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:	St Columcille's Hospital
Address of healthcare service:	Bray Road Loughlinstown Co. Dublin D18 V9K1
Type of inspection:	Unannounced
Date(s) of inspection:	15 and 16 May 2024
Healthcare Service ID:	OSV-0001101
Fieldwork ID:	NS_0079

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

St Columcille's Hospital is a Model 2* statutory, public acute hospital. It is a member of and is managed on behalf of the Health Service Executive (HSE) by the Ireland East Hospital Group (IEHG).† Services provided by the hospital include:

- acute medical in-patient services
- medical assessment unit
- injury unit
- day surgery
- outpatient care
- diagnostic services.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	117 inpatient beds

How we inspect

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

* A Model 2 hospital provides the majority of hospital activities including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.

† The Ireland East Hospital Group comprises eleven hospitals. These are St Vincent's University Hospital, University Hospital Waterford, St Luke's General Hospital Carlow-Kilkenny, Tipperary University Hospital, Wexford General Hospital, St Columcille's Hospital – Loughlinstown, St Michael's Hospital – Dún Laoghaire, Kilcreene Regional Orthopaedic Hospital, National Maternity Hospital, National Rehabilitation Hospital, Royal Victoria Eye and Ear Hospital. The Hospital Group's Academic Partner is University College Dublin (UCD).

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, unsolicited information[§] and other publicly available information.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality

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

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

and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
15 May 2024	13.30 – 17.30hrs	Danielle Bracken	Lead
		Aoife O'Brien	Support
16 May 2024	08.40 – 17.00hrs	Danielle Bracken	Lead
		Aoife O'Brien	Support
		Elaine Egan	Support

Information about this inspection

An unannounced two-day inspection of St Columcille's Hospital was conducted on 15 and 16 May 2024.

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

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

The inspection team visited a number of clinical areas:

- medical assessment unit
- injury unit
- St Anne's ward (orthopaedic rehabilitation and general medical ward).

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

[**] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Representatives of the hospital's executive management team (EMT)
    - interim general manager
    - clinical director
    - director of nursing
- A representative from the Quality Safety and Risk department
- A non-consultant hospital doctor (NCHD)
- Interim Human Resources (HR) manager
- Staff working in the clinical areas visited
- A representative from each of the following hospital committees:
    - infection prevention and control committee
    - drugs and therapeutics committee
    - deteriorating patient committee
    - discharge planning committee

During this inspection, inspectors reviewed documentation and data on site and requested additional documentation and data from hospital management which was reviewed following the inspection.

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 the service.

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

As part of the inspection process, inspectors spoke with three patients about their experience of attending the medical assessment unit. The patients informed inspectors that tests had been carried out promptly and pain relief was provided quickly. These patients said that there had been a long waiting time for test results. However, meals had been provided and patients had been kept well informed in relation to their care and treatment. Staff were described by patients as "very good", "so nice and so kind", "approachable" and "very easy to talk to" and that they were "doing a very good job". Patients also stated that they felt "well looked after" and that they were "very impressed" with their experience and had "nothing but praise" for the service and staff.

Inspectors observed that the waiting area for the medical assessment unit and injury unit was clean on both days of the inspection.

On the first day of the inspection at 3.30pm, inspectors observed that the shared waiting room for the medical assessment unit and injury unit was approximately half full with 12 people present. The medical assessment unit had capacity for 12 patients. On both days of inspection, when inspectors visited the unit there were 11 patients present. On the second day of inspection at 10am, there were two patients present in the injury unit, which had capacity for five.

On the second day of the inspection at 9am, there were 34 patients in St Anne's ward, which had capacity for 36 patients. Inspectors observed that the ward was clean during inspection. Patients in St Anne's ward who spoke with inspectors were aware of their plan of care and were getting timely pain relief when this was required. Staff were described by patients as "very kind". Patients also informed inspectors that they had a choice of meals, and there was a "great set up" for their rehabilitation experience, and that this had "speeded up recovery". A patient stated that the ward could be noisy and sometimes it was hard to sleep, and they had mentioned this to staff.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. Patients who spoke with inspectors told them that call-bells and requests for assistance had been responded to quickly and that the staff "are very good here".

Overall, there was consistency in what patients told inspectors about their experiences of the care they received and what inspectors observed in the clinical areas visited.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Two national standards (5.5, 5.8) assessed on the inspection were found to be compliant with one national standard (6.1) found to be substantially compliant, and one national standard (5.2) found to be partially compliant. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

During a previous inspection of the hospital in June 2022, inspectors found that terms of reference for governance committees required updating and committees had not been meeting as frequently as they should have been. The executive management team had not been meeting formally and the quality and safety committee in place at the time had not been functioning in line with its terms of reference. As part of the compliance plan to address these June 2022 findings, hospital management had committed to updating committee terms of reference and strengthening reporting arrangements. On this inspection, inspectors found that all terms of reference had been recently updated and committees are now meeting in line with their terms of reference. A database was in place, which was used by the Quality Safety and Risk department to monitor committee compliance with their terms of reference, which was demonstrated to inspectors. Additionally, a standardised annual reporting method for committees to report to the clinical governance committee or quality safety executive committee, as relevant, is in place. Compliance with this reporting method was being measured and was demonstrated to inspectors. At that time 11 out of 17 committees had submitted an annual report. At the time of this inspection there were formalised governance arrangements in place in the hospital for assuring the delivery of high-quality, safe and reliable healthcare, in relation to the four areas of focus of this inspection.

The interim general manager, supported by the executive management team (EMT), was the accountable officer with overall responsibility and accountability for the governance of the hospital. The interim general manager reported to the chief operations officer of the hospital group, who in turn reported to the interim chief executive officer of the group. These reporting arrangements were outlined in an organisational chart dated May 2024, which was reviewed by inspectors. There had been interim general managers in place in the hospital since February 2023. The interim general manager at the time of this inspection had been in place since January 2024, leaving their position of operations manager (deputy general manager) vacant. The quality and safety manager position had been vacant since December 2023. At the time of the inspection, no impact of these vacancies was identified, however, in the long term this level of senior management vacancies in the hospital is not sustainable and will lead to an impact on the quality and safety of care to patients. These vacant positions are discussed further under national standard 6.1.

The clinical director, a member of the EMT, provides clinical oversight and leadership of the clinical services provided at the hospital. The director of nursing (DON), a member of the EMT, is assigned with responsibility for the organisation and management of nursing services at the hospital.

The key governance structures assigned with the responsibility for ensuring the quality and safety of healthcare services at the hospital were the executive management committee, the clinical governance committee and the quality safety executive committee. There was a committee reporting chart in place at the hospital,

dated March 2024 which was reviewed by inspectors, and the chart outlined which committees reported to the quality safety executive committee and which reported to the clinical governance committee. The process for ensuring committees met at the required frequency and for tracking attendance was outlined, and shown to inspectors.

