Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Naas General Hospital
Address of healthcare service:	Craddockstown Road Naas Co. Kildare W91 AE76
Type of inspection:	Unannounced
Date of inspection:	17 and 18 July 2024
Healthcare Service ID:	OSV-0001080
Fieldwork ID:	NS_0084

About the healthcare service

Model of Hospital and Profile

Naas General Hospital is a model 3* public acute hospital. It is a member of and is managed by the Dublin Midlands Hospital Group (DMHG)† on behalf of the Health Service Executive (HSE). At the time of the inspection, the HSE was establishing six regional health areas, with plans to align Naas General Hospital to the HSE Dublin Midlands regional health area. Services provided by the hospital include:

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

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	202 inpatient beds 18 day case beds

How we inspect

Among other functions, the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out an unannounced inspection of Naas General Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*.

* A model 3 hospital admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine, and critical care.

† The Dublin Midlands Hospital Group comprises eight hospitals — Naas General Hospital, St James's Hospital, The Coombe Hospital, Midland Regional Hospital Tullamore, Midland Regional Hospital Portlaoise, Regional Hospital Mullingar, St Luke's Radiation Oncology Network and Tallaght University Hospital. The hospital group's academic partner is Trinity College Dublin (TCD).

To prepare for this inspection, healthcare inspectors[‡] reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and unsolicited information[§] and other publicly available information.

During this inspection, inspectors:

- spoke with people who used the healthcare service to find out their experiences of the care received in the hospital
- 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 during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection.

A summary of the findings and a description of how the hospital performed in relation to the 11 national standards assessed during the inspection are presented in the following sections under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors at a particular point in time - before, during and following the on-site inspection at the hospital.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

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

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
17 July 2024	9.00 – 17.25hrs	Elaine Egan	Lead
		Denise Lawler	Support
18 July 2024	8.30 – 15.50hrs	Danielle Bracken	Support
		Cathy Sexton	Support

Background to this inspection

HIQA last undertook an announced inspection of Naas General Hospital in November 2022. The hospital was found to have a good level of compliance with national standards at that time. Hospital management developed a compliance plan setting out the actions to be implemented to bring the service into compliance with the national standards judged to be partially or non-compliant. Progress on the implementation of the compliance plan was reviewed as part of this inspection.

Similar to the previous inspection, this inspection focused on four key areas of known harm:

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

The inspection team visited the following clinical areas:

- Emergency Department, Acute Medical Assessment Unit and Discharge Lounge
- Imaal Ward (31-bedded medical ward, specialising in care the of older persons)

[**] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Liffey Ward 1 and Liffey Ward 2 (30-bedded medical ward).

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

- Representatives of the hospital's Senior Management Team (SMT):
  - General Manager
  - Director of Nursing (DON)
  - Clinical Director
  - Operations Manager
  - Finance Manager
  - Quality Risk and Patient Safety Manager
  - General Services Manager
- Risk Manager
- Bed Manager
- Discharge Coordinator
- Patient Flow Coordinator
- Lead Representatives for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Recruitment Officer and Business Manager
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control Committee (IPCC)
  - Drugs and Therapeutics Committee (DTC)
  - Medication Safety Committee (MSC)
  - Deteriorating Patient Committee (DPC)
  - Quality and Patient Safety Committee (QPSC).

Inspectors also spoke to hospital staff from a variety of disciplines in the clinical areas visited during this 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 receiving care in the service.

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

Inspectors observed good communication between staff and patients in all clinical areas visited. Inspectors also observed how interactions between staff and patients were kind and respectful. The inspectors observed staff responding promptly to patients' request for assistance. Suggestion boxes for patient feedback and posters about giving feedback were displayed in Imaal and Liffey Wards.

Inspectors spoke with a number of patients in the clinical areas visited. Patients were complimentary of the staff, the food provided and reported how staff were *"lovely"*, "*kind and very good" "attentive"*, *"fantastic"*, *"couldn't be nicer "* ,*"were always around and* "very busy". "*Always had a good experience here and prefers genders are not mixed on this ward now"*. Patients described how they were *"seen very quickly"*. Patients told inspectors they would speak with a staff member if they wanted to make a complaint. None of the patients who spoke with inspectors confirmed they had received information about the HSE's complaints process 'Your Service,Your Say'. Inspectors did observe a poster about independent advocacy services displayed in one clinical area visited. Overall, there was consistency with what inspectors observed in the clinical areas visited during inspection, what patients told inspectors about their experiences of receiving care in those areas.

Capacity and Capability Dimension

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

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

Inspectors found the hospital had integrated corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Inspectors spoke with members of the senior management team who demonstrated a clear understanding of their roles, responsibilities and their individual reporting arrangements to the general manager and

SMT. The hospital's organisational chart showed the governance and corporate reporting arrangements in the hospital, and these were mostly consistent with what inspectors were told during the inspection. Inspectors were told the DPC, DTC and MSC reported to the clinical governance committee and this aligned with the reporting arrangements on the hospital's organisational chart. However, that was not consistent with the committees' terms of reference, which specified a reporting arrangement to the QPSC. The general manager was the accountable officer with overall responsibility and accountability for the quality and safety of the healthcare services provided at the hospital. There was a clear and defined reporting structure between the hospital's general manager and the chief operations officer (COO) of DMHG, who in turn reported to the hospital group's chief executive officer (CEO). The general manager, supported by the SMT, monitored the hospital's performance data and oversaw actions taken to enhance the quality and safety of healthcare services provided. The SMT, chaired by the general manager, met twice a month in line with its terms of reference. Meetings of the SMT followed a structured format and were action orientated. Members of the SMT reviewed information related to quality and safety, risk management and staffing levels. Members of the SMT also attended monthly meetings with the DMHG. The hospital's clinical director provided clinical oversight and leadership of clinical services at the hospital. The clinical director was a member of the hospital's SMT and was accountable and reported to the hospital's general manager. The clinical director had a working relationship with the DMHG's clinical director. The DON was a member of the SMT and was assigned with responsibility for the service and management of nursing staff at the hospital.

The multidisciplinary QPSC was the main committee assigned with responsibility for assuring the SMT about the quality and safety of the healthcare services provided in the hospital. This committee, chaired by the clinical director and according to terms of reference met four times a year, however, the committee did not meet in the first quarter of 2024. Minutes of meetings from September and December 2023 and June 2024 showed that the meetings were well attended. A number of subcommittees reported to the QPSC. Three of the subcommittees — IPCC, MSC, and the DPC (including Early Warning Score (EWS) and sepsis management), monitored information on infection prevention and control practices, medication safety and the deteriorating patient. The DPC comprised of a number of subcommittees that focused on specific areas of responsibility, including maternal review, sepsis in maternity patients and bereavement. These subcommittees provided updates on their area of responsibility to the DPC.

Overall, the inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. The key governance committees comprised relevant representation from the senior management team and clinical specialties. It was clear from meeting minutes that actions were assigned to a responsible person and the implementation of agreed actions was monitored by committee members from meeting to meeting. However, the inspectors noted that agreed actions from a number of different committee meetings - QPSC, DPC, DTC, MSC were not time-bound. Therefore, it was difficult to determine whether actions

to improve healthcare services were implemented in a timely manner. There was evidence that the different governance committees discussed and monitored information on the performance and quality of healthcare services and of the hospital's compliance with defined quality metrics. There was a formalised upward reporting structure from each governance committee to the QPSC and or the SMT, and onwards from the general manager to DMHG. Inspectors found improvements following the previous inspection in November 2022. Improvements included the development of a four-year strategic plan 2024 – 2028 setting out the strategic objectives for the hospital over a four-year period, but the plan was being finalised at the time of this inspection. Notwithstanding this;

- the reporting arrangements set out in the hospital's organisational chart and terms of reference for the DTC, MSC and DPC did not align with what inspectors were told during inspection
- the four-year strategic plan needs to be finalised and ratified by SMT, and its implementation progressed.

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.

