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:	Naas General Hospital
Address of healthcare service:	Craddockstown Road Naas Co. Kildare W91 AE76
Type of inspection:	Announced
Date of inspection:	22 and 23 November 2022
Healthcare Service ID:	OSV-0001080
Fieldwork ID:	NS_0012

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Naas General Hospital is a Model 3* public acute hospital. It is a member of and is managed by the Dublin Midlands Hospital Group (DMHG)† on behalf of the Health Service Executive (HSE). Services provided by the hospital include:

- acute medical inpatient services
- elective surgery
- emergency care
- high-dependency care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	189 inpatient beds 18 day case beds
Number of inpatients on day one of inspection	189

How we inspect

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

To prepare for this inspection, healthcare inspectors‡ reviewed relevant information about the hospital. This included any previous inspection findings, information

* A Model 3 hospital admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine, and critical care.
† The Dublin Midlands Hospital Group comprises seven hospitals — Naas General Hospital, St James's Hospital, the Coombe Hospital, Midland Regional Hospital Tullamore, Midland Regional Hospital Portlaoise, St Luke's Radiation Oncology Network and Tallaght University Hospital. The hospital group's academic partner is Trinity College Dublin (TCD).
‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.

submitted by the hospital and unsolicited information[§] and other publically available information.

During the inspection, inspectors:

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

A summary of the findings and a description of how the hospital performed in relation to the national standards assessed during the inspection are presented in the following sections under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors at a particular point in time - before, during and following the on-site inspection at the hospital.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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.

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 November 2022	9.00 – 17.45hrs	Danielle Bracken	Lead
23 November 2022	9.00 – 15.30hrs	Denise Lawler	Support
		Geraldine Ryan	Support
		Aoife Healy	Support

Background to this inspection

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

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

The inspection team visited three clinical areas:

- Emergency department
- Allen ward (mixed surgical and medical ward)
- Curragh ward (general medical ward)

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

- Representatives of the hospital's Senior Management team:
  - General Manager
  - Director of Nursing (DON)
  - Clinical Director
  - Quality Risk and Patient Safety Manager
- Lead Representatives for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager and Medical Manpower Manager, Naas General Hospital
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Medication Safety
  - Deteriorating Patient
  - Unscheduled 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

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 service.

What people who use the emergency department told inspectors and what inspectors observed

Inspectors visited the emergency department and Acute Medical Assessment Unit on the first day of the inspection. The hospital's emergency department is open 24/7 providing undifferentiated care for adults over the age of 16 years with acute and urgent illness or injuries. The majority of the hospital's overall activity from unscheduled care is through the emergency department. The emergency department provides emergency care to a population of over a quarter of a million people in the catchment area of Kildare and West-Wicklow. On the days of inspection, major trauma and fractured neck of femur bypass protocols[§§] were in place at the hospital. Therefore, patients who may present with major trauma, multiple serious injuries and or suspected fractured neck of femur were taken to Tallaght University Hospital, Dublin.

The emergency department had a total planned capacity of 21 bays, comprising:

- eight self-contained cubicles
- two-bedded resuscitation area
- six-bedded observation unit
- two treatment rooms
- three self-contained negative pressure cubicles used for isolation streaming.

The emergency department also had a minor injury unit comprising three treatment bays staffed by two Advanced Nurse Practitioners[***] and an Advanced Nurse Practitioner candidate. An Advanced Nurse Practitioner also provided care in the department's Rapid Access and Treatment (RAT) area.

[§§] Major trauma bypass protocol is used for major trauma and or multiple serious injuries that could result in significant physical harm or death. These may include serious head, chest, abdominal and skeletal injuries sustained as a result of an accident, sports injury or violent act.

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

In addition, two follow-up clinics - a registrar clinic[†††] and a general clinic[‡‡‡] - were held in the emergency department each day, where up to 13 patients were reviewed by a non-consultant hospital doctor (NCHD) at registrar grade and or consultant in emergency medicine. These 13 patients were in addition to the daily emergency department attendances. The medical staffing for these two clinics were from the existing medical staff complement in the emergency department - three whole-time equivalent (WTE) consultants in emergency medicine - 2.5 WTE appointed on a permanent basis and 0.5 WTE on a locum basis and eight NCHDs at registrar grade.

On the first day of inspection, the emergency department was very busy, relative to its intended capacity, with 26 additional patients accommodated on trolleys throughout the department, including on the main access corridor. Hospital management told inspectors that they had implemented the full capacity protocol[§§§] on both days of inspection, in response to the volume of attendances to the emergency department and limited surge capacity within the hospital.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available to staff in the emergency department. Hand hygiene signage was clearly displayed throughout the department. Staff were observed wearing appropriate personal protective equipment (PPE), in line with public health guidelines at the time of inspection.

On the day of inspection, inspectors spoke with a number of patients in the emergency department to ascertain their experiences of receiving care in the department. Patients were complimentary of the staff and reported how staff were '*chatty*', '*very kind*, *they couldn't do enough for you*', '*lovely, but very busy*' and were *'doing their best.'* Patients were complimentary about the meals provided. One patient who spoke with inspectors described how they could not sleep with the bright lights and noise in the department, and how they could not attend to their own personal hygiene because there was no shower facilities. Some patients were frustrated and upset about the waiting times for some diagnostic tests. Some patients were unhappy with the lengthy waiting times for results of investigations and tests carried out. Other patients felt they were not adequately informed about their plan of care and said they '*would like more information*'.

[†††] Patients who presented to the hospital's emergency department and were discharged following review and treatment, but needed a follow-up review within 24 hours of discharge were reviewed by a registrar in the registrar clinic.

[‡‡‡] Patients who presented to the hospital's emergency department and were discharged following review and treatment, but needed a follow-up review within 10 days of discharge were reviewed by a registrar and or consultant in emergency medicine in the general clinic.

[§§§] Full capacity protocol is the final step in hospitals' escalation plans where extra beds are placed in inpatient wards and corridors of hospitals as a measure to address emergency department overcrowding.

The experiences recounted by patients in the emergency department during inspection were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey,[****] where in relation to:

- getting answers to important questions from doctors and nurses in the emergency department — the hospital scored 7.9, which was consistent with the national score of 7.9
- waiting time before being admitted to a ward — the hospital scored 6.3, which was marginally lower than the national score of 6.8.

Patients in the emergency department who spoke with inspectors said they would speak with staff if they wanted to make a complaint. Patients who spoke with inspectors did not get information leaflets about the HSE's complaints process *'Your Service, Your Say'*. Inspectors did not observe information on *'Your Service, Your Say'* on display in the emergency department on the first day of inspection. This is something hospital management should fix following this inspection.

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

Allen ward was a 31-bedded ward consisting of four six-bedded multi-occupancy rooms, one three-bedded multi-occupancy room and four single rooms. The single rooms all had en-suite bathroom facilities. The ward had adequate toilet and bathroom facilities for patient use. The ward was a mixed-gender and mixed-specialty ward with surgical and medical patients. At the time of inspection, 28 of the 31 beds were occupied.

Curragh ward was a 31-bedded ward consisting of four six-bedded multi-occupancy rooms, one three-bedded multi-occupancy room and four single rooms. The single rooms all had en-suite bathroom facilities. The ward had adequate toilet and bathroom facilities for patient use. The ward was a mixed-gender, general medical ward. At the time of inspection, 31 beds were occupied.

Inspectors observed good communication between staff and patients in both inpatient clinical areas visited. Inspectors also observed how interactions between staff and patients were very kind, respectful, reassuring and not rushed. This was confirmed by patients who described staff in the clinical areas visited as *'so kind' and caring.'* Inspectors were told that the patients felt that they could *'speak and ask questions at any time.'* Inspectors observed and staff demonstrated how the privacy and dignity of

[****] The National Care Experience Programme, is a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

patients was promoted and protected by staff when providing care in the two inpatient clinical areas visited.

Inspectors observed suggestion boxes for patient feedback in both inpatient clinical areas visited during inspection. When patients were asked if they knew how to make a complaint they said they would talk to staff.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 85% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, which was slightly above the national average of 82%.

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

Capacity and Capability Dimension

Inspection findings from the wider hospital and two inpatient clinical areas visited related to the capacity and capability dimension are presented under three national standards (5.2, 5.5 and 5.8) from the theme of leadership, governance and management. Key inspection findings leading to these judgments are described in the following sections.

Inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standard (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. Key inspection findings leading to these judgments 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.

The hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Organisational charts submitted to HIQA detailed the direct reporting and accountability arrangements of the various governance and oversight committees to hospital management, and hospital management's reporting arrangements through the Chief Operations Officer to the Chief Executive Officer of the Dublin Midlands Hospital Group. These reporting arrangements were consistent with what inspectors found during inspection and as described by senior management during inspection.

The hospital was governed and managed by the general manager who was accountable and reported to the Chief Operations Officer of the Dublin Midlands Hospital Group, who in turn reported to the Chief Executive Officer of the group.

The hospital's Clinical Director provided clinical oversight and leadership at the hospital. The Clinical Director, who was a member of the hospital's senior management team was accountable and reported to the hospital's general manager, and had a working relationship with the Dublin Midlands Hospital Group's Clinical Director.

The hospital's Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital. The DON, who was a member of the hospital's senior management team, reported to the hospital's general manager and had a working relationship with the Dublin Midlands Hospital Group's Director of Nursing and Midwifery.

Senior Management Team

Naas General Hospital's Senior Management Team was the main corporate governance structure at the hospital. HIQA met with representatives of this team during inspection. The team comprised the general manager, clinical director, DON, operations manager, quality risk and patient safety manager and other senior managers. The team, chaired by the hospital's general manager, met weekly in line with their terms of reference and was assigned with the responsibility for ensuring the delivery of high-quality safe healthcare at the hospital. The team had oversight of the hospital's performance with quality and safety indicators and of actions implemented to improve the quality and safety of healthcare services.

Minutes of meetings of the Senior Management Team, submitted to HIQA, showed that the items reviewed and discussed at meetings were mainly operational with a focus on day to day issues. There was evidence of some discussions relating to strategy and development, although there appeared to be an imbalance in the time given to discuss this, this could be reviewed. There was evidence that the meetings were action-orientated, but the implementation of agreed actions were not routinely monitored from meeting to meeting.

Members of the Senior Management Team attended monthly performance meetings with the management team of the Dublin Midlands Hospital Group, where items such as quality, and patient safety, quality improvement initiatives, operational performance, workforce, and finance were discussed. There was evidence that these meetings were action-orientated, but it was unclear from the minutes of meetings between the hospital and hospital group submitted to HIQA, if the implementation of actions agreed were monitored from meeting to meeting.

Quality and Patient Safety Committee

The Quality and Patient Safety Committee was assigned with the overall responsibility for improving the quality and safety of healthcare services at the hospital. HIQA met with representatives of this committee during inspection. The Quality and Patient Safety

Committee was accountable and reported to the Senior Management Team. The Quality and Patient Safety Committee, chaired by Clinical Director, met every three months in line with its terms of reference. The committee was multidisciplinary, comprising the hospital's general manager, quality, risk and patient safety manager, DON, operations manager and chairs of the different subcommittees with a reporting relationship to the Quality and Patient Safety Committee.

The Quality and Patient Safety Committee delegated elements of its assigned responsibility and function in the areas of infection prevention and control, medication safety, antimicrobial stewardship and sepsis, deteriorating patient and complaints to a number of subcommittees. Each subcommittee had a defined and formalised accountability and reporting arrangement to the Quality and Patient Safety Committee. The subcommittees reported regularly to the Quality and Patient Safety Committee using a standardised approach. A sample of reports reviewed by HIQA showed that the committee had governance and oversight of service user feedback, the reporting and management of patient-safety incidents, the hospital's performance against set metrics, audit findings, risk management, quality improvement initiatives identified or being implemented to improve services, attendance and uptake of mandatory staff training, and updates of relevant policies, procedures, protocols and guidelines. Inspectors noted that audit results and recommendations were not always time-bound and did not always have a designated person assigned with responsibility to implement the recommendation or action.

Minutes of meetings of the Quality and Patient Safety Committee submitted to HIQA showed that committee meetings were well attended, followed a formalised structured agenda, were action-orientated and progress in implementing agreed actions was monitored from meeting to meeting.

At operational level, HIQA was satisfied that there were clear lines of accountability with devolved autonomy and decision-making for the four areas of known harm: infection prevention and control, medication safety, deteriorating patient and transitions of care.

