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:	Midland Regional Hospital Portlaoise
Address of healthcare service:	Block Rd Ballyroan Portlaoise Co. Laois R32RW61
Type of inspection:	Unannounced
Date(s) of inspection:	28 and 29 May 2024
Healthcare Service ID:	OSV-0001075
Fieldwork ID:	NS_0081

About the healthcare service

Model of hospital and profile

Midland Regional Hospital Portlaoise is a model 3* public acute hospital managed by the Dublin Midlands Hospital Group† on behalf of the HSE at the time of inspection. Services provided by the hospital include:

- 24-hour emergency department service
- general surgery
- obstetrics and gynaecology
- general medicine
- paediatric services
- outpatient services.
- transitional care

The hospital serves a population within the counties of Laois, Kildare, Carlow, Offaly and North Tipperary.

The following information outlines some additional data on the hospital.

Model of hospital	3
Number of beds	139 inpatient beds 13 day-case beds

How we inspect

The Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors† reviewed information that included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

* Model-3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute Medicine and critical care.

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

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the 11 national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors during and following the inspection as this inspection was unannounced.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report. The compliance plan submitted by the hospital following this inspection is included in Appendix 2.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
28 May 2024	09:00 – 16:50hrs	Aedeen Burns	Lead
		Denise Lawler	Support
29 May 2024	09:00 – 16:00hrs	Bairbre Moynihan	Support

Information about this inspection

This inspection was performed as part of HIQA's monitoring function. It was an unannounced routine inspection to monitor the quality of the service and assess level of compliance of Midland Regional Hospital Portlaoise with national standards.

The hospital had undergone a previous inspection in April 2023. Following that inspection, the hospital had submitted a compliance plan for standards judged to be partially compliant by HIQA. Progress with the implementation of actions in the hospital's compliance plan was reviewed during this inspection and included is in this report.

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

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

The inspection team visited four clinical areas:

- Emergency Department
- Dunamaise Ward (general medicine and general and gynaecological surgery)
- Transitional Care Unit located in Abbeyleix Community Nursing Unit
- Acute Medical and Surgical Assessment Unit (AMSAU).

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

- Representatives of the hospital's Senior Management Team:

[‡] 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. https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- General Manager
- Director of Nursing
- Director of Midwifery
- Clinical Director

- Quality and Risk representatives
- Lead representative for the non-consultant hospital doctors (NCHDs)
- Human Resource Manager
- A representative from each of the following hospital committees:

- Healthcare Associated Infection Committee
- Drugs and Therapeutics Committee
- The Deteriorating Patient Committee
- Unscheduled Care Committee

Acknowledgements

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

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

Over the course of the inspection, the inspectors visited the emergency department, AMSAU, Dunamaise ward and the Transitional Care Unit located off site in Abbeyleix Community Nursing Unit. The emergency department was the point of entry into the hospital for patients requiring unscheduled or emergency care. It provided undifferentiated care for adults and children 24/7.

The emergency department comprised a triage room, six single cubicles for the treatment of patients requiring isolation facilities (including one controlled ventilation room that was equipped for resuscitation), a resuscitation area comprising three bays, six monitored cubicles and a secure assessment room. There were also six chairs on a corridor for patients deemed fit to sit while awaiting medical review.

There was a two-trolley bay within the adult department for the assessment of children with surgical presentations; this had a separate waiting area. For children with medical presentations, the department was completely separated and had audio and visual separation from the point of entry. It comprised a triage room, a single-bay room, a double-bay room and a one-bay resuscitation area.

Dunamaise ward was a 33-bedded combined general medicine, surgery, and gynaecological surgery ward. At the time of inspection, all beds were occupied.

The Transitional Care Unit was an 11-bedded ward for patients of low and medium acuity for whom the acute phase of treatment was complete. This unit only accepted admissions

from Midland Regional Portlaoise and provided rehabilitation and other medical and nursing services to medically stable patients. There were clear inclusion and exclusion criteria to guide safe admission to the service. At the time of inspection, the ward had two vacant beds. This unit was under the governance of the Midland Regional Hospital Portlaoise.

Inspectors spoke with a number of patients to ascertain their experiences of the care received in Midland Regional Hospital Portlaoise. Patients' experiences were generally good. Patients were very complimentary about the staff, and the care they received. Patients described the staff as "*going out of their way*", "*having time for you*" and "*excellent*". They also commented positively on the food provided. They did however describe challenges of long waits in the waiting room in the emergency department and a lack of space in the six-bedded rooms on the inpatient ward.

Although inspectors observed information on the HSE's complaints process '*Your Service Your Say*' in public areas on the wards visited, patients who spoke with inspectors were not aware of the process for reporting complaints. They did however report feeling confident in approaching staff to make a complaint if necessary, saying they would "*speak to the person in-charg*e" or they would access information about the complaints process online. Overall, patients were very complimentary about the staff and the care received.

