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 Mary's Hospital, Rehabilitation and Community Inpatient Healthcare Service
Address of healthcare service:	Phoenix Park, Chapelizod, Dublin
Type of inspection:	Announced
Date(s) of inspection:	18 and 19 July 2023
Healthcare Service ID:	OSV-0007277
Fieldwork ID:	NS_0046

About the healthcare service

St Mary's Hospital, Phoenix Park was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 9.* St Mary's Hospital comprised 101 beds.

The hospital accommodated 101 rehabilitation beds. Patients were admitted from referring hospitals for various types of rehabilitation including stroke rehabilitation and medical rehabilitation. The hospital also accepted patients for rehabilitation from the community and from the Integrated Care Programme for Older Persons.†

Patients in the units had access to a wide ranging multidisciplinary team which included for example a Consultant-led medical team, physiotherapy, occupational therapy, dietetics and psychology. Admission to the unit was through referral from a Consultant Geriatrician and or following an episode of acute care from a number of nearby acute hospitals including; the Mater Misercordiae University Hospital, Connolly Hospital Blanchardstown and St James's Hospital or directly from the community.

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. To prepare for this inspection, inspectors‡ reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information§ and other publically available information. During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the unit

* HSE Community Health Organisation 9 area consists of Dublin North, Dublin North Central and Dublin North West

† The aim of the integrated Care Programme for Older Persons is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.

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

§ 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.

- 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 under two dimensions of *Capacity and Capability* and *Quality and Safety*.

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 unit. 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 July 2023 19 July 2023	08.45 – 15.30hrs 08.45 – 13.15hrs	Emma Cooke	Lead
		Nora O' Mahony	Support
		Danielle Bracken	Support

Information about this inspection

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

- infection prevention and control
- medication safety
- the deteriorating patient
- transitions of care.[**]

The inspection team visited Blasket ward and Lambay ward and met with staff on Valencia ward.

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

- Interim Director of Nursing, St Mary's Hospital
- Clinical Nurse Manager Blasket ward
- Clinical Nurse Manager Lambay ward
- Clinical Lead, St Mary's Hospital- Consultant Geriatrician
- Senior Pharmacist, St Mary's Hospital
- Quality and Patient Safety Advisor, CHO9
- Infection Prevention and Control Advisor, CHO9
- Operations Manager, St Mary's Hospital

Acknowledgements

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

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

During the inspection inspectors spoke with patients accommodated in the clinical areas visited. Patients stated they were happy with the care they received and were very complementary of staff.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the many patients spoken with. Patients' comments referenced that staff

[**] 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

"*were gentle and kind"* and *"really nice', "we just have to ask for something and it is done" "very well looked after."*

Most people spoken with knew who to speak to if they wished to raise an issue and stated they could speak with staff if they had a concern or complaint.

Capacity and Capability Dimension

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

Inspectors found that there were clear lines of accountability and responsibility in relation to corporate and clinical governance arrangements at St Mary's hospital.

Organisational charts setting out the hospital's reporting structures for nursing structures, management structures and governance and oversight committees submitted to HIQA detailed the direct reporting arrangements for hospital management and accountability relationship to the Head of Older Persons Service CHO9.

Through discussion with staff and senior management, it was evident that the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for healthcare services at the hospital and CHO9 level. However, organisational charts did not always accurately reflect names of accountable or reporting committees as set out in terms of reference for various committees. In addition, inspectors were informed that two clinical areas remained under the medical governance of Connolly Hospital as patients within these areas had been referred directly from this hospital. All other aspects of these patients' care (for example, nursing, health and social care professionals) fell under the remit of St. Mary's Hospital. While these arrangements were supported by a service level agreement, organisational charts did not set out the integrated clinical and corporate reporting structures and arrangements for these clinical areas. Furthermore, it was not clear how issues such as risk management were being managed or escalated for these clinical areas. This was identified as an opportunity for improvement in terms of formalising these reporting structures and arrangements following this inspection.

The interim Director of Nursing (DoN) was responsible for the operational management of the hospital campus and reported to the Hospital Manager and the Director of Nursing for Older Persons Services, CHO9, who reported to the Head of Older Persons Services, who in turn reported to the Chief Officer (CO). The CO reported to the National Director Community Operations, Health Services Executive (HSE). The interim DoN was supported by an Assistant Director of Nursing (ADON) and Clinical Nurse Managers (nine CNM 2 and seven CNM 1 grades). It was reported that the interim DoN post would be vacant following

this inspection and that an interim arrangement would be in place with the post being covered by the Group DoN pending the appointment of a permanent DoN at the hospital. The hospital should progress with plans outlined to inspectors to fill the position of a permanent DoN at the hospital.

Nursing and support staff within the clinical areas reported to a CNM2. Health and social care professionals for example dietitians, physiotherapists and occupational therapists reported within the CHO9 community structures.

Medical cover was available twenty-four hours a day, seven days a week. Five consultant physicians were responsible for the medical care of patients admitted to the hospital, some of which had joint positions with referring hospitals.

At CHO9 level

The Quality, Safety & Service Improvement Department (QSSI)

Under the governance of the CO, and led by a Head of Service, the QSSI Department was set up to drive quality, safety and service improvement strategies through a systematic approach and standardisation of all aspects of services in CHO9. A Quality Patient Safety (QPS) Manager QSSI, reported to the Head of Service. The Quality and Patient Safety Advisor for CHO9 reported to the QPS Manager and worked with and supported local management/key stakeholders in services in CHO9 on all matters relating to identifying quality improvement opportunities.

Community Healthcare Organisation Dublin North City and County Older Persons Management Team Meeting

The Hospital Manager and interim DoN represented St Mary's Hospital at the Older Persons Management Team Meeting. Updates in respect of unscheduled care activity, infection prevention and control, human resources, policies and individual service updates from all the relevant services within CHO9 remit were provided at these meetings.

Dublin North City and County (DNCC) Infection Prevention and Control Steering Committee

CHO9 had an Infection Prevention and Control Committee established at community healthcare organisation level. Chaired by the CHO9 area DoN, the committee met quarterly. Two infection prevention and control nurses from St Mary's hospital represented the hospital at this committee. This committee reported to and were accountable to the QSSI committee.

The hospital had access to an antimicrobial pharmacist at CHO9 level, however, this service was not comprehensive at the time of inspection due to leave.

Dublin North City and County (DNCC) Drugs and Therapeutics Oversight Committee

CHO9 had a Drugs and Therapeutics Committee established at community organisation level to provide governance and oversight of medication safety practices across primary and social care within CHO9. The committee met every three months and the interim DoN represented St Mary's Hospital at this committee. Minutes of meetings reviewed outlined that updates from local Drugs and Therapeutics Committees were a standing item agenda along with medication errors, safety notifications and other matters relating to medication safety such as antimicrobial stewardship, medication shortages and audit activity. This committee reported to and were accountable to the QSSI committee.