Infection Prevention and Control Committee

Inspectors were informed that the hospital's multidisciplinary Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control practices at the hospital. HIQA met with representatives of this committee during inspection. This committee was chaired by the general manager and met every three months in line with its terms of reference. Membership of the committee included the hospital's general manager, a consultant microbiologist, DON, infection control clinical nurse specialists and managers, antimicrobial pharmacist, general services manager, representatives from the hospital's central decontamination unit, operating theatre department, quality, risk and patient safety department and public health. The Infection Prevention and Control Committee was operationally accountable and submitted a report to the Quality and Patient Safety Committee every three months.

The Infection Prevention and Control Committee comprised a number of subcommittees, which included the Environmental and Facilities Hygiene Committee, Decontamination Committee and Antimicrobial Stewardship Committee. It was clear from minutes of meetings reviewed by HIQA that these subcommittees provided the Infection Prevention and Control Committee with an update on issues in their area of responsibility.

The Infection Prevention and Control Committee had oversight of the hospital's performance in relation to infection surveillance and testing, patient isolation, infection outbreak reports, infection prevention and control related patient-safety incidents, risk management, performance with relevant infection prevention and control metrics, audit findings, quality improvement initiatives and attendance and uptake of relevant mandatory staff training.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA were comprehensive, and showed that committee meetings followed a structured agenda, were well attended and that progress in implementing agreed actions was monitored from meeting to meeting.

The hospital's infection prevention and control team were assigned with the responsibility to develop an infection prevention and control plan each year, which set out the infection prevention and control objectives and actions to be achieved at the hospital. The Infection Prevention and Control Committee monitored the progress of implementation of the plan. The infection prevention and control plan is discussed further in national standard 5.5.

Medication Safety Committee

The hospital's Drugs and Therapeutics Committee was assigned with the responsibility to assure the safe, effective and cost-effective use of medication in the hospital. The Medication Safety Committee was a subcommittee of the Drugs and Therapeutics Committee and was assigned with the responsibility for oversight of medication safety practices at the hospital. HIQA met with representatives of these committees during inspection. The Medication Safety Committee, chaired by the chief pharmacist, met every three months in line with its terms of reference. Membership of the committee included the chief pharmacist, medication safety pharmacist, clinical pharmacists and representatives from nurse practice development, NCHDs and the quality, risk and patient safety department. The committee had oversight of medication related patient-safety incidents, service user feedback, medication related risks on the risk register, staff education and training on medication safety practices, medication related audit findings and quality improvement initiatives, and medication policies, procedures, protocols and guidelines.

The Medication Safety Committee was operationally accountable to the Drugs and Therapeutics Committee and also reported to the Quality and Patient Safety Committee every three months. The committee reported on medication safety incidents, medication

related staff education and quality improvement initiatives at meetings every three months of the Drugs and Therapeutics Committee.

The Medication Safety Committee developed and had oversight of the implementation of the hospital's medication safety plan. The 2022 medication safety plan submitted to HIQA identified the key areas of focus and the medication audits to be carried out that year. Although progress against this plan was not formally tracked, minutes of meetings of the Medication Safety Committee submitted to HIQA provided evidence of progress in implementing the key areas identified in the plan. The medication safety plan is discussed further in national standard 5.5.

Representatives from the Medication Safety Committee told inspectors that the Antimicrobial Stewardship Committee provided information on the antimicrobial usage at the hospital at each meeting of the Drugs and Therapeutics Committee and the Infection Prevention and Control Committee. Minutes of meetings of both of these committees submitted to HIQA confirmed this.

The Deteriorating Patient Committee

In 2022, the hospital's Early Warning Score and Sepsis Committees combined to form the Deteriorating Patient Committee. HIQA met with representatives of this committee during inspection. The Deteriorating Patient Committee was co-chaired by the hospital's Clinical Director and Early Warning System Coordinator. The committee met every three months in line with its terms of reference. Membership of the committee included consultant medical, surgical, anaesthetic and microbiology representatives, nursing representatives, resuscitation officer, infection prevention and control team, nurse practice development, quality, risk and patient safety manager. Committee minutes of meetings submitted to HIQA were comprehensive and showed that the committee meetings were well attended, were action-orientated and the progress of implementing actions was monitored from meeting to meeting. The Deteriorating Patient Committee reported to the Quality and Patient Safety Committee every three months.

The hospital had a deteriorating patient improvement programme and the Deteriorating Patient Committee had oversight of the implementation of this programme. The committee also had oversight of the implementation of the national Early Warning Systems — Irish National Early Warning System (INEWS),[††††] Irish Maternity Early Warning System (IMEWS),[‡‡‡‡] sepsis guidelines, risks relating to the clinically deteriorating

[††††] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. 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.

[‡‡‡‡] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

patient, staff education and training on the deteriorating patient, quality improvement initiatives and policies, procedures, protocols and guidelines relating to the recognition and response to the deteriorating patient.

The Deteriorating Patient Committee had a subcommittee, the Maternal Death Review Subcommittee, which monitored the progress of implementation of the recommendations following a review of a patient-safety incident related to a maternal death. This subcommittee provided updates on the progress of implementation of the review recommendations to the Deteriorating Patient Committee.

Unscheduled Care Committee

The hospital did not have a bed management committee, or a specific committee designated to oversee the safe transitions of care, however oversight of unscheduled care activities and issues contributing to delayed discharges at the hospital were monitored at meetings of the Unscheduled Care Committee. HIQA met with representatives of this committee during inspection. The Unscheduled Care Committee, co-chaired by the hospital's Operations Manager and the Unscheduled Care Manager, met every three months, in line with its terms of reference and reported to and was accountable to the Senior Management Team. Membership of the committee included the hospital's general manager, clinical director, DON, assistant director of nursing (ADON) for patient flow, clinical representatives from the emergency department, senior medical social worker and radiology manager.

Minutes of meetings of the Unscheduled Care Committee submitted to HIQA showed that the committee had oversight of issues and initiatives to improve patient flow throughout the hospital, which included attendances to the hospital's emergency department, inpatient bed capacity at the hospital, patient discharges and transfers into and out of the hospital and access to diagnostic services. On the days of inspection there was evidence that proposed measures approved by the Unscheduled Care Committee were being implemented to improve patient flow in the hospital's emergency department. These measures included using the outpatient department to accommodate patients in the emergency department that are admitted and awaiting an inpatient bed, and the reintroduction of daily safety huddles[§§§§] in the emergency department.

Complaints Governance Committee

The hospital had a Complaints Governance Committee, which usually met monthly. HIQA met with representatives of this committee during inspection. Chaired by the hospital's general manager, committee membership included the clinical director, DON, quality, risk and patient safety manager and the quality and patient experience manager. The

§§§§ Safety Huddles are meetings for staff to highlight any current patient safety issues in their clinical area. These meetings can be multidisciplinary, usually taking place at the same time each day and discussing set topics. They allow staff in a clinical area to be proactive in addressing any safety challenges that might occur in everyday practice. This includes the discussion of vulnerable patients and patients at risk of acute clinical deterioration.

committee had oversight of service user feedback, number and type of complaints received, reviews of complaints, staff education and training on service user feedback, and quality improvements introduced to improve service user experience. Minutes of meetings reviewed by inspectors showed that assigned actions were being progressed from meeting to meeting. The committee reported and was accountable to the Quality and Patient Safety Committee. This committee reported on service user feedback and improvements carried out to improve service user experience every year.

Clinical Governance Committee

From a clinical governance perspective, the hospital had a Medical Board in place that liaised directly with the hospital's general manager. A clinical directorate structure was not in place, at the hospital. However, there were identified clinical leads for medicine, including emergency medicine, surgery, radiology, anaesthesiology and stroke who provided clinical leadership and were responsible for the organisation and management of their specialty. The clinical leads were members of a newly formed Clinical Governance Committee, which reported to and was accountable to the hospital's general manager. At the time of inspection, the hospital were in the process of reviewing and updating the reporting arrangements to the Quality and Patient Safety Committee the Clinical Governance Committee. A draft organisational chart submitted to HIQA detailing the revised committee reporting relationships showed that the Unscheduled Care Committee, Drugs and Therapeutics Committee, Clinical Handover Committee and various clinically led working and user groups would report to and be accountable to the Clinical Governance Committee.

It was clear to HIQA that the hospital had defined corporate governance arrangements in place. More defined clinical governance arrangements were being established at the time of inspection. The Senior Management Team were focused on operational day-to-day issues, which had the potential to impact on strategic planning and development of the hospital the team could benefit from having more time on meeting agendas to discuss strategy and planning. The Quality and Patient Safety Committee had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital. Inspectors noted from a review of meeting minutes that the committees reporting in to the Quality and Patient Safety Committee appeared to be effective and functioning well, however documented actions were not always time-bound and did not always have a designated person assigned with responsibility to implement recommendations and actions, and this was an area that could be improved.

Judgment: Substantially compliant

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

Findings relating to the emergency department

On the days of inspection, there were defined lines of responsibility and accountability at the hospital with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. The hospital's Unscheduled Care Committee had oversight of the operational processes in the hospital's emergency department including those that impact on patient flow through the department and surge capacity in the hospital. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the consultant lead in emergency medicine.

The emergency department was the only point of entry into the hospital for patients requiring unscheduled or emergency care. Attendees to the hospital's emergency department can present by ambulance, are referred directly by their general practitioner (GP) or self-refer. On the first day of the inspection, the majority of attendees (36%) to the department arrived via the national ambulance service, 24% were self-referrals and 30% were GP or KDOC[*****] referrals.

The overall attendance rate to the hospital's emergency department in 2021 was 22,476, which represents a 25% decrease on attendances in 2019 (the last full year before the pandemic), and a 14% decrease on attendances to the department in 2020. The attendance rate to the emergency department at Naas General Hospital was lower when compared to other model 3 hospitals,[†††††] with the difference in attendance rate ranging between 3,265 and 24,972 attendees.

Naas General Hospital's emergency department's attendance rate in 2021 equated to an average monthly rate of 1,873 attendees or 62 attendees daily. In 2021, the admission rate from the department to an inpatient bed (conversion rate) was 26%, which indicates that the majority (74%) of patients completed their episode of care in the department. This conversion rate is comparable to other model 3 hospitals inspected by HIQA as part of the current programme of monitoring.

There were 47 patients in the department at 11am. The emergency department was overcrowded and patients experienced lengthy waiting times to be triaged, medically reviewed and assessed, and while waiting for an inpatient bed. Twenty-one of the 47 patients (45%) were admitted and awaiting an inpatient bed. Eight of the 21 admitted

[*****] Established in 2001, KDOC was formed by a group of local GPs in county Kildare to provide an out of hours service for patients with urgent medical needs and whose family doctor is part of the KDOC service.

[†††††] Other hospitals used as comparisons include: Midland Regional Hospital Tullamore, Midland Regional Hospital Portlaoise, Regional Hospital Mullingar, St Luke's General Hospital, Kilkenny, Cavan General Hospital, Mayo University Hospital, Portiuncula University Hospital, Sligo University Hospital, Tipperary University Hospital and University Hospital Kerry.

patients were accommodated on trolleys on the corridor. Spacing between these trolleys was not one metre, as per the national guidance on COVID-19 at the time of inspection, and this posed a cross-infection risk.

On arrival to the emergency department, all attendees were assessed for signs and symptoms of COVID-19 at triage and streamed to the appropriate care pathway. At the time of inspection the longest waiting time for triage was one hour and forty minutes. National guidance sets out that all patients must be promptly assessed for COVID-19 risk on arrival at a healthcare setting. Inspectors raised concerns about the potential patient safety risk of assessing for signs and symptoms of COVID-19 at triage with hospital management on the first day of inspection. After inspection, a high-risk letter was issued in relation to this concern to hospital management. In their response to HIQA, hospital management confirmed that the practice of promptly screening patients for COVID-19 on arrival to the hospital and the streaming of confirmed or suspected cases of COVID-19 to an isolation area would be carried out as per the national guidance on COVID-19.

All attendees to the emergency department were triaged and assigned to the relevant prioritisation category levels 1-5 in line with the Manchester Triage System.[‡‡‡‡‡] On the first day of inspection, after registering, patients waited on average 18 minutes to be triaged, which was marginally longer than the 15 minutes for triage recommended by the HSE's emergency medicine programme. The majority (26) of patients were prioritised as orange category (priority level 2, review within 10 minutes, very urgent cases). Ten patients were prioritised as yellow category (priority level 3, review within 30 minutes, less urgent cases). Staff could view the status of all patients in the emergency department including their prioritisation category levels and waiting times via the hospital's electronic operating system.

The overcrowding in the hospital's emergency department was further compounded by the ineffective patient flow through the department and insufficient surge capacity in the hospital, which contributed to the boarding of 21 patients in the department. The hospital's formalised escalation plan was enacted on both days of inspection to support the effective day-to-day operational functioning of the emergency department and increase inpatient bed capacity in the hospital.

