-led interdisciplinary teams.

Rehabilitation programmes at the NRH are tailored to meet the individual needs of adult and paediatric patients in the following areas of specialty:

- Acquired Brain Injury (including, traumatic, non-traumatic brain injury and other neurological conditions)
- Stroke Specialty Programme
- Spinal Cord System of Care (including, traumatic, non-traumatic spinal cord injury)
- Prosthetic, Orthotic and Limb Absence Rehabilitation (POLAR)
- Paediatric Family-Centred Rehabilitation

**The following information outlines some additional data on the hospital.**

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| **Model of Hospital** | Specialist Rehabilitation Hospital |
| **Number of beds** | 120 inpatient beds |
| **Number of inpatients on day one of inspection** | 119 |

## How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a two-day announced inspection at the National Rehabilitation Hospital to assess compliance with a number of standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, healthcare inspectors* reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and Ireland East Hospital Group, 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 hospital performed in relation to the national standards assessed during the 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 following the on-site inspection at the hospital.

### 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

* Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *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.

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.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| 13 September 2023 | 09.00 – 17.00hrs | Emma Cooke | Lead |
| | | Aoife O'Brien | Support |
| 14 September 2023 | 09.00 – 13.45hrs | Danielle Bracken | Support |

## Information about this inspection

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

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

The inspection team visited two clinical areas:

- Ash Unit (Brain injury unit)
- Oak Unit (Spinal unit)

[‡] 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

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

- Representatives of the hospital's Executive Committee:
  - Hospital Chief Executive Officer
  - Director of Nursing (DON)
  - Clinical Director
  - Director of Operations
- Quality and Risk Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Director of Human Resources
- Director of Operations
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Deteriorating Patient
  - Complex Discharge

**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 receiving care in the service.

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

During this inspection, the inspectors visited two clinical areas — Ash Unit (Brain injury unit) and Oak Unit (Spinal unit). Inspectors observed staff actively engaging with patients in a respectful and kind manner. Patients described how the care was great and were very complimentary about staff who were descried as being very *'approachable'* and *'caring, friendly and helpful' and 'cannot do enough for you'.* Patients described how their call bells were promptly responded to and how their needs were met in a respectful and dignified way. Patients spoke about how staff helped them to build confidence also.

It was evident that patients' personal plans and goals were prioritised by staff and patients described how these were checked daily and patients were encouraged to participate in various activities including sport and activity.

When asked '*what could be improved in the way your service or care is provided?'*, some patients reported that they would like to see the coffee shop remain open for longer to accommodate visitors. Other patients reported how their food choices were recently impacted by leave within the dietetic service but that their specific dietary needs were addressed when this was raised with staff with patients reporting that they *'felt heard'.*

Inspectors found that of the patients spoken with, none were aware of the complaints mechanism. All of them however, explained that if they had an issue, they would speak with the nurse on the ward.

## 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. 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.

Corporate and clinical governance arrangements were in place at the National Rehabilitation Hospital (NRH).

The NRH was a voluntary organisation governed by a Board of Management with a Chief Executive Officer (CEO) appointed by the board to manage the services provided at the hospital. The CEO had overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The CEO also reported to the CEO of the Ireland East Hospital Group and attended monthly performance meetings.

An organisational chart submitted to HIQA detailed the direct reporting arrangements of the hospital's Executive Committee to the Board of Management. During the inspection, hospital management outlined the reporting structures for other committees within the hospital which were consistent with those reported by committee representatives, however, not all oversight committees and reporting arrangements were represented in the organisational chart submitted to HIQA. Hospital management should review and update existing organisational charts to ensure they are representative all committees and groups at NRH and reflect reporting structures outlined to inspectors on the day.

The hospital's Clinical Director provided overall clinical oversight and leadership at the hospital and was a member of the hospital's Executive Committee. Patient care and treatment were delivered by consultant-led interdisciplinary (medical, nursing, health and social care) teams. Five specialist rehabilitation programmes operated under the clinical governance structure. These included:

- Acquired Brain Injury (including, traumatic, non-traumatic brain injury and other neurological conditions)

- Stroke Specialty Programme
- Spinal Cord System of Care (including, traumatic, non-traumatic spinal cord injury)
- Prosthetic, Orthotic and Limb Absence Rehabilitation (POLAR)
- Paediatric Family-Centred Rehabilitation.

Each specialist rehabilitation programme had a designated clinical lead who was responsible and accountable for their programme. The clinical leads reported to and were accountable to the hospital's Clinical Director.

The hospital's interim Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital and was a member of the Executive Committee. Inspectors were informed that a permanent DON post was actively being recruited at the time of inspection and that the interim DON would remain in place pending the appointment of a permanent person to the role.

**Executive Committee**

The Executive Committee was the main governance structure assigned with responsibility for the governance and oversight of healthcare services at NRH. Chaired by the CEO, the committee was accountable to the Board of Management and met monthly in line with its terms of reference. Membership was comprehensive and representative of interdisciplinary teams.

Minutes of meetings submitted to HIQA were comprehensive and meetings followed a standard agenda. The committee had effective oversight of the hospital's risk management processes, complaints process, performance against established quality indicators, and of the quality improvement initiatives implemented to improve the quality and safety of healthcare services at the hospital. Meetings were action-orientated and progress with the implementation of agreed actions was monitored from meeting to meeting. Attendance at meetings was monitored and tracked and inspectors were informed of actions taken in response non attendance of members at meetings.

**Quality, Safety and Risk Committee**

The Quality, Safety and Risk Committee were accountable for developing and delivering an integrated quality, safety and risk management programme on behalf of the executive management team. Chaired by the Clinical Director, membership was representative of interdisciplinary teams. The committee reported to and were accountable to the Executive Committee. The committee met monthly and attendance was monitored and tracked. Inspectors noted that not all members were consistently attending these meetings and hospital management outlined actions that would be taken in response to this. Minutes of meetings submitted to HIQA were comprehensive and meetings followed a standard agenda. The committee had effective oversight of the hospital's risk management processes, incidents, audits and training activity. Updates from the various committees and groups

which reported to the committee were also standing item agendas. Meetings were action-orientated and progress with the implementation of agreed actions was monitored from meeting to meeting. A number of committees and steering groups reported to the Quality, Safety Risk Committee including; Drugs and Therapeutics Committee, Deteriorating Patient Committee and the Falls and Fracture Prevention Steering Group.

At operational level, HIQA was satisfied that the hospital had clear lines of accountability with devolved autonomy and decision-making for the four areas of known harm assessed during inspection.

**Hygiene Infection Prevention and Control Committee (HIPCC).**

The Hygiene Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control and antimicrobial stewardship activities at the hospital. Chaired by the interim DON, the committee was accountable to the Executive Committee. Subcommittees and groups of the HIPCC included the Water Management Steering Committee, Reusable Invasive Medical Devices Committee and the COVID-19 Working Group.