The EMT, according to its terms of reference, was responsible for providing oversight and governance over the delivery of the standard of care to all patients accessing services at the hospital. Chaired by the interim general manager, the EMT comprised senior managers and aimed to meet 10 times a year, and was meeting in line with its terms of reference. Inspectors reviewed meeting minutes from February and April 2024 and noted that members discussed clinical governance, quality and patient-safety, and performance. Assigned actions (to a named person) for follow up were recorded and tracked at each meeting.

The clinical governance committee, according to its terms of reference, oversaw clinical governance structures and quality and patient safety activities. Chaired by the clinical director, it comprises senior managers and clinical representation, and was meeting in line with its terms of reference. Inspectors reviewed meeting minutes from January, April and May 2024 and noted discussion of reports from committees reporting to it, and oversight of hospital activity and quality and patient safety. Assigned time-bound actions for follow up are recorded and tracked at each meeting.

Three committees reporting into the clinical governance committee that relate to the four areas of focus of this inspection were the:

- infection prevention and control committee
- drugs and therapeutics committee
- deteriorating patient committee.

The discharge committee reported into the quality safety executive committee.

The aims of the quality safety executive committee, according to its terms of reference, include informing the hospital's EMT on all significant quality and risk-related issues, and associated action plans. The committee also oversees the work of associated committees. This multidisciplinary committee, chaired by the interim general manager, does not have a meeting frequency outlined in its terms of reference. However, inspectors were informed by the interim general manager that the committee met quarterly and a review of minutes provided to inspectors confirmed this. Inspectors noted from a review of these minutes that the committee was working effectively, for example, there was an agenda in place and items such as quality indicators and patient experience, were discussed at meetings. Assigned time-bound actions for follow up were recorded and tracked at each meeting. The committee had oversight in relation to committees reporting into it, and of the quality and patient safety of the care provided in the hospital. For example, reporting

committees provided updates at each meeting and quality indicators were discussed at meetings.

The multidisciplinary infection prevention and control committee, chaired by the interim general manager, was working effectively and had oversight in relation to implementing the hospital's infection prevention and control programme. A copy of this programme for 2024 was provided to inspectors, which outlined the plan for the year in relation to infection prevention and control. For example; in relation to planned education, audit and monitoring activity. These topics were discussed at meetings of the committee. Minutes of meetings from November and July 2023 and April 2024 reviewed by inspectors showed that the meeting was well attended. There was an agenda in place. The committee has oversight over and reviews rates and outbreaks of infection, audit activity and education in relation to infection prevention and control practices, which were agenda items. In 2024, an action register which tracks the progress of assigned time-bound actions was introduced. The frequency at which the committee should meet was quarterly, however, it did not meet in quarter one of 2024.

The multidisciplinary drugs and therapeutics committee, chaired by a medical consultant, is responsible for oversight in relation to medication management, medication safety and antimicrobial stewardship activity within the hospital. A copy of the hospital's 'Medication Safety Strategy 2024', and the 'Antimicrobial Stewardship annual programme 2024' were provided to inspectors. These documents outlined the priority areas of work for the year in relation to medication safety and antimicrobial stewardship activity, for example, in relation to audit and monitoring. According to the terms of reference, the committee meets every second month and more frequently when required. Inspectors reviewed minutes of meetings which showed that the committee had met in January, February and April of 2024. Inspectors noted from a review of documentation and from meeting with members of this committee that there is oversight in relation to medication management in the hospital and of the antimicrobial stewardship programme. The hospital's chief pharmacist attends the drugs and therapeutics committee in St Vincent's University Hospital. Feedback from this meeting was provided at the St Columcille's Hospital's drugs and therapeutics committee through a standing item on the agenda and is documented in meeting minutes.

The multidisciplinary deteriorating patient committee, chaired by a consultant anaesthesiologist, meets quarterly in line with its terms of reference. This committee is responsible for overseeing the implementation of national guidelines in relation to the Irish National Early Warning System (INEWS), sepsis, and for overseeing the hospital's resuscitation programme. From meeting with committee members and reviewing meeting minutes it was evident that there is oversight in relation to issues that could impact on the timely recognition and response to acutely deteriorating patients. For example; education and training, performance indicators, audit and

patient-safety incidents, were standing agenda items. An action log was introduced in April 2024 to facilitate follow up of time-bound assigned actions identified during meetings, prior to this, actions were not being tracked.

The discharge planning committee oversees the effectiveness of discharge activities within the hospital and meets every second month in line with its terms of reference. From a review of committee minutes, inspectors noted that discussions take place in relation to issues impacting on delayed transfers and measures introduced to improve patient flow within the hospital and patient-flow activity data. An action log was introduced in March 2024 to facilitate follow up of time-bound assigned actions. Inspectors were informed by hospital management that an unscheduled care governance committee was due to be established in the hospital to provide additional oversight in relation to unscheduled care in the hospital. Terms of reference for this committee had been developed and were provided to inspectors.

In summary, following a previous inspection in June 2022, hospital management had made some improvements in relation to the reporting arrangements in place at the hospital. However, while there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare in place at St Columcille's Hospital, in relation to the four areas of focus of this inspection:

- vacancies in senior management positions in the hospital were not sustainable in the long-term
- the frequency of committee meetings were not documented in all committee terms of reference reviewed.

Judgment: Partially compliant

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

At the time of this inspection, there were effective management arrangements in place to support the delivery of high-quality, safe and reliable healthcare services in the hospital.

Inspectors were told that a daily operational safety huddle, attended by management representatives from across the hospital, takes place each morning at 10.30am. Minutes of the huddle provided to inspectors showed that unscheduled and scheduled care activity, staffing and relevant updates, such as from the infection prevention and control team and pharmacy, were discussed.

There was an infection prevention and control team in place at the hospital. The team is led by a consultant microbiologist, based in St Vincent's University Hospital, who is allocated to the hospital and comes on site for six hours a week. There is access to a consultant microbiologist from St Vincent's University Hospital 24/7 by telephone. At the time of inspection, there were 1.5 whole-time equivalent (WTE)[§§] clinical nurse specialists in infection prevention and control, and the team were supported at local level both in the medical assessment unit and in ward areas by infection prevention and control, sepsis, antimicrobial stewardship link nurses.

The hospital's pharmacy service is led by the chief pharmacist. There are arrangements in place to provide a clinical pharmacy service[***] to ward areas daily and the medical assessment unit five times a week, Monday to Friday, by senior pharmacists. A senior pharmacist provided antimicrobial stewardship services in the hospital, and inspectors were told by the consultant microbiologist that this pharmacist works closely with the infection prevention and control team.