Local Hospital Committees

Hospital management had a number of local committees to ensure that appropriate and effective systems were in place to cover all aspects of quality and patient safety:

Senior Management Team (SMT)

The hospital's Senior Management Team was responsible for reviewing the operational issues of St Mary's Hospital. Among its many functions, the team were responsible for reviewing operational issues and activity relating to infection prevention and control, staffing, quality and patient safety issues, finances and HSE related matters. Chaired by the Hospital Manager, the committee met weekly and followed a standard agenda. However, terms of reference did not outline who the committee reported to. Attendees included the interim DoN, Clinical Lead, Human Resources Advisor, Operations Manager, General Services Manager and a representative for Health and Social Care Professionals. Minutes of meetings reviewed outlined updates in respect of incidents, capacity, patient flow activity and updates from relevant departments including nursing, human resources and general services. However, meeting minutes reviewed evidenced that while meetings followed an agenda, actions were not always clear and no time-bound assigned actions were noted or monitored from meeting to meeting. In addition this team was not represented on any organisational charts submitted to HIQA. This represents an opportunity for improvement.

Quality and Patient Safety Committee

The Quality and Patient Safety Committee was reconfigured in 2022 to align with the Quality and Patient Safety Committee at CHO9 level. The aim of the committee was to develop, deliver, champion, implement and evaluate a quality and safety programme for the service. The committee, co-chaired by a Consultant Physician in medicine and the Hospital Manager, met quarterly and were accountable to the Senior Management Team. Minutes of meetings reviewed outlined that meetings followed a structured agenda, were action orientated with persons responsible assigned and progress with actions was monitored from meeting to meeting.

The hospital had a Quality and Patient Safety Advisor who was responsible for co-ordinating update reports from each department and committee within the hospital in advance of the quality and safety committee meeting. The QPS Advisor for the hospital was also a member of the QSSI department and provided updates to this department on behalf of the hospital in relation to risks and quality and safety at the hospital. Quality and safety reports reviewed by inspectors were comprehensive and demonstrated updates from committees and departments, complaints and compliments, audit activity, compliance with standards and regulations.

Infection Prevention and Control and Antimicrobial Stewardship Committee

The hospital had a local Infection Prevention and Control and Antimicrobial Stewardship Committee to provide strategic leadership and direction on infection prevention and control activities across the hospital site. Chaired by the interim DoN, the committee met every two months. Terms of reference outlined that the committee were operationally accountable to the Hospital Governance Group, however, this group was not represented on any organisational charts submitted to HIQA. The committee were also accountable to the CHO9 DNCC IPC Committee and to the Head of Older Persons Services CHO DNCC as required. Meeting minutes reviewed reflected that while some actions were identified, they were not always assigned to an identified person and actions were not always time-bound.

The hospital had two infection prevention and control nurses who provided a service across the St Mary's Campus and were members of the Dublin North City and County (DNCC) Infection Prevention and Control Steering Committee. There were also 18 link infection prevention and control practitioners on the St. Mary's Campus.

Drugs and Therapeutics Committee

The hospital's Drugs and Therapeutics Committee was responsible for providing overall governance of the medication use process at the hospital. Chaired by a Consultant Geriatrician, the committee met every two months. Terms of reference reviewed outlined the committee's many functions and membership was multidisciplinary. Minutes of meetings reviewed outlined that the committee followed a standard agenda and included items such as; medication variances and errors, antimicrobial stewardship and safety notices. Meetings were action orientated with actions time-bound and assigned to individuals. There was evidence that progress with actions was monitored from meeting to meeting.

In summary, St Mary's hospital had corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare, however there was scope for improvement with regard to the following:

- the hospital should update existing organisational charts to ensure they reflect reporting and accountability structures outlined by hospital management and as set out in the terms of reference of various committees.

- the hospital should formalise reporting structures and clinical governance arrangements for clinical areas with service level agreements in place with other hospitals.
- a number of committee meeting minutes would benefit from having clearly defined, time-bound actions that are assigned to individuals for all committee meetings that take place.

Judgment: Substantially compliant

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

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

Infection, prevention and control (internal)

The hospital had two infection and prevention control nurses, one of which was dedicated to the short stay unit. Each clinical area had an infection prevention and control link practitioner who provided guidance and training on matters concerning infection prevention and control.

A comprehensive infection prevention and control work plan and action log for 2023 was developed at CHO9 level and included items such as monitoring of infection prevention and control related data, education and training and audit activity. Progress with the work plan was monitored by a task tracker which outlined progress with actions identified and numbers of actions that had been completed or yet to be started. There was evidence of good progress made in relation to education and building infection control and antimicrobial stewardship capacity across the CHO9 area.

The hospital did not have access to a designated microbiologist for the hospital. Access to microbiology advice was available from the patient's referring hospital as required. The impact of this was identified by the hospital as a risk and was on the hospital's risk register. This is further discussed under national standard 3.1.

Medication safety (internal)

The hospital had a formal arrangement with an external pharmacy supplier who was also represented on the Drugs and Therapeutics Committee and provided regular updates at meetings. The hospital had an onsite pharmacy service, however, this was limited to the supply of controlled medication (MDA medications) only. The external pharmacy service provided a Chief Pharmacist and a pharmacy technician to the hospital who provided a

clinical pharmacy service Monday to Friday, a seven day dispensing service and an out-of-hours emergency service. Management outlined and staff confirmed the arrangements in place for access to the external service during and out-of-hours and were satisfied with the level of clinical pharmacy cover and access to medication provided by the service during and out-of-hours.

The hospital had processes in place for the safe use of medication and practices were reviewed and monitored regularly through internal audit by the hospital and external audit by the external pharmacy supplier. A medicine safety strategy 2022-2025 outlining nine goals was developed for the hospital campus. Each of these goals had associated objectives and measureable indicators identified for achieving these objectives. However, it was not clear how many objectives or goals had been achieved as progress updates with the strategy were not clearly outlined.

The deteriorating patient

While the hospital did not have a deteriorating committee, processes were in place to guide and inform staff on how to manage and care for a patient whose health status was deteriorating. In the event of a patient becoming acutely unwell and requiring transfer to an acute hospital, the medical team arranged the patient's transfer by ambulance to the accepting hospital. The hospital also had a repatriation agreement in place with each referring hospital whereby an arrangement was in place for the patient to be transferred and accepted back to the referring hospital from which they were transferred from. This was guided by a transfer policy and is further discussed under national standard 3.1.

Transitions of care

Inspectors were informed that while the hospital did not have a formal transitions of care committee, the interim DoN and Operations Manager were responsible for patient discharge/transfer and operationally accountable to the Hospital Manager. It was evident that bed management, admissions and transfers featured in other hospital committee meetings and at a weekly case conference meetings. Hospital management also outlined that pharmacy expertise was sought when required where discharge planning for patients involved complex medication regimes.