Like other hospitals inspected by HIQA as part of its current monitoring activity, Naas General Hospital was experiencing difficulty in sourcing suitable residential and rehabilitation care in the community, which contributed to the delay in transferring patients needing that care and support. On the first day of inspection, all 189 inpatient hospital beds were open. However, on that day there were 11 delayed transfers of care from the hospital. Year to date in 2022, the hospital's average length of stay for medical patients was 7.4 days, which was in excess of the HSE's target of seven days or less. The

[‡‡‡‡‡] 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.

hospital's average length of stay for surgical patients was 6.1 days, which was also longer than the HSE's target of 5.2 days or less.

Collectively, the mismatch between availability and demand for inpatient beds, as evident from the findings on the first day of inspection, impacted the flow of patients through the hospital's emergency department and contributed to the boarding of admitted patients in the department. This in turn impacted on patient experience times.[§§§§§] At 11am on the first day of inspection, the patient waiting time for:

- registration to triage ranged from one minute to one hour 38 minutes. The average waiting time was 18 minutes
- triage to medical review ranged from seven minutes to 12 hours. The average waiting time was 3.5 hours
- decision to admit to actual admission in an inpatient bed ranged from six hours to 56 hours.

The waiting times from triage to medical review and from decision to admit to admission in an inpatient bed was tracked and trended by the Unscheduled Care Committee.

A number of hospital admission avoidance pathways and other measures to improve surge capacity and patient flow through the emergency department were in place at the time of inspection. These included:

- Community Intervention Team pathway — a nurse led team, supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home
- Frailty Intervention Team pathway — an interdisciplinary consultant-led team that assess and provide intervention to patients over 75 presenting to the emergency department with frailty
- Integrated Care Programme for Older Persons[******] pathway — this is a national initiative that integrates primary and secondary care services for older people, especially those with more complex needs. In this pathway, care is provided by a multidisciplinary team under the clinical governance of a consultant geriatrician.
- Outpatient Parenteral Antimicrobial Therapy — suitable patients on intravenous antibiotics can be discharged early from hospital and treated in their community setting by a team of specialist nurses

[§§§§§] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

[******] Health Service Executive. *Integrated Care Programme for Older Persons*. Dublin, Health Service Executive. 2022. Available online from: https://www.hse.ie/eng/about/who/cspd/icp/older-persons/

- Chronic Obstructive Pulmonary Disease outreach team comprising a clinical nurse specialist[††††††]
- An Advanced Nurse Practitioner in cardiology who works within a multidisciplinary team providing care for patients who may present to the emergency department with non-acute chest pain
- Carrying out additional ward rounding Monday to Friday by medical consultant staff to identify patients for discharge and or issues impacting on discharge
- Using the SAFER[‡‡‡‡‡‡] patient flow bundle in all clinical areas.

Notwithstanding this, other systems and processes to manage the demand in activity and to support and facilitate the continuous, effective patient flow through the emergency department were not functioning as they should be on the first day of inspection. The hospital's Acute Medical Assessment Unit was not functioning as an alternate flow pathway for patients in order to take pressure from the emergency department. On the day of inspection, all of the patients in AMAU had come from the emergency department.

Findings relating to the wider hospital and two inpatient clinical areas visited

The hospital had management arrangements in place in relation to the four areas of harm for the wider hospital and two inpatient clinical areas visited on the days of inspection and these are discussed in more detail below.

Infection prevention and control

The hospital had an infection prevention and control team comprising:

- 1.33 WTE[§§§§§§] consultant microbiologists — 0.83 WTE consultant microbiologist position was filled permanently and was a joint appointment with Tallaght University Hospital. The consultant microbiologist was onsite in Naas General Hospital once a week. Hospital management were progressing with a recruitment campaign to fill the remaining 0.5 WTE consultant microbiologist position. Clinical staff had access to a consultant microbiologist 24/7.

[††††††] A clinical nurse specialist is a registered nurse that is engaged in specialist practice – a particular area of focus. The clinical nurse specialist works as part of the multidisciplinary team providing specialist care to patients in hospital, community and outpatient settings.
[‡‡‡‡‡‡] The SAFER patient flow bundle is a practical tool comprising five elements to reduce delays for patients in adult inpatient wards (excluding maternity). S-Senior Review - all patients have a senior review by a consultant or by a registrar enabled to make management and discharge decisions. A-All patients have a predicted discharge date. F-Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. E-Early discharge - patients discharged from inpatient wards early in the day. R–Review - a systematic multidisciplinary team review of patients with extended lengths of stay.
[§§§§§§] Whole-time equivalent (WTE) - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

- one WTE ADON with responsibility for infection prevention and control. Hospital management were progressing the recruitment campaign to fill this position at the time of inspection.
- 1.6 WTE clinical nurse specialist and clinical nurse manager (CNM)
- 0.83 WTE staff nurse
- one WTE surveillance scientist.

Hospital management were planning to develop a business case to increase the number of clinical nurse specialists in infection prevention and control by 0.5 WTE. Staff who spoke with inspectors in the clinical areas visited felt very well supported by the infection prevention and control team.

The hospital did not have an overarching infection prevention and control programme[*******] as per national standards.[†††††††] However, the infection prevention and control team were assigned with the responsibility to develop the hospital's annual infection prevention and control plan, which sets out the objectives to be achieved in relation to infection prevention and control every year. Plans reviewed by inspectors for 2021 and 2022 were very comprehensive. In 2022, this plan focused on the surveillance and reporting of transmissible infections and multidrug resistant organisms, antimicrobial stewardship, staff education, patient isolation and management of infection outbreaks, guidelines, the auditing of infection prevention and control practices, which included compliance with hand hygiene practices and the implementation of quality improvement projects to improve infection prevention and control practices. It was clear from minutes of meetings of the Infection Prevention and Control Committee reviewed by inspectors that the progress in implementing this plan was reviewed by the committee.

Antimicrobial stewardship

The hospital had an antimicrobial stewardship team who formed part of the infection prevention and control team and were responsible for implementing the hospital's antimicrobial stewardship programme.[‡‡‡‡‡‡‡] The team comprised of the consultant microbiologists, one WTE antimicrobial pharmacist (acting) and one WTE antimicrobial pharmacy technician, which was a new post and the first of its kind to be approved by the HSE. The antimicrobial pharmacy technician collected and reported on antimicrobial

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

[†††††††] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

[‡‡‡‡‡‡‡] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

surveillance and the hospital's performance with antimicrobial stewardship indicators. These updates included information on findings from the National Point Prevalence Study on antibiotic use in the hospital, audits findings on restricted antibiotic usage and monitoring of antimicrobial spend. Quality improvement initiatives introduced to improve antimicrobial stewardship practices at the hospital included increasing awareness and education of best practice for NCHDs to ensure compliance with national guidance on sepsis and antimicrobial use, and a 'time to switch' antibiotics project which focused on the timely switching of intravenous use antibiotics to oral use antibiotics when needed- which was evidenced in clinical areas inspected.

Medication safety

The hospital had a clinical pharmacy service,§§§§§§§ which was led by the hospital's chief pharmacist. The hospital had:

- 16 WTE pharmacists, which included a chief pharmacist, medication safety pharmacist and three clinical pharmacists. At the time of inspection 13.5 WTE pharmacist positions were filled and 2.5 WTE senior pharmacist positions were unfilled.
- nine WTE pharmacy technicians. At the time of inspection, eight WTE pharmacy technician positions were filled and one WTE was unfilled.

There was a comprehensive clinical pharmacy service in the hospital. There was a clinical pharmacist-led medication reconciliation service in clinical areas visited for all new patients and those transferred into the hospital. Inspectors met with a clinical pharmacist in one clinical area visited who confirmed that medication reconciliation occurred on all new patients.

The 2022 medication safety plan submitted to HIQA identified the key areas of focus and the medication audits to be carried out that year. Areas of focus included implementing safety strategies with respect to high-risk medicines, reviewing patient-safety incident reports to identify trends and implementing an audit schedule. There was evidence of progress in relation to these key areas of focus in minutes of the Medication Safety Committee meetings reviewed by inspectors. However, this progress was not being formally tracked, actions were not always time-bound and did not always have a designated person assigned with responsibility to implement the recommendation or action.

Deteriorating patient

The hospital had one WTE Early Warning System (EWS) Coordinator who supported and educated staff in recognising and responding to patients that were clinically deteriorating. There was a specific system in place at the hospital to alert medical staff when a patient's

§§§§§§§ 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.

early warning system was triggering and needed medical review. The hospital had implemented the INEWS and IMEWS version 2 guidelines and observation charts at time of inspection. This is discussed further in national standard 3.1.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge.

The hospital had:

- one WTE unscheduled care manager
- one WTE ADON for patient flow
- one WTE patient flow coordinator
- one CNM – community intervention team and outpatient parenteral antimicrobial therapy (OPAT)********
- one WTE bed manager
- three WTE discharge planners.

The above staff met at daily patient flow huddles, along with medical social workers to discuss unscheduled care activity, bed management, discharge planning and red and green bed days.†††††††† The hospital had formed links with community services as evidenced through the appointment of a CNM for the Community Intervention Team and Outpatient Parenteral Antimicrobial Therapy (OPAT) service. Hospital managers told inspectors that an Integrated Care Manager had been recruited and was due to commence employment at the hospital shortly. This person would be responsible for facilitating the effective collaboration and integration of hospital and community services. As shown in the hospital's operational plan, the hospital had regular meetings with GPs and public health nurses in the hospital's catchment area. The hospital and Community Health Organisation 7 (CHO 7) had developed and were implementing a joint operational winter plan, with progress in implementing the plan reviewed and discussed at weekly meetings between the hospital and CHO 7. Representatives who met with inspectors told them that these arrangements were working well.

Nursing, medical and support staff workforce arrangements

The human resource department was responsible for workforce management in the hospital. The hospital's human resources manager and medical manpower manager were operationally accountable and reported to the hospital's general manager.

******** Outpatient Parenteral Antimicrobial Therapy OPAT allows suitable patients on intravenous (IV) antibiotics to be discharged early from hospital and treated in their home or community setting by a team of specialist nurses.

†††††††† 'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey.

The hospital's approved complement of nursing staffing was 338.82 WTE. At the time of inspection, 325.72 WTE nursing positions were filled, which represented a variance of 13.1 WTEs (4%) between the approved and actual nursing complement.

The hospital's total approved posts for health and social care professionals was 126.67 WTEs with 33.5 WTE positions unfilled at the time of inspection, which represented a variance of 26%.

The hospital had an approved complement of 28.5 WTE medical consultant staff. At the time of inspection, 30.9 WTE medical consultant positions were filled, above the approved complement of medical consultant staff — 23.5 WTE positions were filled on a permanent basis and 7.4 WTE positions were filled on a locum basis. Of the permanent consultants, two were not on the specialist register with the Irish Medical Council and the hospital had implemented measures, in line with the HSE requirements to support these consultants.

The medical consultant staff were supported by an approved complement of 81 WTE NCHDs at registrar, senior house officer and intern grade. At the time of inspection, 87.8 WTE NCHDs positions were filled, above the approved complement of medical consultant staff — the majority (78 WTE) of these positions were filled on a permanent basis with 9.8 WTE positions filled on a locum or agency basis. The emergency department in particular relied on agency and locum staff to fill consultant and NCHD positions. At the time of inspection, hospital management were actively recruiting to fill these positions.

The hospital reported on staff absenteeism monthly. The staff absenteeism rate for 2021 was 7.9%, which was above the HSE target of 3.5% for that year. Supports in place for staff included promotion of and access to the Employee Assistance Programme. Staff who spoke with inspectors were aware of this programme. Information on health and wellbeing was also shared via the hospital's newsletter *Hospital Link Naas General Hospital*.

Staff training and education

Nursing and healthcare assistant staff attendance at mandatory and essential training was monitored at clinical area level by CNMs. Essential and mandatory training attendance by non-consultant doctors (NCHDs) was recorded on the National Employment Record (NER) system.[‡‡‡‡‡‡‡‡] A greater level of governance and oversight of staff uptake of mandatory and essential training is needed by the senior management team.

Uptake of training for nursing staff and healthcare assistants for hand hygiene was above the HSE target of 90%, uptake of infection prevention and control training was high in these groups. From the information provided to HIQA, uptake by NCHDs of infection prevention and control training, including hand hygiene training required improvement.

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

Medication safety training uptake for nursing staff was good. Uptake of medication safety training for NCHDs was not submitted to HIQA. From information provided to HIQA, uptake of training for INEWS and IMEWS was very high for nursing staff, exceeding the HSE target of 85%, but required improvement for NCHDs. To address this, targeted education was carried out at the hospital to increase INEWS and IMEWS training compliance rates for NCHDs.