The deteriorating patient committee at the hospital, under the clinical leadership of a consultant anaesthesiologist, have implemented a deteriorating-patient improvement programme. At the time of inspection, the programme was supported by two part-time resuscitation officers trained in cardiopulmonary resuscitation (CPR).

The patient flow team comprised a bed manager, a discharge coordinator and a recently appointed admissions coordinator. The admissions coordinator visits the medical assessment unit daily to review patients with a view to avoiding an unnecessary admission. Effective arrangements to manage patient flow are in place in the hospital, these are described in more detail in national standard 3.1.

Day-to-day management of the medical assessment unit, which opens from 8am to 6pm, seven days a week is by the consultant on call and the clinical nurse manager grade 2 (CNM 2).

The injury unit, which sees patients 14 years and above, opens from 8am to 6pm, seven days a week. The unit is overseen by rotating consultants in emergency medicine from St Vincent's University Hospital supported by non-consultant hospital doctors (NCHDs) from St Vincent's University Hospital. The consultants in the injury unit have a direct video link to consultants in the emergency department of St Vincent's University Hospital to access advice about patient stabilisation and appropriate care pathways. This system was demonstrated to inspectors on day two of the inspection. Nursing care and day-to-day management in the injury unit is overseen by the CNM 2, supported by nursing staff.

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

Nursing care and day-to-day management in St Anne's ward is overseen by the CNM 2, supported by nursing staff.

In summary, at the time of inspection there were effective management arrangements in place at the hospital to support and promote the delivery of high-quality, safe and reliable healthcare services.

Judgment: Compliant

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

There are systematic monitoring arrangements in place in the hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided. In particular, patient safety in the hospital was being enhanced by effective monitoring systems for infection prevention and control and antimicrobial stewardship, in addition to systems for managing effective patient flow into and out of the hospital.

Inspectors were informed by senior management and documentation confirmed that monthly performance meetings are held between the hospital and the hospital group, which included oversight in relation to quality and safety, and patient-flow activity. The executive management committee, clinical governance committee and quality safety executive committee, as discussed under national standard 5.2, have oversight of performance data. Information on a range of performance indicators and data related to the quality and safety of healthcare services is published, in line with the HSE's reporting requirements, and is available on the HSE website. For example, these include hospital patient safety indicator reports (HPSIR).

There are formalised risk management structures and processes in place in the hospital and these include a risk register committee, which meets approximately 10 times a year to review the hospital's risk register, and had met in February, March and April of 2024. Minutes of meetings of this committee showed that new and existing risks, control measures and required actions had been discussed. In the minutes reviewed, there was an action log in place and actions were being followed up from meeting to meeting. This committee reports into the quality safety executive committee. There was oversight in relation to risk at the executive management committee, the clinical governance committee, and the quality and safety executive committee, this was demonstrated from speaking with hospital management and from a review of minutes of these committees. A copy of the hospital's risk register

provided to inspectors showed that it was being kept up to date, having last been updated in April 2024.

Inspectors, during a previous inspection of the hospital in June 2022, had found that the clinical incident review group (CIRG) and clinical audit committee had not been meeting at the frequency set out in their terms of reference. On this inspection improvements in relation to meeting at the required frequency for both were noted by inspectors.

The hospital's clinical incident review group is chaired by the interim general manager and meets quarterly in line with its terms of reference. Minutes of these meetings reviewed by inspectors showed that incidents had been discussed in detail. An action log to follow up on completed actions had been introduced in March 2024. For example; one action arising from this meeting related to education and compliance in relation to healthcare record management.

There is a clinical audit committee in place, the purpose of which, according to its terms of reference, is to promote the practice of clinical audit and share ideas of best practice across the hospital. At the time of inspection, this committee was meeting quarterly in line with its terms of reference. Inspectors were told by senior management that there was a process in place to track audit completion, this was also noted in minutes of meetings reviewed by inspectors. There was some evidence of discussion of completed audits, for example, an audit carried out in the injury unit in relation to the type of knee brace to use for patients.

Quality and safety walk arounds were taking place in the hospital. Representation included members of the senior management team. A schedule was in place with six having been completed so far in 2024. Samples of minutes were provided to inspectors for clinical areas visited on this inspection — the medical assessment unit and St Anne's ward. Issues found during the walk arounds had been assigned as actions and there was documentary evidence that these actions had been completed.

As discussed under national standard 5.2, the infection prevention and control committee has oversight in relation to infection prevention and control practices in the hospital. There is an infection prevention and control programme for 2024 in place and progress against this was being measured. For example, there was a suite of 14 infection prevention and control indicators in place, which were provided to inspectors. Indicators were measured every three months, with the exception of hand hygiene which was measured every six months. Indicators included rates of infection acquired in the hospital. Inspectors were told that the annual programme for 2024 was discussed at the infection prevention and control committee, and this was documented in meeting minutes reviewed by inspectors. The programme included carrying out infection prevention and control audits in clinical areas.

An infection prevention and control annual report was developed each year. A copy of this annual report for 2023 was provided to inspectors which detailed rates of infection, education provided, documentation updated and compliance with key performance indicators throughout 2023. There was an infection prevention and control audit plan in place and an audit summary report had been produced for 2023 which was provided to inspectors. This detailed overall compliance levels within clinical areas with infection prevention and control practices, hand hygiene and equipment hygiene, with good levels of compliance found. For example, overall compliance in 2023 with infection prevention and control practices was 95%, patient care equipment was 95% and hand hygiene was 98%.

The drugs and therapeutics committee, as discussed under national standard 5.2, has oversight in relation to medication safety and antimicrobial stewardship practices in the hospital. There was both a medication safety strategy and an antimicrobial stewardship programme for 2024 in place in the hospital. An annual report for 2023 for the drugs and therapeutics committee, reviewed by inspectors, outlined key achievements, including education provided and documentation updated, for example, in relation to medication management, and audits that had been carried out that year. The antimicrobial stewardship annual report for 2023 outlined compliance with antimicrobial prescribing process indicators. Of note, hospital staff had achieved the highest level of accreditation — level 3, with the Global Antimicrobial Stewardship Accreditation Scheme (GAM SAS) for the antimicrobial stewardship processes in place within the hospital.

Performance in relation to unscheduled care activity and patient flow within the hospital is being monitored. Data captured includes the number of attendances to the injury unit and to the medical assessment unit, including self-presenters, patient experience times, delayed transfers of care and average length of stay. Inspectors were told by staff that activity data in relation to the medical assessment unit and injury unit is discussed at clinical governance committee meetings. This was confirmed in meeting minutes reviewed by inspectors. Factors affecting delayed transfers of care and average length of stay are being discussed at discharge planning committee meetings as demonstrated by minutes of meetings reviewed by inspectors and described by committee members for patient flow that met with inspectors. Additionally, committee members outlined how they attended the bed management committee meeting held in St Vincent's University Hospital.