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. The hospital's infection prevention and control team (IPCT) promoted and supported staff in implementing infection prevention and control practices. The IPCT was led by a consultant microbiologist and reported on the monitoring of surveillance and infection prevention control practices to the IPCC. The IPCC devised and approved the hospital's annual infection prevention and control programme that set out the priorities to be focused on. Progress made in implementing the annual plan was formally reported to the IPCC and SMT annually. The annual infection prevention control report for 2023 detailed the work undertaken by the IPCT in that year and the hospital's performance in relation to infection prevention and control practices, surveillance and monitoring, compliance with national standards and appropriate key performance indicators (KPIs). The hospital's performance in these areas are discussed further in national standards 2.8 and 3.1. The hospital's antimicrobial stewardship programme[§§] was implemented by the antimicrobial pharmacist and by the antimicrobial stewardship committee (AMSC). The AMSC was a subcommittee of DTC and had a dual reporting structure to IPCC and DTC. The hospital's pharmacy service was led by the chief pharmacist. The hospital's DTC was the overarching committee overseeing the quality and safety of the pharmacy service in the hospital. The DTC reported to the SMT and QPSC. The MSC was a sub-committee of the DTC and of

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

the QPSC and had a dual reporting structure to the DTC and QPSC. The AMSC were also a subcommittee of the DTC. The hospital's medication safety programme was developed by the medication safety committee (MSC) and implemented by the medication safety pharmacist. Medication safety was an agenda item on the QPSC and the MSC provided quarterly reports to the QPSC on reported medication safety incidents and the measures implemented to improve medication safety in the hospital. Trends and data analysis, audit results, quality improvement initiatives and staff training on medication safety completed in the year were presented in the annual medication safety report, completed by MSC for the DTC and QPSC. A deteriorating patient improvement programme[***] was implemented in the hospital under the clinical leadership of the clinical director, to support the timely recognition and management of clinically deteriorating patients. The DPC provided quarterly reports on relevant audit results, patient reviews, risk assessments and appropriate staff education to the QPSC.

At the time of inspection, the demand for inpatient beds was higher than the actual supply of beds. The hospital was in full escalation and it was evident to the inspectors that actions aligned with that level of escalation were being implemented to manage service demand. These included the use of four additional surge beds in the day ward and using the AMAU as an alternate care pathway from the emergency department. Hospital management monitored the delayed transfers of care (DTOC) and the average length of stay (ALOS) at the unscheduled care governance committee every six weeks.

Overall, it was evident that the hospital had defined management arrangements in place and this was an improvement on previous inspection findings. Since the previous inspection in November 2022, there was evidence that the majority of actions outlined in the compliance plan for national standard 5.5 were implemented. These included the opening of an additional 12-bedded ward, the addition of six trolleys in the emergency department, directing and referring appropriate patients to a new off-site minor injuries unit and daily interactions with community services to support more efficient patient flow in and out of the hospital.

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.

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

There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Information from various clinical and quality sources was collected, compiled and published in accordance with the HSE's requirements. This information provided the SMT and the governance committees with assurances regarding the quality and safety of healthcare services provided in the hospital. The hospital's performance and compliance with quality metrics were also reviewed during monthly performance meetings between the hospital and DMHG.

There were established risk management structures and processes in place in line with the HSE's risk management framework, which supported the proactive identification, analysis, management, monitoring and escalation of reported risks (clinical and non-clinical). The hospital's risk manager was responsible for overseeing the effectiveness of the hospital's risk management processes. The risk manager reported to the QPS manager, who in turn updated the SMT four times a year on the effectiveness of the hospital's risk management structures and members of the SMT discuss new risk assessments at the hospitals regular SMT meeting if required. The governance committees – DTC, IPCC, DCP and MSC – with the support of the risk manager and patient safety manager, were responsible for monitoring the effectiveness of the risk management processes for the clinical services within their area of responsibility. Local risk registers with mitigating actions documented were in the three clinical areas visited by inspectors. Reported risks were managed by the clinical nurse managers (CNMs) and assistant directors of nursing (ADONs). The CNMs implemented actions to mitigate both the actual and potential risks to patients. When necessary, significant risks were escalated to the SMT and documented on the hospital's corporate risk register. The general manager managed and had oversight of the risks and mitigating actions recorded on the corporate risk register. The corporate risk register was reviewed every three months at the corporate risk register committee meeting. Significant high-rated risks and the corresponding mitigating actions were reviewed at the monthly performance meeting between the hospital and DMHG.

There were systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. The QPSC and Serious Incident Management Team (SIMT) were responsible for ensuring that all serious reportable events and serious incidents were reported to the National Incident Management system (NIMS)[†††] and managed in line with HSE's Incident Management Framework. The hospital was transitioning from the paper-based incident report form to an electronic point of entry reporting for patient safety incidents which was planned to be fully implemented by year end 2024. So, at the time of inspection, there was a dual process to report patient-safety incidents – the electronic point of entry reporting and a paper based format using the

[†††] 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 States Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

national incident report form. The SIMT, QPSC and SMT monitored the timelines and effectiveness of the management of adverse events and reported patient-safety incidents. Reports on patient-safety incidents were sent to all governance committees three times a year for review and to ensure the implementation of any relevant recommendations and sharing of learning with staff. All patient-safety incidents were tracked and trended by the QSP department and the information was reported to the IPCC, DTC, MSC, DPC, SIMT, QPSC and SMT. Patient-safety incidents and reviews of patient-safety incidents were also discussed at DMHG performance meetings.

There were processes in place in the quality and safety department to ensure there was a collaborative approach to the auditing, monitoring and improvement of healthcare services. The findings of monitoring activity and implementation of initiatives to improve healthcare services were monitored by the appropriate governance committee, clinical leads and QPSC, who provided the SMT with assurances on the quality of healthcare services delivered in the hospital.

The clinical governance committee and QPSC reviewed findings from monitoring activity and monitored the implementation of quality improvement plans. Patient feedback, compliments and complaints were monitored by the complaints governance committee (CGC). The complaints governance committee, chaired by the general manager, met monthly and reported to the QPSC four times a year. The members of the complaints governance committee provided feedback on the complaints resolution process to staff in their department. Feedback was also provided to nursing staff at ward meetings and safety huddles. Findings from the National Inpatient Experience Surveys and the implementation of related quality improvement plans were reviewed at meetings of the QPSC and at different clinical governance committees. Inspectors found evidence that quality improvement plans were being implemented to improve patients experiences at end of life, patient discharge and clinical handover.

In summary, there are effective monitoring arrangements in place at the hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Judgment: Compliant

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

The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. At the time of inspection, the hospital had a small shortfall (49 whole-time equivalent (WTE)[‡‡‡] (4.4%)) in their

‡‡‡ 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.

overall staff numbers. This shortfall was mainly in administration positions, some of these positions were filled temporarily, some were at pre-employment stage and a small number were unfilled. Hospital management confirmed that all the hospital's funded medical consultant positions were filled at the time of inspection and the majority of permanent medical consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Hospital management also confirmed, that arrangements were in place, in accordance with HSE requirements, to support medical consultants not on a specialist division of the register with the IMC. Medical consultants at the hospital were supported by a total of 82 WTE NCHDs at registrar and senior house officer (SHO) grades providing medical cover across the hospital 24/7. Ten WTE (12%) NCHD positions were unfilled at the time of inspection, however hospital management confirmed that eight of these positions were filled with regular agency staff. Hospital management told inspectors there was no impact on care or service provision from the two outstanding unfilled NCHD positions. The emergency department had 3.9 WTE emergency medicine consultants – 1.9 WTE appointed on a permanent basis and 2.0 WTE appointed on a locum basis. This was an increase of 0.9 WTE in emergency medicine consultant positions since the previous inspection. Emergency medicine consultants provided 24/7 medical cover in the emergency department.

The hospital was funded for a total of 12.5 WTE pharmacists and 6 WTE pharmacy technicians. All the pharmacy technician positions and 10.77 (86%) WTE pharmacist's positions were filled at time of inspection. The unfilled pharmacist's positions impacted on the ability to provide a comprehensive clinical pharmacy service[§§§] and on the surveillance and promotion of medication safety practices across the hospital. This risk, along with mitigating actions was recorded on the hospital's corporate risk register and was escalated to DMHG.