In summary, the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the emergency department, wider hospital and clinical areas visited on the day of inspection. However, HIQA was not assured that these arrangements were effective in addressing the issues found in the emergency department on the first day of inspection. There was evidence that hospital management had implemented a range of measures to improve the flow of patents through the emergency department and to increase inpatient bed capacity in the hospital. However, on the day of inspection the emergency department was overcrowded and was not functioning as effectively as it should be, and had issues with patient flow and capacity, which collectively posed a patient safety risk and was a concern to HIQA. While attendance and uptake of mandatory and essential training was recorded at local clinical area level, a greater level of oversight of staff uptake of mandatory and essential training, particularly in relation to NCHDs is needed by the senior management team. Hospital management acknowledged that the recording of the uptake of mandatory and essential training for medical staff could be improved and were working on introducing measures to improve this, which included having a designated resource in the human resources department.

Judgment: Partially compliant

Other inspection findings relating to the Emergency Department

The following section outlines findings from the inspection as they related to the emergency department. Findings and judgments are presented under three national standards (6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare* relating to the themes of: workforce; person-centred care and support; and safe care and support.

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

A senior clinical decision-maker§§§§§§§§ at consultant level was on site in the emergency department each day, with availability on a 24/7 basis. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

The emergency department had three WTE consultants in emergency medicine — 2.5 WTE appointed on a permanent basis and 0.5 WTE on a locum basis. One of the three consultants in emergency medicine was the assigned clinical lead for the department who was responsible for the day-to-day functioning of the department. The consultants were operationally accountable and reported to the hospital's Clinical Director. The attendance rate to the emergency department at Naas General Hospital was lower when compared to other model 3 hospitals that have been inspected under HIQA's current monitoring programme, however it was also noted that the complement of emergency medicine consultants at Naas General Hospital was less than that of its contemporary hospitals. Reflecting the base of emergency medicine consultant resourcing but acknowledging that the configuration of emergency care at Naas General Hospital involves a bypass mechanism to larger hospitals in the region, the hospital should be assured that there is sufficient continuity and contingency in resourcing for the emergency service at Naas General Hospital.

The hospital is an approved training site for NCHDs on the basic specialist training in emergency medicine. Consultants in the emergency department were supported by 11 NCHDs at registrar and senior house officer grades providing 24/7 medical cover in the department — eight registrars and three senior house officers. Three (27%) of the 11 NCHDs positions at registrar grade were unfilled at the time of inspection. Hospital management were managing the deficit in NCHDs through the use of agency staff, which is not sustainable in the long-term.

The emergency department's approved nursing staff (including clinical nurse managers grade one (CNMs 1)) complement was 54.3 WTE. At the time of inspection, the department's actual complement of nursing staff was 51.76 WTE — 2.54 WTE were on approved statutory leave. This represented a variance of 5% WTE between the approved and actual nursing staff complement. Hospital management were managing the deficit in nursing staff levels through an ongoing recruitment campaign and the use of agency nurses, which is not sustainable in the long-term. The CNM 3 had overall nursing responsibility for the emergency department and was rostered on duty Monday – Friday during core working hours. A CNM2 was rostered on each shift (day and night).

§§§§§§§§ 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.

Through the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*, launched by the Minister of Health in June 2022,[*********] the hospital had recently received approval to increase the nursing staff complement in the emergency department by 11.5 WTE nurses. Hospital management were working to progress the recruitment campaign to fill these new positions at the time of inspection. Other members of the multidisciplinary team in the emergency department included:

- an infection prevention and control nurse
- a clinical pharmacist
- one clinical skills facilitator
- a GP liaison nurse
- a clinical nurse specialist assigned to the Frailty Intervention Team
- three Advanced Nurse Practitioners and one Advanced Nurse Practitioner candidate.

It was clear from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The CNM3 and clinical skills facilitator assigned to the emergency department had oversight of the uptake of mandatory and essential training related to the four areas of harm. The attendance and up take of mandatory and essential training was recorded on a central database and the DON had oversight of this. Training records provided to HIQA for nursing staff in the emergency department showed that there was a good level of uptake for infection prevention and control, medication safety, basic life support, triage and early warning systems training. Healthcare assistants had good uptake of training that applied to them such as infection prevention and control and basic life support training. Records of the uptake of mandatory training for medical staff in the emergency department were not submitted to HIQA.

Nursing staff in the emergency department were supported to undertake postgraduate education related to emergency care. At the time of inspection, a number of nurses were completing postgraduate educational programmes of study in the following areas:

- three nurses were undertaking a postgraduate graduate certificate in specialist nursing - emergency department
- six nurses were undertaking a postgraduate certificate in emergency nursing.

Overall, HIQA found that hospital management were planning, organising and managing their complement of nursing staff in the emergency department to support the provision

[*********] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

of a 24/7 service. The hospital was reliant on agency staff to maintain the medical roster, but this is not a sustainable solution for long term planning. In addition, when compared to other model 3 hospitals inspected under HIQA's current monitoring programme, the hospital should be assured that there is sufficient continuity and contingency in resourcing for medical staff for the emergency service at Naas General Hospital.

Judgment: Partially compliant

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[†††††††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs. Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department. Staff were also observed actively engaging and communicating with patients in a respectful, kind and sensitive way.

Privacy and dignity in the emergency department was supported and generally maintained for patients accommodated in single cubicles. This was confirmed by patients accommodated in single cubicles on the first day of inspection and was consistent with the hospital's findings from the 2022 National Inpatient Experience Survey, where with regard to being treated with respect and dignity while in the emergency department, the hospital scored 8.9, above the national score of 8.7.

Notwithstanding this, during the inspection, inspectors observed the difficulty caused by the overcrowding and trolley congestion in the emergency department. It was clear that the privacy, dignity and confidentiality of patients accommodated on trolleys in the corridor and multi-occupancy areas was severely compromised. For these patients on the corridor, clinical consultations and assessment were carried out in that area. Therefore, it was impossible to maintain the patient's privacy and confidentiality. Others (patients, visitors and staff) could overhear patient-clinician conversations and the exchange of personal information between patients, medical and nursing staff. This was not consistent with the human rights-based approach to healthcare promoted and supported by HIQA, but was consistent with the 2022 National Inpatient Experience Survey, where with

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

regard to privacy when being examined or treated in the emergency department, the hospital scored 8.0, which was marginally below the national score of 8.1.

HIQA acknowledges that initiatives that have been introduced at the hospital to reduce or avoid hospital admission for people attending the emergency department, as described under national standard 5.5, but at the time of inspection, there was limited evidence of innovative person-centred initiatives to improve the patient experience times for older persons attending the department, which is significant considering that approximately 23.4% of attendees to the department the week before HIQA's inspection were over 75 years old.

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 in the emergency department, and this is consistent with the human rights-based approach to care supported promoted by HIQA. Notwithstanding this, the environment and situation in the emergency department on the first day of inspection, significantly impacted on the meaningful promotion of the patient's human rights. HIQA did not find sufficient evidence that actions taken at the hospital were effective in respecting, promoting and protecting the dignity, privacy and autonomy of patients receiving care in the department, especially those accommodated on trolleys in the corridors and multi-occupancy areas. In addition, there was limited evidence of innovative dedicated pathways for older persons attending the emergency department, which is significant given the increasing ageing population in the hospital's catchment area.

Judgment: Non-compliant

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

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the emergency department, in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, patient experience times in the emergency department, delayed transfers of care and average length of stay for medical and surgical patients. Collated performance data and compliance with relevant national key performance indicators was reviewed at meetings of relevant hospital governance and oversight committees — Unscheduled Care Committee, Executive Management Team and at performance meetings with the Dublin Midlands Hospital Group.

Performance data on the patient experience time collected on the first day of inspection, showed that at 1.30pm, the hospital was not compliant with any of the national key

performance indicators on patient experience times set by the HSE. At that time, 56 patients were in the emergency department, of them:

- 26 (46%) patients were in the emergency department for more than six hours after registration — not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 23 (41%) patients were in the emergency department for more than nine hours after registration — not in with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- Seven (13%) patients were in the emergency department for more than 24 hours after registration — not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- Nine (16%) attendees to the emergency department were aged 75 years and over. Only one (11%) of these patients were admitted or discharged within nine hours of registration — significantly short of the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.
- 78% of attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration — short of the national target that 99% of patients aged 75 years and over are discharged or admitted to a hospital bed within 24 hours of registration.

Similar to other emergency departments inspected by HIQA, the hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In 2021, just over a quarter (27%) of ambulances that attended the hospital's emergency department had a time interval of 30 minutes or less, which suggests that ineffective patient flow in the emergency department affects the timely offload of patients arriving to the department via the national ambulance service. Year to date, in 2022, less than a quarter (22%) of ambulances that attended the department had an interval of 30 minutes or less.

Risk management

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at department level with oversight of the process assigned to the CNM 3 and ADON for the emergency department. Risks were recorded on the hospital's corporate risk register.

At the time of inspection, five risks related to the emergency department were recorded on the hospital's corporate risk register — risk of transmission of COVID-19, deterioration of a paediatric patient, deterioration of a pregnant and or postnatal woman, non-consultant doctor staffing and non-compliance of patient experience times. All five risks

were risk-rated high — four were risk-rated red and one risk was risk-rated orange. Actions and controls to manage and minimise the identified risks were clearly set out in the relevant risk assessment forms. The Senior Management Team had oversight of how effective the actions and controls implemented to reduce risks to patient safety.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. Attendees were screened for signs and symptoms of COVID-19 at triage and assigned to the appropriate pathway, which was not in line with national guidance on COVID-19 at time of inspection. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single cubicles with input and oversight from the infection prevention and control team. A nurse from the infection prevention and control team visited the emergency department daily during core working hours and the department had access to a microbiologist 24/7. Patients were also screened for Carbapenemase-producing *Enterobacterales* (CPE) in line with national guidance at the time of inspection. Inspectors were told that CPE screening was not being carried out on all who required it as per national guidance, in the main, due to issues with staff resourcing. However, in the most recent audit of the practice of CPE screening in the department carried out in October 2022, 82% of patients requiring screening were screened on admission. There were plans in place to regularly audit the practice of CPE screening until full compliance with the national guidance is achieved.

Staff confirmed that terminal cleaning[‡‡‡‡‡‡‡‡‡] was carried out following suspected or confirmed cases of COVID-19. The emergency department was generally observed to be clean and well maintained on the first day of inspection. Environmental and equipment hygiene audits were carried out in the department monthly. Action plans were developed to improve any areas of non-compliance. This is discussed further in national standard 2.8.

Medication safety

A clinical pharmacist provided a service to the emergency department when required. Medication reconciliation was carried out by the clinical pharmacist and NCHDs on patient admission. Staff in the department had access to an antimicrobial pharmacist.

Deteriorating patient

The emergency medicine early warning system was not used in the emergency department. The hospital was using the appropriate national early warning systems for the various cohorts of patients — the INEWS for adults (non-pregnant) and IMEWS for pregnancy and postnatal women. Training on the early warning system for staff in the

[‡‡‡‡‡‡‡‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

emergency department was facilitated by the clinical skills facilitator and EWS coordinator every week.

Compliance with the use and completion of the INEWS and IMEWS observation charts, and escalation protocols was audited in the department by the hospital's EWS coordinator. Action plans were developed to improve any areas of non-compliance. The EWS coordinator provided feedback on compliance with INEWS and IMEWS guidance which was shared with the CNM 3 and staff. There was a plan to implement the Emergency Medicine Early Warning System, but inspectors were told the exact date of implementation and roll out of the system was dependent on getting additional nurse staffing in the department. The ISBAR communication tool was used when requesting patient reviews. However, compliance with national guidance on ISBAR was not audited in the department. Compliance with national guidance on sepsis management in the department was audited every six months and findings from the recent audit in July/August 2022 indicated some non-compliance with the correct documentation of the sepsis from and antimicrobial use. An action plan, which included increasing staff education and awareness about antibiotic guidelines, was developed to address the areas of non-compliance with sepsis management.