Patient experience was discussed at the executive management committee, clinical governance committee, quality safety executive committee and discharge planning committee. Examples of measures implemented at the hospital to improve patient experience are discussed under national standard 1.7. The management of and response to complaints about the services are discussed further under national standard 1.8.

In summary, there are systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services at the hospital.
Judgment: Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.
While inspectors identified that hospital management generally planned, organised and managed the workforce, a number of senior management positions were vacant as discussed under national standard 5.2. These included the general manager, the operations manager and the quality and safety manager. Additionally, the complaints manager post was also vacant at the time of the inspection. Hospital management were awaiting approval to hire to these posts through the national derogation process. At the time of the inspection, all consultant positions were filled, with two NCHD positions unfilled, however, these were due to be filled in July 2024. There was a very low percentage of unfilled nursing positions with 7.43 WTE (3.7%) of the funded 199.29 WTE nurses (inclusive of management and other grades) positions unfilled. There were 3.0 WTE (9.4%) unfilled healthcare assistant (HCA) positions in the hospital, which inspectors were told were filled by agency staff. The medical workforce in the medical assessment unit consists of the medical consultant on call, a registrar designated to the medical assessment unit and a senior house officer (SHO) and intern that rotates into the unit. The medical assessment unit was short one NCHD on day one of the inspection due to unplanned leave, however, medical review was being completed within one hour. The medical workforce in the injury unit consists of emergency medicine consultant cover on site three days a week. Staff have access to consultants in St Vincent's University Hospital outside these days through video link as discussed in national standard 5.2. Consultants rotate into the unit and also work in St Vincent's University Hospital and are supported by NCHDS. Inspectors were told by staff that there are four doctors present in the unit on a daily basis, inclusive of a consultant. This was observed on the day of inspection. There was no consultant anaesthesiologist on site in the hospital outside of normal working hours, however, there was access 24/7 to an anaesthesiologist on call, over the phone. Inspectors were informed, and entries on the hospital's risk register confirmed that a business case to increase the number of consultant

anaesthesiologists at the hospital had been submitted to the hospital group in August 2023. This risk was last updated on the risk register in May 2024.

The nursing workforce in the medical assessment unit and injury unit was overseen by the CNM 2. Nurses rotated between the medical assessment unit and injury unit as rostered. The nursing workforce included one candidate advanced nurse practitioner for the medical assessment unit, one advanced nurse practitioner and two candidate advanced nurse practitioners for the injury unit. There was a healthcare assistant rostered to the medical assessment unit on a daily basis. On the days of the inspection there were no deficits in nursing staffing rostered in either units. There were 3.5 WTE staff nurse vacancies on St Anne's ward. Inspectors were told these were due to be filled in the weeks following inspection. On the day of inspection there were no unfilled shifts.

During a previous inspection of the service in June 2022, it was identified that oversight in relation to uptake of mandatory and essential training required improvement. On this inspection, inspectors found that there was a database for mandatory training reporting in place. In general, in the clinical areas visited, inspectors noted a high level of compliance with mandatory and essential training. The uptake of standard and transmission based precautions and infection outbreak management training in St Anne's ward for nursing staff was 78% and for healthcare assistants was 66%. From a review of meeting minutes, inspectors noted that mandatory training was an agenda item for the quality safety executive committee and was discussed at meetings.

While the workforce at the hospital was being planned, organised and managed, some areas for action were noted:

- A number of senior management positions such as the operations manager, quality and patient safety manager and complaints manager were vacant at the time of inspection.
- Uptake of training in infection prevention and control in St Anne's ward requires attention.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. Four national standards (1.6, 1.7, 1.8, 3.3) assessed on the inspection were compliant, and three

national standards (2.7, 2.8, 3.1) were substantially compliant. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

Staff were observed providing a person-centred approach to care, and interactions with patients observed were respectful. Staff were responding promptly to patients' needs and providing assistance. Staff who spoke with inspectors were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

Patients in the medical assessment unit that spoke with inspectors stated that their privacy had been maintained. Efforts were made by staff to ensure that there was sufficient space between chairs in the medical assessment unit, and this was observed by inspectors, on the first day of the inspection. Staff stated that the chair spaces were used for patients who were awaiting test results and or discharge letters before going home and that patients undergoing treatment were reviewed in single rooms and cubicles with curtains. Patients, accommodated in chairs, stated that they had been seen in cubicle spaces and were waiting on test results. Staff stated that office space was used, when required, to hold private conversations with patients. Patients who spoke with inspectors said they were kept up to date in relation to their treatment and test results. There was a wide range of patient information leaflets available in the medical assessment unit as observed by inspectors.

St Anne's ward had one single room. The remaining rooms were multi-occupancy with no en-suite toilet or shower facilities. Staff were aware of the need to promote patients' autonomy in the ward. Privacy curtains were in place and observed to be used by staff when providing care to patients. Staff promoted a positive risk-taking approach to patients with cognitive impairment, such as those with dementia, through encouraging the patients to mobilise safely. At the time of the inspection, preparations were underway to launch the 'get up, get dressed, get moving' campaign with information posters being developed, and these were shown to inspectors.

Staff told inspectors about the family room suite the 'seomra sólás' which could be used when a loved one being cared for in the hospital was at end of life. There was an information leaflet about the family room available which was observed by inspectors, this included information on chaplaincy and patient liaison services.

Judgment: Compliant

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

Inspectors observed staff being respectful, kind and caring towards patients in the clinical areas visited. Patients spoke positively about their interactions with staff.

Efforts were made by staff to get to know patients. Staff described a 'this is me' booklet and inspectors observed 'what is important to me' posters. Staff told inspectors that some patients were encouraged to bring in some personal items to make them feel more comfortable in the surroundings. Patients had access to an outdoor garden space from St Anne's ward, and there was a day room where patients could meet with visitors, and a television room in the ward.

Meals and snacks were provided at various points throughout the day in the medical assessment unit. Patients who spoke with inspectors had all been offered a snack or meal.

Staff who spoke with inspectors told them about some quality improvements that had been introduced at the hospital to improve patient experiences. These included a 'just a minute' (JAM) card. Patients, for example; those who required some extra time communicating, could present the card discretely to those on reception or those caring for them.

Judgment: Compliant

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

Inspectors found there were systems and processes in place in the hospital to respond to complaints and concerns. Complaints were an agenda item at meetings of the executive management team (EMT), quality and safety executive committee, clinical governance committee and at performance meetings with the hospital group. The interim general manager had oversight of complaints and was supported in the management of complaints by the patient liaison officer and the front of house patient manager.

The HSE's *"Your Service Your Say"* (YSYS) policy is in place at the hospital. Information about this policy was displayed in clinical areas visited. Staff in clinical areas who spoke with inspectors were knowledgeable about the complaints management process and focused on local resolution of complaints.