The IPCT comprised 2 WTE consultant microbiologists, 1 WTE ADON, 1.6 WTE clinical nurse specialist (CNS), 1 WTE antimicrobial pharmacist and 2 WTE surveillance scientists. At the time of inspection, 1 WTE antimicrobial technician position was unfilled and a clinical pharmacist was covering until September 2024. Inspectors were informed that the shortfall had impacted on the ability to carry out AMS pharmacy rounds and reviews of antibiotic care bundles.

The hospital was funded for a total of 428.47 WTE nurses (inclusive of management and other grades) with 97% of these positions filled at the time of inspection. Agency nurses familiar with the hospital covered any shortfalls in nursing staff when required. Since the previous inspection in 2022, the hospital had an uplift of 56.5 WTE nursing staff as a result of the Department of Health's safe staffing frameworks.[****] The three clinical areas

[§§§] A clinical pharmacy service – is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

[****] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

visited during inspection had their full complement of nursing staff, but shortfalls arising from short-term absenteeism or statutory leave were reported. The reported shortfall was 2.44 WTE (4%) in the emergency department, 3.2 WTE (14%) in Liffey Wards and 2.14 WTE (9%) in Imaal Ward. The delivery of patient care was supported by healthcare assistants. At the time of inspection, Liffey and Imaal Wards had their complement of funded healthcare assistants.

The reported staff absenteeism rate at the hospital was 5.65% for May 2024, which was above the HSE target of 4% or less. The human resource department tracked absenteeism rates and back to work interviews were carried out. Succession and recruitment and retention planning was an ongoing area of focus overseen by the SMT. An induction programme was provided for all new staff every six months coinciding with the change over of NCHDs. Occupational health supports were available to staff. The occupational health department was located offsite. The hospital manager discussed the challenge in getting occupational health appointments for staff, which had delayed the recruitment process of new staff. This was documented on the corporate risk register and had been escalated to DMHG. There was a focus on staff health and wellbeing, which was promoted by the hospital's wellbeing officer and wellbeing committee. The inspectors were provided with different examples of measures implemented to promote staff health and wellbeing, which included a staff Santa day, office door decoration competition at Christmas and a staff day at Halloween.

The human resource department coordinated, tracked and reported on the attendance and uptake of staff training. The DON was informed when nursing staff needed to update mandatory training. NCHD's attendance at essential and mandatory training was recorded on the National Employment Record (NER) system. Medical consultants had oversight of the uptake of training by NCHDs. Training records reviewed by inspectors showed that the uptake of essential and mandatory training for nurses in medication safety, Irish National Early Warning System (INEWS), transmission-based precautions and guidance on clinical handover was good, with levels above 85%. However, hand hygiene training records indicate that the uptake of training among staff in the emergency department was less than optimal (56% of nurses, 38% of HCAs and 39% of doctors had completed hand hygiene training). Hand hygiene training for staff on Imaal Ward could be improved (84% of nurses and 86% of HCAs had completed hand hygiene training). There was some gaps in the uptake of essential and mandatory training in basic life support, standard-based precautions and complaint management. There were also gaps in the uptake of essential and mandatory training for medical staff. Inspectors were informed the recent appointment of a HR manager will provide oversight on mandatory training attendance rates, with regular updates provided to relevant managers. Staff were also advised to complete training on HSELanD and onsite mandatory training was also provided in the hospital.

Overall, hospital management planned, organised and managed their nursing, medical and support staff to support the delivery of high-quality, safe healthcare services. Hospital

management had made some progress in implementing actions from the 2022 compliance plan related to national standard 6.1, which included increasing the number of consultants in emergency medicine and the overall number of nursing staff. Nevertheless,

- shortfalls in pharmacy staff impacted on the ability to provide a comprehensive clinical pharmacy service
- there were gaps in staff attendance and uptake of mandatory and essential training by medical and nursing staff.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Naas General Hospital was found to be compliant in two national standards (1.7 and 3.3), substantially compliant with two national standards (1.6 and 1.8) and partially compliant with three national standards (2.7, 2.8 and 3.1) assessed. Key inspection findings leading to these judgments are described in the following sections.

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

Inspectors observed how staff in the clinical areas visited promoted a person-centred approach to care and were respectful, kind and caring towards patients. Staff were observed assisting patients in a timely manner when needed. Patients who spoke to inspectors said "*staff were easy to talk to, they tell you about your medication and the plan for going home*". Nursing staff were also observed promoting patient independence.

The physical environment in the clinical areas visited generally promoted the privacy, dignity and confidentiality of patients receiving care. Privacy curtains were used in all multi-occupancy rooms when care was provided. However, overcrowding in the emergency department with admitted patients accommodated on trolleys and chairs did compromise the dignity and privacy for these patients and was not consistent with the human rights based approach supported by HIQA. Staff told inspectors, they tried to place independent patients on the corridors. One clinical area visited had a mixed gender of patients, inspectors were informed that they try to separate genders if possible, risk assessments were documented in the care plan and on a handover sheet.

During the inspection, the inspectors observed how storage of patients' healthcare records was an issue and how patient's personal information, was not always protected appropriately in two of the clinical areas visited. This was brought to the attention of the CNM and immediately addressed. Patient's healthcare records were stored in lockable trolleys located on a corridor beside the nurses' station in one of clinical areas visited, but these cabinets were not locked. This was brought to the attention of the CNM for remedy.

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

- healthcare records should be stored in line with national standards.

Judgment: Substantially compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care at the hospital. Inspectors observed staff to be kind and caring towards patients in the clinical areas visited. This was confirmed by patients who said that staff were "*lovely, kind' and very good", "wouldn't fault them, were brilliant in every way".* The hospital's mission statement was observed in the clinical areas visited by inspectors. The hospital had introduced initiatives to improve the patient experience within the emergency department for example, prioritising the admission of patients over 75 years of age. A new nursing care plan was introduced, nurse champions in the areas of pressure ulcers, falls and dementia were available to staff to ensure a person–centred, individual approach was taken when assessing and planning patient care. Patients who spoke to inspectors were aware of their plan of care, one patient told inspectors "*I know what is going on with my treatment, they tell you about medications and the plan regarding going home* ". Inspectors observed patient information leaflets available and accessible to patients on a range of health topics. At the time of inspection, hospital management were implementing a quality improvement plan to improve end-of-life care for patients.

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 that there were systems and processes in place in the hospital to respond to complaints and concerns. The complaints manager's post was unfilled at the time of inspection and the patient experience manager was the designated complaints coordinator for the receipt and effective handling of complaints. The HSE's complaints management policy *'Your Service Your Say'* was used. Complaints management training was mandatory for all staff and the patient experience manager had oversight of the level and uptake of that training. Point of contact resolution was promoted and supported in line with national guidance. *'Your Service Your Say'* leaflets were seen displayed around the hospital reception desk and in one of the three clinical areas visited. Suggestion boxes for patients to provide feedback on their experiences were seen in all clinical areas visited. Complaints were tracked and trended to identify emerging themes, categories and departments involved. Complaints were discussed in the clinical area with CNMs and reviewed at CGC, QPSC and SMT meetings. Information on complaints and complaints resolution were shared with staff at ward meetings, during safety huddles, through learning notices and via a designated messaging application for smartphones. There was evidence that quality improvement plans were developed following complaints, for example, the number of multi-task assistants allocated to the emergency department to help and support patients was increased. Documentation reviewed by the inspectors showed that, despite staffing challenges, last year the hospital was compliant with the HSE's target to resolve 75% of complaints within 30 days. There were arrangements in place to ensure support services such as advocacy services were available to patients. The inspectors observed information on independent advocacy services displayed in the clinical areas visited. The QPSC monitored and had oversight of quality improvement initiatives and learning from feedback arising from the complaints resolution process.

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

- the complaints manager's post was unfilled at the time of inspection, while it did not impact on the timely management and resolution of complaints on the day of inspection, going forward the current staffing arrangements may not be sustainable
- *'Your Service Your Say'* leaflets were not seen in all clinical areas inspected.

