Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Cavan Monaghan Hospital
Address of healthcare service:	Lisdarn Cavan Co Cavan H12 N889
Type of inspection:	Unannounced
Date(s) of inspection:	22 and 23 May 2024
Healthcare Service ID:	OSV-0001010
Fieldwork ID:	NS_0080

About the healthcare service

Model of Hospital and Profile

Cavan Monaghan Hospital is a model 3*public, acute hospital comprising both Cavan General Hospital and Monaghan Hospital, and is part of the Royal College of Surgeons in Ireland (RCSI) Hospital Group.† Cavan Monaghan Hospital provides services to the population of the counties of Cavan Monaghan, and its catchment area extends to counties Meath, Longford and Leitrim. At the time of inspection, six new regional health areas were being established and implemented by the HSE. As part of this process, the RCSI Hospital Group will become part of the HSE Dublin and North East: health region.

Monaghan Hospital site had a Local Injuries Unit (LIU) (47.6 kilometres from the Cavan site). Unscheduled care and acute inpatient services were provided in Cavan General Hospital site. These include acute medical, surgical, paediatric, obstetrics and gynaecology services. Inpatient step-down and rehabilitation care is provided on the Monaghan Hospital site. Both hospital sites provide outpatient services, surgery and day services.

Model of Hospital	3
Number of beds	293 beds at Cavan General Hospital site (includes 242 inpatient beds including the maternity unit and 51 day case beds) 79 beds at Monaghan Hospital site (includes 59 inpatient beds and 20 day case beds)

How we inspect

The Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out as part of HIQA's role to assess compliance with the National Standards for Safer Better Healthcare. It was a follow on from the previous inspection of the hospital on 5 and 6 July 2022.

† The RCSI Hospital Group comprises ten hospitals. These are Beaumont Hospital, Mater Misericordiae University Hospital, Cappagh National Orthopaedic Hospital, Our Lady's Hospital Navan, Connolly Hospital, Our Lady of Lourdes Hospital – Drogheda, Louth County Hospital, Cavan General Hospital, Monaghan Hospital and the Rotunda Hospital. The hospital group's academic partner is the Royal College of Surgeons in Ireland (RCSI).

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information. The inspectors also reviewed the hospital's compliance plan submitted following HIQA's last inspection in September 2022 and assessed the progress of implementation of the actions in the plan during this inspection.

During the inspection, the inspectors:

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

About the inspection report

A summary of the findings and a description of how the hospital performed in relation to 11 of the national standards assessed during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time — before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in Cavan Monaghan 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.

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

2. Quality and safety of the service

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 May 2024	09.15 – 17.45hrs	Dolores Dempsey Ryan	Lead
		Denise Lawler (Day 1)	Support
23 May 2024	09.00 – 17.09hrs	Nora O Mahony	Support
		Aedeen Burns	Support
		Robert McConkey	Support

Background to this inspection

HIQA carried out an inspection of the Cavan Monaghan Hospital in July 2022 and found that the hospital demonstrated a good level of compliance with ten of the national standards (compliant for 5.8, 6.4 1.7, 3.3 and substantially compliant for 5.2, 5.8, 1.6, 1.8, 2.7, 2.8) with the exception of the national standard 3.1. A compliance plan was submitted to HIQA (2022) for this standard and the hospital had implemented 67% of the plan and were progressing with implementing the rest of the plan at the time of the inspection.

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 management)[**]
- transitions of care.[††]

[§] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice 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

The inspection team visited five clinical areas:

- Emergency Department in Cavan General Hospital, which included the Acute Medical Assessment Unit (AMAU), the Acute Surgical Assessment Unit (ASAU) and the Transit Lounge
- Medical 1, Cavan General Hospital (31-bedded medical and stroke ward)
- Surgical 1, Cavan General Hospital(31-bedded surgical ward)
- Willowbridge Ward, Monaghan Hospital (18-bedded step down ward, that cares for patients availing of stepdown and convalescence care and also patients awaiting placement on the rehabilitation programme)
- Local Injures Unit, Monaghan Hospital (capacity for five bays/trolleys).

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

- Representatives of the hospital's Senior Management Team (SMT):
  - General Manager
  - Director of Operations
  - Director of Nursing (DON)
  - Clinical Director
  - Director of Nursing for Integrated Services for Older people.
- Quality and Patient Safety Manager
- Quality and Standards Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager
- Corporate Business Manager on the Monaghan Hospital site
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control Steering Committee (IPCSC)
  - Drugs and Therapeutics Committee (DTC)
  - Deteriorating Patient Committee (DPC)
  - Transitions of Care Committee (TOCC)
  - Quality and Safety Executive Committee (QSEC).

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

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

Over the course of the inspection, the inspectors observed staff and patient interactions and saw how staff actively engaged with patients in a respectful, cordial, considered and kind way. Inspectors observed staff in all of the wards visited actively listening and effectively communicating with patients in an open and sensitive manner, in line with

their expressed needs and preferences. This was also validated by patients who spoke with inspectors. Staff were described as "lovely and very kind", "could no ask for better staff".

Staff were observed in the wards visited using privacy curtains when providing assistance to patients with their personal care needs and during assessment of needs. Inspectors observed patients on trolleys on the corridor in the emergency department extending onto the corridor of the x-ray department. Patients accommodated on trolleys on the corridor who spoke with inspectors recounted how their privacy was not always maintained.

Inspectors spoke with a number of patients to ascertain their experiences of receiving care in the hospital. Overall, the patients' experiences were good. Patients were very complimentary about the staff. When asked what was good about the healthcare services or care received, patients said "*staff were brilliant*", "*staff see to your needs*", "*staff assist with everything*", and *"have time to spend with you"*. Patients in the emergency department said "*nurses are doing their best*", "*food was good*", "*and staff are very friendly and helpful*". Patients accommodated on trolleys on the corridor in the emergency department were provided with a comfort bag, toiletries, eye cover, ear plugs and non-slip socks. In the Local Injuries Unit (LIU), staff were described as '*really nice and welcoming*', '*seen within an hour*, '*love this place'*.

When asked what could be improved, most patient's said 'nothing'. Patients told inspectors that if they had a complaint, they would speak to a nurse, doctor or contact the HSE. Posters on the HSE's complaints process *'Your Service, Your Say'*, were displayed in all the wards visited. This is discussed further under national standard 1.8.

Overall, patients were very complimentary about the staff and of the care received in both hospital sites and this was consistent with what inspectors observed over the course of the inspection.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Cavan Monaghan Hospital was found to be complaint with two national standards (5.2 and 5.8) and substantially complaint with two national standards (5.5 and 6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

Inspectors found the hospital had formalised integrated corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. The governance arrangements outlined to the inspectors during the inspection were consistent with those detailed in the hospital's organisational charts.

The general manager at Cavan Monaghan Hospital was the accountable officer with overall responsibility and accountability for the governance of the two hospital sites and reported to the Chief Executive Officer (CEO) of RCSI Hospital Group. The clinical director (CD) provided clinical oversight and leadership of clinical services at the two hospital sites. The CD was a member of the SMT and reported to the hospital general manager and to the RCSI Hospital Group clinical director.

The DON and director of midwifery (DOM) were assigned with responsibility for the organisation and management of the nursing and midwifery services in the hospital. The Don and the DOM were members of the SMT and reported to the hospital general manager and to the RCSI Hospital Group chief nursing officer.