The IMEWS observation chart was used for pregnant and postnatal women that present to the emergency department. However, the hospital do not have a consultant obstetrician and gynaecologist on staff and only had a very small number of nurses with up-to-date midwifery experience and expertise. In addition, the inability to monitor fetal wellbeing in pregnant women was a high-rated risk recorded on the hospital's corporate risk register. In the previous years before HIQA's inspection, 25-29 pregnant or postnatal women presented to the hospital's emergency department and were admitted to an inpatient bed. Controls and actions were in place to mitigate the potential risk to the safety of pregnant and postnatal women and to monitor fetal wellbeing during pregnancy. However, HIQA was concerned that there were insufficient resources in the hospital, including expert, experienced medical and nursing staff to provide timely and appropriate care for pregnant and postnatal women and to adequately monitor fetal wellbeing during pregnancy on occasions when women were admitted to Naas General Hospital. This concern was discussed with hospital management during inspection. After the inspection a high risk letter was issued to hospital management seeking assurances on the measures implemented to mitigate associated risks to pregnant and postnatal women that may present for care was sought following inspection. In correspondence to HIQA, hospital management confirmed to that they had implemented formal arrangements to ensure that pregnant women who may present to the emergency department at Naas General Hospital would receive appropriate care in the most suitable setting. If needed, pregnant women who present to the hospital's emergency department will be transferred to the Coombe Hospital or the maternity unit at the Midlands Regional Hospital Portlaoise for appropriate monitoring and assessment. Other measures were also being explored but these needed to be agreed and formalised.

A multidisciplinary safety huddle was held in the emergency department each day at 12pm where issues such as activity levels, staffing and the status of patients in the department were discussed.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers to and from the emergency department. Nursing clinical handover occurred at shift changeover (8am and 8pm).

Management of patient-safety incidents and serious reportable events

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported in line with the HSE's incident management framework. The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents that occurred in the emergency department. Patient-safety incidents and serious reportable events related to the department were tracked and trended by the quality, risk and patient safety department. Feedback on emerging trends and themes was provided by the hospital's clinical risk manager to the CNM 3 and assistant director of nursing for the emergency department. The feedback was shared with staff at the daily multidisciplinary safety huddle.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally by nurse management with oversight from the CNM 3, in accordance with the hospital's complaints policy and the HSE's '*Your Service You Say*'. Complaints relating to the emergency department were tracked and trended by the patient experience manager who was the hospital's assigned complaints officer. The complaints officer met with the CNM 3 and consultant lead of the emergency department weekly to discuss provided feedback on complaints. Information from tracking and trending of complaints was shared with staff in the department via a number of mechanisms — education newsletter, internal hospital email, communication board and communication book.[§§§§§§§§§]

The number of patients boarding in the department on the first day of inspection was symptomatic of ineffective patient flow and limited surge capacity. This impacted on the waiting times for patients where a decision to admit had been made. Considering the increase in morbidity and mortality associated with prolonged waiting times in the emergency department, this was a concern for HIQA. Hospital management need to introduce sustainable improvements to protect patients receiving care in the department from harm and hospital management need to be supported to do this from hospital group and national HSE levels. HIQA was concerned that there were insufficient relevant

[§§§§§§§§§] Communication book – refers to a book kept at local level where new information and updates that needed to be shared with staff was recorded.

experienced medical and nursing staff to provide timely and appropriate care for pregnant or postnatal women and to adequately monitor fetal wellbeing during pregnancy. Hospital management must ensure relevant systems and processes are in place to support the provision of effective maternity care for pregnant and or postnatal women that may present to the hospital, including staff with the necessary experience and expertise.

Judgment: Non-compliant

Inspection findings relating to the wider hospital and two inpatient clinical areas visited

This section of the report describes findings relating to the wider hospital and two inpatient clinical areas visited during the inspection. It sets out the judgments against selected national standards from the themes of leadership, governance and management (5.8), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3).

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report. Data related to emergency department attendances and patient experience times, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents and workforce was reviewed at meetings of the Unscheduled Care Committee, Quality and Patient Safety Committee, Senior Management Team and performance meetings between the hospital and hospital group.

The senior management team carried out leadership quality and safety walk-rounds throughout the hospital. Senior managers who spoke with inspectors stated that the purpose of the walk-rounds were to discuss the quality and safety of the services with staff in the clinical areas visited and told inspectors that there was a prompt sheet for these walk-rounds. This prompt sheet was reviewed by inspectors and topics of discussion included what was working well in the clinical area, challenges and risks in the clinical area that required the support of the senior management team, progress in implementing actions identified during previous walk-rounds, audit findings for the specific clinical area,

quality improvement initiatives implemented or in progress in the clinical areas, patient-safety incidents, patient experience and staff experience.

Risk management

The hospital had risk management structures and processes in place to proactively identify, analyse, manage and minimise risks in clinical areas. Documentation submitted to HIQA showed the risks, corrective actions and controls to mitigate the risks relating to the four key areas of known harm were recorded on the hospital's corporate risk register. There was evidence that the hospital's corporate risk register is reviewed six monthly by the Senior Management Team. Risk was a standing item on the agenda of monthly performance meetings between the hospital and hospital group. The management of risks related to the four areas of known harm is discussed further in national standard 3.1.

Audit activity

The hospital did not have a clinical audit committee that had oversight of all clinical audit activity and or the implementation of quality improvement plans arising from audit findings across the hospital. However, inspectors noted that audit activity in relation to the four areas of known harm was overseen by the relevant governance committee, specifically:

- infection prevention and control audits were overseen by the Infection Prevention and Control Committee
- medication safety audits were overseen by the Medication Safety Committee
- audits in relation to Identify, Situation, Background, Assessment and Recommendation (ISBAR)********** communication tool and clinical handover, were overseen by the Deteriorating Patient Committee.

Audit findings were reported to the Quality and Patient Safety Committee three monthly.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents that 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 SIMT, chaired by the hospital's general manager, met every month. Serious incidents and serious reportable events were also discussed at performance meetings with the hospital group every month. The SIMT overview report for 2021 submitted to HIQA comprehensively set out

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

the recommendations made from each serious incident or serious reportable event review completed that year, and the progress made in implementing the review recommendations.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events relating to the clinical areas visited were reported to the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. The hospital's quality risk and patient safety manager tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the Quality and Patient Safety Committee. Inspectors reviewed several of these reports. Incidents were rated by severity, category and location. Details on patient-safety incidents were reported to relevant governance committees with a reporting arrangement to the Quality and Patient Safety Committee every three months. The chairs of these committees were assigned with responsibility to implement recommendations from patient-safety incident reviews. Patient-safety incidents were also discussed at performance meetings with the hospital group every month. The quality risk and patient safety manager stated that feedback on patient-safety incidents was also provided to CNMs during leadership quality and safety walk-rounds. Patient-safety incidents related to the four areas of harm are discussed further in national standard 3.3.

Feedback from people using the service

The hospital had a Complaints Governance Committee that met monthly to review and discuss findings from the National Inpatient Experience Survey, service user feedback report, service user feedback training and quality improvements to improve healthcare services at the hospital. Hospital management had introduced three quality improvement plans in response to feedback from the National Inpatient Experience Survey 2021. These were:

- improving patient education and communication on antibiotic treatment
- improving patient information at discharge
- improving the effectiveness of leadership quality and safety walk-rounds.

Progress with these plans were reviewed by the Quality and Patient Safety Committee.

The number, type of and category of complaints and improvements introduced at the hospital to improve patients' experiences of receiving care were tracked, trended and published yearly in the hospital's Service User Feedback Report. These improvements included:

- a multi-task attendant at reception to assist the public, one example of this was getting blood samples to the laboratory
- vending machines for the emergency department waiting room

- communication training using the ASSIST[††††††††††] model.

Representatives who met with inspectors also recalled how signage had been introduced to help people find their way in the hospital during construction works.

In summary, HIQA was assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital. Performance against key performance indicators in the four areas of harm was monitored and there was evidence that information from this process was being used to improve the quality and safety of healthcare services and patients' experiences of receiving care at the hospital. Quality improvement initiatives were implemented in response to audit findings, patient-safety incidents and feedback from people using the service.

Judgment: Compliant

Quality and Safety Dimension

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

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

Inspectors observed how staff in the clinical areas visited promoted a person-centred approach to care and were respectful, kind and caring towards patients. Staff were observed explaining aspects of care and providing reassurance to patients when they asked questions. Nursing staff were also observed promoting patient independence.

The physical environment in the clinical areas visited generally promoted the privacy, dignity and confidentiality of patients receiving care. For example, privacy curtains were used in all multi-occupancy rooms when care was provided, and one of the clinical areas visited had a room dedicated for use by families whose relatives were receiving end of life care.

[††††††††††] The ASSIST model of communication promoted by the HSE encourages effective communication with patients and families in a structured way after an adverse event, which can include a patient-safety incident, concern or complaint. A-Acknowledge and Assess, S-Sorry, S-Story and Share, I-Inquire and Information, S-Supports and Solutions, T-travel.

These findings were consistent with the overall findings from the 2022 National Inpatient Experience Survey, where with regard to:

- privacy in the clinical area, the hospital scored 8.3, marginally lower than the national average – 8.6.

During the inspection, inspectors observed how storage of patients' healthcare records was an issue and how patient's personal information, was not always protected appropriately in one of the clinical areas visited. Whiteboards were used to display relevant clinical information and had a folding piece to conceal patient names. However, on one clinical area visited this folding piece was not closed and patient's personal identifiable information were clearly visible. This was brought to the attention of the clinical nurse manager and immediately addressed.

Patient's healthcare records were stored in lockable trolleys located beside the nurses' station in the clinical areas visited, but these cabinets were not locked at the time of inspection. This was brought to the attention of hospital management on the day of inspection.

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. Healthcare records should be managed and stored in line with national standards.

Judgment: Substantially compliant

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

The clinical areas visited by inspectors were very busy, despite this, inspectors observed staff taking the time to speak with patients. Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. Staff were observed answering patient's questions and explaining their plan of care. Patients who spoke with inspectors also felt they could ask staff questions about their care and treatment. Information leaflets were also displayed in the inpatient clinical areas visited and these provided information and advice about healthcare-acquired infection and discharge planning for example.

In one of the clinical areas visited, inspectors noted that new nursing staff were provided with an information pack during their induction to the hospital, which contained the hospital's mission statement. The hospital's mission statement set out the hospital management and staff's commitment to ensuring the delivery of person centred care. It set out ways staff could achieve this, such as introducing themselves by name to patients

and listening, supporting and educating patients and their families throughout the person's hospital stay.

The findings from the 2022 National Inpatient Experience Survey would suggest that elements of the mission statement were being implemented. For example, in relation to the question on whether or not staff introduced themselves when treating and examining the patient, the hospital's score was in line with the national average of 8.7.

Evidence of a strong culture of kindness, consideration and respect could be seen in how hospital management engaged with and responded to feedback from people who use the services. Several improvements were implemented at the hospital to improve the experiences of patients. As described in national standard 5.8 this included communication training. Staff received training on the ASSIST model of communication to support them when communicating with patients and families. Inspectors observed posters outlining the steps of the ASSIST model displayed in the inpatient clinical areas visited. Hospital management also introduced the 'Sending Love' initiative during the COVID-19 pandemic whereby families could e-mail a message to the hospital's quality, risk and patient safety department who subsequently together with the nurse liaison service ensured patients received the messages from their families.

The hospital's newsletter, '*Hospital Link, Naas General Hospital'* showcased the initiatives introduced at the hospital and the commitment of staff to improve healthcare services, and contribute to positive patient experiences.

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.

There were systems and processes in place at the hospital to respond to complaints and concerns. The Complaints Governance Committee had oversight of the effectiveness of the hospital's complaints management process. The quality and patient experience manager was the hospital's designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of complaints resolution at local level in the clinical areas visited. The CNM stated they managed informal complaints about their area of responsibility and assisted the quality and patient experience manager to resolve formal complaints received about their clinical area. Staff who spoke with inspectors confirmed they used the ASSIST model of communication in the resolution of informal complaints. Inspectors were informed and staff confirmed that feedback on complaints and learning from the complaint resolution were shared at shift handover and at safety pauses.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*.'[‡‡‡‡‡‡‡‡‡‡] Inspectors observed information about '*Your Service Your Say*' displayed in the clinical areas visited and other public areas in the hospital. Staff who spoke with inspectors were aware of the '*Your Service Your Say*' complaints process. Inspectors observed suggestion boxes for use by patients to provide feedback on their experiences of receiving care in both inpatient areas visited. Patients who spoke with inspectors said they would talk to staff if they wanted to make a complaint.

The hospital formally reported on the number and type of complaints, verbal and written, received annually. The HSE's 'Your Service Your Say' annual feedback report showed that of the 106 formal complaints received by the hospital in 2021 (excluding withdrawn or anonymous complaints), 100% of formal complaints were acknowledged within five working days and 91 (86%) of them were resolved within 30 working days, exceeding the national HSE target of 75% for investigating complaints.