Judgment: Substantially compliant

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

During inspection, the inspectors observed the physical environment in the clinical areas visited was generally well maintained and clean with a few exceptions. There was

evidence of some wear and tear on woodwork, which did not facilitate effective cleaning and posed an infection prevention and control risk. The design and layout of Liffey Wards did not facilitate an environment that promoted effective infection prevention and control practices in line with national and international best practice. The beds in Liffey Wards were not separated by a distance of one metre in multi-occupancy rooms and there were no single rooms. Imaal Ward had four six bedded bays, one three bedded bay and four isolation rooms with two negative pressure rooms. Beds were observed to be one metre apart in multi-occupancy rooms in Imaal Ward. There was a lack of storage facilities on some clinical areas visited, which resulted in equipment being stored on corridors and in inappropriate areas. The infection prevention and control nurses liaised with staff in the clinical areas visited daily and advised on the appropriate placement of patients and patients were cohorted as per local and national guidance. Risks associated with the ageing infrastructure and lack of appropriate inpatient beds, bathroom facilities and inadequate isolation rooms were recorded on the corporate risk register and were escalated to the DMHG with a plan to increase the number of isolation rooms as part of the strategic plan.

Environmental and terminal cleaning,[††††] was carried out by an external contract cleaning company. The CNMs and the hospital's cleaning supervisor had oversight of the standard of cleaning in clinical areas visited. One ward visited had an active infection outbreak which was being managed at the time of the inspection. Signage in relation to the correct and appropriate use of standard and transmission-based precautions were displayed in clinical areas. However, inspectors observed the door of a room where a patient was requiring transmission-based precautions was open, this was not consistent with national guidance and was raised with CNMs and actioned immediately. The double doors of the ward leading to the main corridor were also observed to be open a number of times during the inspection. Personal protective equipment (PPE) was available outside single isolation rooms and multi-occupancy rooms where patients requiring transmission-based precautions were accommodated. However, the inspectors identified instances of medical and nursing staff not adhering to standard and transmission-based precautions in Liffey Ward 2. This was raised with the SMT during inspection and was addressed immediately.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available to staff in the three clinical areas visited. Hand hygiene signage was clearly displayed throughout clinical areas inspected. Hand hygiene sinks conformed to required specifications.[‡‡‡‡] There was appropriate segregation of clean and used linen and used linen was stored appropriately. Patient equipment was observed to be clean, however, there was some confusion among staff in relation to the system in place to ensure the equipment had been cleaned. The design and delivery of healthcare

[††††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.
[‡‡‡‡] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assembles*. 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

services in the emergency department or in the transit area did not fully protect people awaiting review or admitted patients on trolleys and chairs from risks of harm. These patients were not placed close by the nurses station and did not have call bells to seek assistance when needed.

In summary, the physical environment did not fully support the delivery of high-quality, reliable care and protect the health and welfare of people receiving care.

- there were risks to patients as a result of the ageing infrastructure in Liffey Wards
- there were two infection outbreaks at the time of the inspection
- there was some uncertainty regarding the current system for cleaning of patient equipment
- appropriate standard and transmission-based precautions were not in place as per national guidance, doors of isolation rooms were open
- issues with the appropriate use of PPE
- limited isolation rooms and the use multi-occupancy rooms with limited space between beds in the clinical areas visited and admitted patients were accommodated on trolleys in corridors in the emergency department.

Judgment: Partially compliant

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

Inspectors found that there were assurance systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management used information from a variety of sources (including KPIs, findings from audits, risk assessments, patient safety incident reviews, complaints and patient experience surveys) to compare and benchmark the quality of their healthcare services with other similar hospitals in and outside the DMHG, and to support the continual improvement of healthcare services.

As per HSE's reporting arrangements, hospital management reported monthly on rates of *Clostridioides difficile* infection, Carbapenemase-producing *Enterobacterales* (CPE), hospital acquired *Staphylococcus aureus* blood stream infections, hospital-acquired COVID-19 and infection outbreaks. The IPCT generated and submitted a summary report on organism surveillance (Methicillin-resistant *Staphylococcus aureus* (MRSA), *Vancomycin-Resistant Enterocci* (VRE), *Clostridioides difficile*, CPE, Extended-spectrum Betalactamase (ESBL), *Aspergillus* (influenza, respiratory syncytial virus (RSV) and noravirus)) to the IPCC three monthly. A comprehensive report of the hospital's healthcare-associated infection surveillance was submitted annually to the IPCC and SMT.

Monthly environment, patient equipment and hand hygiene audits were carried out by the IPCT using a standardised approach and audit findings were reported to IPCC. A sample

of environmental and patient equipment hygiene audits were provided to the inspectors. There was evidence of a good level of compliance with expected environmental hygiene standards in the three clinical areas visited. Compliance rates for environmental hygiene standards ranged from 94% to 96% on Imaal Ward, 90% to 100% on Liffey Wards and 95% to 98% in the emergency department. However, compliance rates for patient equipment hygiene standards was less positive, ranging from 78% to 91% (emergency department), 82% to 94% (Imaal Ward). Recent patient equipment hygiene audits for Liffey Wards were not provided to the inspectors. There was evidence that quality improvement plans were developed to improve environmental and patient equipment hygiene standards when they fell below the 80% rate set by the hospital management. However, the actions in quality improvement plans were not always time-bound or had a designated person assigned with responsibility to implement the action. This finding was similar to previous inspection findings in November 2022. Hand hygiene audits were carried out by the IPCT and audit findings for the months preceding this inspection showed results ranging from 80% to 100% in the clinical areas visited by inspectors. When hand hygiene standards fell below expected standards, additional hand hygiene education was provided by the IPCT and the practice was re-audited.

Medication audits were carried out and audit findings were reported to MSC. Recent audits included an insulin storage audit which was reviewed at MSC and results were to be circulated to nursing staff and it was agreed to re-audit to ensure recommendations were implemented. 'Know Check Ask'[§§§§] audit results showed not much improvement from previous audit and a quality improvement project was ongoing. Other quality improvement projects implemented included implementation of new monographs[*****] and a monograph folder on alteplase[†††††] in place in the emergency department, pre-printed infliximab[‡‡‡‡‡] prescriptions and updating intravenous monographs in the hospital. All quality improvement projects were time-bound and had an assigned person to oversee implementation of projects. The hospital's audit plan for 2024 did include audits on medication reconciliation and high-risk medications. Quality improvement initiatives implemented in 2023 to improve medication safety practices were described in the annual medication safety report. Medication practices in the three clinical areas visited were monitored monthly as part of the nursing and midwifery quality care metrics and there were good levels of compliance at the time of inspection. There was evidence that antimicrobial stewardship practices at the hospital were monitored and evaluated. These included participating in the European Centre for Disease Prevention and Control point prevalence survey of hospital-acquired infections and antimicrobial use. There was a focus on changing from intravenous antibiotic use to oral use and a quality improvement plan was developed to improve antibiotic prescribing in the hospital. Use of meropenem and

[§§§§] Know Check Ask "My Medicines list" is an up to date written or printed list of all prescribed medications, so that health professionals can check that medicines and combinations are effective and safe.
[*****] A document that describes the properties, indications and conditions of use of a drug and contains other information that maybe required for optimal, safe and effective use of the drug..
[†††††] Alteplase is a medicine used to dissolve blood clots.
[‡‡‡‡‡] Infliximab is a medicine used to enhance and improve the immune system.

ertapenem were being monitored and antimicrobial education focused on NCHDs and nurses. The antimicrobial stewardship team reported to the IPCC and to the DTC.