Overall, the hospital had effective management arrangements in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm. Opportunities for improvement were identified in relation to the following:

- the need to ensure that there is access to a designated consultant microbiologist for the hospital
- evaluate progress made with goals and objectives set out in the hospital's medication safety strategy.

Judgment: Substantially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Minutes of meetings reviewed reflected that performance data was reviewed at meetings internally and at CHO9 level.

Monitoring service's performance

The hospital collected data on a range of different measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents, clinical audit, service user feedback, infection prevention and control surveillance and workforce. It was evident that collated performance data was reviewed at hospital and CHO9 level meetings.

Risk management

The hospital had risk management structures and processes in place to proactively identify, analyse, manage and minimise identified risks. Risks that could not be managed at clinical level were escalated to the Senior Management Team and recorded on the hospital's corporate risk register.

The Senior Management Team and Quality and Patient Safety Committee had oversight of the management of identified risks. Risk registers were reviewed formally on a quarterly basis by the Senior Management Team. The Quality and Patient Safety Advisor also met with the CHO9 Area Manager on a quarterly basis to review the hospital's risk register. There was evidence that the risk register was informed by multiple data sources including clinical incidents and regularly reviewed and updated. However, some risks on the register were noted to be closed but remained on the register. While it was reported that risk assessments were completed at clinical area level, inspectors only saw evidence of this in one of the clinical areas inspected. The management of reported risks related to the four areas of known harm is discussed further in national standard 3.1.

Audit activity

The Quality and Patient Safety Committee had oversight of clinical audit activity, however there was no clinical audit facilitator to co-ordinate audit activity at the hospital. Audit activity was overseen by the relevant department, for example, medication safety audits were overseen by the Drugs and Therapeutics Committee and nursing audits were overseen by the nurse practice development department. Hospital management outlined that a clinical audit facilitator was a resource required by the hospital and that an overarching audit committee was previously in place but this had yet to be re-established. Notwithstanding this, audit plans were in place for relevant departments and outlined in

quality and safety reports submitted to HIQA. Findings and the learnings from audit activity were shared with staff in the clinical areas through the use of information boards and at clinical handover. Audits will be discussed further in national standard 2.8.

Management of serious reportable events and patient-safety incidents

The hospital's Serious Incident Management Team had oversight of the management of serious reportable events (SREs) and patient-safety incidents which occurred in the hospital. The team were responsible for ensuring that all category 1 and SRE incidents were managed in line with the HSE's Incident Management Framework. Chaired by the Hospital Manager, the SIMT reported to the Quality and Patient Safety Committee and were accountable to the Senior Management Team. The committee met on a scheduled basis to monitor and gain assurance in relation to the on-going management of all category 1 incidents and serious reportable events and also convened on an unscheduled basis to review new category 1 incidents. Evidence from meeting minutes confirmed that SREs were discussed at senior management team meetings and quality and patient safety meetings, evidencing good oversight of SREs within the hospital. Inspectors were informed by staff in clinical areas visited that learning from SREs was discussed and shared and that action plans were implemented as required.

There were effective systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. Patient-safety incidents were logged on the National Incident Management System (NIMS)[††] in line with the HSE's Incident Management Framework. Incident reporting process flow charts were in place to guide and support staff in the clinical areas when an incident occurred. Patient-safety incidents related to the four areas of known harm are discussed further in national standard 3.3.

Feedback from people using the service

Quality and Safety Walk rounds commenced in 2022 and were conducted by senior hospital management on a monthly basis. The purpose of these walk rounds was to allow senior management to have a structured conversation around safety with frontline staff and service users. Records of recent walk rounds completed for clinical areas showed that these were aligned to the themes of the national standards and time-bound action plans with persons responsible for addressing these actions were developed in response to findings. There was evidence that service user feedback was obtained, documented and actioned as part of quality and safety walk rounds. An opportunity for improvement identified from a recent quality walk round was the need to issue surveys to patients on discharge to ascertain their feedback on their overall stay. This should be progressed by the hospital. In addition, staff in the clinical areas reported that reports and action plans in respect of walk rounds that had been completed in May 2023 had yet to be fed back to staff in the clinical area.

[††] The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

Overall, 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. Opportunities for improvement were identified in relation to:

- ensuring risks that have been addressed and closed were updated on the risk register.
- establishing formalised structures for centrally controlling audit activity at the hospital to promote quality management of the audit process and shared learning.

Judgment: Substantially compliant

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

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. However, there remained a number of staffing deficits across all disciplines at the time of inspection.

It was evident from meeting minutes and from interviews with senior management that workforce was reviewed daily and formally at meetings convened internally and externally at CHO9 level.

A senior clinical decision-maker[‡‡] at consultant level was on-site in the hospital each day. The hospital were approved for 1.95 whole-time equivalent[§§] (WTE) consultant posts which were filled at the time of inspection. Consultants were supported by 10 WTE non-consultant hospital doctors (NCHDs) at registrar grade and senior house officer (SHO) grade. There were three vacant posts (two Registrar and one SHO) at the time of inspection. During out-of-hours the on-call senior house officer was available on site for medical review of patients. There was also access to an on-call registrar and consultant off site. Hospital management and staff reported that this arrangement was currently satisfactory noting that the hospital was not at full occupancy levels but recognised the need to keep the level of out-of-hours medical cover under review given the recent expansion in bed capacity from 70 to 101 beds. Hospital management should review this on a regular basis to ensure the level of out-of-hours medical cover is sufficient to meet the needs of patients.

The hospital's approved complement of nursing staff was 97 WTE. At the time of inspection the actual nursing staff complement was 91.4 WTE resulting in 5.6 WTE deficit.

[‡‡] 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.
[§§] Whole-time equivalent - 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.

Nurse staffing rosters reviewed in the clinical areas inspected showed that on average there was a shortfall of one nurse per shift in the clinical areas. This was as a result of clinical areas not having their approved compliment of nursing staff and long term leave. Shortfalls with nursing rosters was mainly being filled with staff redeployment, staff doing overtime and/or on occasions the use of agency staff.

The hospital were approved for 35.6 WTE healthcare assistants (HCA's) of which 34.6 WTE were in position at the time of inspection resulting in 1.0 WTE vacant post only.

There were a number of vacant posts across all health and social care professionals with the biggest deficit noted in the physiotherapy department where 4 WTE posts out of an approved 12.8 WTE posts were vacant. Furthermore, there was a deficit of approximately 50% of WTE speech and language therapists and 25% of WTE occupational therapists. Inspectors discussed the impact these vacant posts were having on the ability to provide the necessary rehabilitation that this patient cohort required with senior management recognising that there was a potential risk of delayed rehabilitation and longer stays in hospital due to reduced access to services caused by staff shortages from health and social care professionals. Hospital management detailed existing controls in place including the need to prioritise caseloads by triaging patients. There was evidence that staffing shortfalls were kept under review with updates and progress monitored and discussed at senior management meetings.