Capacity and Capability Dimension

Inspection findings related to the 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 and management and workforce. Midland Regional Hospital Portlaoise was found to be compliant with national standard (5.5), substantially compliant with national standard 5.8 and partially compliant against two standards assessed (5.2 and 6.1). Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.
Inspectors found that the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. However, the hospital's Quality and Safety Executive Committee (QSEC), with responsibility for governance and oversight of improving the quality and safety of healthcare services at the hospital, had only met once since the HIQA inspection in 2023. Reconvening this committee was part of the hospital's compliance plan post the 2023 inspection. Organisational charts submitted to HIQA detailed the direct reporting arrangements for hospital management and the various governance and oversight committees within the hospital and to the hospital group. The hospital was governed and managed by the general manager who reported to the Dublin Midlands Hospital Group (DMHG) chief operations officer, who in turn reported to the chief executive officer (CEO) of the DMHG. The clinical director of the hospital provided clinical oversight and leadership of the clinical services provided at the hospital. The director of nursing (DON) and the director of midwifery (DOM) were assigned responsibility for the oversight, organisation and management of nursing and midwifery services at the hospital. The clinical director, the DON and the DOM were all members of the Senior Management Team (SMT) and reported directly to the general manager. The Senior Management Team (SMT) was the body responsible for providing safe effective services by leading and directing performance at the hospital. This was the most senior decision-making group and reported to the general manager. The SMT membership comprised the senior leads for clinical and operational teams[††] within the hospital. The SMT had up-to-date terms of reference (TOR) and the group met weekly. Minutes of their meetings submitted to HIQA, showed that meetings followed a structured format and key areas of potential patient harm were addressed. However, actions arising were not always clear or time-bound. Overall, the evidence provided demonstrated that this committee provided governance and oversight of the quality of healthcare services provided at Midland Regional Hospital Portlaoise. The Quality and Patient Safety Executive Committee (QSEC) was established to provide assurance to the Senior Management Team (SMT) that there were appropriate and effective systems in place for all aspects of quality and safety of services which fall under the remit of the Midland Regional Hospital Portlaoise. The QSEC was not meeting as per its terms of reference – this was also a finding in the 2023 inspection. The committee had only held one meeting since 2020, which was in November 2023. Inspectors did not find evidence that the quality and safety function at the hospital had been strengthened as the hospital had outlined in action two relating to standard 5.2 in the compliance plan following

[††] An operational team undertakes ongoing activities that are required for the provision of goods or services. For example, finance, facilities and HR.

the 2023 inspection. Hospital management attributed the lack of progress in this area to the hospital's ongoing challenge in recruiting a quality patient safety manager, a consumer affairs manager and clinical risk and safety officer (maternity services). This is discussed further under standard 6.1.

The lack of a functioning QSEC impacted the governance and oversight arrangements in place for the committees outlined below, related to the four areas of focus of this inspection, as the TOR of each of these committees indicated that they should provide reports to the QSEC:

- Healthcare Associated Infection (HCAI) Committee
- Drugs and Therapeutics Committee
- Unscheduled Care Group
- Deteriorating Patient Committee

Senior managers, who spoke with HIQA, described a mechanism whereby members of the SMT were present as required members on all of the governance committees that would usually report to QSEC. They reported that SMT discussed quality and patient safety and managed the risk register through the SMT. This was supported by documentary evidence submitted to HIQA.

Governance and oversight of issues relating to effective access and egress from inpatient and emergency care services were delegated to the Scheduled and Unscheduled Care Groups. The Unscheduled Care Group had responsibility to examine and continually review pathways for unscheduled care patients presenting to the hospital, to review and optimise patient flow practices and to review compliance with key performance indicators (KPIs). This group reported to the SMT monthly. As per the terms of reference, the Unscheduled Care Group should provide reports to the QSEC, and meet every eight weeks or more frequently if necessary. Evidence provided to inspectors indicated that this group had not met since January 2024.

The hospital publicly reported performance on KPIs relating to scheduled and unscheduled care on the HSE platform. KPIs such as average length of stay, readmission rates and bed days lost to delayed transfers of care met national targets.

The hospital's multidisciplinary Healthcare Associated Infection Committee was responsible for the governance and oversight of infection prevention and control practices at the hospital. A locum consultant microbiologist chaired this committee.

As per their terms of reference, the Healthcare Associated Infection Committee was accountable to the QSEC. In the absence of a regularly convening QSEC, inspectors were informed that a senior manager was a member of the Healthcare Associated Infection Committee and delivered the HCAI reports to the SMT.This was supported by documentary evidence seen by inspectors. The HCAI committee received and reviewed reports from the hygiene supervisor, maintenance officer, surveillance scientist, infection and prevention control nurse and the antimicrobial pharmacist. Minutes of meetings of the

HCAI Committee supplied to HIQA, demonstrated, that other than not reporting to QSEC, this committee was meeting and functioning as per their terms of reference and had governance and oversight over infection prevention and control practices in the hospital.