Compliance with the early warning system escalation and response protocol were audited every second month as part of the nursing and midwifery quality care metrics. Inspectors found compliance rates in the months preceding the inspection varied and not all performance metrics were collated consistently every month, therefore it was difficult to compare results month by month. There was no evidence seen by the inspectors that time-bound actions were implemented to improve compliance rates when practices fell below expected standard. Sepsis was audited as part of test your care metrics, Liffey Ward and Imaal Ward were both 100% compliant in March 2024 with escalating care using the sepsis form. Findings from a recent sepsis audit were reviewed at DPC with discussion regarding actions required to improve areas of poor performance a number of actions were taken, including re-audit, all actions were assigned to a responsible person for implementation. Quality improvement plans recently implemented included staff sepsis awareness day, sepsis awareness section in the staff newsletter and sepsis posters. Clinical handover occurred twice daily in the clinical areas visited. Monitoring compliance with national guidance on clinical handover and the use of Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_2$) communication tool[§§§§§] occurred in two of the three clinical areas visited. All audit findings were shared with CNMs, heads of departments, clinical directors and the SMT. Compliance with ISBAR was audited in Imaal Ward and Liffeys Wards as part of nursing and midwifery care metrics with low levels of compliance documented. There was no evidence seen by the inspectors that time-bound actions were implemented to improve compliance rates when practices fell below the expected standard. Audits relating to transitions of care were not submitted to HIQA.

Staff in clinical areas visited were not aware of the hospital's findings from the National Inpatient Experience Survey. Hospital management had with the HSE developed a quality improvement plan to address the survey findings, but staff could not provide examples of quality improvements measures implemented to improve the patient experience.

Overall, the hospital was monitoring and evaluating healthcare services provided at the hospital to improve care. Evidence that monitoring and evaluation of services was used to improve practice was not provided for all monitoring and audit activity. Nonetheless,

- auditing of compliance with clinical handover and $ISBAR_2$ use was not in line with national guidance
- when practices fell below expected standards, quality improvement plans were not always developed to improve clinical practice. Quality improvement plans should be

[§§§§§] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_2$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

time-bound with named persons assigned to enable implementation of actions detailed in the plan
- staff in clinical areas visited were not aware of quality improvements implemented arising from National Inpatient Experience Survey.

Judgment: Partially compliant

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

There were arrangements in the hospital to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care. There were systems in place to proactively identify, assess and manage immediate and potential risks to patients. Risks were recorded on local risk registers. In the clinical areas visited, risks identified were assessed and analysed by CNMs and an ADON. The risk manager advised and supported the CNMs in this process. Actions were applied to mitigate the risks to patients and responsibility for implementing and overseeing the effectiveness of these actions lay with the CNMs. Significant risks, not managed at clinical area level were escalated to the SMT for review and consideration for inclusion on the corporate risk register. The general manager oversaw the management of risks recorded on the corporate risk register and risk was a standing agenda item at the QPSC. The risks and mitigating actions recorded in the corporate risk register were reviewed by the SMT every three months. Four significant high-rated risks were also reviewed at the most recent monthly performance meetings between the hospital and DMHG. At the time of the inspection, a number of high-rated risks related to the four areas of harm were recorded on the corporate risk register. These included infection prevention and control, deteriorating patient, transitions of care and the pharmacy service. Staff in the clinical areas visited had not received training on the HSE's most recent risk management framework, but there were plans to roll out that training to relevant staff across the hospital later this year.

Patients admitted to the hospital were screened for MDROs – *Clostridioides difficile* infection, *Staphyloccus aureus* blood stream infections, CPE, VRE, MRSA and COVID-19 and measles. Patients were screened for CPE in line with national guidelines. Audit findings reviewed by inspectors showed a good level of compliance (ranging from 87%-97%) with CPE screening. Action plans were devised and implemented to bring the hospital into full compliance with national guidance on CPE screening. CPE screening audit results 2023 reflected an increase in the number of patients screened for CPE between January and December in patients attending the emergency department. The hospital's information management system alerted staff to patients who were previously inpatients

with confirmed MDROs. Compliance with MDRO screening was audited by the IPCT with oversight by the IPCC. If isolation facilities were not available, a risk assessment was carried out and suitable patients were cohorted in multi-occupancy rooms. At the time of the inspection, there were two active infection outbreaks - COVID-19 and VRE. Hospital management had convened multidisciplinary outbreak teams to advise and ensure that the management of these outbreaks aligned with best practice standards and guidance.

A limited clinical pharmacy service was provided at the hospital. Pharmacy-led medication reconciliation was not under taken on all patients. Medication reconciliation was carried out during admission to hospital which was clearly indicated in the medication reconciliation policy. Medication stock control was carried out by pharmacy technicians. Inspectors were informed the hospital had a list of sound alike look alike drugs (SALADS) and the hospital's list of high-risk medications aligned with the acronym 'A PINCH'.****** However, the inspectors did not see evidence of this in the clinical areas visited by inspectors. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care in hard copy format and through an application for smart phones. Temperature logs on medication fridges were not checked daily in two clinical areas visited and this was discussed with the CNM during inspection.

Staff used the most recent version of the national early warning systems for the various cohorts of patients. The 'Sepsis 6' care bundle and $ISBAR_2$ communication tool were also used. Hospital management were planning to implement the Emergency Medicine Early Warning System (EMEWS) in the emergency department, but there was no definitive date for its implementation. Staff in the clinical areas visited were knowledgeable about the INEWS escalation and response protocol and there were effective processes in place to ensure the timely management of patients with a triggering early warning system. However, inspectors reviewed a sample of healthcare records and found that the plan of care was not always documented following patient review. This finding was discussed with the CNM during inspection.

There were systems and processes in place to support discharge planning and the safe transfer of patients within and from the hospital. Each patient had a planned date of discharge. Daily and weekly bed management meetings were held with representation from the hospital and community services. Issues that impacted on the discharge process, complex discharge cases and action required to enable the safe discharge of patients were discussed at these meetings. The hospital had access to approximately 17 convalescence and or rehabilitative care beds in community hospitals. Hospital admission avoidance initiatives such as the Frailty Intervention Team (FIT), Community Intervention Team (CIT) and Outpatient Parenteral Antibiotic Therapy (OPAT) were used. However, the increase in demand for unscheduled and emergency care, issues with patient flow as

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

manifested in the 40% of patients lodging in the emergency department, contributed to longer patient experience times (PETs) for patients receiving care in the emergency department. The number of new attendances to the hospital emergency department, PETs, ALOS of medical and surgical patients and DTOC were tracked in line with the HSE's requirements. Collated information on PETs, ALOS and DTOC was discussed as part of the daily situational report and at monthly meetings of the SMT.

Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. Patients were accommodated in designated treatment areas, on trolleys in the corridor and in the transit unit in the emergency department. The waiting time from:

- registration to triage ranged from 10 minutes to 1 hour. The average waiting time was 5.5 minutes, which was an improvement on previous inspection findings (average time was 18 minutes) and better than the triage time of 15 minutes recommended by HSE's emergency medicine programme
- triage to medical assessment ranged from 1 hour 5 minutes to 2 hours 47 minutes for non-urgent patients. The average wait time was 1 hour 51 minutes, which was an improvement on previous inspection findings (3.5 hours)
- decision to admit to actual admission in an inpatient bed ranged from 5 hours 20 minutes to 26 hours and 51 minutes, an improvement on previous inspection findings, which ranged from 6 hours to 56 hours

10.55% of emergency department patients left before completion of treatment in 2023 and up to the time of inspection this was 7.1%

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

- 20 (44%) patients in the emergency department were in the department for more than six hours after registration. This was not in line with the HSE's target that 70% of patients be admitted or discharged from the department within six hours of registration, but was similar to HIQA's previous inspection findings.
- 18 (40%) patients in the emergency department were in the department for more than nine hours after registration. This was not in line with the HSE's target that 85% of patients be admitted or discharged from the department within nine hours of registration, however, it was similar to HIQAs previous inspection findings.
- 3 (7%) patients in the emergency department were in the department for more than 24 hours after registration. Again, this was not compliant with the HSE's target of 97% for this KPI although, it was an improvement on the previous inspection findings.
- 2 (4%) patients aged 75 years and over were in the emergency department greater than six hours of registration. This was not in line with HSE's target of 95%

of all attendees aged 75 years and over at the emergency department who are either discharged or admitted within six hours of registration.
- 1 (2%) patient aged 75 years and over was in the emergency department greater than nine hours of registration and this was an improvement on the previous inspection findings.
- 1 (2%) patient aged 75 years and over was in the emergency department greater than 24 hours of registration and this was an improvement on the previous inspection findings.