Verbal and written complaints were tracked and trended by the hospital's quality, risk and patient safety department, to identify the emerging themes, categories and departments involved. Themes from complaints received in 2021 included communication and information, safe and effective care and access. Collated data on the hospital's compliance with national guidance and standards on complaint management was submitted monthly to the Complaints Governance Committee and the Quality and Patient Safety Committee every three months.

Although quality improvement plans to address the themes identified through complaints were not in the format of assigned, time-bound action plans, there was evidence that the hospital had introduced some quality improvement initiatives and learning notices were shared to promote these initiatives amongst staff. For example, inspectors observed learning notices related to the importance of protecting patient's property. At the time of inspection, at least 150 staff had completed the Effective Complaints Handling module on HSeLanD. The hospital held two service user feedback engagement days in 2021 and in 2022.

Staff in one of the clinical areas inspected that were the subject of a complaint received feedback from their line management. Staff who provided input into the formal complaint resolution process received feedback from the quality, risk and patient safety department. Complaints were also discussed with staff in clinical areas during the leadership quality and safety walk-rounds.

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

The quality, risk and patient safety department tracked patient advocacy activities in the hospital. Representatives from the quality patient safety and risk department who spoke with inspectors stated that information leaflets on independent advocacy services, external to the hospital, was provided to patients as required and a representative from an independent advocacy service visited the hospital to promote and explain their role.

Overall, there were systems and processes in place at the hospital 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 day of inspection, inspectors visited two inpatient clinical areas and observed that overall the hospital's physical environment was secure, well maintained and clean with few exceptions. There was evidence of general wear and tear of woodwork and floor surfaces, with paint work and wood finishes chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk. CNMs who spoke with inspectors stated they were satisfied with the maintenance services and how maintenance issues were responded to promptly when requested.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Hand hygiene sinks in the clinical areas visited did not conform to national requirements.[§§§§§§§§§] Physical spacing of one metre was observed to be maintained between beds in multi-occupancy rooms.

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

Environmental cleaning and terminal cleaning was carried out by an external cleaning company. There were local policies in place for environmental and equipment cleaning. The clinical areas visited had access to cleaning resources 24/7. Cleaning supervisors and clinical nurse managers had oversight of the cleaning and daily cleaning schedules in the clinical areas visited. CNMs who spoke with inspectors stated they were satisfied with the

[§§§§§§§§§] 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

level of cleaning resources during and outside core working hours to keep the clinical areas clean and safe.

Cleaning of equipment was assigned to healthcare assistants. In the clinical areas visited, the equipment was generally observed to be clean. There was a checklist system in place to identify equipment that had been cleaned. 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. Audit results in relation to environmental and equipment hygiene are discussed in national standard 2.8.

The hospital had implemented processes to ensure appropriate placement of patients — the infection prevention and control nurse liaised with bed management on the placement of patients daily. The hospital was challenged with the limited number of single rooms in each clinical area. Documentation submitted to HIQA showed that, over a three month period (July to September of 2022), on average 35 patients a day requiring isolation facilities were not accommodated in such facilities within 24 hours of admission. To mitigate this risk patients with the same infective status were cohorted in multi-occupancy rooms and inspectors observed this on inspection. The limited number of isolation facilities was a risk recorded on the hospital's corporate risk register. At the time of inspection, a new unit was under construction comprising 12 single rooms, all with en-suite bathroom facilities and hospital management expected this unit to be fully operational in quarter two of 2023.

In summary, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. Issues identified on the days of inspection included a lack of isolation facilities and hand hygiene sinks that did not conform to national requirements – these issues had been highlighted to the hospital as areas for improvement during a previous HIQA inspection.

HIQA acknowledges that hospital management were progressing with the construction of a new 12 single room isolation facility and the refurbishment of clinical areas. These measures will help reduce the risk of infection outbreaks and support effective environmental cleaning. However, notwithstanding this, the issues identified on the days of inspection did present a potential risk to patient safety.

Judgment: Partially compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and

to the hospital group on the quality and safety of the services provided at wider hospital level. HIQA found that the hospital had monitored and reviewed information from multiple sources including: risk assessments, patient-safety incident reviews, complaints, patient experience surveys, audit findings and the hospital's performance with key performance indicators for the four areas of known harm.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices at the hospital. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Environmental audits were carried out monthly, equipment and hand hygiene audits were carried out every three months and a national hand hygiene audit was carried out yearly using a standardised approach.

Infection prevention and control audit summary reports submitted to HIQA showed that one of the inpatient clinical area visited had achieved a high level of compliance with equipment hygiene standards in February, May and August 2022 (all above 93%), but in November 2022 compliance had slipped to 75%. However, in another inpatient clinical area visited, compliance with equipment hygiene standards was an area that could be improved (audit findings ranged from 76% to 88%). Inspectors noted that recommendations or actions were not identified in completed equipment hygiene audits and or action plans developed to improve hygiene standards.

Environmental hygiene audits submitted to HIQA showed that the inpatient clinical areas visited achieved a high level of compliance ranging from 91-96% during the first six months of 2022. Quality improvements to address environmental issues viewed by inspectors were focused on refurbishment of the physical environment.

The clinical areas visited were compliant with the HSE's target of 90% for effective hand hygiene practices. There was evidence that time-bound action plans were developed when hand hygiene standards fell below acceptable levels. Audit findings and the learnings from audit activity were shared with staff in the clinical areas through the use of learning notices and information boards.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.********** The infection prevention and control team submitted a healthcare-associated infection

********** Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf

surveillance report to the Infection Prevention and Control Committee every three months. These reports were also shared with medical consultants and clinical staff.

In line with the HSE's national reporting requirements, the hospital reported on rates of:

- *Clostridioides difficile* infection
- CPE
- hospital-associated cases of *Staphylococcus aureus* blood stream infections
- hospital-associated cases of COVID-19
- staff cases of COVID-19 and outbreaks.

In 2021, the hospital's rate of hospital-associated *Clostridioides difficile* was above the HSE's target of less than 2 per 10,000 bed days. Furthermore, data from January to September of 2022 showed that the hospital had:

- 12 new cases of hospital-associated *Clostridioides difficile*
- three new cases of hospital-associated CPE
- four cases of hospital-associated *Staphylococcus* aureus blood stream infection.

HIQA was satisfied from speaking with representatives from the infection prevention and control team and a review of meeting minutes that the team were effectively managing the four cases of hospital-associated *Staphylococcus* aureus blood stream infection and the 12 new cases of *Clostridioides difficile* at individual case level. Minutes of the Infection Prevention and Control Committee reviewed by inspectors showed that a wider multidisciplinary team approach when investigating cases of hospital-acquired infection could be improved. It was evident that quality improvement initiatives where introduced following the cases of *Clostridioides difficile*, which included increasing staff awareness and education of the appropriate use of proton pump inhibitors,[††††††††††] as recommended by a review of *Clostridioides difficile* cases in 2022.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. These included participating in the HSE's national antimicrobial point prevalence study. The Infection Prevention and Control Committee had oversight of the hospital's level of compliance with antimicrobial stewardship key performance indicators, which included antimicrobial consumption, appropriateness of antibiotics, dose, route and duration and compliance with sepsis guidelines in relation to antibiotic prescribing and administration. There was evidence that quality improvement plans were developed to improve antimicrobial use at the hospital, which included targeted staff education on

†††††††††† Proton pump inhibitors are medications that reduce the production of acid by the stomach. Reduced stomach acid is a risk factor for *Clostridioides difficile* infection.

sepsis guidelines and antimicrobial guidelines provided by the infection prevention and control team and EWS Coordinator.

Medication safety monitoring

There was some evidence of monitoring and evaluation of medication safety practices at the hospital. The safe storage and custody of medicines was monitored at clinical area level. Medication safety audits were limited. There was evidence of audit carried out in the following areas:

- restricted antibiotic use
- proton pump inhibitor use
- know, check, ask approach ‡‡‡‡‡‡‡‡‡‡‡
- insulin storage and labelling.

Audit reports submitted to HIQA set out recommendations to improve medication practices at the hospital, however no time-bound action plans were developed to support the implementation of these recommendations.

Some quality improvement initiatives were introduced to improve medication safety practices at the hospital. This included an information campaign on sound-alike, look-alike drugs (SALAD)§§§§§§§§§§§ and an information leaflet on high-risk medications. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

Performance data relating to the escalation and response of the deteriorating patient was collated monthly through Test your Care metrics.********** The EWS Coordinator had oversight of the auditing of compliance with national guidance on IMEWS, INEWS and sepsis was assessed. Audit findings in relation to the INEWS escalation and response protocol from July to October of 2022, showed that the frequency of observations and documentation of evidence that a registrar or consultant reviewed a patient with an INEWS score of seven or more were two areas of practice requiring improvement.

‡‡‡‡‡‡‡‡‡‡‡ Know, check, ask, promotes the use of a three-step approach to help increase awareness of, and education the public about the importance of using medication safely.
§§§§§§§§§§§ SALADS are 'Sound-alike look-alike drugs'. The existence of similar drug and medication names is one of the most common causes of medication error and is of concern worldwide. With tens of thousands of drugs currently on the market, the potential for error due to confusing drug names is significant.
********** Test your Care metrics are a collection of nursing and midwifery care indicators and patient experience questions to monitor and improve the standards of patient care.

Inspectors saw documentary evidence of and the EWS Coordinator told inspectors that a number of quality improvement initiatives were implemented to improve compliance with national guidance on the early warning systems, these included the:

- use of a modified IMEWS observation chart for Naas General Hospital
- re-introduction of the ISBAR communication tool sticker to be used when documenting the escalation process for a deteriorating patient
- implementation of an updated adult sepsis form
- introduction of a sepsis trolley in the emergency department.

The Deteriorating Patient Committee monitored progress in implementing these quality improvements and the Quality and Safety Committee had oversight of this process.

Transitions of care monitoring

The hospital reported on the number of inpatient discharges, delayed transfers of care and new attendances to the emergency department every month as part of the HSE's reporting requirement. Performance data in relation to patient transfers and discharges was reported to and discussed at meetings of the Unscheduled Care Committee. Patient flow and hospital activity were also discussed at the daily patient flow huddle.

Compliance with national guidance on clinical handover was audited. Initiatives were planned to improve compliance with guidance on clinical handover. Documentary evidence reviewed by inspectors showed that these included involving healthcare assistants in clinical handover and introducing a structured template using the ISBAR format for weekend clinical handover by medical staff.

Overall, the hospital had systems to monitor and evaluate healthcare services provided at the hospital. Evidence of audit activity could be strengthened in the area of medication safety and clinical handover. In addition to this, HIQA noted that recommendations and actions from audit findings were not always time-bound and did not always have a designated person assigned with responsibility to implement the recommendation or action in an effort to increase compliance with national standards and guidance.

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.

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. The hospital's senior management team were assigned with the responsibility to review and manage risks that impact on the quality and safety of

healthcare services. Risks that could not be managed at hospital level were escalated to the Dublin Midlands Hospital Group.

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

- a lack of isolation rooms
- physical environment and infrastructure
- bed management demands due to COVID-19
- lack of obstetrics or gynaecology specialist services
- inappropriate or inadequate clinical handover processes.

Inspectors were satisfied from viewing the risk assessments carried out for these risks that corrective controls and that time-bound, assigned actions were implemented to mitigate the actual and possible risks to patients.

Infection prevention and control

The infection prevention and control team maintained a local risk register of identified infection risks. These risks included the risk of harm due to non-compliance with safe infection prevention practices due to a lack of staffing in the infection prevention and control team. It was clear to inspectors from review of meeting minutes that the infection prevention and control risk register was reviewed at each meeting of the Infection Prevention and Control Committee. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register.

Infection outbreak preparation and management

The hospital had a designated ward where COVID-19 positive patients were accommodated and cared for. At the time of inspection, there were a number of active infection outbreaks, these included COVID-19, *Clostridioides difficile* infection and CPE infection, Inspectors observed that these outbreaks were being well managed in clinical areas visited. In 2022, the hospital had 24 outbreaks of COVID-19. A multidisciplinary outbreak team was convened to advise and oversee the management of COVID-19 outbreaks at the hospital.

Inspectors reviewed a recent COVID-19 outbreak management report submitted to HIQA. The report was comprehensive, it outlined the control measures and actions taken to mitigate the risk to patient safety, and recommendations to reduce the risk of reoccurrence of an outbreak. Actions implemented following the outbreak included an increased presence of the infection prevention and control team in the clinical areas to support staff and ensure effective infection prevention and control practices at the hospital. However, HIQA noted that recommendations and actions from the outbreak review were not always time-bound and did not always have a designated person

assigned with responsibility to implement the recommendation or action. An Area of good practice noted by inspectors was the utilisation of the Health Protection Surveillance Centre (HPSC) checklist to support COVID-19 outbreak management and the use of a 45 item audit tool to assess infection prevention and control practices in the clinical area where the outbreak occurred. Inspectors reviewed a sample of healthcare records and there was evidence that patients' infection status was recorded on admission and discharge documentation.