The number and type of formal complaints received annually at the hospital are reported. Complaints were tracked and trended to identify emerging themes, categories and departments. In 2023, 98% of complaints were resolved within 30 working days, exceeding the national HSE target of 75% which was a significant improvement on previous inspection findings.

Recommendations from complaints were monitored by the quality and safety executive committee. Inspectors saw evidence of shared learning, and quality improvements implemented in response to complaints was provided by the hospital, this included:

- additional staff allocated to the medical assessment unit and injury unit reception desk from 8am to 6pm to minimise check-in times.
- a patient property check list was introduced in the hospital.

A patient advocacy liaison service (PALS) was available in the hospital to support patients and their families in making complaints. Inspectors observed a poster in relation to advocacy services displayed on a noticeboard in St. Anne's ward. Staff offered opportunities and methods for patients to raise a concern or make a complaint and to provide feedback, such as through satisfaction surveys, complaints forms and feedback boxes. However, on the days of the inspection, patients who spoke with inspectors were not familiar with the hospital's complaints process, but outlined that if they had a complaint they would speak to a member of staff.

Overall, since HIQA's last inspection, there was a significant improvement in the management and oversight of complaints at the hospital. The majority of complaints and concerns were resolved promptly and efficiently in line with HSE timelines.

Judgment: Compliant

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

During this inspection, inspectors found that the physical environment in clinical areas visited did not fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users. Hospital management were

challenged by the aging physical environment, however, inspectors found this to be well maintained.

There was a lack of isolation facilities at the hospital which posed a risk in relation to the spread of infection. There were eight ward-based single rooms in the hospital, of which three had en-suite toilet and shower facilities. None of these rooms had negative pressure ventilation. These issues were also identified during an inspection of the hospital in June 2022. In order to address the lack of isolation facilities, capital investment and building works were required. A development control plan for the hospital had been submitted to the hospital group in February 2024. Inspectors reviewed the hospital risk register and noted a number of controls were in place to address the risks associated with a lack of isolation rooms. Controls included screening of patients for infection and an isolation policy was in place. These are discussed further under national standard 3.1.

The infection prevention and control team told inspectors that the infrastructure of the hospital contributed to outbreaks of infection. This was confirmed in outbreak reports for 2024 for COVID-19 and norovirus reviewed by inspectors. Outbreak reports attributed existing infrastructure such as a low number of single rooms and shared toilets as potential factors contributing to these outbreaks. From a review of meeting minutes of the infection prevention and control committee, inspectors noted that there had been 13 outbreaks of infection in the hospital in 2023, seven of these were COVID-19 outbreaks and four were norovirus outbreaks. Staff in clinical areas visited told inspectors they had not received official outbreak reports, however, the CNM 2 attended infection prevention and control committee meetings where outbreaks across the hospital were discussed.

The medical assessment unit had six cubicles with privacy curtains and three single rooms, none of which had en-suite toilet or shower facilities. The unit could take up to four additional patients seated on chairs. There were two toilets for patient use. On the first day of the inspection there were no patients requiring transmission based precautions in the unit. The injury unit had five cubicle spaces and one toilet for patient use.

St Anne's ward was a 36-bedded orthopaedic rehabilitation and general medical ward, the ward had a number of multi-occupancy rooms; seven four-bedded, one three-bedded, two two-bedded and one single room. A one metre distance between beds in multi-occupancy rooms was observed. None of these rooms had en-suite shower or toilet facilities. There were seven toilets and two showers in the ward accessed from the ward corridor for use by patients.

During this inspection, infection prevention and control practices for those requiring transmission-based precautions were observed and found to be in line with national guidance. On occasion, patients with the same type of infection could be cohorted on the ward, usually in a 2-bedded room under the direction of the infection prevention

and control team. Inspectors were told that a toilet could be designated for use by patients in the room if required.

Inspectors observed signage on how to correctly use personal protective equipment (PPE) displayed in clinical areas and there were plentiful supplies of PPE available. Clinical hand-wash sinks observed throughout clinical areas conformed to requirements.[†††] Inspectors observed hand-washing technique posters displayed beside clinical hand-wash sinks. Alcohol gel was readily available in clinical areas visited. Linen and waste was observed by inspectors to be appropriately stored and segregated.

In general, the clinical areas visited were clean and well maintained. Environmental and equipment audits were being carried out in clinical areas visited, this is discussed further under national standard 2.8. There were environmental and equipment decontamination books in place in clinical areas visited, these included checklists of items to be cleaned on a daily and monthly basis. Inspectors reviewed these checklists and noted that the records were up to date. In addition to the checklists, there was a tagging system in place, for equipment in low use, documenting when the equipment was last cleaned.

Clinical nurse managers expressed that they were satisfied with the level of cleaning and access to maintenance services. Maintenance staff were located off site, however, there was a new maintenance manager in post, based on site at the hospital. This was an improvement on a previous inspection of the hospital in June 2022 when there had been no on-site maintenance presence. As discussed under national standard 5.8, quality and safety walk arounds had been introduced in the hospital. Staff provided positive feedback to inspectors on the walk arounds, and told inspectors that long-standing maintenance items had been addressed due to actions arising out of the walk arounds. This was noted in walk around minutes reviewed by inspectors, which documented actions in relation to for example, maintenance on ward doors and a damaged work station being replaced on St Anne's ward and the heating system being repaired in one of the offices in the medical assessment unit.

In summary, inspectors found improvements had been made at the hospital since the last inspection in relation to the maintenance of the physical environment in clinical areas. These included the on-site presence of a maintenance manager and the implementation of quality and safety walk arounds which had addressed some maintenance issues. However, while the hospital had implemented a number of mitigating factors to minimise the risk of the spread of healthcare acquired infections, outbreak reports identified:

[†††] Clinical hand wash basins should conform to *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

- a lack of isolation facilities at the hospital which had contributed to outbreaks of infection within the hospital.

Judgment: Substantially compliant

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

While there were systems and processes in place at the hospital to systematically monitor, evaluate and continuously improve the effectiveness of the healthcare provided there, clinical handover was not being audited at the hospital, and not all audits had resulted in time-bound assigned actions to address findings.

As discussed under national standard 5.8, hospital management are publicly reporting data required for Hospital Patient Safety Indicator Reports (HPSIR). This information was used to assess the quality and safety of services provided and to benchmark performance.