The hospital's SMT had responsibility for the overall governance and performance of the hospital ensuring that services were safe and effective as outlined in its terms of reference. Chaired by the general manager, the SMT met monthly and membership was appropriate and included the quality and patient safety manager and the business manager from Monaghan Hospital. It was evident from minutes of meetings reviewed by inspectors, and discussions with staff representatives that the SMT was functioning effectively. Performance meetings were held with the RCSI executive team on a monthly basis where key quality and performance metrics were reviewed and the implementation of agreed actions monitored. Additional reports reviewed included the quality and safety report, the human resource report and the finance report. The hospital had a strategic plan which set out the Senior Management Team's goals and priorities in relation to performance metrics for 2024- 2026. There was evidence that these strategic objectives were being implemented through governance committee structures outlined below.

The hospital's multidisciplinary QSEC was responsible for providing the hospital's senior management team with assurances on the quality and safety of healthcare services in the hospital. Chaired by the clinical director, the committee met every eight weeks in line with its terms of reference and membership included representation from the SMT and Monaghan Hospital. Since the last inspection, the QSEC was restructured and two recommendations arising from this restructuring process were implemented. These recommendations related to the introduction of a range of performance metrics and a focus on supporting a culture of quality improvement.

Nine clinical governance committees (CGCs) included the Medicine Services Clinical Governance Committee, the Surgical Services Clinical Governance Committee and the Emergency Services Clinical Governance Committee reported to QSEC. The CGCs were responsibility for monitoring the performance of clinical services within their remit and membership included members of QSEC and the SMT. Monaghan Hospital was represented on CGCs by the corporate business manager and the ADON for Monaghan Hospital.

The QSEC devolved assigned responsibilities and functions for the four areas of known harm to the IPCSC, DTC, DPC and the TOCC. The hospital had a well-established multidisciplinary IPCSC who were responsible for the governance and oversight of infection prevention and control practices at the hospital. Chaired by the hospital's general manager, the committee met every quarter, in line with its terms of reference and meetings were well attended. Membership included representatives from the SMT, a consultant microbiologist and the ADON from Monaghan Hospital. The IPCSC was operationally accountable and reported to the QSEC every quarter. This committee provided updates to the QSEC on infection prevention and control practices, the number and management of infection outbreaks and on compliance with environmental hygiene and decontamination standards.

The hospital had a well-established multidisciplinary DTC with responsible for the governance and oversight of medication safety practices, including antimicrobial stewardship practices in the hospital. Chaired by a medical consultant, the committee met approximately every six weeks, in line with its terms of reference and meetings were well attended. Membership was appropriate and included members of the SMT, the chair of the Medication Safety Committee and the ADON for Monaghan Hospital. The DTC was operationally accountable and reported to the QSEC every quarter. The chair of the DTC and the chief pharmacist who were members of QSEC provided a report which included data on key performance metrics (KPIs) in relation antimicrobial stewardship and medication safety incidents. The Medication Safety Committee (MSC) was a sub-committee of the DTC and its responsibilities included implementing the DTC's draft strategy plan (2024) which had yet to be approved by the SMT. The ADON for Monaghan Hospital was a member of the MSC.

The DPC provided governance and oversight of the hospital's level of compliance with national guidelines on the early warning systems[‡‡] and sepsis management. The DPC met monthly in line with its terms of reference and reported to the QSEC every two months. Meetings were co-chaired by the director of operations and the DON. Membership included members of the SMT, an advanced nurse practitioner (ANP) in critical care outreach, ADONs and consultant leads from each Clinical Governance Committee, end of

[‡‡] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient. EWS includes Irish National Early Warning Systems (INEWS), Irish Maternity Early Warning Systems (IMEWS), Paediatric Early Warning System (PEWS) and Emergency medicine Early Warning System (EMEWS).

life co-ordinator, ADON from Monaghan Hospital and the sepsis lead from the RCSI Hospital group. Five working groups reported to DPC each quarter— the deteriorating patient (EWS) working group, resuscitation working group, sepsis working group, end of life working group and the morbidity and mortality working group. Updates on the quality improvement initiatives being progressed by the five subgroups were provided to the QSEC each quarter. The sub-groups reported on audit findings, training and quality improvement initiatives. The clinical lead for DPC presented updates to the QSEC from the five sub-groups of DPC on quality improvement initiatives being progressed including clinical handover and audit findings.

The hospital's newly established TOCC monitored and had oversight of transitions of care within and from the acute hospital setting, including oversight of patients discharge to Monaghan Hospital, Lisdarn Transitional Unit and tertiary care sites. Chaired by the director of operations, the committee reported to QSEC and membership included representatives from the SMT, DON for integrated services for older persons, nursing and midwifery staff, patient flow staff, the clinical leads and the ADONs from the Clinical Governance Committees, an ADON for Monaghan Hospital and the lead for health and social care professionals. The committee had met once in March 2024 and needed time to prove its effectiveness. Separately, there was evidence that the SMT, QSEC, Emergency Services Clinical Governance Committee and the RCSI Hospital Group had ongoing governance oversight of Cavan and Monaghan Hospital's scheduled and unscheduled activity.

In summary, on the day of inspection, there was evidence of strong corporate and clinical governance and leadership at the hospital. Inspectors found that the governance committees with responsibility for the quality and safety of the service were effective and meeting in lines with their terms of reference.

Judgment: Compliant

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

The inspectors found that Cavan Monaghan Hospital had effective management arrangements in place in relation to the four key areas of harm.

The IPCSC supported and oversaw the implementation of the infection prevention and control team's (IPCT) operational plan for 2024. This plan outlined the areas of focus which included surveillance of hospital associated infections (HCAIs), infection outbreak management, audit activity and screening of multidrug resistant organisms (MDROs). Inspectors viewed the IPCT's operational plan for 2024 and noted that there was evidence

that they were actively implementing elements of the plan and updating the status comments.

The hospital's pharmacy service was led by the chief pharmacist. Measures to support medication safety practices were set out in the DTC draft strategic plan (2024) for medication safety. These included eight objectives related to progressing medicine information leaflets for patients, developing and reviewing medication policies, reviewing drug prescriptions, high risk medicines and training. The MSC provided updates at each DTC meeting on the implementation of the strategic plan.

The hospital's antimicrobial stewardship team (AMST) included a consultant microbiologist and antimicrobial pharmacists who reported to the DTC. Members of the AMST provided the DTC with updates on antimicrobial prescribing practices, audit findings, compliance with antimicrobial KPIs and antimicrobial stewardship guidelines, staff training and education. The AMST had developed an action plan with 13 objectives for 2024 to support antimicrobial stewardship in the hospital. There was evidence that the AMST were progressing with implementing the action plan for 2024 which included monitoring key performance indicators and reporting findings to governance committees on audit data, policies and antimicrobial prescribing.

To support effective management arrangements in relation to the care of the deteriorating patient, a deteriorating patient improvement programme[§§] under the clinical leadership of a consultant physician had been implemented across both hospital sites. The DPC set out two key priorities in the deteriorating patient improvement programme to be progressed in 2024. One priority related to improving the efficiency and efficacy of clinical handover and the second priority related to implementing a 'Hospital at Night' initiative to develop and embed a multidisciplinary team based approach to providing safe and effective patient centre care overnight. The clinical lead provided updates on the progress made with the implementation of the clinical handover project at the QSEC meetings.

A critical care outreach team from the intensive care unit (ICU) were available to provide support to staff when required when a patient's condition deteriorated. A consultant in the emergency department was the assigned sepsis lead for the hospital. Patient were accessed for sepsis related symptoms at triage and there were two sepsis trolleys in the department to provide the necessary equipment to facilitate patient assessment.