Terms of reference submitted to HIQA were in draft format and required final approval. The committee met monthly in line with its terms of reference and provided monthly summary reports to the Executive Committee. Minutes submitted to HIQA were comprehensive and showed that meetings followed a structured agenda and were action-orientated, with the implementation of agreed actions monitored from meeting to meeting. Minutes of meetings reviewed showed that attendance at committee meetings was also tracked and monitored.

It was evident from minutes that the committee had effective oversight of the implementation of the hospital's infection and prevention control programme, antimicrobial stewardship activities, the hospital's compliance with key infection prevention and control performance indicators, relevant audit findings, patient-safety incidents and risks, the development and implementation of relevant policies, procedures and guidelines, and staff education and training.

Operational responsibility for implementing the hospital infection prevention and control plan was assigned to the hospital's infection prevention and control (IPC) team. The IPC team produced an annual report which outlined progress against the hospital's IPC plan. This will be discussed further in national standard 5.5.

**Drugs and Therapeutics Steering Group**

The Drugs and Therapeutics Steering Group was responsible for the governance and oversight of medication safety practices at the hospital. The committee, chaired by a Consultant in Rehabilitation Medicine and a Medical Board Representative was operationally accountable to the Quality, Safety and Risk Committee.

The Group comprised interdisciplinary membership and met every eight weeks in line with its terms of reference. Attendance was also monitored and tracked. It was evident from minutes submitted to HIQA that meetings of the committee were well attended and followed a defined agenda, which included items such as medication safety, prescribing policies, medication incidents and updates in respect of matters relating to microbiology and diabetes and the hospital's antibiotic consumption rates. Meetings were action-orientated and progress with the implementation of agreed actions was monitored from meeting to meeting.

The Group had effective governance and oversight of the hospital's medication safety programme. A medication safety strategy (2022-2024), which comprised short-, medium- and long-term goals to support safe medication practices at the hospital was developed by the Pharmacy Department and approved by the Quality, Safety and Risk Committee. This will be discussed further under national standard 5.5.

**The Deteriorating Patient Committee (DPC)**

Hospital management had established a Deteriorating Patient Committee in September 2022. The committee was responsible for the implementation of national guidance in relation to sepsis management, early warning systems and resuscitation. Subgroups of the committee included: INEWS, Sepsis and Cardiopulmonary resuscitation (CPR), however, these were not represented on organisational charts submitted to HIQA. Chaired by the resuscitation officer, the committee convened every six weeks in line with its terms of reference and was accountable to the Quality, Safety and Risk Committee. Minutes of meetings submitted to HIQA were comprehensive and meetings followed a structured agenda, were action-orientated and the implementation of agreed actions was monitored from meeting to meeting.

**Transitions of care**

Inspectors were informed that the hospital were in the process of formalising a Complex Discharge Committee to establish structures in place for the transitions of care. There were a number of existing oversight arrangements in place for the transitions of care at the time of inspection including; each programme having a programme manager with responsibility for patient flow and a rehabilitation co-ordinator with responsibility for the hospital's waiting list. Delayed discharges were also discussed at the Operations Management Committee who were accountable to the Executive Committee. While hospital management reported that these arrangements were effective, the need to formalise structures and systems in place to support transitions of care at hospital and group level was recognised.

In summary, the hospital had defined corporate and clinical governance arrangements in place. Opportunities for improvement were identified based on the following findings:

- hospital management should review and update existing organisational charts to ensure they are representative all committees and groups at NRH

- progress plans to formalise structures and systems in place at hospital and group level to support transitions of care

**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.

Effective management arrangements were in place at NRH to support the delivery of safe and reliable healthcare services.

**Infection, prevention and control**

The hospital's multidisciplinary infection prevention and control team comprised:

- 0.38 whole-time equivalent (WTE)[††]consultant microbiologist
- 2 WTE infection prevention and control nurses- one at clinical nurse manager grade 2 (CNM2) and one CNM 3 grade
- 1 pharmacist who provided an antimicrobial stewardship role of 1-2 hours per week.

The hospital had an overarching infection prevention and control programme which included an antimicrobial stewardship programme and plan. It was evident from documents reviewed by inspectors that the IPC team reported on progress on implementing the objectives and actions in the annual plan to the Hygiene Infection Prevention and Control Committee. The IPC team completed a comprehensive annual report, which detailed the activities completed and the quality improvement initiatives put in place to minimise the transmission of healthcare-acquired infections to patients and staff. Inspectors also reviewed a separate antimicrobial stewardship team report for 2022 which outlined progress against achievements in 2022 and set out the antimicrobial stewardship team's plans for 2023.

Clinical staff had 24/7 access to laboratory services at St Vincent's University Hospital and access to microbiology advice during out-of-hours. While the hospital did not have a dedicated antimicrobial stewardship pharmacist, inspectors were informed that weekly antimicrobial stewardship rounds were carried out at the hospital by the consultant microbiologist and the pharmacist who provided an antimicrobial stewardship service of 1-2 hours per week.

**Medication safety**

[††] 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.

The hospital had a clinical pharmacy service,[‡‡] which was led by the hospital's Chief Pharmacist. Pharmacy staffing at the hospital comprised:

- 1 WTE Pharmacy Manager
- 3.8 WTE senior pharmacists
- 3.6 basic grade pharmacists
- 4 pharmacy technicians.

At the time of inspection, the hospital were approved for 7.4 WTE pharmacists (3.8 WTE senior pharmacists and 3.6 WTE basic grade pharmacists), however only 5.5 WTE were filled, which equated to a variance of 1.9 WTE. The hospital was also approved for four pharmacy technician posts, however, only three were filled equating to a deficit of one WTE. Notwithstanding this deficit, all units had a dedicated clinical pharmacy service and pharmacists also provided a dispensary service for patients availing of therapeutic leave on a weekly basis.

Pharmacist-led medication reconciliation was carried out for all patients in advance of admission, on admission and on discharge. Pharmacists also attended weekly consultant ward rounds.

The hospital's medication management strategy 2022-2024 outlined key areas of focus to support safe medication practices at the hospital including short medium and long term goals for reducing medication errors. The strategy focused on a number of key areas including the governance of medication safety, medication risk management, high-risk medications, monitoring and evaluation of medication practices and medication related staff education and training. However inspectors noted that there was no medication safety plan in place to support the operational implementation of the strategy which represents an opportunity for improvement following this inspection.

The pharmacy department also produced an audit plan setting out planned audits to monitor for compliance with medication fridges, documentation of allergies and controlled medications. This will be discussed further in national standard 2.8.