The human resource department at CHO 9 level, was responsible for workforce management in the hospital. The department tracked and trended staffing levels and absenteeism rates, which were reported at CHO9 meetings. Inspectors were informed that the absenteeism rates for the hospital year-to-date (2023) was 6.2%, which was significantly above the HSE's target of 4% or less.

Staff training

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice every two years.

Training records provided to inspectors for the hospital demonstrated that improvements were required in staff training compliance across a number of areas, in particular infection prevention and control training and outbreak management amongst nursing staff. Training records for doctors were not available at the time of inspection. Hospital management informed inspectors that training records for household cleaning staff were held off site by cleaning contractors.

Records provided showed that staff compliance for hand hygiene fell below the HSE target of 90% for nurses, healthcare assistants and doctors. Health and social care professionals achieved 90% compliance with hand hygiene training.

Compliance with medication safety training for nursing staff was 90%, however, compliance amongst doctors required significant improvement with training records

indicating that only 18% of doctors completed medication safety training in the past two years.

Records reviewed showed that 86% of nurses, 100% of healthcare assistants and 58% of doctors had completed basic life support in the previous two years.

Nurses and healthcare assistants received complaints management training with compliance noted at 51% and 53% respectively.

Hospital management informed inspectors that training records may not be fully up-to-date for all disciplines and that the current system for recording the uptake of mandatory and essential training at the hospital did not facilitate effective oversight of staff training compliance due to the number of systems in place for recording staff 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. This issue should represent a key focus for early improvement efforts following HIQA's inspection.

Overall, inspectors found that hospital management were planning, organising and managing their workforce to support the provision of high-quality, safe healthcare. However, management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients. Opportunities for improvement were identified in relation to the following findings:

- shortfalls in health and social care professional staffing levels needs to be addressed.
- attendance at and uptake of mandatory and essential training for relevant staff requires improvement particularly in areas such as infection prevention and control.

Judgment: Partially compliant

Quality and Safety Dimension

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

Staff promoted a person-centred approach to care and were observed by inspectors as being respectful and caring while maintaining patients' dignity and privacy at all times.

Inspectors noted that staff actively engaged with people using the service throughout the inspection and they were observed being kind and caring in those interactions. Inspectors heard staff communicating with people using the service in relation to their needs and

preference (for example, relating to meals, mobilisation or personal care). Some patients spoken with reported that staff immediately responded to call bells.

Inspectors observed personal privacy for patients was noted to be promoted and supported during the inspection. Physical distancing of one metre was maintained between beds. Curtains were supplied around each bed and were drawn appropriately.

Patients' personal information and charts in the clinical areas visited were stored in a secure manner. Inspectors observed signage in place on some patients' doors outlining patients' preferences as to how they wish to be communicated with.

Overall on the day of inspection, inspectors were generally assured that the hospital demonstrated a person-centred approach to assist and promote the autonomy, privacy and dignity of people receiving care which is consistent with the human rights-based approach to care promoted by HIQA.

Judgment: Compliant

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

Overall, it was evident that a culture of kindness and consideration was actively promoted by all staff. Patients were communicated with in a sensitive manner and stated they were comfortable raising any issue with staff.

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. For example, staff were observed responding in a timely and calm way to patients. There was evidence that staff knew patients well and some family members of patients spoken with were complimentary about the care their family received and the level of communication afforded to them.

Leaflets informing patients and relatives on how to raise a complaint were noted in the clinical areas inspected including information on the HSE's '*Your Service Your Say'.****** The hospital had arrangements in place to facilitate access for patients to independent advocacy services where required and inspectors also observed these posters on display in the clinical areas.

Judgment: Compliant

****** Your Service, Your Say' is the name of the HSE's complaints process for all users of HSE funded services. In addition to being a complaints process, "Your Service, Your Say" is also a way to provide feedback to the HSE

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

There were systems and processes in place at the hospital to respond to complaints and concerns received from patients and their families.

At a local level the interim Director of Nursing and Operations Manager were the two designated complaints officers with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints for the hospital. The hospital also had a designated complaints manager who operated at CHO9 level and linked in with the hospital to provide support in relation to the management of complaints. The management of complaints was guided by a complaints policy.

There was evidence of effective systems and oversight of complaints at the hospital. Complaints relating to the hospital were discussed at senior management team meetings and a quarterly report was provided to the Quality and Patient Safety Committee. Complaints were also discussed at the complaints management forum at CHO9 level which met quarterly.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*.'[†††] Staff recorded verbal and written complaints locally, implemented subsequent quality improvement plans, shared learning from complaints and described how they updated the person who raised the complaint. This is an example of good practice.

Recent examples of the complaints and compliments reports submitted to the Quality and Patient Safety Committee were comprehensive and provided updates in relation to the committee's progress on achieving priorities, numbers of complaints and compliments received, audits and walk rounds, progress with quality improvement initiatives and risks or issues for escalation to the quality and safety committee. Reports reviewed for June 2023 outlined that the hospital received 10 complaints year-to-date, all of which were closed at stage one and 31 compliments across the hospital campus.

The hospital maintained a tracker of all complaints and compliments which was regularly updated. The main themes identified from complaints related to food, menu options and laundry. Inspectors were informed of quality improvement initiatives and changes to practice that had been recently introduced in response to complaints.

Updates on complaints received were captured in minutes of various hospital committees. At CHO9 level, it was noted in a sample of meeting minutes reviewed that complaints, if any, were tracked, trended and learning shared. Staff spoken with were aware of how to support a patient in raising a concern or making a complaint, and of the hospital policy.

[†††] 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.

Staff stated that complaints were addressed at ward level and if a complaint could not be resolved locally, they would escalate the complaint to management. Staff verified that informal complaints were tracked, trended and learning was shared with staff at staff handover meetings and safety pauses.

Point of care complaints resolution training had recently been provided to staff with approximately 60-70% of relevant staff having received this training.

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.

Inspectors visited two clinical areas and observed that overall the physical environment was generally well maintained and clean with few exceptions. Inspectors found that both clinical areas were bright, well maintained and generally clean. Notwithstanding this, opportunities for improvement were identified in relation to the requirement to have appropriate storage for patient equipment. Furthermore there was a lack of isolation rooms with en-suite facilities at the hospital.

Environmental cleaning was carried out by dedicated cleaners. Equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned, for example, use of checklists. There was evidence of oversight of daily cleaning schedules by cleaning supervisors and clinical staff. Clinical nurse managers reported satisfaction with the current cleaning arrangements and resources in place.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located with hand hygiene signage clearly displayed throughout the units. Inspectors noted that hand hygiene sinks throughout the clinical areas inspected conformed to national requirements.[‡‡‡] Infection prevention and control signage in relation to transmission based precautions was observed in areas visited.