At the time of inspection, the hospital had 10 delayed discharges, similar to previous inspection findings. Hospital management attributed the delay in transferring patients mainly to lack of community beds.

Staff had access to a range of up-to-date infection prevention control, medication safety, transitions of care and the deteriorating patient policies, procedures, protocols and guidelines. All policies procedures and guidelines were mostly accessible to staff via a document management system and in hard copy format. Inspectors found a small number of policies in hard copy format were not in date in one clinical area visited and this was escalated to the CNM. Staff in one clinical area visited had difficulty accessing policies, procedures, protocols and guidelines on the computer system.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm - infection prevention and control, medication safety, the deteriorating patient and transitions of care. Despite systems in place to support patient flow, the design and delivery of healthcare services did not fully protect people awaiting review or accommodated on trolleys in the emergency department from risk of harm. Additionally:

- Staff in the clinical areas visited had not received training on the HSE's most recent risk management framework
- The EMEWS training was not yet implemented in the emergency department
- A small number of hard copy medication safety policies were not up to date
- The hospital did not yet have a full clinical pharmacy service
- Medication fridges temperatures not checked daily
- No list of high-risk medications and 'SALADS' in the clinical areas visited
- A plan of care not always documented following a medical review for patients with a high INEWS.

Judgment: Partially compliant

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

There was a system in place in Naas General Hospital to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines. Line managers reviewed patient-safety incidents which occurred in their area in conjunction with an ADON and the quality and safety manager. Patient-safety incidents were reported to NIMS. Hospital management reported the number of clinical incidents per 1,000 bed days used (BDU) to NIMS to the HSE monthly. Staff who spoke with inspectors were knowledgeable about what and how to report a patient-safety incident, and were aware of the most common patient-safety incidents reported in their area. The IPCT reviewed all relevant infection prevention and control patient-safety incidents, made recommendations for corrective actions and these were reported to the IPCC. Medication related patient-safety incidents were categorised on NIMS as relating to a person or a dangerous occurrence. All medication related incidents were reviewed by the quality and patient safety department and pharmacy department and or nursing department. The number of medication safety incidents reported in 2023 increased by 63% when compared to those reported in 2022. Medication related incidents were track and trended, by the quality risk and patient safety department and this information was shared with the DTC, MSC and QPSC. Learning notices were issued and case studies presented at various education forums to share information from patient-safety incidents. Information on patient-safety incidents were shared with staff at ward meetings.

Information on the number and types of reported patient-safety incidents, serious reportable events and serious incidents and compliance with NIMS timelines was collated by the quality and patient safety manager. This information was included in the quality and patient safety report submitted three monthly to the SMT, quarterly to the DMHG and was also in the quality and safety annual report. A sample of the quality and safety reports submitted to the SMT reviewed by the inspectors only contained information about patient-safety incidents in one of the four area of harm (medication safety).

In 2023, the hospital reported 85% of patient-safety incidents to NIMS within 30 days, this was in line with the national target (70%). Hospital management reported that sometimes it was challenging to complete comprehensive reviews of adverse events within the national target of 125 days. The complexity of the case and or availability of subject matter experts were the main reasons mentioned by hospital management for the non-compliance with this timeline. Inspectors were told that the patient services manager supported patients and kept them updated and informed during the investigation process.

All serious patient-safety incidents and serious reportable events were reported to the general manager and the SIMT. All preliminary assessment reports (PARs) and internal reviews in progress were discussed at the relevant governance committee meeting. The implementation of recommendations from reviews of patient-safety incidents was the responsibility of the relevant governance committees, monitored by the quality and

patient safety department and the SIMT. Overall, the hospital had a robust system in place to identify, report, respond to and manage patient-safety incidents.

Judgment: Compliant

Conclusion

An unannounced inspection of Naas General Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare.* The inspection focused on four areas of known harm- infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

There were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. Improvements from the previous inspection included the development of a four-year strategic plan 2024 – 2028 setting out the strategic objectives for the hospital over a four-year period, and this plan was being finalised at the time of this inspection. The hospital had defined management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services, an improvement on previous inspection findings. There were systematic monitoring arrangements in place in the hospital for identifying opportunities to continually improve the quality, safety and reliability of healthcare services. Hospital management planned, organised and managed their nursing, medical and support staff to support the delivery of high-quality, safe healthcare services. The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. This was an improvement on a previous inspection with an increase in consultants in emergency medicine and in the overall numbers of nursing staff. Nevertheless, there were shortfalls in pharmacy staff which impacted on the ability to provide a comprehensive clinical pharmacy service. There were also gaps in staff attendance and uptake of mandatory and essential training by medical and nursing staff, attendance at hand hygiene training could be improved.

Quality and Safety

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients and this is consistent with the human rights-based approach to care promoted by HIQA. Patients spoke positively about their experiences of receiving care in the hospital. The hospital had systems and processes in place to respond promptly and effectively to complaints and concerns raised by patients and others. The complaints manager's post was unfilled at the time of inspection, but it did not impact on the timely management and resolution of

complaints. The physical environment did not fully support the delivery of high-quality, reliable care and protect the health and welfare of people receiving care. There were admitted patients accommodated on corridors in the emergency department. There were two infection outbreaks at the time of the inspection. There was some uncertainty regarding the current system for cleaning of patient equipment. Appropriate standard and transmission-based precautions were not as per national guidance and there were issues observed with the appropriate use of PPE in one clinical area visited. The ageing infrastructure of Liffey Wards was apparent with the limited space between beds. The hospital was monitoring and evaluating healthcare services provided at the hospital to improve care. However, auditing of compliance with clinical handover and ISBAR should be an area of focused improvement. Quality improvement plans were not always developed to improve clinical practice and they should be time-bound with named persons assigned to enable implementation of actions. Staff in clinical areas visited were not aware of quality improvements implemented arising from National Inpatient Experience Survey. The hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm. Despite systems in place to support patient flow, the design and delivery of healthcare services did not fully protect people awaiting review or accommodated on trolleys in the emergency department from risk of harm. PETs were similar or improved from HIQA's previous inspection. Staff had not received training on the HSE's most recent risk management framework. The EMEWS training was not yet implemented in the emergency department. A small number of hard copy medication safety policies were not up to date. The hospital did not yet have a full clinical pharmacy service. The temperatures on medication fridges were not checked daily. There was no high-risk medications or 'SALADs' lists in the clinical areas visited. Standard and transmission-based precautions guideline precautions were not adhered to by staff in one clinical area visited. A plan of care not always documented following a medical review for patients with a high INEWS. The hospital had a robust system in place to identify, report, respond to and manage patient-safety incidents in line with national legislation and standards, policy and guidelines. The implementation of recommendations from reviews of patient-safety incidents was the responsibility of the relevant governance committees, monitored by the quality and patient safety department and the SIMT. Recommendations from the review of patient safety incidents were shared with staff to support service improvement. Completing comprehensive reviews of adverse events within the national target of 125 days could be a challenge at times due to the complexity of the case and or availability of subject matter experts.