**Deteriorating patient**

The hospital's Deteriorating Patient Committee was responsible for progressing the hospital's deteriorating patient improvement programme. A clinical lead had each been appointed for each subgroup's areas of responsibility — CPR/Resuscitation and INEWS and Sepsis. The hospital was using the appropriate national early warning systems for the various cohorts of patients — INEWS (V 2.0),[§§] IPEWS and the Identify, Situation, Background, Assessment and

[‡‡] 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.
[§§] 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

Recommendation (version 3) (ISBAR3)*** communication tool. Compliance with the early warning systems was audited and quality improvement plans were implemented as required to ensure compliance with national guidance. Inspectors were informed that the hospital was using the Irish Paediatric Early Warning System chart from another paediatric hospital. However, it was recognised that there was a requirement to modify this chart for local hospital use. Hospital management should progress with implementing the identified modifications to ensure guidelines are relevant and applicable to the cohort of patients at the hospital and support staff to effectively escalate concerns.

**Transitions of care**

Transitions of care incorporates internal transfers, shift and interdepartmental handover, external transfer of patients and patient discharge. The safe transition of care in NRH was managed via a number of structures at the hospital — the Operations Management Committee, programme managers for each of the programme, a complex discharge planner and a rehabilitation co-ordinator. Inspectors were informed that the hospital were looking to formalise and streamline structures in place for the transitions of care. At the time of inspection, delayed episodes of care were monitored and discussed at the Operational Management Committee. The hospital were experiencing on average 12-16 episodes of delayed transfers of care each month. Hospital management reported that these delays were often attributed to the limited availability of suitable community supports and home care services which impacted on the ability to transfer patients home.

Complex discharges were monitored and escalated at programme level by programme managers and the rehabilitation co-ordinator had responsibility for the management of waiting lists within the hospital. The hospital were planning on establishing a strategic complex discharge committee at group level to formalise structures and processes in place for the safe transitions of care both within the hospital and at group level and had convened three meetings to date with representation from HSE community, chief operations officer IEHG, clinical programme leads and medical social workers from NRH. Inspectors were informed that the hospital were in the process at developing terms of reference at the time of inspection.

Overall, inspectors found that the hospital had effective management arrangements in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm outlined above. Notwithstanding this, it was evident that NRH remains challenged by the limited availability of suitable community services to support the timely discharge of patients. Opportunities for improvement identified related to:

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.

*** Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

- the need to develop a medication safety plan to support the operational implementation of the medication safety strategy.

**Judgment:** Substantially compliant

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

NRH had systematic monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. NRH reported on a range of KPIs, in line with the HSE's reporting requirements. Collated performance data was reviewed at monthly meetings of the Executive Committee and monthly performance meetings between the NRH and IEHG.

**Risk management**

The hospital had risk management structures and processes in place to proactively identify, analyse, manage and minimise identified risks. Each programme had their own risk register and risks that could not be managed at programme level were escalated to the hospital's corporate risk register. Risks identified at local clinical area level were also escalated to programme risk registers if they could not be managed locally.

The Executive Committee and Quality and Safety Risk Committee had oversight of the management of identified risks and the effectiveness of the actions to manage and mitigate identified risks. High-rated risks not managed at hospital level were escalated to the Ireland East Hospital Group.

Inspectors found that not all identified risks were appropriately escalated to the corporate risk register and evaluated at executive committee level. This related to an identified risk associated with transitions of care. The management of reported risks related to the four areas of known harm is discussed further in national standard 3.1.

**Audit activity**

There were processes and structures in place to monitor all clinical audit activity carried out across the hospital. The NRH Audit Committee were a sub-committee of the board with responsibility for corporate audit governance. Inspectors were informed that clinical audit was managed by the QSR Committee with a view to developing a new clinical audit committee in 2024. In the interim, co-ordination of audit activity at the hospital was the responsibility of the quality improvement and accreditation officer. Audit activity was also managed at programme and departmental level with certain departments developing an annual audit schedule.

**Management of serious reportable events and patient-safety incidents**

Inspectors found there was effective and efficient oversight of the reporting and management of serious reportable events, serious incidents and patient-safety incidents that occurred in NRH. The hospital's SIMT were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. The SIMT also had oversight of the timeliness of implementation of recommendations from reviews of serious reportable events, serious incidents and patient-safety incidents which were monitored and updated on master tracker. SIMT membership included appropriate clinical and executive committee representatives from NRH. The SIMT reported and was operationally accountable to the NRH Board of Management. Updates on reviews and reports were also given to the Quality, Safety and Risk Committee.

Inspectors were informed that the SIMT met on a scheduled and unscheduled basis (in the event of a category 1 incident), however, terms of reference, approved in 2023, outlined that the SIMT met on an unscheduled basis only. Furthermore minutes of meetings submitted to HIQA suggested that the SIMT had only convened on a scheduled basis once this year in July 2023 where it was acknowledged that meetings should be regularly set. Hospital management must ensure that scheduled SIMT meetings are held as planned in line with terms of reference.

There was evidence that learnings from serious reportable events, serious incidents and patient-safety incidents were shared with clinical staff at clinical handover and multidisciplinary safety huddles, this will be discussed further under national standard 3.3.

**Feedback from people using the service**

NRH had a number of processes in place to ensure feedback from patients was recorded and acted upon. Each board meeting featured an anonymous patient story whereby a rehabilitation consultant was in attendance and was afforded the opportunity to inform the board of a patient journey at NRH. Patient forums were scheduled on a monthly basis in each of the clinical areas. The hospital also completed 'uSPEQ' surveys which were provided by an external company and enabled patients to provide feedback anonymously following discharge. Data from the survey was collected and summarised in a yearly report for the hospital.

Overall, the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services. Opportunities for improvement were identified based on the following findings:

- not all identified risks were appropriately escalated to the corporate risk register and evaluated in terms of effectiveness of controls at executive committee level
- management must ensure that scheduled SIMT meetings are held as planned in line with terms of reference.

**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 NRH had appropriate arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. Notwithstanding this, on the day of inspection there were a number of unfilled positions across the majority of staff disciplines. The hospital also recorded inadequate staffing resources across disciplines of nursing and health and social care professionals as a high-rated risk on the corporate risk register.

**Medical workforce**

The hospital was funded for 13 WTE medical consultants of which all were filled at the time of inspection. Consultant staff across NRH were supported by NCHDs at registrar and SHO grades providing 24/7 medical cover. NRH had an approved funding for 19 WTE NCHDs across the different grades. At the time of this inspection, 17 WTE were filled, resulting in two WTE unfilled NCHD positions. Following this inspection, inspectors were informed that these vacant positions were actively being progressed.