Hazardous material and waste were safely and securely stored in the clinical areas inspected. Inspectors also observed appropriate segregation of clean and used linen. However, inspectors observed a lack of appropriate storage facilities for patient equipment in both clinical areas.

Inspectors noted that there was a lack of patient monitoring equipment specifically for patients who require isolation which had been previously identified by the hospital. Where equipment needed to be shared with patients requiring isolation, there was a clear awareness amongst staff of the need to decontaminate equipment in line with guidelines

[‡‡‡] 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

issued about cleaning. Notwithstanding this, the hospital should review the current supply of patient monitoring equipment to ensure it is adequate to meet the current needs of patients, particularly for patients requiring isolation.

Access to maintenance on site was reported to be satisfactory, however, staff reported that on occasions there may be long delays if maintenance issues had to be followed up off-site.

The hospital had a total of 101 beds, however there were only 17 single rooms available for isolation purposes. Recognising the insufficient numbers of isolation rooms available, the hospital implemented and staff described processes to ensure appropriate placement of patients who require single rooms for isolation purposes including the use of an isolation prioritisation protocol. Staff in the clinical areas with multi-occupancy rooms described how patients who required isolation for transmission-based precautions would be transferred to another clinical area if an isolation room was not available. On the day of inspection, the majority of patients requiring isolation were accommodated in single rooms with en-suite toilet facilities with the exception of one patient. Inspectors were informed that no isolation room was available and that infection prevention and control advice was sought in relation to the placement of this patient and control measures put in place. All single rooms in the clinical areas inspected had en-suite facilities. Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms.

In summary, the physical environment and patient equipment in the clinical areas inspected was observed to be generally clean and well maintained with few exceptions. However, 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 at all times due to the following findings:

- insufficient number of isolation rooms available at the hospital
- insufficient storage space for patient equipment within the clinical areas inspected.

Judgment: Partially compliant

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

Through oversight by hospital management and at CHO9 level, it was evident that the unit was effective in proactively and systematically monitoring, evaluating and responding to information from multiple sources to inform improvement and provide assurances on the quality and safety of the service provided to patients.

Infection prevention and control monitoring

Assurance as to the effectiveness of the infection prevention and control systems and processes were provided through audit and monitoring of multiple elements of the infection prevention and control programme as follows:

- healthcare acquired infections
- antimicrobial consumption rates
- hand hygiene audits
- environmental and equipment audits
- outbreak management
- infection prevention and control training
- staff vaccination levels (Influenza and COVID-19)
- quality and safety walk rounds.

Monthly environment, equipment and hand hygiene audits were undertaken at the hospital using a standardised approach. Environmental hygiene audits submitted to HIQA for April 2023 showed that the inpatient clinical areas achieved a high level of compliance with average results reported at 94.45%. Time-bound action plans with persons responsible identified were developed to address issues identified, however, action plans were not always updated to reflect whether identified actions had been completed.

Equipment hygiene audit results were reviewed in clinical areas inspected where high levels of compliance were also noted with one clinical area achieving 100% compliance in July 2023. Environmental and equipment hygiene audit findings were discussed at the corporate hygiene committee chaired by the Hospital Manager.

Monthly hand hygiene audits were also completed in clinical areas. Clinical areas visited were compliant with the HSE's target of 90% for effective hand hygiene practices. Hand hygiene audit results for July 2023 for the clinical areas inspected were equal to or above the target of 90%.

Hospital management monitored and regularly reviewed a range of data in relation to the prevention and control of healthcare-acquired infection.

Inspectors were informed that patients were not routinely screened on admission and that patients were only screened for multidrug resistant organisms or transmissible infections if patients became symptomatic. Inspectors were informed that prior to transferring to the hospital, patients' infection status was assessed as part of the referral process. However, referral forms reviewed as part of the hospital's admission policy did not have a section to indicate that a patient's infection status was discussed and documented prior to referral. Notwithstanding this, there was evidence that a patients' infection status was assessed and documented in a sample of admission documentation in healthcare records reviewed by inspectors in the clinical areas inspected. Guidance on 'COVID-19 testing requirements for new admissions to St Mary's' was developed to support staff to identify patients who may require testing.

The hospital recently experienced two confirmed outbreaks of COVID-19 and Norovirus in March 2023. Outbreak management teams were convened in response to these outbreaks and outbreak reports were completed in line with national guidelines. A communication pathway for outbreak management was available in the clinical areas to guide and support staff to identify, escalate and manage outbreaks. Inspectors reviewed risk assessments which were completed for the affected clinical areas which outlined actions required and controls in place to manage the outbreak. Outbreak reports reviewed by inspectors outlined contributing factors that impacted on the prolonged status of the outbreak and learning opportunities. However, representatives from infection prevention and control highlighted that a lack of a designated consultant microbiologist was impacting on the hospital's ability to produce more comprehensive outbreak management reports.

Medication Safety

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication audits were carried out in the following areas:

- medication safety, prescribing, administration
- medication reconciliation
- custody and storage of controlled drugs
- compliance with completion of medication prescription administration record (MPAR).

Quality and safety reports for June 2023 reviewed by inspectors outlined audit results of safe medication management practices across all clinical areas. Compliance ranged from 84%-86%. Audit of both onsite and offsite pharmacy services was evident and action plans were developed following audit activity to improve medication safety practices at the hospital and examples of these were observed in clinical areas inspected.

Deteriorating patient

There were systems and processes in place for the identification, management and escalation of patients who deteriorated and required transfer to an acute care facility. This process was formally documented and available to staff in the clinical areas.

The HSE Early Warning Systems used in acute care were not designed for and currently do not apply to the rehabilitation and community inpatient healthcare services. However, the hospital were using the Irish National Early Warning System (INEWS) (version 2),[§§§] observation chart and staff had received training to support its implementation. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. Inspectors were informed that the hospital were looking to adapt the national early warning system to ensure that it was applicable to the

[§§§] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.

cohort of patients within the hospital. A working group, led by the interim DoN, was convened within the hospital to progress this.

Transitions of care

The hospital had documented inclusion and exclusion criteria in place for transferring patients to the hospital for formal rehabilitation. The hospital reported performance data in relation to the number of admissions, patient discharges, transfer to acute services and mean length of patient stay. The hospital reported a total of ten delayed discharges at the time of inspection. These were primarily attributed to complex social care cases and were kept under review at weekly case management meetings. It was evident that performance data in relation to patient transfers and discharges was discussed at various internal and CHO9 management meetings.

Staff used a number of transfer and discharge forms to support the exchange of information, which is imperative to the safe transition of care. Checklists had also been developed to guide and support staff when preparing for patient admissions. However, a review of patient documentation relating to transitions of care by the hospital is recommended to ensure hospital documentation captures if a person is colonised or infected with a transmissible infection.