The hospital's Drugs and Therapeutics Committee was assigned responsibility for the governance and oversight of medication safety practices at the hospital. Senior management were represented on the membership and medication safety was a standing agenda item at SMT meetings. As per their TOR, the Drugs and Therapeutics Committee should also report to the QSEC quarterly. Documentation and information provided on inspection provided evidence that the committee had a set agenda covering items as per the terms of reference. Minutes reviewed by inspectors demonstrated good attendance at meetings. Meeting actions were assigned to a responsible person, although not all actions had associated time frames. With the exception of reporting to the QSEC, this committee was functioning as per its terms of reference and had governance and oversight of medication safety practices at the hospital.

Membership of the Deteriorating Patient Committee comprised the general manager, other representatives from the SMT and clinical staff. This committee was responsible for the oversight and management of systems in place for the recognition and management of the deteriorating patient and sepsis management for adult, maternity, and paediatric patients at the Midland Regional Hospital Portlaoise. A consultant physician chaired this committee. Terms of reference indicated that this committee should report their progress to QSEC, but aside from this, the committee was meeting with the frequency, membership, attendance and agenda consistent with the objectives of their terms of reference. There was evidence that this committee had good oversight and governance of processes in place for the deteriorating patients and sepsis.

The hospital had formalised corporate and clinical governance arrangements in place however, the Unscheduled Care Group and the QSEC were not meeting as per their terms of reference. The hospital's QSEC had reconvened in November 2023, but had not met since. This did not align with the actions outlined in the compliance plan following the inspection of 2023. The non-performance of this committee has implications for the hospital's governance structure, leading to potential gaps in the coordination and integration of risk management and quality activities across committees and departments.

Judgment: Partially Compliant

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

Inspectors found that there was evidence of management, structure, controls and processes in place to support and promote the delivery of high quality, safe and reliable healthcare services in the Midland Regional Hospital Portlaoise. The SMT had formed several teams and committees to support the achievement of their strategic goals and

provide oversight of practices related to the four key areas of harm: infection prevention and control, medication safety, the deteriorating patient and transitions of care.

The hospital had a multidisciplinary infection prevention and control (IPC) team and had an overarching infection prevention and control programme as per national standards.[‡‡] A consultant microbiologist who was working remotely and based in the UK led this team. The infection prevention and control team and surveillance scientist had developed infection prevention and control plans that set out objectives to be achieved in relation to infection prevention and control in 2024. These objectives focused on reduction of HCAIs, monitoring and epidemiology, training and workforce, surveillance and audit. The IPC team provided quarterly and yearly updates of their progress to the HCAI committee. Inspectors were provided with documentary evidence that monitoring, training, surveillance, and audit were occurring and that the audit cycle was completed with action plans and re-audit. This is discussed further in standard 2.8.

Evidence was seen of appropriate outbreak management and reporting. The hospital had recently appointed an antimicrobial pharmacist, and had commenced an antimicrobial stewardship programme[§§] at the time of inspection. However, progress was limited as the antimicrobial pharmacist was not allocated full time to this role due to staffing deficits in the pharmacy department. This is further discussed under standard 6.1.

The chief pharmacist led the hospital's pharmacy service and medication safety practices in Midland Regional Hospital Portlaoise. The hospital's Medication Safety Programme outlined the systems and processes in place for medication safety at the hospital and included the hospital's short and long-term medication safety objectives. Evidence of advancement of the strategy was seen in documentary evidence and in clinical areas. Staff spoken to in the clinical areas were aware of the high-risk medications identified by the group, and the actions and practices to support safe use of these medications.

A full clinical pharmacy service[***] was not available to all areas in the hospital; this is discussed further under standard 6.1 and 3.1. It was clear that patient safety related to medication management in Midland Regional Hospital Portlaoise was supported through a medication safety programme that was underpinned by formalised governance structures through the Drugs and Therapeutics Committee, with clear accountability arrangements to the senior management team.

[‡‡] National Clinical Effectiveness Committee. National Clinical Guidelines No. 30. Infection Prevention and Control. 2023. Available on line from: https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-summary-report

[§§] Antimicrobial stewardship programme – refers to a set of coordinated measures designed to improve and measure the appropriate use of antimicrobials for example the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

[***] 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.