There was a senior clinical decision-maker[†††] at consultant level on-site in the hospital Monday to Friday during core hours. During the out-of-hours period, there was one on-call senior house officer or registrar that was available on-site for medical review of patients. At weekends an additional on-call doctor was on during the day 08:30am to 16:30pm mainly to facilitate hospital admissions. Medical staff spoken with during the inspection were satisfied with these arrangements and outlined that they were sufficient to meet the current bed capacity numbers at the hospital. However, these arrangements require review particularly in the context of the planned increase of patient numbers at NRH and should be subject to ongoing review when the hospital is caring for long-term ventilated patients.

**Health and social care professional workforce**

The filling of pharmacist's positions at NRH was challenging for hospital management. As outlined in standard 5.5, the hospital were operating with a deficit of 1.9 WTE pharmacists and one WTE pharmacy technician posts. While all inpatient clinical areas had a dedicated clinical pharmacy service, inspectors were informed that this was often challenging to provide due to the existing shortfall in pharmacy staff.

[†††] 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.

There were a number of vacant posts across all health and social care professions. At the time of inspection, unfilled staffing positions included 12 WTE physiotherapy posts, three WTE occupational therapy posts, a 0.5 WTE dietician post and 3.5 WTE medical social worker posts. Following this inspection, inspectors were informed that of the 12 WTE physiotherapy posts, 6 WTE were being covered by temporary agency staff with an additional 3.5 WTE temporary agency cover actively being progressed. While it was evident that hospital management were striving to fill vacant physiotherapy posts, the reliance on temporary agency staff is not sustainable in the long term.

Inspectors discussed the impact these vacant posts were having on the ability to provide the necessary rehabilitation that this patient cohort required with senior management recognising that there was a potential risk of delayed rehabilitation and longer stays in hospital due to reduced access to services caused by staff shortages from health and social care professionals. Hospital management detailed existing controls in place including the need to prioritise caseloads. Group therapy sessions were also being provided to ensure patients' needs were met, however, hospital management reported that certain forms of therapy were occasionally impacted such as hydrotherapy in order to facilitate physiotherapy sessions.

There was evidence that staffing shortfalls were kept under review with updates and progress monitored and discussed at senior management meetings.

**Nursing workforce**

The hospital was approved for 299.70 WTE nurses (inclusive of management and other grades). At the time of inspection, 260.20 WTE nursing positions were filled resulting in a deficit of 39.5 WTE. The deficit in nursing staff occurred across various grades and positions, however, staff nurses accounted for the majority with 27 WTE staff nurse positions unfilled. Nursing staff were supported by HCAs of which there were also 5 WTE HCA positions unfilled at the time of inspection.

Shortfalls between the funded, and actual filled nursing staff positions (including management and other grades) were evident across the inpatient clinical areas visited during this inspection. Deficits in nursing and HCA shifts were mainly being filled by staff doing overtime shifts or the use of agency, however, hospital management outlined that the use of agency was kept to a minimal.

Inspectors were informed that recruitment campaigns for nurses and HCA staff were ongoing with fortnightly interviews planned. Hospital management reported that recent recruitment campaigns for nursing staff were successful with 14 WTE nursing positions due to commence this year and a further 20 WTE positions due to commence next year. A staffing retention and recruitment group was established to support ongoing recruitment campaigns.

NRH's staff absenteeism rate in September 2023 was 5.72% (4.88% non-COVID-19 related) and 0.84% COVID-19 related), slightly higher that the HSE's target of 4%.

**Staff uptake of essential and mandatory training**

CNMs had oversight of the attendance at and uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and INEWS on the HSE's online learning and training portal (HSELanD). Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in NRH.

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice at a minimum every two years. Documentation on training uptake, reviewed by inspectors showed that the uptake of essential and mandatory training in standard and transmission-based precautions, hand hygiene, basic life support, the early warning system and sepsis management was generally good for nursing staff, HCA staff and housekeeping/cleaning staff. However, the uptake of training required significant improvement amongst medical and health and social care professionals.

Training compliance with the national guidance on clinical handover with ISBAR (launched in NRH in July 2023) also required significant improvement across all staff disciplines with training records indicating that staff compliance with this training ranged between 2% and 7% across the various disciplines.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare.. Notwithstanding this, there remains a number of unfilled staff positions across the majority of disciplines. Inspectors note the responsiveness of the hospital to enhance out-of-hours medical cover particularly at weekends to facilitate patient admissions. However, hospital management should keep out-of-hours medical cover arrangements under continuous review particularly in the context of long-term ventilated patients and the planned increase in bed capacity. Furthermore, hospital management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients. Opportunities for improvement were identified in relation to the following findings:

- the reliance on nursing and HCA staff to do overtime for unfilled shifts is not sustainable in the long-term. Hospital management should progress plans to address the current and projected deficit for existing and future bed capacity at the hospital
- shortfalls in health and social care professional staffing levels needs to be addressed to limit the impact on patients' rehabilitation programmes
- attendance at and uptake of mandatory and essential training requires improvement particularly amongst medical staff and health and social care professionals

- hospital management should seek to improve their compliance level with the HSE target for absenteeism.

**Judgment:** Partially compliant

## Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the 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 NRH were committed to promoting a person-centred approach to care and were observed by inspectors to be respectful, kind, courteous and caring towards patients.

Staff in the inpatient clinical areas visited during this inspection promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring and being responsive to patient's individual needs. In general, the physical environment in the inpatient clinical areas visited promoted the privacy, dignity and confidentiality of patients. This was consistent with the human rights-based approach to care promoted by HIQA.[‡‡‡]

Privacy and dignity was supported for patients through the provision of single rooms with en-suite facilities. Patient's preferences were also sought pre-admission in relation to diet and maintaining autonomy over their activities of daily living. Inspectors observed examples of care passports which detailed patients' specific needs relative to their activities of daily living and specific communication needs. Behaviour plans were in place for patients who required them and inspectors observed discreet signage on patient doors outlining their personal preferences based on individualised needs.

Patient's personal information was protected and stored appropriately in the clinical areas visited.

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

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|---|
| In summary, the physical environment in the clinical areas inspected promoted the privacy, dignity and confidentiality of patients receiving care. |
| **Judgment:** Compliant |

| Standard 1.7: Service providers promote a culture of kindness, consideration and respect. |
|---|
| Inspectors observed staff to be respectful, kind and caring towards patients in the inpatient clinical areas visited. In general, staff were observed to actively listen to and effectively communicate with patients in an open and sensitive manner, in line with the patient's expressed needs and preferences.<br><br>This was confirmed by patients who spoke positively about their interactions with staff in the clinical areas visited. A culture of kindness, consideration and respect was promoted at the hospital through the development of a number of practices. For example patients were provided with information about their care and encouraged to be active in the decision-making about their plan of care through initiatives such as 'Who Am I'. Patients were encouraged to participate in goal setting for their duration of stay and were afforded choice in terms of activities they would like to participate in.<br><br>Overall, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for patients receiving care at the hospital. |
| **Judgment:** Compliant |

| Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. |
|---|
| There were systems and processes in place at the hospital to respond to complaints and concerns received from patients and their families.<br><br>The Patient Experience Healthcare Data Manager was the designated complaints officer for the hospital. At the time of inspection the Quality and Risk Manager and Director of Operations were fulfilling this role due to leave. |

There was oversight and monitoring of the timeliness of responses and the management of complaints by the relevant governance structures — Operations Management Committee, Quality Safety and Risk Committee and Executive Management Committee. Quarterly reports relating to complaints were also submitted to the Ireland East Hospital Group.