In summary, the hospital had effective systems in place to monitor and evaluate healthcare services at the hospital. Notwithstanding this, opportunities for improvement were identified in relation to the following findings:

- a review of patient documentation relating to transitions of care to ensure all relevant information is captured.
- the need to ensure early warning systems and guidelines in place at the hospital for the deteriorating patient are appropriate and effective to the hospital's patient profile.

Judgment: Substantially compliant

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

The hospital had systems in place to identify and manage risks. Risks in relation to the service were recorded on a risk register and reviewed at quarterly risk management meetings attended by the interim DoN, Hospital Manager, the GM and QPS advisor. Risks were also formally reviewed at CHO9 level with the Older Persons Service Manager on a quarterly basis and meeting minutes reflected this.

Inspectors reviewed the hospital's risk register of which there was a total of 12 risks actively open on the register. Risks reviewed had owners assigned and controls and actions

in place to manage and reduce recorded risks. There was evidence that risks and associated controls were being regularly updated.

Infection prevention and control

Risks relating to infection prevention and control on the risk register included:

- risk of harm to service user and staff arising from potential/confirmed outbreak of COVID-19.
- risk of harm to a person due to contracting legionella through inhalation of tiny airborne droplets and particles containing legionella bacteria
- risk of delay in clinical diagnosis due to reduced or unavailable microbiology laboratory services on weekends and bank holidays
- risk of samples being sent to an incorrect facility due to staff submitting samples to multiple pathways
- risk of spread of infection to patients, staff and visitors due to lack of isolation rooms where demand exceeds capacity.

Risks relating to reduced or unavailable microbiology lab services and the risk of samples being sent to an incorrect facility were recorded as high rated risks by the hospital and were further discussed with senior hospital management in terms of the effectiveness of existing controls in place to reduce identified risks. Hospital management reported that access to microbiology advice was available from the patient's referring hospital as required and patients could be transferred back from the receiving hospital if their condition deteriorated. Staff also had access to an external microbiology laboratory for results during out-of-hours. Additional controls in place included access to antimicrobial guidelines and 24/7 medical advice. Hospital management were monitoring the impact of this specific risk and reported that no adverse incidents or delays in initiating treatments for patients had occurred at the time of inspection. Hospital management also informed inspectors that funding for a consultant microbiologist for CHO9 level was approved, however, there was no plan or agreed timeframe as to when this post may be in place. Acknowledging that management had already identified the requirement for access to designated consultant microbiologist, this should be progressed at community organisation level to better support the service.

In relation to risks identified with sending samples to multiple laboratories, hospital management had developed a standard operating procedure for submitting samples to a laboratory which was communicated to all staff and inspectors observed guidance on identifying appropriate laboratories on display in the clinical areas inspected. Overall hospital management reported that existing controls in place to mitigate against this particular risk were effective. However, inspectors noted that nursing staff in the clinical areas did not have access to laboratory results and that only doctors could access these results. This was raised with senior hospital management as an area that needs to be addressed noting that nurses having access to relevant patient test results is a necessary

requirement for the provision of safe and effective care particularly in the context of medication safety and infection prevention and control.

The hospital had a formal legionella risk assessment completed in 2022 and responsibility and oversight of these risk assessments and associated controls in place rested with the Hygiene Committee and Infection Prevention and Control Committee.

Medication safety

There were no risks relating to medication safety on the risk register at the time of inspection. This was discussed with the Drugs and Therapeutics Committee who outlined that risks that could not be managed by the committee would be escalated to the corporate risk register if needed.

The hospital had a list of high-risk medications. Staff described the use of risk reduction strategies to support safe use of medicines in relation to for example, antibiotics, anticoagulants, insulin and opioids. The hospital had also developed a list of sound-alike look-alike medications (SALADs). These were observed in clinical areas inspected and staff were knowledgeable of same.

Medication reconciliation

The hospital had a policy to guide and inform staff on medication reconciliation.

Documentation reviewed and staff spoken with by inspectors indicated that medicine reconciliation was in place and staff were knowledgeable about the process. Doctors were required to do medication reconciliation on admission, discharge and transfer to the hospital. A medicine reconciliation admission, transfer, discharge checklist viewed included an up-to-date medicine list for patients admitted to the service and this was checked by the medical team. The pharmacist also reviewed prescriptions and checked medicine administration documentation at dispensing. Any discrepancies noted were reported to the clinical nurse managers and or doctors.

The hospital had access to an antimicrobial pharmacist at CHO9 level however this person was on leave. Antimicrobial activities were being monitored by the infection prevention and control team. Staff had access to the hospital pharmacy out-of-hours medication via the ADON or night CNM2 in charge.

Medicines were stored in a secure manner. Designated fridges for medicines requiring storage at a required temperature were available. Fridge temperatures were noted as recorded on a daily basis.

Deteriorating patient

As outlined in national standard 2.8, the hospital had documented processes in place for staff to follow in the event of a patient becoming unwell and staff spoken with were able to describe the procedures in place.

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 support safe and effective discharge planning. The risk of delayed rehabilitation for patients was noted on the risk register and discussed further with senior hospital management where it was outlined that there was a potential for some patients to have longer stays in hospital due to reduced access to services caused by staffing deficits in health and social care professionals. This was regularly reviewed by senior hospital management and additional controls in place to minimise this risk included the use of a patient triage system to prioritise patients.

Other risks on the hospital's risk register included a risk relating to safeguarding. This was discussed further with hospital management where it was explained that these risks had been identified as a result of recent incidents relating to safeguarding. Through discussion with hospital management and the review of quality improvement plans, it was evident that immediate actions had been put in place in relation to these incidents and that this risk was to remain open pending the completion of safeguarding training by all staff.

Policies, procedures and guidelines

There was a suite of policies, procedures and guidelines in place for staff in relation to infection prevention and control, medication safety, deteriorating patient and transitions of care. These were available at ward level in hard copy and electronically. However, inspectors noted that staff in both clinical areas experienced difficulty with accessing policies electronically which was raised as an opportunity for improvement with senior management on the day of inspection. In addition, a number of policies reviewed required updating.

In summary, it was evident that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. Hospital management were aware of the risks within the hospital and it was evident that the risk register was kept under regular review and that risks were informed by ongoing monitoring and evaluation of the service as well as clinical incidents. Opportunities for improvement were identified in relation to:

- the need to engage with CHO9 and progress plans to ensure the hospital has access to a designated consultant microbiologist
- the need to ensure all staff have access to laboratory results to support the provision of quality and safe care
- the need to ensure that staff can access relevant and up-to-date policies, procedures and guidelines.

Judgment: Substantially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines.