The hospital had management arrangements in place to support patient flow and discharge planning, which were functioning as well as they should be on the day of inspection. Unscheduled care activity including patient experience times (PETs), delayed discharges and capacity issues were monitored at hospital's clinical governance meetings

[§§] Deteriorating Patient Improvement Programme is a standardised, high quality systematic approach to the recognition, response and management of the deteriorating patient through the implementation of National Early Warning Systems (EWS). Access online from: https://www2.healthservice.hse.ie/organisation/qps-improvement/deteriorating-patient-improvement-programme/

including QSEC and the RCSI Hospital Group meetings. A bed management team which comprised a patient flow ADON, a discharge coordinator and a DON for integrated services for older people managed the transitions of care between the hospital and community services. The DON for integrated services for older persons played a key role in coordinating transitions of care services between Cavan Hospital, Monaghan Hospital, Lisdarn Unit, nursing homes and community services.

The DON for integrated services chaired forum meetings ('Moving Forward Together Forum') with community services approximately every four months to focus on integrating services and lessen patient admissions to the hospital in cases where the patient could be supported through other more appropriate care pathways. Membership of this forum included the DON for integrated services, service manager for older person's services, the directors of nursing for nursing homes, medical physicians and relevant community representatives. There were no delayed transfer of care (DTOC) in the hospital on the days of inspection, which is to be commended.

Over the two days inspection, the hospital was in black escalation with a number of patients accommodated on trolleys on the main corridor in the emergency department. It was evident to inspectors that actions taken by the executive management team to manage patient flow on the day of inspection were aligned with the actions in the hospital's escalation plan. Actions taken included:

- Convening escalation meetings with executive management, bed management and nursing management to review the activity in the emergency department and the wider hospital and open surge capacity beds. Three daily huddle meetings were held to review the hospital's status and agree actions to enhance patient flow arrangements and patient discharges.
- Admitted patients who were accommodated in the AMAU overnight were reviewed and transferred to the transit lounge which allowed the AMAU to function as a pathway for patients in the emergency department.
- Following assessment, low risk ambulant patients were transferred to the Transit Lounge.
- The hospital had opened a three bedded acute surgical assessment unit (ASAU) in October 2023 which was functioning on the day of inspection.
- Surge capacity beds were opened in two clinical areas, although limited to two beds.
- Patients who were deemed suitable were transferred to the LIU in Monaghan Hospital.
- Schedule care arrangements and DTOC were reviewed to create capacity.

In summary, over the two days of inspection, it was clear to the inspectors that the SMT were responsive and reactive, and had good operational grip on issues that impacted patient flow and effective discharge planning. Inspectors found that the hospital was in black escalation and patients were accommodated on trolleys in the emergency department. To address this, inspectors noted that:

- There was a concentrated effort by SMT to deescalated and manage the situation in line with the hospital's escalation plan.
- The emergency department, AMAU, ASAU and the transit lounge were functioning reasonable well although there is room for improvement to ensure that zero admitted patients are accommodated on trolleys in the emergency department.
- The DTOC rate was zero and the average length of stay for medical and surgical patients was compliance with HSE targets. Collectively, these indicated that patient flow arrangements were effective as they could be.

Judgment: Substantially compliant

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

The hospital had effective systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Information on a range of different clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with the HSE's reporting requirements. Collated performance data, which included quality and performance metrics from Monaghan Hospital was reviewed every eight weeks at the QSEC meetings, at quarterly clinical governance committees meetings, at monthly SMT meetings and at the monthly performance meetings with the RCSI Hospital Group.

There were formalised risk management structures and processes in place to proactively identify, analyse, manage, monitor and escalate identified risks. The hospital's corporate risk register was reviewed at SMT meetings every eight weeks and the significantly high rated risks were reviewed at the monthly performance meetings with the RCSI Hospital Group. Each Clinical Governance Committee had their own risk register, which was reviewed quarterly at a pre-governance meeting by the quality and patient safety manager, the chair of the committee and the ADON. Risks that could not be managed locally were escalated to the hospital's corporate risk register.

Governance oversight of audit was provided by SMT, QSEC and the CGCs. The hospital had a clinical lead for audit (consultant in medicine) and a clinical audit facilitator who supported the coordinated approach to auditing. There was evidence that each Clinical Governance Committees had developed an annual programme plan for audit and clinical

audit updates including recommendations were an agenda item for discussion at their committee meetings. There was also evidence that the QSEC monitored the development of audit plans by the Clinical Governance Committees. In addition, the SMT had oversight of audit findings and quality improvement initiatives implemented to address areas that fell below standard.

The hospital's quality and patient safety manager tracked and trended reported patient-safety incidents and provided this information in the quality and patient safety performance report to the SMT, QSEC and at monthly performance meetings with the RCSI Hospital Group.

The hospital's Serious Incident Management Forum (SIMF) had oversight of the management of serious reportable events and serious incidents, which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The forum met monthly and membership included the hospital general manager, deputy hospital manager, the clinical director, all clinical leads, the quality and patient safety manager, the DON and the DOM. The SIMF was accountable to QSEC and information on reported serious reportable events and serious incidents was included in the quality and patient safety performance report presented at the monthly performance meeting with the RCSI Hospital Group. The QSEC monitored the implementation of recommendations arising from the review of serious reportable events and serious incidents and after action reviews were completed following a serious patient safety incident.

The hospital's quality and safety department had responsibility for monitoring findings from the National Inpatient Experience Survey 2022. Three quality improvement initiatives related to improving multidisciplinary communication with patients and their families, providing medication information to patients and improving discharge planning were being implemented in response to the survey findings. There was evidence that the implementation of these quality improvement initiatives was monitored at QSEC meetings.

In summary, hospital management had effective monitoring arrangements in place in the hospital to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. There was evidence of strong governance oversight of collated performance data including the implementation of quality improvement initiatives and recommendations from reviews to ensure the quality and safety of the service.

Judgment: Compliant

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

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. In relation to workforce arrangements in Monaghan Hospital, the corporate business manager was operationally responsibility for the hospital and reported to the general manager for Cavan Monaghan Hospital, Monday to Friday.

The hospital was funded for 45 whole-time equivalent (WTE) [***] medical consultant positions (across specialties) and 49 WTE medical consultants' positions were filled, an increase of 8%. Medical consultants were support by 130 WTE NCHDs at registrar and senior house officer (SHO) grade. At the time of inspection 136 (62 registrars, 70 SHOs and 4 specialist registrars) NCHD's positions were filled.

The emergency department was funded for 6 WTE emergency medicine consultants, and 4 WTE (67%) emergency medicine consultant's positions were filled (2 WTE positions were filled permanently, 1 WTE on an acting basis and 1 WTE on a locum basis). One of the 4 WTE emergency medicine consultants was the assigned clinical lead for the emergency department. Hospital management had advertised many times to fill the emergency medicine consultant's unfilled positions, but the recruitment process was unsuccessful. Consultants in emergency medicine were on site in the emergency department during core working hours (8am-5pm), Monday to Friday. Outside core working hours, the on-call consultant in emergency medicine provided cover after 5pm for Cavan Monaghan Hospital sites. The on-call consultant in emergency medicine was supported by the on-call medical registrar and senior house officer (SHO). Inspectors were told that a second SHO was rostered in the last eight months to provide cover for the wards from 5pm to 9pm. A senior clinical decision-maker,[†††] at registrar grade was onsite in the emergency department 24/7.