A hospital-wide programme aimed at improving care for deteriorating patients was implemented under the clinical leadership of a consultant physician. The Deteriorating Patient Committee had oversight of the adoption of national guidelines related to Early Warning Systems (EWS)[†††] and sepsis. Subcommittees, chaired by the director of midwifery for the Irish Maternity Early Warning System (IMEWS) and a consultant paediatrician for the Irish Paediatric Early Warning System (IPEWS), ensured compliance in those specialist areas. The Deteriorating Patient Committee had oversight of the hospital's level of compliance with national guidelines on these systems. There was evidence that actions within the programme for the deteriorating patient were being actively managed and enacted within the hospital. Inspectors saw evidence of audit cycles for compliance with actions, and QIPs to improve response to the deteriorating patient. This is discussed further in standards 2.8 and 3.1.

The hospital had arrangements in place to monitor and manage issues that impacted patient flow and transitions of care. Hospital activity, the demand on resources and the capacity of the organisation to meet those demands, were monitored regularly through structures from department to group level. These included daily ward-based multidisciplinary rounds, patient flow meetings, and senior nurse management meetings. There was also evidence of regular reviews of performance through the Unscheduled Care Group and performance meetings with DMHG.

The hospital had an emergency department escalation policy and a hospital escalation policy, which aligned with the HSE's escalation plan to manage the demand for unscheduled and emergency care, and to ensure all available capacity and options were used. On the day of inspection, the hospital was in level 1[‡‡‡] escalation as per the hospital escalation policy, and had implemented the relevant actions of the hospital's escalation plan. Hospital management had engaged with stakeholders to ensure formal bypass arrangements were in place for specific patient cohorts where applicable.

The hospital had links with community services through groups such as the Laois Winter Action Team Unscheduled Care (the activity of this group now extends past winter) and the chronic disease hubs. These links were used to provide integrated services and support discharge to the community as early as possible. Since the 2023 HIQA inspection, the hospital had opened 11 transitional care beds in Abbeyleix Community Nursing Unit. There were policies and procedures in place to support safe transfer of patients to and from this unit for elective and emergency patient transfers.

In summary, it was evident that the hospital management had defined structure, controls and processes in place to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. The hospital had effective

[†††] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient. Irish National Early Warning System (INEWS) for adults. IPEWS for children and IMEWS for pregnancy and 42 days post-partum. EMEWS is designed for use in the adult population in the emergency department.

[‡‡‡] As per the escalation plan of Midland Regional Hospital Portlaoise Level 1 refers to less than 7 people admitted and awaiting beds in the emergency department with no patients breaching PET targets.

management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Judgment: Compliant

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

The hospital had monitoring arrangements in place to identify and act on opportunities for continuously improving the quality, safety, and reliability of healthcare services. Data from various sources was collated and published in compliance with the HSE's reporting requirements. Performance data was reviewed regularly in SMT meetings and during performance meetings between the hospital and the hospital group. There was evidence that the SMT were monitoring data from the four known areas of harm which were the focus of this inspection. The arrangements in place for the monitoring of risks to continue in the absence of a grade-eight quality and risk manager were described to inspectors during this inspection.

The hospital had formalised risk management structures and processes in place to proactively identify, analyse, manage, and escalate risks. The risk policy in use was that of 2018-20, but inspectors were advised that staff training was completed and rollout of 2023 HSE Enterprise Policy was imminent.

The directors of nursing and midwifery, with support from the quality and patient safety department staff, identified, managed, and monitored risks within their areas of responsibility. Clinical nurse managers (CNMs) were responsible for escalating and implementing corrective measures for potential risks within their areas. High-rated risks were escalated to the senior management team and recorded in the hospital's corporate register. The senior management team had oversight of the hospital's risk management processes, and managed the risks recorded in the hospital's risk register.

The hospital had systems in place to identify and manage patient safety incidents. The Serious Incident Management Team (SIMT) ensured that all serious reportable events and incidents were reported on the National Incident Management System (NIMS) and managed according to the Health Service Executive's (HSE) Incident Management Framework. Inspectors saw evidence that the SIMT and the SMT had oversight of the management of adverse events and patient safety incidents within the hospital.

Staff and senior management reported the promotion of point of contact resolution of complaints at stage one, as per the HSE's Comments Compliments and Complaints Policy. The consumer affairs manager post, with responsibility for management of complaints, was vacant since August 2023. This vacant post impacted the management of the complaints at the hospital. This is discussed further in standard 1.8. Staff reported that

feedback on complaints and compliments was disseminated to staff at departmental handovers.

The hospital had recently appointed a clinical audit coordinator and were in the process of formulating an audit plan. There was evidence of audit and quality improvement cycles relating to the four areas, which were the focus of this inspection. These are discussed further under standards 2.8.

Overall, hospital management was effectively identifying and acting on opportunities to continuously improve the quality and safety of healthcare services. The SMT was systematically monitoring performance against key performance indicators in the four areas of focus of this inspection. Quality improvement initiatives were implemented in response to audit findings and patient safety incidents. However, due to staff shortages, complaints management and the use of feedback from service users to improve services was not optimal.