Staff uptake of COVID-19 vaccination was high for doctors, nursing staff and healthcare assistants but uptake of flu vaccine for nurses and healthcare assistants was below the HSE's target of 75%, this was an area that required improvement.

Medication safety

There was a comprehensive clinical pharmacy service at the hospital. HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications, this was not in the format of 'A PINCH'. However, staff who spoke with inspectors were knowledgeable about high-risk medicines. Inspectors observed the use of risk reduction strategies to support safe medication practices in relation to anticoagulants, insulin and opioids. This included the use of a medication prescription and administration record which had a dedicated colour coded section for safe prescribing of anticoagulants. The hospital had also developed a list of sound-alike look-alike medications (SALADs). Prescribing guidelines including antimicrobial guidelines and medication information was available and accessible to staff at the point of care through an electronic document management system.

Medication reconciliation was undertaken on admission by clinical pharmacists. It was evident that clinical pharmacists were accessible to staff and visited clinical areas daily. Medication stock control was carried out by pharmacy technicians. Pharmacy technicians also reviewed patient's medication prescriptions and administration records and flagged issues for review with the clinical pharmacists. There were staffing deficits within the pharmacy team and in an effort to mitigate against this the team had looked at ways of expanding the role of pharmacy technicians and fully utilising their skillset. Notwithstanding this deficit, staff who spoke with inspectors in the clinical areas visited stated that they felt supported by clinical pharmacists and pharmacy technicians.

Deteriorating patient

The hospital had implemented the INEWS and IMEWS version 2 guidelines and observation charts. A clinical facilitator and the EWS Coordinator provided staff with training on how to recognise and respond to a patient whose clinical condition was deteriorating.

Staff who spoke with inspectors in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient. The hospital had a dedicated system to alert medical staff that a patient whose early warning system was triggering

needed medical review. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. A sample of healthcare records reviewed on inspection showed that the escalation protocol for the deteriorating patient was being followed in line with protocol. The ISBAR communication tool was used when requesting patient review.

Safe transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services, and to support safe and effective discharge planning. Safety huddles were held mid-morning and mid-afternoon in the clinical areas visited using the ISBAR communication tool format. Operational issues that could impact on patient safety and patient's care plan were discussed at the safety huddles.

Policies, procedures and guidelines

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

The hospital had a suite of up-to-date medication safety policies, procedures, protocols and guidelines, which included guidelines on prescribing and administration of medication, high alert medicines and sound alike look alike drugs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care.

The hospital had implemented the national guidance on sepsis management and had up-to-date policies for the deteriorating patient adapted from national guidance on INEWS and IMEWS. The hospital adapted the national guidance on communication and clinical handover and used a number of transfer and discharge forms to support the safe transitions of care. All policies, procedures, protocols and guidelines were accessible to staff via a computerised document management system.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. Areas for improvement included ensuring recommendations and actions from outbreak reviews are assigned and time-bound and increasing uptake of flu vaccine for some disciplines.

Judgment: Substantially compliant

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

There were systems in place at the hospital to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital's rate of reporting of clinical incidents to the National Incident Management System (NIMS) within 30 days of date of notification had increased slightly in 2022 (January to August) to 67.4% when compared to 66% for the entire year in 2021, but the rate of reporting is marginally below the HSE's target of 70%.

Staff who spoke with HIQA were knowledgeable about how to report and manage a patient-safety incident and were aware of the most common patient-safety incidents reported — slips, trips and falls, pressure ulcers and medication errors. Patient-safety incidents in relation to the four key areas of harm were tracked and trended by the quality, risk and patient safety department, and a report summarising the numbers and categories of reported patient-safety incidents was submitted to the Quality and Patient Safety Committee every three months. In addition, a summary report on patient-safety incidents related to the four areas of known harm was compiled for relevant governance committees that had a reporting arrangement to the Quality and Patient Safety Committee every three months. The implementation of recommendations from reviews of patient-safety incidents was monitored by the hospital's quality, risk and patient safety department and SIMT.

The hospital's SIMT met monthly to review new serious and moderate reported patient-safety incidents and the progress in implementing recommendations from closed patient-safety incident reviews. The SIMT compiled a report, which provided a detailed overview of the serious incidents and serious reportable events and the recommendations arising from each of these reviews, annually. The report for 2021 reviewed by inspectors showed that approximately 72% of recommendations from the 12 serious incidents and serious reportable events reviewed in that year had not been fully implemented at that time. When discussed with hospital management during inspection, inspectors were told that implementation of recommendations from serious incidents and serious reportable events was an areas of focus for the hospital and the Dublin Midlands Hospital Group.

Infection prevention and control patient-safety incidents

The quality, risk and patient safety department produced a report every three months detailing infection prevention and control related patient-safety incidents. These incidents were reviewed at each meeting of the Infection Prevention and Control Committee. It was evident to inspectors from a review of documentation that the committee had identified the potential to improve the patient-safety incident report format to make it easier to identify incidents and actions required to reduce reoccurrence.

Medication patient-safety incidents

Medication patient-safety incidents were categorised according to severity of outcome as assigned by the NIMS database. Medication related patient-safety incidents were reported to the Medication Safety Committee. In 2021, 75 medication patient-safety incidents were reported in the hospital, of these, none were extreme or major incidents. Medication patient-safety incident data viewed by inspectors showed that there had been 29 incidents reported in quarter two of 2022, this was a reduction on the previous quarter which had a total of 37 incidents and a reduction on the same period the previous year which had a total of 46 incidents reported. Higher reporting rates of clinical incidents generally mean there is a good reporting culture and greater visibility of risk at the hospital, which are key determinants for safer healthcare services.

Incidents relating to acute deterioration and transitions of care

Patient-safety incidents related to deteriorating patients or transitions of care were not tracked and trended at the hospital, but incidents relating to assessment, monitoring, documentation, treatment and interventions were tracked.

Feedback relating to patient-safety incidents was provided informally by clinical nurse managers, clinical pharmacists and the infection prevention and control team. More formal feedback on patient-safety incidents and actions to reduce the possibility of reoccurrence were discussed during quality and safety walk-rounds carried out by the senior management team. Inspectors observed shared learning notices arising from patient-safety incidents displayed in clinical areas visited. Learning notices that had been developed after patient-safety incidents and were shared with staff and the Dublin Midlands Hospital Group included:

- correct placement of a feeding tube
- patient identification for diagnostic imaging
- hand hygiene and glove usage
- safe prescribing and administration of anticoagulant medication

Overall, while there were systems and processes in place at the hospital to identify, report, manage and respond to patient-safety incidents, HIQA was not fully assured that these systems and processes were operating to their full potential. Compliance with timelines for the reporting of patient-safety incidents to NIMS and ensuring recommendations arising from the review of serious incidents and serious reportable events were fully implemented are two areas that could be improved.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of Naas General Hospital to assess compliance with national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. The inspection also assessed levels of compliance against a number of national standards in the emergency department. Overall, the hospital was judged to be:

- Compliant in three national standards (5.8; 1.7; 1.8)
- Substantially compliant in five national standards (5.2; 1.6; 2.8; 3.1; 3.3)
- Partially compliant in three national standards (5.5; 6.1 ED; 2.7)
- Non-compliant in two national standards (1.6 ED; 3.1 ED)

Capacity and Capability

Naas General Hospital had defined corporate governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. Hospital management were in the process of establishing defined clinical governance arrangements. There was governance and oversight of the issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital. The hospital had clear management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the emergency department, wider hospital and two inpatient clinical areas visited on the days of inspection. There was evidence of devolved accountability and responsibility.

Operationally, there was evidence that hospital management had implemented a range of measures to improve the flow of patents in the emergency department and increase surge capacity but it was evident from findings on the first day of inspection that the department was not functioning as effectively as it should be. The emergency department was overcrowded and there were issues with effective patient flow through the department and surge capacity in the hospital, which collectively posed a patient safety risk and was a concern to HIQA. The environment and situation in the emergency department significantly impacted on the meaningful promotion of the patients' human rights.

HIQA found that arrangements were in place to organise and manage nursing and medical staff in the emergency department to support 24/7 healthcare. Notwithstanding this, it was noted that the complement of emergency medicine consultants at Naas General Hospital was lower than that of other contemporary Model 3 hospitals. The hospital had occupational health and other support systems in place to support staff. The senior management team need to have a greater level of oversight of staff attendance at and uptake of mandatory and essential training. It is essential that hospital management

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

There were systematic monitoring arrangements in place at the hospital to identify and act on opportunities to continually improve the quality and safety of healthcare services.

Quality and Safety

HIQA was not fully satisfied that the hospital had systems in place to identify, prevent or minimise unnecessary or potential risk and harm associated with the provision of care and to support people receiving care at the hospital. Attendees to the hospital's emergency department were screened for signs and symptoms of COVID-19 at triage and assigned to the appropriate pathway thereafter, but this was not in line with national guidance on COVID-19 at the time of inspection, which was a concern for HIQA. HIQA was not assured that there was sufficient medical and nursing expertise to provide timely and appropriate monitoring and care for pregnant or postnatal women who may present to the hospital for emergency care. Immediately following this inspection, HIQA escalated these concerns to senior management at the hospital. Hospital management provided assurance that structures was revised to ensure all patients presenting to the hospital for care would be promptly screened for signs and symptoms of COVID-19. Hospital management also confirmed that they had implemented formal arrangements to ensure that pregnant women who may present to the emergency department at Naas General Hospital would receive appropriate care in the most suitable setting.

The hospital promoted a person-centred approach to care. Staff were kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their experience of receiving care in the hospital and were very complimentary of staff. The hospital was aware of the need to support and protect more vulnerable patients and had developed a plan to act on findings from the National Inpatient Experience Survey related to these patients.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of single room isolation facilities and hand hygiene sinks did not always conform to national requirements, which posed an infection prevention and control risk. Not all healthcare records were managed and stored in line with national standards.

The hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and to patient safety incidents. However, hospital management should ensure compliance with timelines for data entry to NIMS and the implementation of recommendations from reviews of patient-safety incidents is timely.

There were systems in place to monitor, evaluate and improve healthcare services provided at the hospital. However, time-bound action plans were not always developed to action findings and or recommendations from audit activity to improve practices and standards in the four areas of known harm.

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

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management **Judgment relating to overall inspection findings**	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant

Capacity and Capability Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
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

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Compliance Plan for Naas General Hospital OSV-0001080
Inspection ID: NS_0012

Date of inspection: 22 and 23 November 2022

Compliance Plan

Compliance Plan Service Provider's Response

National Standard Judgments relating to overall inspection findings	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant

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

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

- As per response submitted by NGH on 15th December 2022 NGH have recommenced conducting COVID 19 screening questionnaire at point of entry to the Emergency Department.
- NGH have secured an additional 12 single bed ensuite rooms due to be operational Q2 2023 which will increase bed capacity and expedite placement of patients requiring isolation.
- NGH have implemented a number of specific measures to enable more effective patient flow across the Hospital:
    - NGH have commenced engagement with external Consultancy firm in Q4 2022 regarding Acute Floor project to seek to improve patient flow through the Emergency Department. This project has commenced in Q1 2023
    - NGH have increased to twice weekly meetings with CHO 7 (one of which is onsite in NGH) to expedite timely management and discharge of complex cases and Delayed Transfers of Care.
    - Senior Management attendance twice daily at multidisciplinary bed management meetings and weekly Length of Stay Meetings (all patients LOS >14 days reviewed) with Patients Flow/USC/MSW/Discharge Teams to ensure effective patient flow and timely egress from acute Hospital.
    - Refocus on 'Red2Green' project and R2G Champions appointed on each ward ensuring efficient and effect patient flow – Q1 2023

- NGH have commenced work on developing an over 75's stream within ED and are actively engaging with all stakeholders regarding implementation of this pathway in Q1 2023.
- NGH are initiating a Quality Improvement Plan (QIP) for this over 75's pathway and have appointed a lead to commence rollout Q3 2023.
- Multiple attempts by NGH to recruit permanent ICPOP Consultant and Registrar in 2022, to be readvertised in April 2023.
- NGH have commenced utilisation of ICPOP Early Supported Discharge (ESD) stream while awaiting appointment of ICPOP Consultant Q4 2022.
- NGH have commenced utilisation of ECC Cardiology, Respiratory and Endocrinology Hubs to effectively manage integrated patient care with community services. ECC Cardiology and Respiratory Consultants have been appointed and are going through recruitment process with expected start date Q2 2023.
- During peak periods of activity NGH deploy a Senior Decision Maker (Medical Consultant) in ED out of hours to improve ED Patient Experience Times (PET).
- Appointment of Discharge Liaison MSW to follow patients care to offsite beds ensuring appropriate follow up – commenced in January 2023.
- NGH have appointed an additional Patient Flow Co-ordinator, CIT OPAT Lead, Integrated Care Lead and third Discharge Planner to improve patient flow – currently going through recruitment process Q1/Q2 2023.
- NGH received 13.5 WTE posts across Nursing and Health and Social Care Professionals through Unscheduled Care Winter plan 2022 submission to DMHG/National – posts currently being recruited.