A consultant physician based in Cavan General Hospital had clinical responsibility for all the inpatients in Monaghan Hospital and was on site in the hospital one day a week. This consultant was supported by a medical registrar and a senior house officer who were onsite Monday to Friday from 9am to 5pm. In the Local Injuries Unit in Monaghan Hospital during core working hours, one emergency medicine NCHD at registrar grade and one SHO were onsite from 8am to 8pm seven days a week. A second medical registrar was onsite from 12 midday to 8pm five days a week.

Outside of core working hours, the medical registrar on call in Cavan General Hospital was available via phone to provide support and advice to staff in Monaghan Hospital to

[***] 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.
[†††] 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.

support timely intervention should a patient's condition deteriorate. Patients that were unwell in Monaghan Hospital and required transfer to the emergency department in Cavan Hospital were transferred via ambulance in line with the 37 protocol.[‡‡‡] Staff called 999 for an emergency ambulance for patients in Local Injuries Unit who require urgent transfer to the emergency department in Cavan Hospital, for example following a cardiac arrest. Ninety-seven (97%) percent of staff in Monaghan Hospital (2024) had completed basic life support training and relevant medical and nursing staff had completed advanced cardiovascular life support (ACLS) training.

Not all of the permanent medical consultants were on the specialist division of the register with the Irish Medical Council (IMC). The clinical lead of each clinical governance committee provided oversight of and support to those not on the specialist registrar.

The hospital was funded for 18.36 WTE pharmacists and 12 WTE pharmacy technicians. At the time of inspection, 16% (3 WTE) of pharmacist's positions were unfilled and two of the three pharmacist's positions were unfilled due to statutory leave. In addition, 12.5% (1.5 WTE) of the pharmacy technician's positions were unfilled, which all impacted on the hospital's ability to provide a comprehensive clinical pharmacy service[§§§] across the hospital. This risk was escalated to the DTC and recorded as a high-risk on the hospital's corporate risk register. The risk was managed by ensuring that high-risk medicines received a clinical pharmacist review. Ward areas visited on the day of inspection had access to a clinical pharmacist.

The lack of a clinical pharmacy service for all areas of the hospital was similar to the inspection finding in 2022 and an area of focus in the hospital's compliance plan, but not progressed. Hospital managers told inspectors that business cases were developed, but the HSE recruitment embargo introduced in October 2023, had impacted the hospital's ability to recruit clinical pharmacists.

The nursing and midwifery staff levels for Cavan Monaghan Hospital was 550 WTE in 2022 and increased to 650 WTE in 2024. This represented an increase of 100 WTEs (18.1%). Of the 100 WTEs, 46 WTE nursing positions were funded through the Department of Health's staff staffing frameworks[****] The remainder were funded through other pathways. At the time of the inspection, 40.93 WTE (7%) nursing staff positions were unfilled due to statutory leave entitlements. Hospital management told inspectors that this risk was recorded on the corporate risk register and monitored at the safe staffing implementation group meetings. The safe staffing framework does not apply to midwifery.

[‡‡‡] Protocol 37: has been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.
[§§§] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[****] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

The emergency department was funded for 51.50 WTE nursing staff (inclusive of CNMs) and 53.25 WTE nursing positions were filled at the time of inspection, which represented an increase of 3% since HIQA's last inspection in 2022. Senior nursing management deployed an additional 2 WTE to the emergency department to cover temporary vacancies due to statutory leave and reduce the requirement for agency usage.

Surgical 1 was funded for 24.46 WTE nurses (including CNMs), with 34 positions filled. However, due to the high levels of temporary vacancies attributed to statutory leave, nursing management deployed additional 10 WTEs to cover temporary deficits. This was achieved through redeployment from other areas and recruitment of new staff. Surgical 1 was not staffed under the Department of Health's staff staffing frameworks at the time of the inspection.

Medical 1, was funded for 33.50 WTE nurses (including CNMs) with 33 WTE nursing positions filled. Of the 33 nursing positions filled, 3 WTE were unavailable due to statutory leave. Willowbridge ward in Monaghan Hospital was funded for 14.50 WTE nurses (including CNMs), with 13.84 WTE positions filled. There were 3.52 WTE on statutory leave. Agency staff and or nursing staff from the hospital did extra shifts to fill any nursing staff shortfalls.

The Local Injuries Unit located in Monaghan Hospital had 1 WTE CNM 1, 1 WTE staff nurse, three registered ANPs and three candidates advanced nurse practitioner. The clinical lead for the emergency department in Cavan General Hospital had responsibility for the Local Injuries Unit. The Emergency Services Clinical Governance Committee who reported to QSEC had responsibility for monitoring risks and activity at the emergency department and the Local Injuries Unit.

During core working hours, an ADON and ward CNMs managed Monaghan Hospital. Outside of core working hours, a CNM3 provided cover from 8pm to 8.30am seven nights per week, and provided cover from 8.00am to 8.30pm at the weekend. A CNM2 from the ward provided cover for Monaghan Hospital from 5pm to 9pm, with the support from the on-site ADON in Cavan Hospital. Inspectors raised the lack of a CNM3 onsite from 5pm to 9pm and the DON and members of SMT told inspectors that they were satisfied with the management arrangements in place in Monaghan Hospital to support the quality and safety of the service.

Cavan Monaghan Hospital was funded for 124.8 WTE healthcare assistants and 115.85 WTE of these positions were filled, representing a variance of 7.2%.

The hospital's human resource department tracked and reported on staff absenteeism rates and these rates were reviewed at meetings of the SMT, QSEC and monthly performance meetings with the RCSI Hospital group. In April 2024, Cavan General Hospital's reported absenteeism rate (included COVID-19 related absences) was greater than 7% and Monaghan Hospital's absenteeism rate was 5.5%, both were above the HSE's target of 4%. Back to work interviews were completed by CNMs and ADONs and

staff in the wards visited had access to support services, including occupational health services and the employee assistance programme.

Staff attendance and uptake of mandatory and essential training was monitored at meetings of the SMT, QSEC, Clinical Governance Committees and performance meetings with the RCSI Hospital Group. In addition, attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff was monitored at ward level by the CNMs with the ADONs. Training records reviewed by inspectors showed that the overall uptake of essential and mandatory training in the wards visited was good. The hospital's overall compliance rates for hand hygiene training for nurses was 90% and for transmission-based precautions was 93%. The hand hygiene training compliance for HCAs was 100% and 94% for standard based precautions. However, there were gaps in the uptake of essential and mandatory training for some of the medical staff related to hand hygiene and infection prevention and control training.

There was good compliance with staff training in the Irish National Early Warning System (INEWS),[††††] Irish Maternity Early Warning System (IMEWS)[‡‡‡‡] and the Emergency Medicine Early Warning System (EMEWS). Staff had also attended training on the HSE's healthcare communication programme. Seventy-nine percent (79%) of staff had completed training on open disclosure on the HSE's learning platform (HSELand). Staff attendance rates and uptake of essential and mandatory training were similar to the findings from the last inspection. Overall, there was no change in the level of compliance with this national standard.

In summary,

- Overall, the uptake of essential and mandatory training in the clinical areas visited was good, but there were gaps in the uptake of essential and mandatory training for some of the medical staff.
- The hospital's absenteeism rate requires continuous monitoring to meet the HSE's target (4%).
- The hospital had staff deficits, particularly in relation to the pharmacy department.

Judgment: Substantially compliant

[††††] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.
[‡‡‡‡] IMEWS is a nationally agreed system developed for early detection of life-threatening illness in pregnancy and the postnatal period.