Judgment: Substantially Compliant

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

The inspectors found that the workforce arrangements in place in Midlands Regional Hospital Portlaoise were not fully effective in supporting and promoting the delivery of high quality, safe and reliable healthcare in the emergency department and wider hospital.

The hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare, and workforce management was guided by a formalised human resource operational strategy for Midland Regional Hospital Portlaoise 2023-2026, but there were a number of vacancies in key positions leading to gaps in service provision. A number of high-rated risks related to staffing were recorded on the hospital's corporate risk register. Workforce management was a standing agenda item at the monthly performance meeting with the DMHG and there was evidence of succession planning at the hospital.

At the time of inspection, all 34.8 whole time equivalent (WTE)[§§§] medical consultant positions across a range of specialties were filled. Four consultants were not on the relevant specialist division of the register with the Irish Medical Council and the clinical director provided support and oversight for these consultants. Consultant doctors were supported by their full complement of 114 WTE non-consultant hospital doctors (NCHDs).

There were three WTE consultant posts in emergency medicine two of whom were locum on the day of inspection. As highlighted in the 2023 HIQA report, these three consultants in

[§§§] WTE – whole-time equivalent, this 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.

emergency medicine covered a 24/7 on-call rota for the emergency department. After midnight, medical patients who attended the emergency department were under the care of the medical consultant on-call for the hospital. The emergency consultant provided on-call cover for other presentations. The emergency department had a small number of consultants relative to the number of attendances (42,616 in 2023).[****]

One of the three WTE consultants in emergency medicine was the assigned clinical lead for the emergency department and was responsible for the day-to-day operational functioning of the department. Consultants in the emergency department reported to the clinical director. Attendees to the emergency department from 8am to 12 midnight were assigned to the on-call consultant in emergency medicine. If admitted, the patient was assigned to the specialist consultant on call, and remained in the emergency department until an inpatient bed was available. A consultant in emergency medicine was present in the department during core hours 8am to 5pm Monday to Friday. After 5pm Monday to Friday and at weekends, the on-call roster was operational. The consultants in emergency medicine were supported by 15 NCHDs at registrar grade all of these positons were filled. A senior decision maker at registrar grade was onsite in the emergency department 24/7. The hospital was not an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine.

The emergency department had its full complement of nursing staff (43.5 WTE) as per the Department of Health's safe staffing framework[††††] this represents an uplift of 4.1 WTE since the HIQA's previous inspection in 2023. The department was fully staffed on the day of inspection. The emergency department had a complement of 8 WTE healthcare assistants, and all of these positions were filled. The department had a deficit of one HCA on the day of inspection due to sick leave.

The hospital had an infection prevention and control team which comprised one WTE consultant microbiologist, a regional ADON with 0.5 WTE responsibility for Midland Regional Hospital Portlaoise and 0.5 WTE Midland Regional Hospital Tullamore, 2.95 WTE CNM 2s, 1.5 WTE surveillance scientists and an antimicrobial pharmacist. Similar to findings of previous inspection, the consultant microbiologist's position was filled on a locum basis and the microbiologist was consulting remotely from the UK. This arrangement had been risk assessed and remained on the hospital's risk register. The SMT reported that this post was due to be to be advertised again soon.

Pharmacy were carrying a deficit of 30% of pharmacist grade staff, which affected the hospital's ability to provide a full clinical pharmacy service[‡‡‡‡] across the hospital including

[****] As compared with University Hospital Sligo, Midlands Regional Hospital Tullamore, University Hospital Kerry, and Midlands Regional Hospital Mullingar HSE Urgent and Emergency Care report data 2024

[††††] 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.

[‡‡‡‡] 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. Comprehensive clinical

antimicrobial stewardship. Pharmacists divided their time across duties on wards, dispensary, antimicrobial stewardship, medicine reconciliation and other pharmacy functions. The medication safety pharmacist post was vacant. The risks associated with these unfilled posts were escalated to the hospital's corporate risk register and to the DMHG. The impact of these unfilled posts is discussed further under standard 3.1.

The hospital reported having implemented the Department of Health's safe staffing framework[§§§§] for nursing in all medical, surgical wards and the emergency department of the hospital. Rosters reviewed by inspectors demonstrated adequate staffing levels in the clinical areas visited since implementation of the safe staffing framework.

There were vacant posts in the quality and patient safety department such as the quality patient safety manger grade-eight, the consumer affairs manager and the clinical risk officer (maternity services). Recruitment of replacement posts was impacted by the HSE recruitment embargo of late 2023. A risk assessment had been performed outlining the impacts of these vacancies on user experience and reaching key performance indicators. The risk was escalated to the hospital's corporate risk register and had been escalated to the group. The impact of these vacancies will be discussed further under standard 1.8.