Clinical incidents were reported on a paper-based system and logged on the National Incident Management System (NIMs). † There was evidence that the hospital and CHO9 management had oversight of the management of incidents. Clinical incidents were reviewed at monthly clinical review committee meetings attended by the interim Director of Nursing, a consultant geriatrician, assistant directors of nursing and health and social care professionals. Reports and meeting minutes reviewed evidenced that patient-safety incidents and near misses were reviewed and that actions arising from previous meetings were followed up. Incidents were tracked and trended and monthly summary report submitted to the Quality and Patient Safety Committee.

The hospital's annual incident review report for 2022 outlined that a total of 365 incidents occurred at the hospital which was an increase on the 255 incidents reported in 2021, demonstrating an improved incident reporting culture at the hospital. The majority of these incidents related to slips, trips and falls. Reports reviewed provided a breakdown of these incidents in terms of type of incident, location, day of week, time of day, potential causes, and types of injury. All incidents were reviewed and escalated to SIMT if required as outlined in national standard 5.8.

Hospital management outlined quality improvement initiatives introduced in relation to the tracking and trending of falls incidents. For example, the falls committee along with the falls clinical nurse specialist recently redesigned the post falls review form and this form was being piloted on two wards. The falls policy was also being reviewed as part of this initiative.

Staff in the clinical areas inspected were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported (slips, trips and falls, pressure ulcers and medication errors). Feedback on patient-safety incidents was provided to CNMs who stated that learning was shared with staff at shift handover meetings, ward meetings and safety pause meetings.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of St Mary's Hospital to assess compliance with national standards from the *National Standards for Safer Better Healthcare.* The inspection

focused on a selection of the national standards, and as part of the same inspection HIQA placed a particular focus on measures the hospital had put in place to manage four areas of known potential patient safety risk – infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, HIQA found the hospital to be:

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

Capacity and Capability

St Mary's Hospital had defined corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, HIQA found that governance arrangements could be strengthened to further improve the effective oversight of the quality and safety of healthcare services provided at the hospital. The hospital should review and update organisational charts to ensure they reflect existing accountability structures and formalise reporting structures and clinical governance arrangements in place for clinical areas with service level agreements in place with other hospitals.

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. There was evidence that risks were informed by multiple sources of information and that these were kept under regular review by senior management. However, some risks reported to be addressed and closed remained on the risk register. The hospital had an audit programme in place with oversight by the Quality and Patient Safety Committee. The hospital should look to reinstate formalised structures and centrally control audit activity at the hospital to promote quality management of the audit process and shared learning.

Hospital management were working to actively recruit staff to fill vacant positions. Notwithstanding this, there were a number of vacancies across all staff disciplines and most evident across health and social care professionals which had the potential to impact on patient care. Hospital management should progress with recruitment plans outlined to inspectors to fill vacant positions. Hospital management should continue to engage with CHO9 and progress plans to ensure that the hospital have access to designated consultant microbiology advice. Staff attendance at and uptake of mandatory and essential training was identified as an opportunity for improvement particularly in relation to infection prevention and control training.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and 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.

The physical environment in the clinical areas was generally clean and well maintained. However, considering the lack of isolation rooms, the physical environment could not always adequately support the delivery of high-quality, safe, reliable care to protect people using the service and had the potential to increase the risk of cross infection.

HIQA was satisfied that there was a system in place at the hospital to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm. There was evidence that identified risks were managed appropriately and corrective controls implemented and evaluated in terms of their effectiveness to minimise the risk. Notwithstanding this, the hospital should review the current system in place for accessing laboratory results so that all staff have the ability to access relevant timely patient information to support the delivery of safe and effective care.

Following this inspection, HIQA, through the compliance plan submitted by hospital management, will continue to monitor progress of actions identified in this report.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant

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

Compliance Plan for St Mary's Hospital, Phoenix Park

OSV-0007277

Inspection ID: NS_0046

Date of inspection: 18 and 19 July 2023

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
a) Shortfalls in health and social care professional staffing levels needs to be addressed • All vacant posts are submitted to Paybill for approval to backfill without delay. Once approval is received the position is then sent to CHO DNCC Recruitment Unit for advertising. These positions are then tracked and monitored at local level to ensure efficient and timely process is followed. • CHO DNCC Recruitment Unit maintain and monitor panels for HSCPs and liaise with local services in relation to the processing of approved posts which again have been advertised as widely as possible.	

- From a CHO perspective there are on-going efforts to explore ways to entice HSCPs to take up a role with the HSE and intensive recruitment efforts as outlined above apply to HSCP and all disciplines.
- In addition CHO DNCC promptly offer new HSCP Graduates posts and recruit them as assistants pending registration. This is in an effort to retain these Graduates and not lose them to other organisations.
- The recruitment Unit in CHO DNCC are actively pursuing overseas recruitment in an effort at identifying potential physiotherapists, occupational therapists and dietitians for St. Mary's. There is also work being carried out nationally to progress overseas recruitment of speech and language therapists also.
- The clinical therapy manager continues to monitor and assess vacancy levels and ensures measures are put in place to alleviate possible service risks pending optimum staffing levels being reached.
- At CHO level an exercise is being completed to identify posts that are currently filled by agency staff with a view to the feasibility of these being considered for agency conversion, subject to a defined process.
- There is a dedicated HR resource on site who is responsible for tracking and trending staffing levels and absenteeism rates which are also reported on centrally in respect of all services within CHO DNCC and are circulated to the Senior Management Team, CHO DNCC.
- We will continue on-going monitoring of absenteeism levels with a targeted approach being taken in respect of disciplines reporting the highest rates of absence.
- We will continue to support individual managers to intervene early when attendance issues arise.
- We will actively continue promotion of employee's responsibility to comply with the terms of the Managing Attendance Policy 2014.

The Inspectors were informed that shortfalls with nursing rosters was mainly being filled with staff redeployment, staff doing overtime and/or on occasions the use of agency staff.

- There is on-going, intensive efforts to recruit nursing staff for all approved vacancies.
- CHO DNCC Recruitment Unit currently have rolling campaigns and all posts are advertised as widely as possible, e.g. www.publicjobs.ie / nursing journals / linkedin etc.
- CHO DNCC also partake in other recruitment initiatives such as Recruitment Fairs and currently operate a 'Refer A Friend Scheme' to encourage existing HSE staff to promote working in the HSE as a career choice for people they know.
- In the meantime all deficits are monitored and assessed by the clinical manager to ensure safe staffing levels are maintained at all times.
- These efforts will continue going forward and are on-going.

b) Attendance at and uptake of mandatory and essential training for relevant staff requires improvement particularly in areas such as infection prevention control.
Improvements were required in staff training compliance across a number of areas, in particular infection prevention and control training and outbreak management amongst nursing staff.