Audit activity in relation to infection prevention and control is overseen by the infection prevention and control team. Audits routinely undertaken include hand hygiene, environment and patient equipment audits. The household team also carry out environment and equipment audits. There were high levels of compliance noted from completed audits reviewed by inspectors. For example; hand hygiene audit scores averaged from January to May 2024 for the medical assessment unit and injury unit and for St Anne's ward were above 93% (target 90%). Patient equipment scores for the same time period were 97.2% and 90.3% respectively. Infection prevention and control audits had been carried out by the infection prevention and control team in March 2024 for the medical assessment unit and injury unit and in April 2024 for St Anne's ward. These audits covered 15 audit areas including the general environment, sharps management, and patient equipment. Overall compliance scores for the medical assessment unit and injury unit, and St Anne's ward for these suite of audits were 95% and 97% respectively (target 85%), and results, observed by inspectors, were emailed to the clinical nurse manager. Items highlighted for improvement within these audits included the general environment with scores of 85% for both areas. Even though the target compliance level was met, assigned, time-bound quality improvement plans were produced to address areas for improvement, which included floor and ceiling repairs, which were escalated to maintenance staff. Compliance with Carbapenemase Producing *Enterobacterales* (CPE) screening was audited at the hospital in September 2023, with 100% compliance achieved.

There was an audit plan in place in the hospital in relation to medication safety. At the time of the inspection, monthly audit was being carried out in relation to Venous

thromboembolism (VTE)[‡‡‡] risk assessment and quarterly antimicrobial prescribing process indicators were being measured. Audits in relation to insulin prescribing and medication management had been added to the audit plan for 2024 but had not yet commenced at the time of the inspection.

Audits in relation to deteriorating patients such as the Irish National Early Warning System and sepsis audits were being carried out in the hospital. Inspectors noted that there was high compliance with Irish National Early Warning System audits in the clinical areas visited with the medical assessment unit scoring 94.9% in February 2024 and St Anne's ward scoring 98.2% in March 2024. Staff described and documentation outlined areas for improvement. These included documentation that appropriate escalation to the nurse in charge had occurred. A hospital-wide sepsis audit in the first three months of 2024 highlighted that completion of all relevant sections of the sepsis form was an area for improvement. However, there was no time-bound assigned action plan arising from this audit to address the findings. Clinical handover effectiveness was not being audited in the hospital at the time of the inspection in line with national guidance.

Compliance with performance indicators in relation to transitions of care and patient flow are monitored in the hospital including the number of attendances to the medical assessment unit and injury unit, patient experience times, delayed transfers of care and average length of stay.

On the first day of inspection, the average time patients spent waiting in the medical assessment unit for medical review was 35 minutes. For April 2024, 83% of patients were admitted or discharged within six hours of registration in the unit, this meant that the target of 75% had been achieved. This was a slight improvement on the figures from 2023 where 81.4% compliance had been achieved.[§§§] From January to April 2024, approximately 15% of patients attending the unit had been admitted to an inpatient bed in the hospital. This was a decrease on the same time period in 2023, where 17% of patients had been admitted. On the first day of inspection, the average time patients spent waiting for medical review in the injury unit was 18.5 minutes and the average time for their episode of care to be completed was 60 minutes. Delayed transfers of care in the hospital were being monitored. At the time of inspection, these were being managed with low numbers reported.

Inspectors observed a quality board in St Anne's ward displaying information in relation to performance with key metrics. Test your care metrics were recorded in the ward, and results reviewed showed high levels of compliance (98-100%). The CNM 2 in the medical assessment unit and injury unit was measuring a number of performance measures in both units based on test your care metrics. One quality improvement implemented in response to these findings was to improve documentation that a meal had been given to patients at set meal times. A

[‡‡‡] Venous thromboembolism is a blood clot that forms in a vein.
[§§§] Data for percentage of patients who are discharged or admitted from AMAU within six hours of AMAU registration, reporting period September 2023. HSE Management Data Report.

documentation audit carried out in the injury unit in March 2024 showed 100% compliance for documentation of medication allergies.

In summary, there were systems and processes in place in the hospital to monitor, analyse, evaluate and respond to information in relation to the quality and safety of care provided in the hospital. Notwithstanding this:

- clinical handover was not being audited in the hospital in line with national guidance
- there was no time-bound assigned action plan arising from a hospital-wide sepsis audit to address the audit findings.

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.

While there were systems and processes in the hospital to identify, evaluate and manage immediate and potential risks to patients, in relation to the four areas of focus, to protect them from harm, some areas required attention. For example; at the time of inspection some policies were in draft format and or due for update.

Risk registers were in place at local level and these were available to view on the hospital's shared drive. Staff in clinical areas visited stated that they were supported by the Quality Safety and Risk department in undertaking risk assessments. In general, staff were knowledgeable in relation to risk management and understood the particular risks relevant to their clinical area. For example, one of the risks recorded on the risk register in the medical assessment unit was the risk of self-presenters that fell outside of the acceptance criteria. From a review of the risk register, inspectors noted that there were controls in place to manage this risk which staff were able to describe to inspectors.

The infection prevention and control team carried out risk assessments to inform risks recorded on the hospital's risk register, and this was discussed at infection prevention and control committee meetings and recorded in meeting minutes reviewed by inspectors.

Patients with infection prevention and control alerts were flagged on the hospital's laboratory system, which was checked the day prior to patient procedures so that an isolation room could be assigned. On admission to the hospital, patients were screened for Multi-drug resistant organisms (MDROs) in line with national guidance in clinical areas visited. For example; Methicillin Resistant *Staphylococcus Aureus* (MRSA) and Carbapenemase Producing *Enterobacterales* (CPE). Patients showing respiratory symptoms were screened for COVID-19 and influenza. There was a patient

placement policy in place at the hospital. Patients requiring transmission-based precautions were isolated as per the advice of the infection prevention and control team in line with the patient placement policy. Weekly antimicrobial stewardship rounds were carried out in clinical areas by the consultant microbiologist and antimicrobial stewardship pharmacist. There was evidence of clinical pharmacy review in the antimicrobial section of patient medication prescribing and administration records reviewed by an inspector. For example, a recommendation to switch to oral antibiotics had been accepted. Antimicrobial administration guidance was displayed in clinical areas as observed by inspectors.

There was a clinical pharmacy service in the hospital Monday to Friday, clinical pharmacists visited the medical assessment unit five times a week, Monday to Friday, and visited St Anne's ward daily. Medication reconciliation was undertaken for all patients on admission and discharge. Inspectors were told that clinical pharmacists undertook medication reconciliation and patients' medication prescription and administration records reviewed by inspectors showed that medication reconciliation and clinical pharmacy review had been undertaken for those patients. There was a pharmacy technician service for stock control to all ward areas and to the medical assessment unit. Access to medicines information at the point of prescribing and administration was readily available. This included information on the hospital's shared computer drive and access to St Vincent's University Hospital's medicines information on computers. There was a list of high-risk medicines and sound-alike look-alike drugs (SALADS) in the medicines safety folder on the hospital's shared computer drive, this was demonstrated to inspectors who also noted the information displayed in St Anne's ward.