The hospital had a complaints management system and adapted the HSE's complaints management policy '*Your Service Your Say*' [§§§] for local use. There was evidence that hospital management supported and encouraged point of contact complaint resolution in line with national guidance, whereby informal and formal complaints were managed at local clinical area level by the CNM and designated complaints officer.

The hospital tracked and trended and formally reported on the type of feedback received which was categorised as positive, general suggestion and negative. Dashboard reports reviewed by inspectors provided an overview of feedback received and were presented at relevant oversight committees. Complaints were tracked and trended to identify emerging themes, categories and departments involved. For the first six months of 2023, the hospital received 292 pieces of feedback (compliments and complaints), the majority of which related to catering, access and communication and information.

There was evidence that quality improvement initiatives were developed and implemented to improve services and care also as a result of feedback received. For example, the hospital were in the process of embedding the 'you said, we did initiative' whereby some units had boards displaying actions taken in response to patient feedback.

Staff who spoke with inspectors in the clinical areas visited received feedback on complaints received and the complaints resolution process. Verbal complaints were also recorded at clinical level through the completion of the verbal complaints feedback form which was recently introduced as part of complaints training for staff.

Inspectors observed NRH comment and complaint procedure leaflets displayed in the clinical areas visited on the days of inspection and on entrance to the hospital. The majority of patients who spoke with inspectors were not provided with information on the hospital's complaints process, but all said that they would speak with a nurse or a member of staff if they wanted to raise a concern. Access to information on advocacy services was not on display in the clinical areas inspected, however, leaflets were observed on display at the main hospital reception.

[§§§] 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.

Overall, NRH had systems and processes in place to respond to feedback, complaints and concerns raised by people who use their services. Hospital management should continue to implement measures to support the prompt, open and effective resolution of complaints within national HSE targets so as to improve the experience of people using the service.

**Judgment:** Compliant

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

During inspection, inspectors observed that, the physical environment of the two clinical areas visited was generally well maintained and clean. The inpatient clinical areas visited had adequate communal toilet and bathroom facilities for patient use.

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 hand hygiene sinks throughout the unit conformed to national requirements. Inspectors noted that wards were generally spacious and maintained in a tidy manner. Storage rooms were clean and clutter-free.

Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited. Staff were observed to be complying with the 'bare below the elbow' initiative used to facilitate effective handwashing and infection prevention and control. Personal Protective Equipment (PPE) was available outside isolation rooms where patients with confirmed or suspected infections were accommodated.

Environmental cleaning was carried out by cleaning staff employed through an external contract, however, each clinical area had their own designated cleaner. Out-of-hours cleaning was undertaken by contract cleaning staff. Cleaning supervisors and CNMs had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal cleaning was carried out by designated cleaning staff.

Cleaning of equipment was assigned to healthcare assistants. In the clinical areas visited, the equipment was observed to be clean and there was a system in place to identity equipment that had been cleaned using a green 'I am Clean' tagging system. Hazardous material and waste was safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place during and outside core working hours for their areas of responsibilities. Staff also reported that they were generally satisfied with the maintenance services at the hospital.

In summary, inspectors found that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients.

**Judgment:** 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 monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided. HIQA found that the hospital monitored and reviewed information from multiple sources including patient-safety incident reviews, complaints, risk assessments and patient experience surveys.

**Infection prevention and control monitoring**

HIQA was satisfied that the IPC Committee had oversight of the monitoring of infection prevention and control practices at the hospital. Monthly environment, equipment and hand hygiene audits were undertaken at the hospital using a standardised approach.

The IPC team completed monthly audits on hand hygiene, care bundle compliance, screening compliance and environmental and equipment hygiene. Audit frequency was also determined by the average compliance rate achieved by the clinical areas. Clinical area peer reviews were also coordinated and implemented by the IPC team, with representation from nursing management, health and social care professionals, risk management and programme managers to monitor a randomly chosen unit on various infection prevention and control and health and safety issues.

Summary reports of completed environmental and hygiene audits in 2022 reviewed by inspectors demonstrated good overall levels of compliance across the areas audited with average compliance levels ranging from 88% to 100%. Audit findings and the learnings from audit activity were shared with staff in the clinical areas through the use of information boards and at clinical handover.

Average hand hygiene audit results for the hospital in 2022 were 98%, which were above the HSE's target of 90%.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection.[****] In line with HSE's national reporting requirements, the infection prevention and control team conducted surveillance of alert organisms and monitored and reported on new cases of *Methicillin-resistant Staphylococcus aureus* (MRSA), *Vancomycin-resistant Enterococcus* (VRE), *Carbapenemase-Producing Enterobacterales* (CPE), *Clostridioides difficile,* hospital-acquired COVID-19 and outbreaks. Further key performance indicators identified by the hospital included new cases of NRH acquired blood stream infections. For year-to-date (August 2023), the hospital's rate of new cases of alert organisms monitored was below national HSE targets which is commendable. The hospital reported similar rates for 2022 also.

NRH commenced urinary tract infection (UTI) surveillance in 2021 and surveillance reports reviewed by inspectors outlined that rates of UTI and catheter acquired urinary tract infections (CAUTI) for 2022 and 2023 were above set targets. UTI surveillance reports reviewed by inspectors detailed the actions taken by the hospital to address non-compliance with KPI's associated with UTI/CAUTI which included updating of catheter care bundles, engaging care bundle champions in clinical areas and arranging care bundle awareness days. Performance data in relation to these key performance indicators were reported at monthly HIPCC meetings and yearly performance was detailed in the hospital's comprehensive infection prevention and control report.

NRH screened for MRSA and CPE on admission. Screening compliance for 2022 was reported at 100%.

NRH performed monthly sampling of water outlets to test for the presence of *Legionella* bacteria which was identified in a limited number of outlets at the hospital. Reports reviewed detailed the actions taken in response to issues identified which included flushing regimes and continuous re-sampling of areas following the implementation of corrective measures.

Aspergillosis risk assessments were completed in relation to ongoing works at the hospital and regular aspergillosis prevention meetings were convened to monitor the effectiveness of controls in place.