- The ADON reviewed and audited all Health Care Assistants, Ward Care Assistants and Nursing training records immediately following the inspection to establish compliance levels with mandatory training and identify staff who did not have up-to-date training.
- Confirmation has been received that all computers have been upgraded and tested in all units.
- Extra computers are being made available to ensure easy access for online training.
- A meeting was organised by the DON for Older Persons with the nurse managers from all units to request that all staff within their remit have completed mandatory online training by the end of October. This deadline is achievable due to support from link nurse practitioners on each unit.
- This will be followed up by a follow up practical session onsite before the end of November 2023 carried out in conjunction with the Infection Prevention Control team in the QSSI Department.
- A member of staff in nursing administration has been identified to coordinate training records for all staff in the hospital. These records have been centralised and all records are now up to date.
- This staff member monitors and reviews the records weekly and then reminds nurse managers if a training record is due to expire.
- Nurse managers inform the individual staff member of expiry of a certificate and arranges for the individual's training to be completed within an agreed timeframe

Training records for doctors and housekeeping and cleaning staff were not available at the time of inspection.

- Training records for ward catering assistants were held partially in units and the catering department. These records are now centralised and all staff will be fully compliant in mandatory training by end of November 2023.
- Training records for doctors are available on a system called DIME which is for doctors only. New groups of NCHDs have 2 months to complete all the relevant training and are entitled to x1 study leave day to complete all HSELand training.
- Their line manager will conduct an audit and review of their mandatory training status and will ensure that all training will be completed by the end of October 2023.

Records provided showed that staff compliance for hand hygiene fell below the HSE target of 90% for nurses, healthcare assistants and doctors. Health and social care professionals achieved 90% compliance with hand hygiene training.

- The ADON has reviewed and audited all Health Care Assistants, Ward Care Assistants and Nursing training records.
- A meeting was organised by the DON for Older Persons with the nurse managers from all units in order to reiterate that all staff within their remit have completed mandatory online training by the end of October 2023. This is achievable with the support of link nurse practitioners on each of the units.
- This will be followed up by a follow up practical session on site before the end of November 2023 which will be carried out in conjunction with the Infection Prevention Control team in the QSSI Department.

Compliance with medication safety training for nursing staff was 90%, however, compliance amongst doctors required significant improvement with training records indicating that only 18% of doctors completed medication safety training in the past two years.

- The Lead Consultant will carry out a review in relation to doctors training records by the end of September 2023.
- All doctors will be requested to complete mandatory training by end of October 2023.
- Training records will be monitored on an ongoing basis by the Lead Consultant.

Records reviewed showed that 86% of nurses, 100% of healthcare assistants and 58% of doctors had completed basic life support in the previous two years.

- The ADON has carried out a review and identified staff members whose training has expired or has yet to complete training (i.e. new starters).
- There are 12 training days for BLS training organised between now and the 2nd December for all relevant staff on campus.
- All staff will be fully compliant with training requirements by 2nd December 2023.

Nurses and healthcare assistants received complaints management training with compliance noted at 51% and 53% respectively.

- The ADON has carried out a review and identified staff members who require training.
- The nursing manager in each unit has contacted all relevant staff in relation to completion of this training.
- This training can be completed on line. The Director of Nursing Older Persons will ensure that all staff are compliant by the end of October 2023.
- The CHO DNCC Complaints Manager will do face-to-face *'point of contact resolution training'* sessions on campus with relevant staff before year end.

Timescale:

a) Recruitment is ongoing as stated above there are rolling competitions

(b) We will have achieved completion of all mandatory training by the end of Quarter 4 2023.

National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
a) Insufficient number of isolation rooms available at the hospital	

- No multi-occupancy room contains more than four patients
- There is ongoing risk assessment with IPC input to assess facility layout. This is conducted during regular bed management meetings with the ADON, Bed Manager and IPCN.
- This Risk assessment includes IPC support and advice on the following:
    - Identify rooms which are suitable for isolation purposes. Rooms with en-suite and hand hygiene sink are prioritised
    - Up to 3 patient rooms are identified as potential isolation suites. These rooms to be repurposed as isolation rooms if there is an initial suspected infection until pathogen is confirmed, accepting that there may be different pathogens circulating.
    - Communication will be sent to patients/families of the potential for movement out of these rooms in this emergency scenario, and the fact that the requirement will be for a short term period for the duration of the outbreak only.
    - If an outbreak is confirmed, review of ability to cohort patients with the same pathogen, and how this area can be closed off from other areas of the unit (e.g. site the cohort area away from main thoroughfare / main door into unit).
    - Co-horting advice is given based on laboratory results to confirm diagnosis as it is. A person with flu cannot be cohorted with a person with COVID as they are a risk to each other. Ensure cohort area identified has access to a bathroom dedicated to patients with infections that is not used by any other patients on the unit.
    - Colour coding system is used to identify isolation areas / cohort areas and patients with confirmed and suspected infections (Red/Orange/Green)
    - Consideration is given to how care needs will be met for patients who are isolated i.e. activities/communication/psychosocial support/visits

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

- Any future re-modelling / refurbishment will prioritise the development of single en-suite rooms, and where appropriate two-bedded in patient accommodation in line with AMRIC (2023) Infection Control Guiding Principles for Buildings – Acute Hospitals and Community Healthcare Settings.

b) Insufficient storage space for patient equipment within the clinical areas inspected

- A review of available storage space is being carried out by the ADON and Operations Department in all units.
- This review will be completed and implemented by the end of October 2023.
- The Physiotherapy and Occupational Therapy Managers have been requested by senior management to ensure that all equipment stored in the units is necessary due to the limited space available for storage on certain units.

- This task is to be completed by the end of December 2023.
- The hospital is initiating the setting up of an equipment library. This involves:
    - asset tagging all medical equipment and furniture on the Campus.
    - all equipment will be checked to ensure that it is working as desired and servicing is up to date.
    - broken or out of date equipment will receive an end of life certificate.
- This equipment library will be maintained and monitored on an ongoing basis by the operations department personnel
- Our priority is sourcing a suitable location in order to progress this project and this should be commencing by Q1 2024.

The inspector recommended that the hospital should review the current supply of patient monitoring equipment to ensure it is adequate to meet the current needs of patients, particularly for patients requiring isolation.

- The current supply of patient monitoring equipment has been reviewed by the ADON.
- All equipment has been checked to ensure that it is functioning correctly.
- There is currently an adequate supply of patient monitoring equipment available in each unit also taking into account isolation units.
- There will be ongoing monitoring and reviewing of this equipment by the nursing manager and ADON.

It was reported to the Inspector that access to maintenance on site was reported to be satisfactory, however, staff reported that on occasions there may be long delays if maintenance issues had to be followed up off-site.

- A new reporting system (Tririga) has been set up by the maintenance department in order to centralise and streamline the process.
- This system involves filling out a blue docket which is forwarded to St. Mary's Operations Department to be logged onto the system.
- This system is ultimately managed by the maintenance department in estates for all of CHO DNCC.
- Maintenance issues are prioritised on this system depending on urgency and nature of the issue.
- This system can be accessed by nominated personnel on the campus in order to check progress status.

Timescale:
Q1 2024