The Irish National Early Warning System was implemented in the hospital to manage the recognition and response to patients with acute clinical deterioration. As discussed under national standard 2.8, there was high compliance in relation to escalation and response. The Identify, Situation, Background, Assessment, Recommendation (ISBAR) tool was in use in the hospital to escalate patients that were deteriorating. Resuscitation officers could be called to review deteriorating patients. One of the single rooms in the medical assessment unit was designated as a resuscitation bay. Scenario-based training on responding to deteriorating patients, such as those in cardiac arrest, was provided by the resuscitation officers every Monday in the medical assessment unit. Staff who carried the cardiac arrest bleep and responded to cardiac arrests, could also be contacted to review deteriorating patients through a medical emergency team bleep call. Patients requiring a higher level of care were transferred to the observation unit in Lourdes ward or transferred out of the hospital by ambulance. There was a system in place to manage self-presenters to the medical assessment unit that were outside of the acceptance criteria. These patients were reviewed by a doctor and senior nurse and stabilised prior to transfer to a more

suitable hospital, such as St Vincent's University Hospital. On the days of inspection, no patient self-presented to the medical assessment unit.

Access to the medical assessment unit for patients 16 years and over is through appointment only. Patients are referred to the medical assessment unit from general practitioners (GPs), the National Ambulance Service and St Vincent's University Hospital. There are strict inclusion and exclusion referral criteria in place. There were systems and processes in place in the hospital to promote safe transitions of care and safe discharge. For example;

Bed capacity and potential transfers and admissions to the hospital are discussed at various meetings throughout the day. These include:

- 9am whiteboard discussions in relation to patients being cared for
- 9.30am bed management meeting attended by the director of nursing (DON)
- 10.30am daily operational safety huddle, which some staff remotely access by telephone
- 11.15am 'navigational hub', attended by the infection prevention and control team to discuss appropriate patient placement and also accessed by telephone
- 4pm multidisciplinary whiteboard discussion in the medical assessment unit to make final decisions on patient discharges and admissions
- 6pm daily bed status handover to the site manager.[****]

During the afternoon of day one of the inspection, inspectors observed good patient flow within the unit. A process for the predicted date of discharge had been implemented in the hospital and had been incorporated into the medical assessment unit's patient assessment documentation, admission form, and the patient admission booklet. Inspectors observed that predicted dates of discharge had been recorded on a whiteboard in St Anne's ward. Predicted dates of discharge and factors impacting on discharges were discussed at daily ward rounds at 4pm. There are weekly multidisciplinary meetings attended by bed management and delayed discharges are discussed at this meeting.

Inspectors noted there were a number of initiatives introduced at the hospital to shift the focus of care to being provided closer to people's homes, thereby reducing unnecessary hospital admissions. Some of these initiatives were in collaboration with St Vincent's University Hospital. For example; in collaboration with St Vincent's University Hospital, an 'Emergency Department in the Home' (EDITH) service was provided by hospital staff, providing some care in the home to patients, and as a result, avoiding a potential hospital visit. Other measures include a candidate (in training) advanced nurse practitioner for frailty, a multidisciplinary frailty intervention therapy team (FITT) and an admissions coordinator all of which work to assess

[****]A site manager is a hospital manager, usually a nurse, who manages the hospital site outside core working hours.

whether patients require admission or can be supported in other ways, including care in the home and return visits to review clinics. Some of these review clinics were virtual between the patient and hospital staff, and as a result, this avoided unnecessary travel to the hospital by these patients. A GP liaison nurse is in place who coordinates medical assessment unit appointments, and also links in regarding patient needs within the community; for example, with the community intervention team (CIT) and the integrated care programme for older persons (ICPOP). The medical assessment unit and injury unit have a number of review clinics in place, some of which help to avoid admission; for instance, diagnostic review clinics, where patients can return home until blood results and diagnostic imaging results are available. Inspectors were told by staff in both units that access to diagnostics was generally good and this helped to avoid admission.

There was an 'Inter-ward handover sheet' in place for direct ward-to-ward transfer and an 'Inter-hospital transfer patient handover form' in ISBAR format and this was also used for nursing home transfers. Nursing shift handover forms shown to inspectors were also in ISBAR format. Staff stated that in St Anne's ward, safety huddles took place at shift handover and safety concerns were also documented in a communication folder in the ward. At the time of the last inspection of the service in June 2022, there was no face-to-face handover taking place between doctors at shift handover. During this inspection, there had been improvement in this area, with medical and nursing staff telling inspectors that face-to-face handover was taking place between doctors following shifts where they were on call. As part of a quality improvement initiative a 'Medical on-call handover form' in ISBAR format had been introduced and this was provided to inspectors. There was an 'Acute Medical Pathway to Refer and Transfer Patients from St Vincent's University Hospital to St Columcille's Hospital' in place and this detailed the acceptance criteria for transferred patients. Inspectors were informed and documentation reviewed confirmed that medical consultants made final decisions on whether to accept transfers from St Vincent's University Hospital and transfers to the medical assessment unit from the national ambulance service.

Staff demonstrated how to access policies, procedures, protocols and guidelines on the hospital's computer system. There were a number of policies and procedures in place in relation to the four areas of focus of this inspection, and almost all of these were up to date. At the time of the inspection, the medication management policy was being reviewed and a draft admissions policy and draft clinical care communication and handover policy were near completion.

In summary, hospital staff were minimising the risk of harm to patients associated with the design and delivery of safe healthcare, with one area for action identified:

- Some policies required updating and or were in draft format and not yet approved for use.

Judgment: Substantially compliant

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

There are effective oversight arrangements in place at the hospital in relation to identifying, reporting, managing and responding to patient-safety incidents. Discussion of patient-safety incidents and serious reportable events (SREs) took place at the clinical incident review group (CIRG) as discussed under national standard 5.8. Incident data was discussed at the executive management committee, quality safety executive committee and clinical governance committee as shown by meeting minutes reviewed by inspectors.

The National Incident Report Form (NIRF) was not in use at the hospital, instead, patient-safety incidents were reported using one of three tailored report forms; a medication safety report form, a falls incident review form and an incident occurrence form for general patient-safety incidents. Patient-safety incidents were reported to the National Incident Management System (NIMS).[††††] Hospital management were publicly reporting on the rate of clinical incidents as reported to NIMS per 1000 bed days through Hospital Patient Safety Indicator Reports (HPSIR). This had not been the case at the time of a previous inspection in June 2022. There was a high level of compliance in the hospital with entry of patient-safety incidents on to NIMS within 30 days of notification. An average of 94% compliance had been achieved within a rolling year (target 70%). This was an improvement on previous inspection findings in June 2022, where the target for reporting of patient-safety incidents on to NIMS had not been met. At the time of the inspection, training in relation to electronic point of entry for patient-safety incidents directly into NIMS was underway, with staff due to move to this new process in June 2024.