- NGH have appointed a nominated HR staff member to oversee mandatory and essential training and HR Manager updates Senior Management Team on monthly stats Q1 2023

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

- NGH seeking an additional Bed Manager (CNM2) to ensure service continuity and provision of 7/7 service during peak winter/surge pressures Q4 2023
- A dedicated 11 bedded AMAU unit is due to be operational Q2 2024 which will allow for efficient streaming directly from ED and will also facilitate direct GP referrals (via Swiftqueue appointment booking system)
- NGH have commenced a new Development Control Plan (DCP) in conjunction with HSE Estates to develop and prioritise the short to long term capital plan for the hospital. This is expected to be published in Q4 2023.
- In addition to this NGH have completed feasibility studies and have recently submitted the following capital reconfiguration projects through HSE Estates to the

HSE National Capital & Property Steering Committee for approval to be added to the HSE National Capital Plan -

- expansion of acute floor to include an additional 11-14 bedded transition/admissions unit,
- reconfiguration and refurbishment of 55 current inpatient beds
- reconfiguration of an operating theatre into two endoscopy procedure rooms and a new Day Ward.

➢ These projects will look to address surge capacity deficits, infrastructural, infection control and patient flow challenges. The steering group capital approval decision is expected in Q2 2023.

Timescale: (a) Interim actions: Q1-Q3 2023 (b) Long-term plans: Q2 2024+

National Standard **Judgments relating to Emergency Department findings**	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Partially compliant

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

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

➢ NGH met with the Emergency Medicine Programme lead in December 2022 regarding allocation of additional 51 ED Consultants nationally (no allocation to NGH). NGH have requested this be reconsidered in the context of low WTE Consultant base when compared to other model 3 Hospitals.

➢ NGH submitting business case to DMHG seeking to increase ED Consultants to reduce reliance on agency staff and stabilise Emergency Department workforce Q1 2023.

➢ NGH have secured approval for an additional permanent ED Registrar and an additional temporary ED Registrar through Unscheduled Care Winter Plan 2022 submission and are currently recruiting these posts and have support from DMHG for July 2023 intake.

➢ NGH have secured approval for a Grade VIII HR and Medical Manpower Manager who will lead on recruitment and retention initiatives.

➢ NGH run regular targeted advertisements to fill all vacant positions both through HSE and agency campaigns.

- NGH continue to engage with external specialist recruitment agencies for the recruitment of medical staffing overseas and have highlighted the requirement for National/Regional recruitment campaign to DMHG and Acute Operations.
- NGH have secured approval for additional 11.5 WTE Nursing staff as part of safer staffing review and they are currently going through recruitment process Q1/Q2 2023.
- NGH have secured approval for permanent AMAU Consultant from National Acute Medicine Programme and is going to the Consultant Application Advisory Committee (CAAC) February 2023 meeting.

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

- NGH are actively working in conjunction with Dublin Midlands Hospital Group with regards to permanently filling ED NCHD vacancies. This includes the possibility of initiating an overseas recruitment campaign

Timescale: (a) Interim actions: Q1-Q2 2023 (b) Long-term plans: Q4 2024

National Standard **Judgments relating to Emergency Department findings**	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non Compliant

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

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

- NGH Hospital Management acknowledges the capacity and space deficits and limitations of current infrastructure, notwithstanding the above all efforts are made to ensure the privacy, dignity and confidentiality of patients accommodated on trolleys in the emergency department is maintained.
- NGH have secured an additional 12 single bed ensuite rooms due to be operational Q2 2023 which will increase bed capacity and expedite placement of patients requiring isolation.
- NGH have implemented a number of specific measures to enable more effective patient flow across the Hospital:
    - NGH have commenced engagement with external Consultant firm Q4 2022 regarding Acute Floor project to seek to improve patient flow through the Emergency Department. This project has commenced in Q1 2023

- NGH have commenced work on developing an over 75's stream within ED and are actively engaging with all stakeholders regarding implementation of this pathway in Q1 2023.
- NGH are initiating a Quality Improvement Plan (QIP) for this over 75's pathway and have appointed a lead to commence rollout Q3 2023.
- Multiple attempts by NGH to recruit permanent ICPOP Consultant and Registrar in 2022, to be readvertised in April 2023.
- NGH have commenced utilisation of ICPOP Early Supported Discharge (ESD) stream while awaiting appointment of ICPOP Consultant Q4 2022.
- During peak periods of activity NGH deploy a Senior Decision Maker (Medical Consultant) in ED out of hours to improve ED Patient Experience Times (PET).
- Appointment of Discharge Liaison MSW to follow patients care to offsite beds ensuring appropriate follow up – commenced in January 2023.
- NGH have appointed an additional Patient Flow Co-ordinator, CIT OPAT Lead, Integrated Care Lead and a third Discharge Planner to improve patient flow – currently going through recruitment process Q1/Q2 2023.
- NGH received 13.5 WTE posts across Nursing and Health and Social Care Professionals through Unscheduled Care Winter plan 2022 submission to DMHG/National – posts currently being recruited.

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

- A dedicated 11 bedded AMAU unit is due to be operational Q2 2024 which will allow for efficient streaming directly from ED and will also facilitate direct GP referrals (via Swiftqueue appointment booking system)
- NGH have commenced a new Development Control Plan (DCP) in conjunction with HSE Estates to develop and prioritise the short to long term capital plan for the hospital. This is expected to be published in Q4 2023.
- In addition to this NGH have completed feasibility studies and have recently submitted the following capital reconfiguration projects through HSE Estates to the HSE National Capital & Property Steering Committee for approval to be added to the HSE National Capital Plan -
  - expansion of acute floor to include an additional 11-14 bedded transition/admissions unit,
  - reconfiguration and refurbishment of 55 current inpatient beds
  - reconfiguration of an operating theatre into two endoscopy procedure rooms and a new Day Ward.
- These projects will look to address surge capacity deficits as well as infrastructural, infection control and patient flow challenges. The steering group capital approval decision is expected in Q2 2023.

Timescale: (a) Interim actions: Q1-Q3 2023 (b) Long-term plans: Q2 2024+

National Standard Judgments relating to Emergency Department findings	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant

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

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

- As per response submitted by NGH 15th December 2022, in conjunction with DMHG, Coombe Hospital and Midlands Regional Hospital at Portlaoise have established a pathway for the monitoring of pregnant women and their respective foetuses.
- NGH have secured an additional 12 single bed ensuite rooms due to be operational Q2 2023 which will increase bed capacity and expedite placement of patients requiring isolation.
- NGH have implemented a number of specific measures to enable more effective patient flow across the Hospital:
- NGH have commenced engagement with external Consultant firm Q4 2022 regarding Acute Floor project to seek to improve patient flow through the Emergency Department. This project has commenced in Q1 2023.
- NGH have increased to twice weekly meetings with CHO 7 (one of which is onsite in NGH) to expedite timely management and discharge of complex cases and Delayed Transfers of Care.
- Senior Management attendance twice daily at multidisciplinary bed management meetings and weekly Length of Stay Meetings (all patients LOS >14 days reviewed) with Patients Flow/USC/MSW/Discharge Teams to ensure effective patient flow and timely egress from acute Hospital.
- Appointment of Discharge Liaison MSW to follow patients care to offsite beds ensuring appropriate follow up – commenced in January 2023.
- Refocus on 'Red2Green' project and R2G Champions appointed on each ward ensuring efficient and effect patient flow – Q1 2023
- Multiple attempts by NGH to recruit permanent ICPOP Consultant and Registrar in 2022, to be readvertised in April 2023.
- NGH have commenced utilisation of ICPOP Early Supported Discharge (ESD) stream while awaiting appointment of ICPOP Consultant Q4 2022.
- NGH have commenced utilisation of ECC Cardiology, Respiratory and Endocrinology Hubs to effectively manage integrated patient care with

community services. ECC Cardiology and Respiratory Consultants have been appointed and are going through recruitment process with expected start date Q2 2023.

- During peak periods of activity NGH deploy a Senior Decision Maker (Medical Consultant) in ED out of hours to improve ED Patient Experience Times (PET).
- NGH have appointed an additional Patient Flow Co-ordinator, CIT OPAT Lead, Integrated Care Lead and third Discharge Planner to improve patient flow – currently going through recruitment process Q1/Q2 2023.
- NGH have secured approval for additional 11.5 WTE Nursing staff as part of safer staffing review and they are currently going through recruitment process Q1/Q2 2023.
- NGH allocated an additional 13.5 WTE posts across Nursing and Health and Social Care Professionals through Unscheduled Care Winter plan 2022 submission to DMHG/National – currently being recruited.
- In order to reduce reliance on agency medical staffing NGH management have sought to offer existing locum NCHDs HSE contracts.
- NGH submitting business case to DMHG to increase ED Consultants to reduce reliance on agency staff and stabilise Emergency Department workforce Q1 2023**.**
- NGH have secured approval for an additional permanent ED Registrar and an additional temporary ED Registrar through Unscheduled Care Winter Plan 2022 submission and are currently recruiting these posts and have support from DMHG for July 2023 intake.
- NGH have secured approval for a Grade VIII HR and Medical Manpower Manager who will lead on recruitment and retention initiatives.
- NGH run regular targeted advertisements to fill all vacant positions both through HSE and agency campaigns.
- NGH continue to engage with external specialist recruitment agencies for the recruitment of medical staffing overseas and have highlighted the requirement for National recruitment campaign to DMHG and Acute Operations.
- NGH have secured approval for permanent AMAU Consultant from National Acute Medicine Programme and is going to the Consultant Application Advisory Committee (CAAC) February 2023 meeting.
- NGH Infection Prevention Control (IPC) continue to audit compliance with CPE screening in line with national standards.

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

- NGH seeking an additional Bed Manager (CNM2) to ensure service continuity and provision of 7/7 during peak winter/surge pressures Q4 2023

- A dedicated 11 bedded AMAU unit is due to be operational Q2 2024 which will allow for efficient streaming directly from ED and will also facilitate direct GP referrals (via Swiftqueue appointment booking system)
- NGH have commenced a new Development Control Plan (DCP) in conjunction with HSE Estates to develop and prioritise the short to long term capital plan for the hospital. This is expected to be published in Q4 2023.
- In addition to this NGH have completed feasibility studies and have recently submitted the following capital reconfiguration projects through HSE Estates to the HSE National Capital & Property Steering Committee for approval to be added to the HSE National Capital Plan -
    - expansion of acute floor to include an additional 11-14 bedded transition/admissions unit,
    - reconfiguration and refurbishment of 55 current inpatient beds
    - reconfiguration of an operating theatre into two endoscopy procedure rooms and a new Day Ward.
- These projects will look to address surge capacity deficits, infrastructural, infection control and patient flow challenges. The steering group capital approval decision is expected in Q2 2023.

Timescale: (a) Interim actions: Q1-Q2 2023 (b) Long-term plans: Q2 2024+

National Standard **Judgments relating to wider hospital and inpatient clinical areas findings**	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

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

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

- NGH have secured an additional 12 single bed ensuite rooms due to be operational Q2 2023 which will increase bed capacity and expedite placement of patients requiring isolation.
- NGH have a clinical wash hand basins replacement programme in place and are actively replacing sinks across the Hospital and will have approximately 75% complete by Q4 2023.

- NGH submit annual priority lists through the various National funding streams i.e. Minor Capital, AMRIC, HCAI etc., for minor infrastructure improvements to ensure compliance with the latest regulatory guidance and standards. Ongoing.
- NGH continue to work with HSE Estates in order to progress infrastructural improvements

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

- NGH have a clinical wash hand basins replacement programme in place and are actively replacing sinks across the Hospital, completion of this program is expected by Q4 2024.
- A dedicated 11 bedded AMAU unit is due to be operational Q2 2024 which will allow for efficient streaming directly from ED and will also facilitate direct GP referrals (via Swiftqueue appointment booking system)
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