Following this inspection, HIQA will, through the compliance plan submitted by the hospital management as part of the monitoring activity, continue to monitor the progress in implementing actions being employed to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
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.	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	
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

Capacity and Capability Dimension	
National Standard	**Judgment**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	

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

Compliance Plan for Naas General Hospital OSV-0001080

Inspection ID: NS_0084

Date of inspection: 17 and 18 July 2024

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

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

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

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

Physical Environment

The necessity for significant and sustained infrastructure investment into NGH has been identified by the Senior Management Team (SMT) as both a strategic and operational key priority. Additional and modern infrastructure will enhance both capacity and patient flow processes onsite greatly. In addition, the replacement of ageing infrastructure and the addition of single occupancy rooms would be extremely beneficial from an infection prevention and control perspective. Significant progress has been realised in terms of enabling capital projects including:

- 11 Bay AMAU currently under construction and due to become operational early Q2 2025
- 15 Bed Short Stay Admission Ward in design phase and construction due to commence in 2025 with likely operational date in 2026
- Redevelopment of existing Day Ward due to take place in Q1 2025
- Redevelopment of current Lakeview Mental Health Ward and reconfiguration to acute beds will take place on the opening of the new Acute Mental Health build (circa 2030)
- Four storey build including 49 single occupancy beds in early planning

stages with hope to complete in circa 2033

Liffey wards

The current limitations with the ageing infrastructure on the Liffey wards is acknowledged. To address some shortcomings renovations to the Liffey wards were completed in late 2023; this included new flooring, painting, and upgrades to bathrooms and fire exits. However due to competing demands the continued utilisation of these beds for admitted patients is required. The Bed Management Team select the most appropriate patients for admission to the Liffey ward (e.g low acuity patients, independent or assist of one, stable and likely to have an imminent discharge date). The IPC team have completed a Risk Assessment with respect to the Liffey wards and infrastructural risks have been identified on the Corporate Risk Register of the hospital. All current existing IPC control measures are documented including 24 hour microbiologist consultation and patient screening on admission.

The hospital's long term plan is to replace/reconfigure Liffey Ward and this is reflected in the hospitals Development Control Plan. Specifically, the capital request referenced previously for 49 single occupancy beds which on completion would potentially allow the hospital to repurpose these wards. This project is unlikely to be completed until 2033. To note, the hospital is also exploring other potential options to increase the inpatient bed stock further in the intervening period.

Storage facilities on Wards

The hospital is currently in the early stages of piloting and implementing "The Productive Ward"; a key element of this is the holding of optimal stock levels in clinical areas and ensuring appropriate storage space. The project is led by the General Services Manager- completion date Q4 2025.

Bed Management Strategy

Further initiatives to improve bed management and patient flow (beyond capital projects listed above) are listed below.

- Opening of AMAU on extended working day 7/7 in Q2 2025 will enable improved patient flow
- Inpatient Consultant evening ward rounds within ED would enhance senior timely decisions making Aim: Ql/2 2025 (Owner: General Manager/Clinical Director)
- Ongoing optimisation of Scheduled care beds in periods of surge in so far as possible
- Offsite Local Injuries Unit opened in Q1 2024

- Additional Medical SHO currently working in ED on twilight shift on pilot basis to support rapid assessment of Medical patients

Emergency Department patients/transit area

Inspectors noted patients in the ED/transit area did not have call bells to seek assistance when required. NGH acknowledge this and in recognition of same have put in place a number of mitigating steps to manage same effectively.

Nursing staff for admitted patients

In line with national guidelines, NGH have in place dedicated nursing staff to monitor and evaluate on an ongoing patients admitted within ED

Fit to Sit

Following assessment patients in ED are assessed as to whether they are able to sit or if they need to remain on a trolley. Fit to Sit is a methodology promoting independence and improving health outcomes.

Rapid Assessment and Treatment

Rapid Assessement and Triage (RAT) has been piloted at NGH in October 2024. Senior clinician RAT may enable high-acuity presentations to be identified in a timely manner reducing PET and promoting early intervention and improved patient outcomes. The outcome of the RAT pilot in NGH showed to have reduced PET by 1.5hrs. NGH project plan is to go live with imbedded RAT in Ql 2025 with a dedicated space, appropriate resources and pathways in place to support the iniative.Owner: Clinical Director

New Short Stay Unit

NGH has received HSE initial capital funding approval to progress a new 15-bed admissions unit adjacent to the ED. This unit will consist of individual patient cubicles, each equipped with handwashing sinks and call bells. This will facilitate the more timely flow of admitted patients within the ED to an admitted bed. Owner: General Services Manager

Infection Prevention and Control

Inspectors observed the door of a room where a patient was requiring transmission based precautions was open; this is not consistent with local policy. Staff are aware that doors to isolation rooms should be closed at all times for patients being cared for under droplet and airborne precautions, as well as for patient being cared for in protective isolation.

Inspectors observed the double door of a ward leading to the main corridor was open a number of times during the inspection. There is a plan to change these

doors into swipe access automated double doors in the future by Q3 2025. A capital funding submission for this project is scheduled for submission in Q1 2025.

The inspectors identified instances of staff not adhering to standard transmission based precautions in Liffey ward 2. This is a breach of local policy and staff are continuously reminded on the necessity to observe the required IPC practices. Staff are aware that they should adhere to droplet precautions when caring for COVID-19 contact patients.

The IPC team continuously audit these practices across the hospital and promote adherence to relevant policies both formally and informally.

Equipment cleaning

Inspectors noted that patient equipment was observed to be clean, however there was some confusion among staff relating to the system in place to ensure the equipment has been cleaned.

To note, a cleaning and disinfection practical training education program has been rolled out at NGH. The training is organised by the Household Services Supervisor in collaboration with IPC. Every clinical ward area has a cleaning checklist which guides staff on what equipment needs to be cleaned daily and weekly. This is monitored weekly by the IPC ADON. Any concerns are raised by the IPC ADON to the ward CNM for actioning.

All of the cleaning staff, MTA's and HCA's have received training on Tristel Fuse cleaning product and it is readily available in the cleaning cupboards on all wards. Any training or cleaning deficits are addressed by the IPC ADON.

Timescale: Q3 2025

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

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

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

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

National Inpatient Experience Survey

Inspectors found that staff in clinical areas were not aware of findings from the NIES and the associated quality improvement measures. The hospital would accept that whilst it does have specific QIPs in place following on from previous NIES there is room for improvement in communicating learnings and involving staff within the clinical areas re same. The hospital introduced two QIPS on foot of the 2022 NIES which focused on improving communication with service users/families/ward staff. A Patient Admission pack was also launched as part of the oucome of the 2022 report. The findings from the NIES 2024 will be presented to the Heads of Service in Q4 2024. Learning notices will be shared throughout the hospital via Sharepoint, digital screens, Learning posters and the hospital publication, Hospital Link. (Responsibility: Patient Experience Manager)

2024 NIES Feedback

NGH have recently submitted two quality improvement projects for 2024/25 to the National Team (November). These QIPs are designed specifically to address two of the key issues identified in the feedback. The first QIP is the 'Johns Campaign', with the aim of providing the option for a designated Primary Contact to stay with the vulnerable patient to facilitate improved communications with the vulnerable patient and their primary contact. The second QIP is the introduction of a 'HSE Health Passport'. This is a tool designed to support people with a intellectual disability express their needs when in a healthcare setting. These QIPs have been introduced at a Lunch and Learn in Nov 2024, and a further one is planned for Q1 2025. Responsibility: Quality and Patient Safety Manager.

Additional steps to support dissimenation of NIES Service user feedback and related QIPs:

- Newly launched NGH Staff Intranet in November: allows for rapid communication of material
- Use of digital screens across the hospital in areas of high footfall:
- Staff Learning Notices: with NIES Feedback (2024) to be developed and disseminated by Ql 2025 (Owner: Quality and Patient Safety Manager)
- As part of the forthcoming quarterly Heads of Service meeting a presentation (December 2024) is scheduled to outline learnings/deficits/QIPs to be implemented (Owner: Quality and Patient Safety Manager)
- National Communications Programme Module 1 continues to be rolled out out hospital wide

Quality Improvement and Audit

Clinical Handover & ISBAR3

- The Medical Assessment Performa (MAP) has been in place for 3 years and is audited annually by the Medical NCHD lead (supported by Nursing Practice Development Unit). The findings from the last audit, February 2024, were presented and discussed at the Clinical Handover Committee meeting, June 2024 and learnings are shared with the medical teams via the Medical NCHD Lead.

- There was an Audit of surgical admissions (based on ISBAR:3) completed in May 2024. As a result of this audit, a Surgical Assessment Proforma (SAP) was developed from May through to Sept 2024. This ISBAR:3 friendly tool provides a structure for doctors completing a surgical patient admission. This SAP is currently being piloted with a plan to reaudit in December 2024 by the surgical NCHD lead, supported by Nursing Practice Development Unit. Findings from the audit will be presented to the Clinical Handover Committee.