**Antimicrobial stewardship monitoring**

[****] 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

It was evident that antimicrobial stewardship practices and activities were consistently monitored and evaluated at the hospital. Inspectors reviewed the Antimicrobial Stewardship Team Report for 2022 which detailed performance against objectives for 2022 which included audit activity, performance with KPI's, education and policies and procedures and guidelines. Performance against set KPIs associated with the use, dosage and documentation of antimicrobials was monitored on a quarterly basis and reported overall performance reported year end which ranged from 79% to 96% compliance with indicators set. Reports reviewed set out a number of objectives for the AMS team for 2023.

Antimicrobial stewardship newsletters were also disseminated amongst clinical areas to provide updates to staff in relation to AMS activities at hospital and inspectors observed recent examples in clinical areas inspected which had been circulated in March and June of 2023.

**Medication safety monitoring**

There was evidence of monitoring and evaluation of medication safety practices at the hospital. The Drugs and Therapeutics Committee established a number of KPI's through which to monitor and evaluate medication safety activity at the hospital. These included:

- the development of two DTC newsletters each year
- completion of two audits associated with compliance with healthcare records and the medication and prescribing administration record (MPAR) (target > 85%)
- annual aggregate of medication incidents (1 per year)
- national antimicrobial audit (1 per year)
- nurse prescribing audit

There was evidence that these activities were completed in line with targets set with all areas performing above the set target apart from one audit related to compliance with healthcare records. However, it was not clear from documentation reviewed if action plans or quality improvement plans were introduced for areas which did not perform in line with set targets.

Inspectors were informed that a schedule of medication safety audits is agreed annually. Examples of clinical audits carried out by the pharmacy included allergy documentation, insulin pen labelling, medication fridge monitoring and VTE.

**Deteriorating patient monitoring**

The NRH had established a number of KPI's for the purpose of monitoring and evaluating systems and processes in place for the deteriorating patient. These were primarily associated with the use of use of the early warning system and included monitoring the frequency of meetings of the Deteriorating Patient Committee, staff

compliance with training, INEWS audit activity and the escalation of risk issues associated with the deteriorating patient.

The hospital took part in the IEHG Sepsis Audit in November 2022 and 2023. There was evidence that quality improvement plans were developed in response to recommendations arising from these audits. Compliance with national guidance on the use of ISBAR was audited at the hospital.

**Transitions of care monitoring**

The Quality and Risk Department completed an aggregate review of unplanned transfers in 2022. Unplanned patient transfers were recorded when there was a clinical deterioration in the patient's condition and transfer to an acute hospital was considered the most appropriate management. The patient may be attending an NRH in-patient or day-patient programme. Each unplanned transfer was subject to a peer review by a Consultant in Rehabilitation Medicine or the registrar other than the primary treating team.

In 2022, there were eighty-two (82) unplanned transfers recorded. This was an increase of 35 on unplanned transfers recorded in 2021 (47) representing a 42.6% in 2022. The report reviewed outlined reasons for transfer, hospitals receiving transfers, days between date of admission and date of transfer. The report issued a number of recommendations arising from the review which would benefit from the development of a time-bound action plan to ensure opportunities for improvement in relation to patient care at NRH.

Overall, HIQA found that the hospital had effective systems in place to monitor and evaluate healthcare services provided at the hospital. It was evident that information from monitoring activities was being used to improve practices in relation to the four areas of known harm. Opportunities for improvement were identified in relation to the need to ensure time-bound action plans are developed in relation to non-compliances with audit activity and review reports.

**Judgment:** Substantially compliant

| Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. |
| --- |
| The hospital had systems in place to identify, evaluate and manage risks to people using the service in the four areas of known harm, however, HIQA found opportunities for improvement in relation to the management of risks associated with transitions of care.<br><br>NRH maintained a corporate risk register which was reviewed and updated regularly at meetings of the Board of Management, Executive Management Committee and Quality, Safety and Risk Committee. Inspectors were also informed that the top five risks are escalated to the Ireland East Hospital Group (IEHG) for review at the IEHG/NRH |

performance management meetings. Risk registers were also in place at programme and departmental level.

At the time of inspection, seven high-rated risks related to the four areas of known harm were recorded on the hospital's corporate risk register. These included risks related to:

- increased waiting times/delayed access for patients on the waiting lists for the various rehabilitation programmes
- risk of harm to service user and or staff due to COVID-19
- failure of the paging system to communicate medical emergencies
- pharmacy department infrastructure

Senior hospital management outlined the existing controls in place and discussed their effectiveness in reducing identified risks. It was evident that risk assessments were completed and reviewed and updated at relevant oversight committee meetings.

At clinical level, CNMs were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential patient safety risks in their clinical areas.

**Infection screening and outbreak management**

There was one high-rated infection prevention and control risk on the corporate risk register which related to risk of harm to service user and or staff due to COVID-19. Existing controls in place at the time included a separate COVID-19 risk register and contingency plans which were further discussed with IPC representatives and senior hospital management. It was evident that the effectiveness of controls to minimise the risk were monitored and discussed at relevant oversight meetings and detailed in IPC reports.

Patients were screened for MDROs (VRE, MRSA) including CPE on admission and re-admission to the hospital. Patients were also re-screened for MRSA every 30 days. Patients who were suspected or symptomatic for COVID-19 were promptly screened in line with guidance in place at the time of inspection. Inspectors reviewed a sample of patient healthcare records and discharge documentation and noted that the patient's MDRO or other transmissible infection status was recorded. However, information on patient's COVID-19 vaccination status was not recorded on all the healthcare records reviewed.

There were six outbreaks in NRH in 2022, five COVID-19 outbreaks and one Influenza A outbreak. It was evident that multidisciplinary outbreak teams were convened to advise and oversee the management of infection outbreaks. Outbreak reports were completed for the outbreaks in line with national guidelines. A sample of outbreak reports reviewed by inspectors outlined potential contributing factors and recommendations to reduce

reoccurrence of the infection outbreak. The process of managing an infection outbreak was underpinned by a formalised up-to-date policy.

**Medication safety**

One risk relating to the pharmacy department infrastructure was escalated to the corporate risk register. Hospital management outlined plans in place to re-locate the pharmacy department to ensure the pharmacy department was compliant with relevant standards.

Despite the shortfall in pharmacy positions, NRH provided a clinical pharmacy service. Medication reconciliation was carried out on admission and discharge and a further review carried out during the patient's admission. Inspectors observed NRH's high-risk medications list, which aligned with the acronym 'A PINCH'[††††] and sound-alike look-alike medications (SALADs) list. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of prescribing.