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

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

It was evident to the inspectors that all staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients and this was consistent with the human rights-based approach to care promoted by HIQA. In the three wards visited, staff were observed using privacy curtains to protect the patient's privacy and dignity. Staff were also observed taking a family to a side room to maintain confidentially when sharing information. However, on the first day of inspection, the emergency department was overcrowded and this compromised the dignity, privacy and confidentiality of patients in the department. Staff told inspectors that during times of escalation, rooms in the outpatient's department were used when carrying out clinical assessment, this promoted the confidentially, privacy and dignity of patients attending the emergency department. Nevertheless, patients in the emergency department had no access to shower facilities and had to go to another ward (Medical 2) to shower, which impacted their privacy and dignity.

Consistent with the findings from the last inspection, patient's personal information in Medical 1, Surgical 1 and the emergency department was observed not to be protected which was not in line good practice guidelines. This was brought to the attention of the clinical nurse manager in the clinical areas visited, but not addressed at the time of the inspection. Staff in Surgical 1 told inspectors they were waiting for the delivery of a new white board which will provide protection for patient's personal information.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this was consistent with the human rights-based approach to care promoted by HIQA. However,

- the emergency department was overcrowded, which impacted patient's privacy and dignity

- patients in the emergency department had no access to shower facilities within the department
- patient information was observed not to be protected in the wards visited.

Judgment: Partially compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors and described staff as *"lovely and very kind"*, and said how they "*could not ask for better staff"*. Staff *"had more time to spend with you"* and were *"good to come when needed"* to provide assistance. Staff in the emergency department were observed by inspectors to be kind and caring towards patients and tried to respond to their individual needs. Meals and snacks were provided to patients in the emergency department.

Inspectors found evidence of a person-centred approach to care, especially for vulnerable patients receiving care. For example, in the emergency department, there was one waiting room for frail older persons and patients with dementia were assigned to a designated cubicle area close to the nurse's station. To support end of life care, the hospital had appointed an end of life coordinator and there was a room prioritised in Medical 1 for patients requiring end of life care.

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

Judgment: Compliant

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

In Cavan Monaghan Hospital, the complaints officer's role and responsibilities were combined with the patient liaison officers' role. There was a culture of complaints resolution in the wards visited. Verbal complaints were recorded on the point of contact complaint resolution form and where possible resolved locally by the CNMs. Complaints that could not be resolved locally were escalated to the ADON and the quality and patient safety manager. ADONs provided feedback on complaints to the CNMs and staff that were the subject of the complaint. Feedback was also shared with the wider ward staff at

meetings which included the safety huddle meetings. Staff provided inspectors with examples of quality improvement initiatives that were developed and implemented following the complaint resolution process to improve the patient's experience.

The SMT, QSEC and the RCSI Hospital Group had oversight of the effectiveness of the hospital's complaints management process. The quality and patient safety department produced a monthly quality and safety performance report, which included a complaints analysis report on complaints received and closed out. This report was reviewed at SMT, QSEC and the RCSI Hospital Group monthly performance meetings. In addition, the complaints analysis reports was also reviewed at CGCs meetings. Implementation of recommendations was monitored at governance meetings and by the ADONs and the complaints coordinator. The hospital used the HSE's complaints management policy '*Your Service Your Say*.'[§§§§] The hospital was 100% compliant with meeting the HSE's target to investigate and resolve 75% of complaint received within 30-days. This is an improvement on the findings from the last inspection.

Overall, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by 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.

On the days of inspection, inspectors observed that overall the hospital's physical environment was clean with few exceptions. There was evidence of general wear and tear. In Medical 1, inspectors observed equipment stored on the corridor as there was limited storage space. Congestion on corridors could pose a risk to patient safety. The emergency department was part of the hospital building, but the admission and triage areas were located in a temporary prefabricated building structure which was observed to be a small, restrictive with narrow corridors, which was challenging for both staff and patients. The inpatient ward areas visited by inspectors had adequate shower and toilet facilities, but patients attending the emergency department had no access to shower facilities within the department and had to go to another ward to access a shower.

Environmental cleaning was carried out by an external contract cleaning company. Cleaning supervisors and CNMs had oversight of the cleaning standards and cleaning schedules in the wards visited. The CNMs who spoke with the inspectors were satisfied with the level of cleaning staff in place 24/7. The hospital had a tagging system to identify clean equipment. Curtains were changed every three months as part of the terminal

[§§§§] 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.

cleaning process. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the wards. Inspectors noted that not all clinical hand hygiene sinks in the wards visited conformed to national requirements.[*****]

Appropriate infection prevention and control signage in relation to transmission-based precautions was observed in the wards visited. Staff were also observed wearing appropriate personal protective (PPE) equipment in line with the public health guidelines in place at the time of inspection. Physical distancing of one metre[†††††] was observed to be maintained between beds in multi-occupancy rooms. In the emergency department, where trolleys were lined up along the corridor end to end, a minimum distance of one meter was not maintained.

There was a formalised process in place to ensure appropriate placement of patients requiring transmission-based precautions. This process was overseen by the infection prevention and control team and patients were prioritised in line with antimicrobial resistance and infection control guidance (AMRIC). The hospital had 19 single rooms, but hospital management felt this number of single rooms was insufficient and the lack of single rooms was recorded as a high-risk on the corporate risk register.

In summary, the physical environment for the most part did adequately support the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. However,

- physical spacing of 1 metre was not maintained between trolleys in the emergency department due to overcrowding conditions.

Judgment: Substantially compliant

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

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

[†††††] Infection Control Guiding Principles for Buildings. Acute Hospitals and Community Healthcare Settings (2023). Available online from https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/buildingsandfacilitiesguidance/Infection%2

Cavan Monaghan Hospital had systems and processes in place to systematically monitor, evaluate and continuously improve the healthcare services and care provided. The hospital used national performance indicators and benchmarks to monitor the quality and safety of care and its outcomes. The hospital also monitored additional key quality and performance indicators for the RCSI Hospital Group, which were reviewed monthly and published by the RCSI Hospital Group.

The hospital monitored and publically reported monthly on rates of hospital acquired *Clostridioides difficile* infection, (CPE), *Staphylococcus aureus* blood stream infections, the percentage of compliance with *Carbapenemase-Producing Enterobacterales* (CPE) screening criteria, the number of new CPE cases and the number of new cases of hospital-acquired COVID-19. Information reviewed by inspectors showed that the hospital was complaint with the national targets for all for the above infections (March 2024).

There were nine (9) new CPE cases between June 2023 and April 2024. Inspectors were told that ongoing control measures to prevent CPE transmission had been implemented and monitored through relevant hospital committees. The hospital achieved 97% compliance with CPE screening criteria in March 2024.

The IPCSC had oversight of the findings from environmental audits, patient equipment audits, hand hygiene audits and the hospital's compliance with infection prevention policies, procedures, guidelines and protocols. In the wards visited, environmental and patient equipment hygiene audits completed by the hygiene department in the months before this inspection showed a good level of compliance (93% - 100%) with expected standards. Quality improvement plans (QIPs) were developed when standards fell below expected standards. The wards visited were also compliant with the HSE's target of 90% for hand hygiene practices. In the emergency department, where the hand hygiene standards had dropped below the required standards in April 2024, a QIP was implemented and following a re-audit (May 2024), the department achieved 100% compliance with hand hygiene standards.