Hospital training records reviewed by inspectors showed that the uptake or recording of essential and mandatory training for staff was not optimal. There was no central mechanism in the hospital to record and monitor the staff attendance at mandatory and essential training. A risk assessment had been undertaken on this issue, and this risk was escalated to the DMHG. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system which the hospital could access.***** Records seen by inspectors showed doctors had compliance of 71% for hand-hygiene training, 74% for INEWS training and 68% for basic life support training.

The CNMs and Nurse Practice Development Unit (NPDU) monitored attendance at mandatory and essential training by nursing, midwifery and healthcare assistant staff at clinical area level. Evidence was seen that oversight of mandatory training for nurses, midwifes and HCAs was undertaken by the DON and DOM through the CNMs/CMMs as per actions described in the compliance plan following the 2023 inspection. However, records provided by the clinical areas visited on inspection showed a wide variance in the levels of compliance in with mandatory and essential training for nurses across wards, ranging from 37% to 100% compliance with training in standard and transmissions based precautions, 47% to 100% compliance for INEWS training and 60%-100% compliance with hand-hygiene training. Nursing, medical and support staff who spoke with inspectors confirmed

pharmacy services employ a collaborative approach to achieving medication optimization through team-based collaboration to initiate, modify, monitor, and/or discontinue medications.

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

***** The National Employment Record is a national system for recording non-consultant hospital doctor evidence of training.

that they had received formal induction training on commencement of employment in the hospital.

The human resource department tracked and reported on staff absenteeism rates with oversight at SMT meetings and monthly performance meetings with the DMHG. The hospital's overall absence rate for May 2024 was 6.92%. This was not compliant with the HSE's target of 4% or less. Staff could be referred to or self-refer to occupational health and had access to an employee assistance programme to support wellbeing.

Overall, while there had been an uplift in medical and nursing staff resourcing since HIQA's previous inspection, the hospital had experienced challenges in filling staff positions in the quality and patient safety and pharmacy departments. Staffing shortfalls in the quality and patient safety and pharmacy departments had affected complaints management and the provision of clinical pharmacy services at the hospital. This is discussed further under standard 1.8 and 3.1. The microbiologist service continued to be delivered remotely. Three consultants continue to deliver the service in the emergency department. This is a lower provision of consultant WTEs compared with other model three hospitals with similar attendances. While some of these vacancies were related to the HSE's recruitment embargo, introduced in quarter four of 2023, some issues predate this situation as indicated by the corporate risk register Uptake and monitoring of completion of mandatory and essential training was not optimal.

Judgment: Partially Compliant

Quality and Safety Dimension

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

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

Staff working in the hospital had an awareness of, and were observed delivering care that promoted dignity privacy and autonomy and was consistent with a human rights-based approach to care promoted by HIQA.

Due to space constraints, arrangement of accommodating patients on chairs in a corridor in the emergency department as observed on the previous inspection continued. For patients in this area discussions with staff were not confidential, however patients were taken to a private area if they were to be examined. Building to expand the emergency department was underway with completion anticipated in 2025. Patients, when admitted to surge capacity in AMSAU, were accommodated on trolleys not beds for the duration of their stay in AMSAU.

Most patients on Dunamaise ward were accommodated in six bedded multiple-occupancy rooms. These rooms were small and patients complained that this affected their comfort. Privacy curtains were used to promote the privacy, dignity and confidentiality of patients receiving care in multi-occupancy rooms. A designated single room was available and used for patients approaching end of life. There was a family room available to accommodate patient's families or facilitate private conversations.

The inspectors observed that there was a facility for patients' healthcare records and patients' personal information to be stored in line with general data protection and regulation standards. Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital. However, the physical infrastructure at the time of inspection meant that, at times, private conversations in the emergency department took place in a corridor space, patients did not have adequate space in six-bedded rooms in Dunamaise ward and patients were accommodated on trolleys for the duration of their admission to AMSAU.

Judgment: Substantially Compliant

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

Evidence indicated that staff of Midland Regional Hospital Portlaoise actively fostered a culture of kindness, consideration, and respect for individuals receiving care.

During the inspection, staff interactions with patients witnessed, in the clinical areas visited, were consistently respectful, kind, and caring. Patient feedback on the day further confirmed these impressions. A clinical nurse specialist in dementia supported the delivery of patient-centred care for this patient cohort. A translation service was available for patients who did not speak English, but patient information leaflets were only available in English.