**Deteriorating patient**

Inspectors noted that a risk relating to failure of the paging system to communicate medical emergencies was placed on the corporate risk register. This was discussed further with senior hospital management who outlined that the risk was identified in response to an incident that had occurred at the hospital that did not result in any adverse outcome for patients. It was also informed by a number of false emergency calls that were triggering on the bleep system that required further review. Documentation reviewed by inspectors outlined that regular emergency system review meetings were convened to identify required actions and monitor progress with these actions. A system review by external engineers was completed and works had commenced to install booster signal aeriels. While the immediate risk identified was managed, a number of upgrade works were ongoing at the time of inspection.

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose condition deteriorates. The INEWS and IPEWS guideline and observation chart was used in NRH with a review of these guidelines in process to ensure they were appropriate for use and relevant to the cohort of patients at NRH. Staff in the clinical areas visited were knowledgeable about the INEWS escalation process. Staff reported that there was no difficulty accessing medical staff to review a patient experiencing acute clinical deterioration. The $ISBAR_3$ communication tool was used when requesting a medical review of a patient.

[††††] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

Inspectors reviewed a sample of healthcare records and found that the majority of INEWS charts were completed and calculated correctly in line with the INEWS escalation protocol.

**Safe transitions of care**

NRH had systems in place to support the safe discharge and transfer of patients. However, inspectors found that an identified risk reported by staff associated with transitions of care was not escalated to the corporate risk register. This related to the care and management of long-term ventilated patients at the hospital. Staff informed inspectors of the various risks identified associated with the care and management of these patients. For example, inspectors were informed that in the event that a patient receiving long-term ventilation should deteriorate during out-of-hours, the level of onsite medical cover may not always be sufficient to meet the needs of other patients in the hospital and that this had the potential to impact on the timely review of other patients. In addition, noting that NRH may not routinely have long-term ventilated patients, staff outlined the need to ensure that the relevant skill set to provide specialised care to these patients was being maintained.

Hospital management outlined the existing and additional controls in place to mitigate against the risks identified by staff, including the ability of the hospital to receive only one long-term ventilated patient at a time, access to an on-call consultant, the placement of the patient on a dedicated high dependency ward (HDU) ward and the appointment of a respiratory Advanced Nurse Practitioner (ANP) to provide formal education and training to staff. However, inspectors noted that this risk was not escalated to the hospital's risk register and a formal risk assessment was not completed. Furthermore, inspectors identified that policies and procedures in place to support the care and management of long-term ventilated patients had not been updated to reflect the expansion of receiving long-term ventilated patients as part of other hospital programmes (i.e. brain injury programme) and not just as part of the spinal injury programme.

This was discussed further with senior hospital management and a completed risk assessment for a potential incoming long-term ventilated patient was provided to inspectors which detailed controls in place to mitigate against risks identified. Hospital management should ensure that out-of-hours medical cover arrangements in place are kept under review to ensure the needs of all patients can be met when caring for long-term ventilated patients and that staff are provided with the necessary education and training to provide quality and safe care.

**Policies, procedures and guidelines**

The hospital had a suite of 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 medication policies, procedures,

protocols and guidelines. However, policies relating to the care and management of long term-ventilated patients required review and updating. All policies, procedures, protocols and guidelines were accessible to staff via the hospital's intranet.

In summary, while NRH had systems and processes in place to proactively identify and manage the potential risks associated with the four areas of known harm, not all identified risks associated with the transitions of care were escalated and evaluated at executive level. There was scope for improvement in the following areas:

- risks identified in relation to the care and management of long-term ventilated patients should be formally and regularly reviewed and evaluated at senior hospital management level
- the level of medical out-of-hours cover should be kept under review to ensure the needs of all patients can be met when the hospital is in receipt of long-term ventilated patients

patient's COVID-19 or COVID-19 vaccination status was not recorded on all patient healthcare records or discharge documentation.

**Judgment:** Partially compliant

| Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. |
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There were systems in place at the hospital to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Patient-safety incidents were discussed at meetings of the Quality, Safety and Risk Committee with oversight provided by the Executive Committee. The risk management department produced an annual summary report of incidents for 2022.

Incidents were reported locally on a form sent to the Quality and Risk Manager where they were reviewed and entered onto the National Incident Management System (NIMS). A summary dashboard report was prepared each month for the Board of Management, Quality, Safety and Risk Committee and the Executive Management Committee. These reports were also accessible to all staff. Clinical areas also received a detailed monthly report of all incidents reported in their area for discussion with interdisciplinary team members.

In 2022, a total of 1627 incidents (clinical and non-clinical) were reported to NIMS. This represents a 33.5% increase in the number of incidents recorded when compared to 2021 figures. This increase can be attributed to the high number of COVID-19 cases reported during 2022 and an improved incident reporting culture. As of June 2023, the hospital reported 589 incidents.

Incidents were tracked and trended, according to type of incident, numbers, location, severity and types of persons involved. Inspectors reviewed monthly summary reports on all incidents that were compiled for relevant governance committees which included information on incident reporting against monthly KPI targets, top ten incidents and overall trends of incidents. The majority of incidents that occurred as of June 2023 related to medication errors, slips trips and falls and care management. Reports reviewed also outlined that delayed reporting occurred on two non-consecutive months in January and May of 2023, however, the remaining months met the target of reporting 90% of incidents to NIMS within 30 days of occurrence.

At the time of inspection, three serious reportable events (SRE's) were currently under review at the hospital, two of which related to falls incidents and one related to pressure ulcer management. In 2022, there were six reviews completed in response to category two incidents[‡‡‡‡], four of which were classified as SRE's. Reviews were completed for all incidents and reports submitted and accepted by the QSRM Committee. Hospital management reported that no category one incident had occurred at the hospital since 2021.

There was evidence that there was monitoring of the implementation of recommendations arising from patient-safety incidents. Inspectors reviewed status reports which outlined recommendations and actions aligned to specific incidents, timeframes and persons responsible for following up on actions and overall status of the actions.

**Infection prevention and control patient-safety incidents**

Patient-safety incidents related to healthcare-acquired infections were also reported to NIMS. Inspectors were informed that the IPC team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective action or preventative measures. Reported infection prevention and control patient-safety incidents were tracked and trended monthly by the infection prevention and control team. NRH recorded 534 infection prevention and control related incidents in 2022, the majority of which (470), related to staff testing positive for COVID-19.

**Medication patient-safety incidents**

Medication patient-safety incidents were reviewed by the pharmacy manager in collaboration with the quality and risk manager who categorised the incidents in terms of severity of outcome as per the Incident Management Framework. The majority of incidents were recorded as Category 3 (minor/negligible) incidents.

[‡‡‡‡] Clinical and non-clinical incidents rated as moderate as per the HSE's Risk Impact Table.

Quality improvement initiatives targeted at improving medication safety practices at the hospital arising from patient-safety incidents were implemented and evidence of these were observed by inspectors during inspection.