Medication safety audits results were monitored at DTC, CGCs, QSEC and the RCSI Hospital Group. Medication audits carried out in Medical 1, the emergency department and Willowbridge ward in the months before this inspection showed a variation in compliance (88.55% – 100%) with best practice standards for medication management. There was evidence that QIPs were developed in Medical 1 when medication standards fell below acceptable levels for medication audits. Medication practices were also monitored monthly as part of nursing and midwifery quality care metrics.
The ADONs discussed the nursing and midwifery quality care metrics findings with the CNMs who shared the information with staff at meetings which included the safety pause meetings. There was evidence that AMS practices were monitored by the DTC and CGCs. Inspectors were told at interview that medication reconciliation was prioritised for high risk patients. Inspectors found that of the nine healthcare records reviewed, only one had medication reconciliation completed on admission.

The DPC and the deteriorating patient (EWS) working group which was a sub-group of the DPC had oversight of INEWS audit results. Compliance with the early warning system escalation and response protocol was audited monthly as part of the nursing and midwifery quality care metrics and compliance rates for patient monitoring and surveillance for the months preceding the inspection varied (range from 80% to 100%) across the wards visited. The nursing and midwifery quality care metrics results were verbally fed back by the ADONs to the CNMs and discussed with staff at meetings including the safety huddle meetings. Inspectors found evidence of monitoring of INEWS observation charts in the months before HIQA's inspection in Medical 1 and Surgical 1 and compliance rates ranged from 85.6% to 91.8%. These audits identified areas for improvement. However, inspectors found that quality improvement plans had yet to be implemented. There was evidence that a quality improvement plan was developed and actions were being implemented following a self-assessment analysis on compliance with the early warning systems[‡‡‡‡‡] recommendations. In addition, there was evidence provided to inspectors that nursing staff had achieved 99% compliance with INEWS training in 2024 and medical staff had achieved a compliance rate of 78% for INEWS training, below the HSE target of 90%.

The emergency department had successfully implemented the emergency medicine early warning score (EMEWS) system for non-admitted patients, The hospital had audited the EMEWS and a QIP was implemented to address areas that fell below expected standards.

The hospital had introduced a transitions of care clinical handover audit tool (May 2024), but had yet to complete an audit. The emergency department had audited compliance with the use of the Identify, Situation, Background, Assessment, Recommendation/Read Back/ Risk communication tool ($ISBAR_{3)}$[§§§§§] for nurse shift handover (2024). The department scored 100% with the exception of one area which was identified for improvement. Likewise, medical staff in the emergency department had completed audits (2023-2024) of their documentation related to their three daily clinical handover meetings and there was evidence that practice had improved. There was also evidence that quality improvement initiatives related to multidisciplinary team (MDT) clinical handover were being progresses in the hospital.

Performance and activity metrics, including PETs were monitored at CGC meetings, QSEC meetings, the SMT meetings and at the performance meetings with the RCSI Hospital Group. The hospital tracked the average length of stay (ALOS) and the number of DTOCs. At the time of inspection, the hospital was compliant with the HSE's ALSO targets for medical and surgical patients. The percentage of discharge letters issued to general practitioners (GPs) within one week was monitored at QSEC and the RCSI Hospital Group

[‡‡‡‡‡] Irish National Early Warning System (INEWS) V2 National Clinical Guideline No 1. Access on line: https://www.gov.ie/en/collection/cc5faa-national-early-warning-score-news/

[§§§§§] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

monthly performance meetings. The hospital had achieved compliance rates ranging from 80% (January 2024) down to 76 % (March 2024) and below the RCSI Hospital Group's target of 100%. However, this was an improvement on the compliance rates found on the last inspection. Staff in Surgical1, Medical1 and Willowbridge wards told inspectors that their wards were meeting compliance with discharge summaries being completed in line with the hospital and RCSI Hospital Group's key performance metric.

Overall, there was evidence that Cavan Monaghan Hospital was systematically monitoring and evaluating healthcare services provided at the hospital. However, while HIQA acknowledges that the hospital had provided INEWS training to staff,

- the hospital needs to ensure that QIPs are implemented when compliance rates for INEWS fall below expected standards following INEWS audit findings. INEWS training for medical staff was not at the HSE level of 90%.

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.

Cavan and Monaghan Hospital had systems in place to proactively identify, evaluate and manage immediate and potential risk of harm to people using the service, including ensuring that the necessary actions were taken to eliminate or minimise these risks. The hospital's corporate risk register was reviewed at monthly SMT meetings and at monthly performance meetings with the RCSI Hospital Group.

High-rated risks recorded on the corporate risk register at the time of inspection, included risks associated with the emergency department's infrastructure, admitted patients waiting for an in-patient bed in the emergency department, the lack of clinical pharmacists and nurses for specialised areas, lack of compliance with clinical handover policies and risks of patients acquiring hospital associated infections due to insufficient facilities. There was evidence on the day of inspection that controls were being implemented to mitigate these risks. For example, multidisciplinary clinical handover meetings were implemented.

In the wards visited, the CNMs escalated risks to their ADON, the DON and to these were recorded on the relevant CGC's risk register. The emergency department had a risk register which was reviewed quarterly by the consultant lead and the ADON for emergency medicine with a manager from the quality and safety team. The risk register was an agenda item for discussion at the quarterly Emergency Services Clinical Governance Committee meetings. Infection prevention and control related risks were recorded on each CGC's risk register. Infection prevention and control risks were

discussed at the IPCSC meetings and reviewed at a pre-CGC meetings with the lead from the CGC, the ADON and the quality and patient safety manager.

The hospital's information patient management system (iPMS) supported the identification and appropriate management of patients with multi-drug resistant organism screening (MDROs) by alerting staff to patients who were previously inpatients with MDROs. All patients were screened for CPE on admission. Selected patients were screened for *Methicillin-Resistant Staphylococcus Aureus* (MRSA) who had a previous history of MRSA and were transferred from other hospitals, nursing homes or transferred out to step-down and rehabilitations units on the Cavan Monaghan campus. Patients transferred from tertiary centres were also screened for *Vancomycin-Resistant Enterococcus* (VRE). Staff in the wards visited reported that the infection prevention and control nurses (IPCNs) visited the wards and the emergency department daily and were very supportive. Staff had access to a clinical microbiologist advice 24/7. The IPCNs visited Monaghan Hospital each week. Patients with communicable infection diseases were risk assessed, prioritised and isolated according to the hospital's standard operating procedure for the prioritisation of single rooms for patients who presented with infection prevention and control risks.

To date, in 2024, Cavan General Hospital had COVID-19 outbreaks in three wards and an influenza A outbreak in one ward. Monaghan Hospital had COVID-19 outbreaks in three wards. Multidisciplinary outbreak teams were convened to advise and oversee the management of these outbreaks and implement control measures that aligned with best practice standards and guidance. Inspectors reviewed three outbreak reports (January-February 2024) and these reports outlined the outbreak control measures implemented including audits completed in relation to hand hygiene, personal protective equipment and environmental audits with compliance rates over 90%. There was also a record of antimicrobial usage, where applicable. There was evidence that actions were identified and a named person identified to follow up on these actions. However, there was no record of lessons learned from the infection outbreaks in the reports, but there was evidence in the minutes of the clinical governance meetings view by inspectors that outbreak management control measures were discussed. Hospital management also reported to inspectors that lessons learned from outbreaks were shared at IPCSC meetings which the clinical leads and service managers were members. The IPCSC, QSEC, CGCs, and the RCSI Hospital Group all had oversight of the management of infection outbreaks.