- A 'Nursing Shift-to-Shift Clinical Handover Audit' completed in March 2024. As a result of this audit, a QIP was developed to include HCAs in this nursing clinical handover. This is currently being piloted (Sept 2024 - Jan 2025) and will be audited in QI 2025.

- The QRPS Manager and Patient Safety Team deliver ongoing training sessions on the use of ISBAR:3 to NCHD's, HCA's, CNM's and overseas nurses on orientation/induction.

- Auditing of compliance with clinical handover and ISBAR:3 is the responsibility of the Clinical Handover Committee. Audit schedule re same is to be raised by the Chair of the Committee (Owner: Patient Safety Manager)

- A standard communication template regarding pre alert calls has recently been developed between the National Ambulance Service and ED staff. This form is specifically designed to follow the ASHICE/IMIST ISBAR:3 Model of communication and information gathering. This form is currently in use in the ED and will be audited in QI 2025 by the QRPS Manager. (Owner: QPS Manager)

Quality Improvement Plans when Practice falls below standards

Environment and Patient Equipment cleaning

As previously mentioned, the Inspectors noted that patient equipment was observed to be clean, however there was confusion among staff relating to the system in place to ensure the equipment had been cleaned. This has since been addressed by the Hygiene Services group (see below).

A cleaning and disinfection practical training education program has been rolled out at NGH. This training was organised by the Household Services Supervisor and the CDU Manager in collaboration with IPC. Every clinical ward area has a agreed cleaning checklist which guides staff on what equipment needs to be cleaned on a daily and weekly basis. This is monitored

weekly by the IPC ADON. Any concerns are raised by the IPC ADON to the ward CNM for actioning.

Where cleaning audit results show that cleaning standards have fallen below 80% the IPC ADON will convene a Hygiene Services meeting to identify the areas of concern and highlight the issues influencing low audit results. This group has met in 03/10/2024 and 27/11/2024. On the 27/11/2024 the Action Plan from the previous meeting was reviewed and another Action Plan was developed by the IPC ADON incollaboration with the Household Services Supervisor, the CDU Manager, CNM's, HCA's and the ADON Nursing Workforce planning. The Action Plan details each individual responsible for each action and is time bound to the 31st of January. The Action Plan details the following;

- Standardised Cleaning Checklist to be used throughout the hospital
- Standardised Mattress cleaning checklist to be agreed and used throughout the hospital
- All cleaning checklist to be completed on a daily/weekly basis as agreed
- Disposable basins in use on the Surgical ward and ICU
- Next meeting of Hygiene Services is set for January 2025. All actions from the Action Plan of 27/11/2024 to be completed at this date

All of the cleaning staff, MTA's and HCA's have received training on Tristel Fuse cleaning product and it is readily available in the cleaning cupboards on all wards. Any training or cleaning deficits are addressed by the IPC ADON.

NGH recognise the necessity to continuously review, audit and learn. All learnings/audit findings will be imparted by the IPC ADON to the CNM's in a timely and effective manner to support service improvement

Timescale: Q1 2025

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

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

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

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

ED patients accommodated on trolleys/awaiting review

As per 2.7, the Hospital is cognisant of the need to adopt and develop the infrastructure and capacity within the hospital to enable treatment is as safe,timely and appropriate as possible. Some of the measures the hospital have put in place/planning to put in place to support this objective are set out below:

- Local Injuries Unit (offsite) opened in Q1 2024
- Opening of AMAU on extended working day 7/7 planned in Q2 2025 to support imoroved patient flow
- Rapid Assement and Triage (RAT) to be introduced in ED Q 1 2025
- Inpatient Consultant on Call evening ward rounds planned introduction in Q1/2 2025 within ED which will support the timely provision of care by a senior Clinician
- Optimisation of Scheduled Care beds in periods of surge in so far as possible to assist in timely admission
- Opening of Short Stay Ward in 2026 will benefit most the recently admitted ED patients and should reduce the PET of admitted patients within ED
- Utilisation of appropriate surge beds capacity both onsite and offsite to optimise wait times

Training on recent HSE Risk Management Framework

The QRPS manager and patient safety team have delivered training sessions on HSE's Risk Management Framework to NCHD's, HCA's, CNM's and overseas nurses on orientation in 2023 and 2024. The NCHD's induction has been amended to include a presentation on Incident Reporting.

NGH staff are already using the National Incident Reporting Forms (NIRF) to report incidents in line with the National Incident Management Framework. There is a healthy culture of incident reporting at NGH and the details on completed paper based forms are inputted to the NIMS system by the QRPS Incident Inputter. NGH staff engage in the current incident reporting process, despite its challenges, with approx. 2,028 incidents reported in 2023.

To improve the process of incident reporting NGH are in the process of implementing the National Electronic Point of Entry System. This is in line with NGH'S Quality and Risk Strategy and aligns with the HSE Patient Safety Strategy 2019 - 2024, Section 2. Empowering and Engaging Staff to Improve Patient Safety. Training has been delivered to key QPS staff who in turn will use Train the Trainer approach throughout the hospital to roll out the remaining educational ePOE system requirements. The anticipated timeline for complete adoption hospital wide of the electronic system is Q2 2025. Areas within NGH that have completed e POE training to date are:

- Quality & Risk Department
- Radiology
- Pharmacy
- Lab Scientists
- Clinical Nutrition
- ICU
- HIPE
- OT (in progress)
- Physio (in progress)

The Clinical Risk Manager, the Patient Safety Manager and a Patient Services officer have developed in-house on the spot training for NIRF reporting. These training sessions are supported by HSELand training. The training is delivered to small groups of staff on the ward floor to minimise disruption to service. It is anticipated that all hospital staff will receive incident management training by end Q3 2025

Timeline for completion: Q3 2025/0wner: Quality & Patient Safety Manager

EMEWS Training in ED

NGH recognise the value of implementing the EMEWS to ensure safe, timely, appropriate monitoring and management of adult patients from triage through to assessment admission or discharge from the ED. This is a priority for NGH in 2025 and we are currently at the scoping stage of the project; this will be implemented in a 2 phased approach with an aim to "go Live" in Ql/2 2025. Responsible person - Director of Nursing

Hard Copy Medication Safety Policies Out of Date

A review of all Medication Safety PPPG's has occurred and a plan is in place to update any deemed out of date. Relevant Wards have been advised that all current PPPG's are available on QPulse and to discard any hard out of date copies that might be on the ward. The Medication Safety Committee submits a quarterly report to the QRPS committee detailing planned audits and the status of ongoing audit. Responsible person: Chief Pharmacist Medication Safety/Q3 2025

No Full Clinical Pharmacy Service (Liffey Ward)

Our clinical pharmacy service capacity has been impacted due to staffing challenges and by the constraints of the HSE pay and numbers strategy. Our objective remains to achieve full approved staffing levels in pharmacy to restore full service as soon as feasible and have taken measures to safeguard our inpatient service such as ceasing or minimising our external support to long term facilities where feasible. The Liffey ward continues to have a pharmacy technician service. Any queries or medication safety concerns arising on the Liffey ward will be directed to a

clinical pharmacist via the technician service. Owner: Chief Pharmacist

Ward Medication Fridge Temperatures not Checked Daily

Medication fridges are required to be checked daily by nursing staff. However it was observed by inspectors that this was not the case in two clinical areas. In response to same Nursing Practice Development have been advised and requested to advise all Ward Managers of the importance of daily ward medication fridge temperature recording. Guidance on medication temperature safety is contained within PPPG82 Medication Management and is available on QPulse. In addition all the medication Fridges have an inbuilt alarm where the alarm sounds if temperature too high or too low. Owner:Relevant ADON/Nurse Practice Development Lead

No List of High Risk medications and SALADS in the Clinical areas Visited

This list should be readily available in relevant clinical areas. These have now been supplied to ED and the Liffey Wards These lists are also available on the medication Hub and newly launched staff intranet. Owner: Chief Pharmacist

Timescale: Q3 2025