Tracking and trending of patient-safety incidents was taking place at the hospital. An annual incident report was produced. This included the number, type and location of patient-safety incidents. Separate reports every three months in relation to medication related patient-safety incidents were produced, which outlined the type and location of where these incidents had occurred and detailed the most common types of prescribing incidents. Staff told inspectors that medication related patient-

[††††] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
[††††] HSE –Incident Management Framework and Guidance. 2020. Available online from: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

safety incidents were discussed at the drugs and therapeutics committee, this was noted in minutes of committee meetings reviewed by inspectors.

Staff who spoke with inspectors were knowledgeable about how to report and manage patient-safety incidents. Inspectors were told that patient-safety incidents were discussed at weekly nurse manager meetings and at safety huddles in clinical areas visited.

In summary, there are effective oversight arrangements in place at the hospital in relation to identifying, reporting, managing and responding to patient-safety incidents. Improvements compared to previous inspection findings from June 2022, in relation to public reporting of patient-safety incident rates and compliance with key performance indicators in relation to timely reporting of incidents into NIMS were noted by inspectors on this inspection.

Judgment: Compliant

Conclusion

An unannounced inspection of St Columcille's Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*.

Overall, inspectors found evidence of good levels of compliance with national standards on this inspection. Areas that required addressing, related to infrastructural issues in the hospital and a number of unfilled senior management vacancies at the time of the inspection. Improvements from a previous inspection of the service in June 2022 were noted by inspectors. These related mainly to committee reporting structures, which had been strengthened since the last inspection.

Capacity and Capability

Inspectors found that there are formalised governance arrangements and effective management arrangements in place in the hospital for assuring the delivery of high-quality, safe and reliable healthcare, in relation to the four areas of focus of this inspection. However, a number of senior management positions were vacant at the time of inspection, and the existing governance arrangements in place were not sustainable in the long-term. Improvements since a previous inspection of the service in June 2022 noted by inspectors included: terms of reference of committees were up to date, committees were meeting at the frequency set out in the terms of reference and committees were reporting to the relevant governance structures.

The systematic monitoring arrangements in place in the hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided had been improved since a previous inspection of the service. Monitoring structures such as the clinical incident review group and the clinical audit committee which had not been meeting regularly in the past were found on this inspection to be meeting at the frequency set out in their terms of reference.

As mentioned earlier, a number of senior management positions in the hospital were vacant or filled on an interim basis at the time of this inspection. However, in general, the workforce arrangements supported and promoted the delivery of high-quality, safe and reliable healthcare in the hospital.

Quality and Safety

Staff who spoke with inspectors were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff at the hospital had introduced a number of initiatives to improve the experience of patients in the hospital. It was clear to inspectors that patient feedback was valued by staff at the hospital. Inspectors found that complaints received by the hospital were well-managed.

The physical environment in clinical areas visited did not fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users. This was due, to infrastructural issues at the hospital. There was a lack of isolation facilities at the hospital, and this had contributed to outbreaks of infection at the hospital. Issues with the hospital infrastructure were recorded on the hospital's risk register and had been escalated to the hospital group. These issues require capital investment and building works to remedy.

The effectiveness of the healthcare provided in the hospital was systematically monitored, evaluated and improved. One area that was not being audited at the time of inspection was the effectiveness of the clinical handover processes in the hospital. Additionally, there were systems in place in the hospital to protect service users from the risk of harm, in particular, in relation to the four areas of focus of this inspection. This included infection prevention and control, medication safety, acute clinical deterioration and safe transitions of care. Most policies, procedures, protocols and guidelines related to these areas of focus were found to be up to date, with some requiring review. There are effective oversight arrangements in place at the hospital in relation to identifying, reporting, managing and responding to patient-safety incidents.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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	Compliant

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

Appendix 2 – Compliance Plan Service Provider's Response

Compliance Plan St Columcille's Hospital

OSV-0001101

Inspection ID: NS_0079

Date of inspection: 15 and 16 May 2024

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

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

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

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

Committee Terms of Reference:

- All committee Terms of Reference (TOR) have been reviewed and frequency has been added, revised members, and roles within committee.
- Committee secretary has been appointed with responsibilities including:
- Creation of a yearly schedule of meetings, submitted to the QSR department.
- QSR send reminder notifications for meetings.

Quality, Patient Safety and Risk Department (QSR)

QSR maintain a strong governance database to ensure compliance and enhance accountability and has implemented the ISBAR Committee Compliance Bundle and introduced a suite of templates as a monitoring arrangement.

Achievements include:

- Revised and implemented a committee reporting structure, with a clear committee organogram disseminated to all committees.
- All committees identify key and regular TOR revisions which include frequency.
- Implementation of a standard TOR template.
- Monitoring of committee meeting activity and attendance compliance.
- Annual committee reports submitted to the QSR Department, identifying actions, outcomes, and recommendations.

Measurable

- A Committee Compliance Database is maintained in the QSR department to monitor and manage committee activity to ensure compliance.
- Requirements include an annual committee meeting schedule, quorum achievement, TOR revision and frequency and submission of an annual report incorporating the ISBAR tool.
- All ISBARs are sent to relevant committees under committee governance structure.

Achievable

- QSR ensure all TORs are compliant and ensure frequency is documented and adhered to.
- QSR collate the compliance bundles and develop and disseminate annual committee compliance report and include schedule of meeting for year ahead.
- Focus on identifying governance gaps, reporting on key priorities, evaluating progress, and planning action steps.

Realistic

- Committees are operationally accountable and report to the respective governance committees as per committee governance organogram.
- All committees have frequency and schedule of meetings year ahead and is monitored by QSR.
- QSR department submit compliance / non-compliance reports to the relevant governance committees and ensure action plans are developed and actioned.
- Quality, Safety and Risk Coordinators oversee frequency of committee meetings.

Timely

- QSR ensure all TORs have been revised and schedule of meetings developed and booked.
- Committee Annual Report template disseminated by the end of Q3 each year and ISBARs are completed by end of Q4 and submit to governance committees.
- Annual reports submitted from committees to the QSR department by the end of January of the subsequent year for dissemination to relevant governance committees as per reporting schedule and committee governance structure.

Vacancies in senior management positions:

The General Manager resumed their permanent role on 20th May 2024.

The Operations/Deputy Manager resumed their role on 20th May 2024.

All temporary Executive Management team vacancies have been submitted to the REO for approval.

To date SCH have been approved the following senior manager positions for Stage 1 of recruitment:

- Quality, Safety & Risk Manager
- Human Resources Manager
- General Support Services Manager
- Centre Obesity Management Operations Manager
- Finance support Manager

Timescale:

Committees - Q3 2024 – Implemented

Vacancies – In progress