A limited clinical pharmacy service was provided in the hospital due to limited resources. High risk medication were reviewed by a clinical pharmacist. Inspectors were told that a daily pharmacy service was provided to Surgical 1 and Medical 1, but not all clinical areas had access to a regular clinical pharmacy service. There was no designated clinical pharmacist assigned to the emergency department due to statutory leave, but staff had access to the antimicrobial clinical pharmacist who attended the Medicine Services Clinical Governance Committee, the Surgical Services Clinical Governance Committee and the

Emergency Services Clinical Governance Committee meetings. The chief pharmacist also attended the Medicine Services Clinical Governance Committee meetings. There was a very limited clinical pharmacist service in Monaghan Hospital, but staff could access clinical pharmacist advice via the telephone when the clinical pharmacist was not available on the ward. In addition, a pharmacy technician visited the wards to monitor medication stock levels.

Medication reconciliation was completed on admission for patients on high risk medicines and patients on multiple drugs when requested by a doctor or nurse. Inspectors observed the use of risk reduction strategies to support the safe use of medicines in relation to anticoagulants, insulin and opioids. The hospital had a sound-alike-look-alike drug (SALAD) list and a list of high-risk medications. Prescribing guidelines, including antimicrobial guidelines were available and accessible to staff on the hospital intranet and on a medical knowledge management application for mobile telephones.

The hospital had implemented an electronic INEWS. Staff in the ward areas visited reported that the system worked well and a clinical engineer was available to address technical issues when they arose. Training on the electronic INEW system was also provided to staff. The IMEWS observation chart was used for pregnant women and for women post miscarriage admitted to Surgical 1. Staff in Monaghan Hospital were using the most recent version of the INEWS observation chart.

During core working hours, if a patient's condition deteriorated in Monaghan Hospital, the onsite medical registrar and the SHO were informed. During out of hours, if a patient's condition deteriorated, staff communicated with the medical registrar on call in Cavan General Hospital using the Identify, Situation, Background, Assessment, Recommendation/Read Back/ Risk ($ISBAR_{3)}$[******] communication tool and if required, the patient was transferred to the emergency department in Cavan General Hospital using Protocol 37.[††††††] The ISBAR communication template was not formally used for shift handover. Inspectors viewed the healthcare record of nine patients and noted that the ISBAR sticker was used when escalating concerns about a triggering early warning system to the medical team and a treatment plan was in place. There was evidence that multidisciplinary team clinical handover meetings occurred and consultants from all specialities attended these meeting with the ANP for critical care outreach.

The hospital's policies, procedures and guidelines were approved by the appropriate CGCs. The hospital had a range of local infection prevention and control, medication safety policies, procedures, protocols and guidelines. The hospital also had a range of

[******] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

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

national policies, procedures, protocols and guidelines related to the clinical deteriorating of patients.

The hospital had management arrangements in place to monitor issues that impacted on the effective and safe transitions of care and patient flow. The bed managers met with consultants weekly to discuss patients in hospital for more than 10 days. In addition, there were two multidisciplinary team meetings per week to review patient's length of stay, delayed patient discharges and patient's expected date of discharge. Despite the systems in place to support patient flow and early discharge, there was a greater demand for inpatient beds relative to the hospital's bed capacity.

Over the duration of the two day inspection, the emergency department was in black escalation. On the first day of the inspection at 11.00am, there were 49 patients (admitted and non-admitted) in the emergency department and 12 (24.4%) of these patients were admitted patients awaiting an in-patient bed. Overcrowding in the emergency department caused by the extra trolleys throughout the emergency department posed a significant risk to the delivery of safe, quality care for patients and staff. On day two of inspection, many of the admitted patients into the emergency department were moved to inpatient wards, this indicated to inspectors that the patient flow pathways from the emergency department, which included the AMAU, ASAU and the transit lounge were functioning as well as they could be. However, the hospital would benefit from additional surge capacity beds to reduce the number of admitted patient waiting in the emergency department.

On arrival to the emergency department, all attendees were triaged and prioritised in line with the Manchester Triage System.[‡‡‡‡‡‡] The average waiting time in emergency department:

- for registration to triage was 22 minutes, which was slightly outside the 15 minutes recommended by the HSE's emergency medicine programme
- for triage to medical assessment was 20 minutes
- for medical assessment to decision to admit was 4 hours 52 minutes
- from decision to admit to an inpatient bed was 2 hours 56 minutes.

A number of hospital admission avoidance pathways and other measures were used to support efficient patient flow in the hospital. These included:

- The Local Injuries Unit in Monaghan Hospital

[‡‡‡‡‡‡] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

- The AMAU and ASAU pathways in the emergency department in Cavan General Hospital
- Frailty Intervention Therapy Team (FITT) pathway
- Maternity pathway
- Hip fracture pathway
- Deep vein thrombosis pathway and the Stroke pathway
- Orthopaedic patient pathway to Our Lady of Lourdes Hospital, Drogheda or Connolly Hospital, Blanchardstown
- Neurosurgery, ophthalmology and ear, nose and throat (ENT) patient pathways to Beaumont Hospital
- Community Intervention Team (CIT)
- Access to transitional care beds in Lisdarn Unit and Monaghan Hospital.
- Trauma Inter-hospital Referral Process.§§§§§§

The hospital's AMAU and ASAU were functioning as intended on the day of inspection with 30 patients reviewed daily in AMAU and the ASAU could see up to 10 to 15 patients a day in line with its inclusion and exclusion criteria. Activity in the AMAU and ASAU was monitored at the Emergency Services Clinical Governance Committee meetings. The hospital had a transit lounge with 12 recliner chairs. Patients were transferred directly from AMAU or from emergency department to the transit lounge and reviewed there by either a medical or surgical consultant. Patients who had their tests and investigations completed were discharged home or admitted to an inpatient bed in Medical 3 (short stay ward), if needed. The transit lounge opened from 07.30am to 6pm. The hospital had a policy which defined the criteria for patients admitted to the transit lounge.

Data on the hospital's emergency department PETs collected at 11.00am on the first day of inspection, showed that the hospital was compliant with four of the six HSE's targets and non-compliant with two. At 11.00am:

- 15% (7) of 49 patients were in the emergency department for more than six hours following registration, this was in line with HSE's target of 70%.
- 9% (4) of 49 patients were waiting in the emergency department for more than nine hours of registration, this was in line with HSE's target of 85%.

§§§§§§ Trauma Inter-hospital Referral Process§§§§§§ (1800-TRAUMA / 1800-872-862) is a centralised referral system for inter-hospital major trauma referrals operated through the National Trauma Desk of the National Emergency Operations Centre (NEOC) of the National Ambulance Service.

- None of the patients were in the emergency department greater than 24 hours of registration.
- 30% (15) of 49 patients aged 75 years were waiting in the emergency department greater than six hours of registration, this was not in line with HSE's target of 95%.
- 20% (9) of 49 patients aged 75 years were in the emergency department greater than nine hours of registration, this was not in line with HSE's target of 99%.
- None of the 49 patients aged 75 years were waiting in the emergency department greater than 24 hours of registration, this was in line with HSE's target of 99%.

The percentage of patients who left the emergency department before completion of care in 2023 and year to date in 2024 was 0.4%. Inspectors were told at interview that consultants in emergency medicine reviewed the notes of all patients who came through the emergency department in Cavan Hospital for the previous 24. In addition, x-rays were reviewed within 24hours by a consultant radiologist for patients who attended LIU.