**Deteriorating patient**

NRH tracked and trended clinical incidents relating to the deteriorating patient and this was also a standing item agenda at meetings of the DPC committee. There was evidence that appropriate action was taken in response to incidents that occurred at the hospital associated with the deteriorating patient.

**Safe transitions of care**

As discussed in national standard 2.8, NRH were reporting unplanned transfers to NIMS. In 2022, there were eighty-two (82) unplanned transfers recorded. This was an increase of 35 on unplanned transfers recorded in 2021 (47) representing a 42.6% in 2022. A detailed aggregate review of unplanned transfers in 2022 was completed which provided valuable information to the service in relation to transitions of care and was identified as an example of good practice.

Overall, HIQA was satisfied that the hospital had systems in place to identify, report, manage and respond to patient-safety incidents and there was evidence that quality improvement initiatives arising from patient-safety incidents were implemented.

**Judgment:** Compliant

## Conclusion

HIQA carried out an announced inspection of National Rehabilitation Hospital to assess compliance with national standards from the *National Standards for Safer Better Healthcare.* The inspection focused on a selection of the national standards, and as part of the same inspection HIQA placed a particular focus on measures the hospital had put in place to manage four areas of known potential patient safety risk — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, HIQA found the hospital to be:

- compliant in four national standards (1.6, 1.7, 2.7, 3.3)
- substantially compliant in five national standards (1.8, 2.8, 5.2, 5.5, 5.8f)
- partially compliant in two national standard (3.1, 6.1).

**Capacity and Capability**

HIQA found that NRH had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare and had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. Hospital management should review and update existing organisational charts to ensure they are representative all committees and groups at NRH and reflect reporting structures outlined to inspectors on the day.

NRH had effective management arrangements in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm outlined above. Notwithstanding this, it was evident that NRH remains challenged by the limited availability of suitable community services to support the timely discharge of patients. It was evident that hospital management were responsive to this challenge and implemented a range of measures at local and group level to address this challenge.

HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare. However, there remains a number of unfilled staff positions across the majority of disciplines. Hospital management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients. Furthermore, NRH should keep the provision of medical cover out-of-hours under review particularly when the hospital is caring for long-term ventilated patients.

**Quality and Safety**

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their experience of receiving care in the hospital and were very complimentary of staff.

NRH had systems in place to effectively manage and monitor feedback and complaints. There was evidence that quality improvement initiatives were developed and implemented to improve services and care also as a result of feedback received.

HIQA was 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.

There were systems and processes in place to proactively identify and manage the potential risks associated with the four areas of known harm. However, not all identified risks associated with the transitions of care were escalated and evaluated at executive level. Risks identified in relation to the care and management of long-term ventilated

patients should be formally and regularly reviewed and evaluated at senior hospital management level.

HIQA was satisfied that the hospital had systems in place to identify, report, manage and respond to patient-safety incidents in particular, in relation to the four key areas of harm. There was evidence that quality improvement initiatives arising from patient-safety incidents were implemented.

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 implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to properly address HIQA's findings at the hospital, in the best interest of the patients that the hospital serves.

## 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 of National Rehabilitation 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:

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| **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. | Substantially compliant |
| **Standard 5.8:** Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. | Substantially compliant |
| **Theme 6: Workforce** | |
| National Standard | **Judgment** |
| **Standard 6.1:** Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare | 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. | Compliant |
| **Standard 1.7:** Service providers promote a culture of kindness, consideration and respect. | Compliant |
| **Standard 1.8:** Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. | Substantially compliant |
| **Theme 2: Effective Care and Support** | |
| **National Standard** | **Judgment** |
| **Standard 2.7:** Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. | Compliant |

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

## Appendix 2. Compliance Plan.

## National Rehabilitation Hospital Response.

# Compliance Plan for: National Rehabilitation Hospital

**Inspection ID: NS_0055**
**Date of inspection: 13 and 14 September 2023**

**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

- Hospital Management in partnership with the Human Resources Department will continue to progress with recruitment efforts to address the current vacancies across the hospital and to support the provision of high-quality and safe care to our patients.
- Since the inspection a HSE recruitment pause / embargo has been initiated which poses further challenges to the NRH in the short term. The NRH, however has requested a derogation given we are a national and essential service and we are awaiting response on same.
- Continue efforts with the NRH Recruitment and Retention working group by meeting on a regular monthly basis to address challenges in recruitment and retention across the organisation including Nursing and HSCP posts.
- Continue with international recruitment, exploration of Staff Bank set up for HSCP and Nursing and also the expansion of our Social Media Plan for the hospital.
- Continue in our efforts to increase compliance levels in attendance at and uptake of mandatory and essential training, not only among the areas highlighted but hospital wide. We will continue with our centralised system for tracking compliance levels

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| across the organisation via the development of individual training matrices and training compliance reports for hospital management to action.<br>• Hospital Management will continue to focus efforts and commitment towards effective absence management and seek to improve the compliance for absenteeism. A broad spectrum of health and wellbeing initiatives are available to support staff and to mitigate against work related illness and injury. The focus on absence management remains one of prevention, and health and wellbeing promotion.<br><br>Nursing management will continue to work with human resources to fill our present vacancies to reduce overtime shifts for staff due to unfilled shifts. |
| Timescale: Ongoing – monthly review meetings and reports as outlined above. |

| National Standard | Judgment |
|---|---|
| Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. | Partially compliant |
| Outline how you are going to improve compliance with this standard. This should clearly outline:<br><br>(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.<br><br>(b) where applicable, long-term plans requiring investment to come into compliance with the standard<br><br>• Information regarding patients COVID-19 status will be recorded on each patients' Electronic Patient Record. An alert symbol for COVID-19 will be displayed on the patient status at a glance board (PSAG) for all COVID-19 positive or suspected COVID-19 cases.<br>• The patients' interdisciplinary discharge report template will be updated to include a record of a patients' COVID-19 status and COVID-19 vaccination status.<br>• A formal risk assessment will be carried out for transitions of care and ventilator dependent patients and will be sent to the CEO/Quality and risk manager for review and inclusion on the corporate risk register.<br>• Admissions for ventilator dependency patients will remain at 50% capacity, senior management will continue to evaluate service capacity to ensure adequate nursing, respiratory physiotherapy, and medical cover to meet the needs of the patients. Senior management will continue to recruit staff to these key posts to ensure the presence of a skilled and knowledgeable workforce to manage long term ventilated patients undergoing rehabilitation. | |

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| • Update of the scope of service of the Spinal cord systems of Care programme to reflect expansion of receiving long term ventilated patients from other rehabilitation programmes.<br>• Update of the NRH tracheostomy policy to reflect expansion of receiving long term ventilated patients from other rehabilitation programmes. |
| Timescale: Completion by end of Q1 2024 |