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.
Staffing shortfalls within the quality and patient safety department affected the hospital's timely management of complaints. The quality patient safety manger grade-eight, the consumer affairs manager and the clinical risk officer (maternity services) posts were vacant at the time of inspection. Inspectors were informed that the consumer affairs manager was the designated complaints officer for the hospital with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. In the absence of the consumer affairs manager, inspectors were informed that the partnering with patients co-ordinator followed up on complaints, including bringing them to the attention of relevant senior managers. The DOM and DON were providing oversight of complaints in their areas of responsibility and these were discussed with the CNMs for the areas involved. Serious complaints were escalated to the SMT. Complaints were triaged for risk. However, from evidence provided during this inspection not all complaints were being managed in line with national guidance. The hospital was not meeting the HSE's KPI for resolution within a 30-day timeframe. Letters were issued to complainants to explain the delay in managing their complaint. Point of contact complaint resolution was promoted and supported in line with national guidance. The hospital formally reported on the number and type of written complaints received to the HSE annually. The hospital adopted the HSE Comments, Compliments and Complaints policy of 2017. This was available electronically in clinical areas. Information about how to make a complaint via the HSE's '*Your Service Your Say*' was displayed in the clinical areas visited. The hospital did not have a dedicated patient advice and liaison service. In the absence of the QSEC meetings, formal complaints were discussed at SMT meetings. Serious complaints were escalated to the hospital's performance meeting with the DMHG. Overall, deficits in staffing in the quality and patient safety department had affected the hospital's capacity regarding timely management and organisational oversight of complaints.
Judgment: Partially Compliant

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

On the days of inspection, inspectors visited three clinical areas and observed that overall the hospital's physical environment was largely unchanged since the last inspection. The facility was generally well maintained and clean. Signs of general wear and tear were present, including chipped paint, wood or plaster. In areas where surfaces were damaged thorough cleaning was not possible.

Dunamaise ward was a 33-bedded ward. The ward comprised multiple-occupancy rooms (four six bedded, one two bedded), two secure rooms with a shared bathroom and five single rooms with ensuite toilet and shower facilities. The multi-occupancy rooms did not have ensuite toilet and shower facilities, but there was adequate shower and toilet facilities on the ward. Inadequate spacing in the six-bedded rooms of this ward, identified in the 2023 inspection, remains an issue, was on the risk register of the hospital, and was commented on by patients using the service. If necessary the two-bedded room, which had an anteroom and ensuite toilet and shower could be used for isolation.

The transitional care unit in the Abbeyleix Community Nursing Unit comprised 11 beds in a combination of multiple and single occupancy. One isolation room had ensuite toilet and shower facilities. There were adequate toilet and showering facilities for patients. At the time of inspection, the ward had two vacant beds.

Access to isolation facilities in the hospital was limited. This risk was recorded on the corporate risk register. The hospital used national guidelines to support prioritisation of the placement of patients requiring transmission-based precautions. The infection prevention and control nurse liaised daily with bed management and ward staff on the placement of patients.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available in the clinical areas. Inspectors noted that the majority of hand hygiene sinks throughout the hospital conformed to national requirements. This was an improvement on the 2023 inspection findings and was evidence of the implementation of actions in the compliance plan submitted to HIQA.

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

The clinical areas visited had dedicated cleaners. Cleaning supervisors and CNMs had oversight of the standard of cleaning and were satisfied with the level of cleaning staff in place. In clinical areas visited, patient equipment was observed to be clean. There was a system in place to identify equipment that had been cleaned. Hazardous material and waste were safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

However, cleaning equipment in two of the areas visited was not stored in line with national guidance,[†††††] leading to a risk of contamination, and a flat mop system was not used in line with nationally recommended practice. These were brought to the attention of hospital management on the day of the inspection.

Appropriate swipe access had been installed on medication preparation areas as per the compliance plan submitted to HIQA since the 2023 inspection.

Although elements of the compliance plan relating to the environment had been addressed, the physical environment of the hospital was largely unchanged since the last inspection and so, spacing in some multi-occupancy rooms remained problematic and there was a shortage of isolation rooms. The guideline for prioritising use of these rooms was overdue for update. Storage of cleaning equipment was inappropriate in two of the areas visited.

Some elements of capital plans to improve the campus were at an advanced stage while others were still at the planning stage. This continuing scheme of works will be essential in providing a physical environment that supports the delivery of high quality, safe, reliable care.

Judgment: Partially Compliant

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

During the inspection, Midland Regional Hospital Portlaoise demonstrated assurance systems for monitoring, evaluating, and enhancing healthcare services and patient care. Hospital management utilised various information sources including KPIs, audit findings, risk assessments, patient safety incident reviews and patient experience surveys to assess the quality of their healthcare services.