Overall, it was evident that the hospital had systems in place to proactively identify and manage immediate and potential risk of harm to people using the service. However,

- the hospital was non-compliant with two of the six HSE's target on emergency department PETs for patients aged 75 years who were waiting in the emergency department greater than six hours and nine hours of registration.

Judgment: Substantially compliant

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

Cavan Monaghan Hospital had a patient-safety incident management system in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Governance oversight of patient safety incidents was provided by the SMT, QSEC, CGCs, and the RCSI Hospital Group. A monthly quality and patient safety analysis report was submitted to the SMT, QSEC and presented at the RCSI Hospital group monthly performance meetings. The quality and safety analysis report provided information on the number of serious reportable events and serious incidents, incident trend analysis, compliance with complaints KPIs, incident reviews in progress, staff complaints training compliance rates, open disclosure metrics, the implementation of recommendations from reviews and the hospital's risk register. A quality and patient safety report was also presented at the each CGCs meetings by the ADON or by a staff member from the quality and safety department.

The hospital used electronic point of entry reporting[*******] and the CNM 2s had oversight of all clinical incidents reported. These incidents were escalated to the CNM 3s and the ADONs for review before being sent to the quality and patient safety manager. Staff who spoke with the inspectors were knowledgeable about how to report and manage a patient-safety incident, and were aware of the most common patient-safety incidents reported — pressure ulcers and medication errors. Feedback on learnings from patient-safety incidents was provided by CNMs to staff at safety pause meetings and staff could describe quality improvements initiatives implemented after patient-safety incidents reviews. The ADONs were responsible for implementing the recommendations arising from a patient safety incident in the ward areas they had responsibility for.

Patient-safety incidents were tracked and trended. Medication safety incidents were tracked and trended and reviewed as part of an incident analysis summary report at CGCs quarterly meetings. In addition, the number of medication safety incidents reported on the National Incident Management System (NIMS)[†††††††] was reviewed at each CGC and monitored at QSEC meetings. Inspectors were told that the majority of medication incidents were reported by clinical pharmacists and nurses. Infection prevention and control incidents rates were tracked and trended and monitored quarterly at CGCs meetings, two monthly at the QSEC meetings and at the RCSI Hospital Group monthly performance meetings.

On the day of inspection, inspectors were told at interview that patient-safety incidents in relation to the deteriorating patient were monitored as part of care management incidents at QSEC meetings and tracked in the hospital's quality and patient safety performance report. Inspectors were provided with examples of incidents related to transitions of care.

The QSEC and SIMF were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Patient-safety incident reporting to NIMS was timely and in line with national targets.

Overall, the hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents.

Judgment: Compliant

[*******] Electronic point of entry reporting is where frontline staff enter incidents directly onto the. National Incident Management System eliminating the need for

[†††††††] NIMS is a confidential highly secure web-based IT system that links hospitals and other health social care enterprises to a core database.

Conclusion

HIQA carried out an unannounced inspection of Cavan and Monaghan Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Health*.

Capacity and Capability

Cavan Monaghan Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. On the day of inspection, there was evidence of strong corporate and clinical leadership at the hospital. Inspectors found that clinical governance oversight of the quality and safety of the service was more robust following the review of the QSEC structures since the last inspection. Hospital management had introduced a range of performance metrics which the nine clinical governance committees including the specialist committees reported on quarterly to the QSEC to provide assurance on the quality and safety of the service. There was also evidence of strong governance oversight of the implementation of quality improvement initiatives and recommendations from reviews to ensure the quality and safety of the service.

Over the two days of inspection, it was clear to inspectors that the hospital's senior management team were responsive and reactive, and had good operational grip on issues that impacted patient flow and effective discharge planning. Inspectors found that the hospital was in black escalation and patients were accommodated on trolleys in the emergency department. Despite this, there was evidence that patients were accessing in-patient beds in the hospital through the patient flow arrangements in place linked to an increased patient discharge rates. There was no delayed transfer of patient care at the time of inspection and the average length of stay for medical and surgical patients was compliant with HSE targets. Collectively, these indicated that patient flow arrangements were effective. This findings is consistent with the findings from the last inspection.

Staff attendance and uptake of essential and mandatory training was good, but there were gaps for some of the medical staff with regard to infection prevention and control training. The hospital's absenteeism rates requires continuous monitoring, review and auctioning to come into alignment with the national target.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. People who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff describing them as kind, friendly and helpful. While 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, the confidentiality, privacy and dignity

of patients in the emergency department was comprised. In addition, patient information was observed not to be protected in three of the wards visited, which was consistent with findings from the last inspection.

The hospital's physical environment did for the most part adequately support the delivery of high-quality, safe, reliable care to protect people using the service. However, the physical environment in the emergency department had no shower facilities and toilet facilities were limited. Physical distancing of one meter was not maintained between trolleys on corridors in the emergency department.

The healthcare services and care provided in Cavan Monaghan Hospital were systematically monitored and evaluated and there was evidence that hospital management acted on opportunities to continually improve the quality and safety of services. The hospital was monitoring compliance with the national guidance on clinical handover and had implemented quality improvement initiatives in relation to multidisciplinary team clinical handover. However, inspectors found that quality improvement plans had yet to be implemented in response to INEWS audit findings (2024) in two of the clinical areas visited. There was evidence that a quality improvement plan was developed and actions were was being implemented following a self-assessment analysis on compliance with the early warning systems recommendations.

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents and manage immediate and potential risk of harm to people using the service. Notwithstanding this, overcrowding in the emergency department posed a significant risk to the delivery of safe, quality care and was an infection prevention and control risk for patients and staff. The hospital was complaint with four and non-compliant with two of the six HSE's target on emergency department PETs.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with improvements of the physical environment in the emergency department at the hospital.

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

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

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

Capacity and Capability Dimension	
Overall Governance	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	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.	Compliant
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially 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.	Compliant

Quality and Safety Dimension	
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan

Service Provider's Response

National Standard	Judgment
Standard 1.6 Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Outline how you are going to improve compliance with this national standard. This should clearly outline: (a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards. (b) where applicable, long-term plans requiring investment to come into compliance with the national standard Please see Compliance Plan below.	
Timescale:	

Compliance Plan

Item 1 **"The emergency department was overcrowded, which impacted patient's privacy and dignity"** (p18)

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

Actions	**Timescale**
Staff will continue to utilise rooms in the outpatient's department for carrying out clinical assessments.	Ongoing

(b) Long-term plans

Actions	**Timescale**
Capital finance secured for our new ED department which will include enhanced patient facilities and space. Currently awaiting planning permission.	2027

Item 2 **"Patients in the emergency department had no access to shower facilities"** (p18)

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

Actions	**Timescale**
Patients will continue to be supported to use the shower facilities in Medical 2 as necessary	Ongoing

(b) Long-term plans

Actions	**Timescale**

Capital finance secured for our new ED department which will include enhanced patient facilities and space. Currently awaiting planning permission.	2027

Item 3 "Patient information was observed not to be protected in wards visited" (p18)

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

Actions	**Timescale**
Hospital trolleys are closed and lockable and a new lockable trolleys will continue to be phased in throughout the hospital. Admin staff to undertake a shake test and measure the chart size to ensure integrity and compliance of record size. Admin staff to undertake reconciliation of charts each morning and evening.	Q1 2025 Completed October 2024 and ongoing Completed October 2024 and ongoing
GDPR campaign will include chart compliance and Data Protection at ward level	Q1 2025
Practice development have piloted new whiteboards that include a panel to hide patient identifiers which will be erected in all adult in-patient wards	Q2 2025

(b) Long-term plans N/A