Healthcare Associated Infection Committee (HAIC) were actively monitoring and evaluating infection prevention and control practices in clinical areas. Audit reports submitted to HIQA showed that the clinical areas visited on the day of inspection had achieved a good level of compliance with environmental and patient equipment audits in the months preceding the inspection. Audit findings were shared with clinical staff, but not all areas had developed time-bound action plans to address areas requiring improvement. The CNMs of the areas had responsibility for implementing action plans when developed. Clinical areas visited had rates of 90-100% compliance with local audits of hand hygiene practice in the three months preceding this inspection. This was compliant with the HSE's target of 90% for hand hygiene practices. Hospital management

[†††††] Infection Prevention and Control (IPC) National Clinical Guideline No. 30 Department of Health 2023

actively monitored and routinely assessed performance indicators related to the prevention and control of healthcare-associated infections. ‡‡‡‡‡

The infection prevention and control team submitted a healthcare-associated infection surveillance report to the HAIC at regular intervals. In line with HSE's national reporting requirements, the hospital reported on rates of Clostridioides difficile (C.difficile), carbapenemase-producing enterobacterales (CPE) and hospital-acquired staphylococcus aureus blood stream infections. The IPC team reported rates of 75- 100% compliance with surveillance testing for CPE in 2023 and 85-100% for quarter one 2024. Rates of new infection for staphylococcus aureus and C.difficile as reported nationally were meeting standards set by the HSE.

Evidence was submitted to HIQA of the monthly audit of elements of medication safety as part of standardised collection of nursing and midwifery quality care metrics within the hospital. The audits demonstrated good levels of compliance in most elements; however recording of allergies and legibility of prescriptions were areas identified for improvement. Healthcare records reviewed by inspectors on the day of inspection showed good compliance with recording of allergies. There was evidence of audit of controlled drug storage, the 'red apron' initiative§§§§§ and the use of concentrated electrolytes. Audit findings were shared with staff in clinical areas. The Drugs and Therapeutics Committee provided oversight for medication safety audits. Associated time-bound action plans were developed and there was evidence of implementation of recommendations and re-audit. Responsibility for the actions related to improvement plans lay with the NPDU.

Midland Regional Hospital Portlaoise had one of the highest rates of antimicrobial consumption for model 3 hospitals in the country 2023.****** There was evidence that monitoring and evaluation of antimicrobial stewardship practices had commenced with the appointment of an anti-microbial stewardship (AMS) pharmacist. These included participating in the national antimicrobial point prevalence study and reporting on compliance with antimicrobial stewardship key performance indicators. There was evidence that this was discussed at SMT and that education and measures to improve practice were implemented, such as the use of restrictive prescribing guidance.

The hospital regularly audited performance metrics of the escalation response to acutely deteriorating patients. Audits of healthcare records were carried out to ensure compliance with national guidance on the national early warning systems. Audits of compliance with national guidance on clinical handover, the use of the Identify Situation Background

‡‡‡‡‡ Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018.
§§§§§ Red 'do not disturb' aprons: worn by nurses to reduce interruptions during medicines administration as interruptions during medication administration rounds can contribute to medications errors.
****** Surveillance of Antimicrobial Consumption in Hospital Sector 2023.

Assessment Recommendation (ISBAR)[††††††] communication tool and sepsis management were also carried out. Audit results were communicated to senior management team, the deteriorating patient committee and to clinical areas. High levels of compliance were demonstrated in these audits and the audit cycle was completed with time-bound action plans in any areas requiring improvement and re-audit. Responsibility for the action plans was allocated to CNMs, clinical skills facilitators and consultants for the areas.

In accordance with the standards set by the HSE, the hospital monitored multiple performance indicators. These included hospital activity and capacity, the number of new patients in the emergency department, patient experience times (PETs), the average length of stay (ALOS) for medical and surgical patients (elective and emergency surgery), and instances of delayed transfer of care (DTOC). This data was included in various HSE reports including the daily urgent and emergency care report. It was examined during the monthly meetings of the SMT. Metrics pertaining to both unscheduled and scheduled care were also reported and reviewed during the monthly performance meetings held between the hospital and the DMHG. There was evidence that patient feedback through national experience programmes were included in monitoring of performance, and action plans were developed in line with the hospital's results.

Overall, inspectors found that the hospital were systematically monitoring and evaluating healthcare services and using data-driven decision making to improve healthcare outcomes at the hospital.

Judgment: Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.
The Midland Regional Hospital Portlaoise had arrangements in place to identify evaluate and manage the risk of harm related to design and delivery of the healthcare service. This included the onward reporting of risks, and design and oversight of mitigating measures to manage risks on an ongoing basis. The SMT had responsibility for oversight of the corporate risk register. Risks were escalated to the hospital group as necessary during performance meetings. In the clinical areas visited, risks were evaluated and managed by the nurse managers for the areas and escalated through their management structures if necessary. Staff had access to electronic copies of policies procedures and guidelines in clinical areas and an information leaflet and a quick guide to reporting incidents and near misses was available.

[††††††] The ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework, endorsed by the World Health Organisation, provides a standardised approach to communication, which can be used in any situation it is promoted by the HSE as part of National Clinical Guideline No.1 INEWS and the National Healthcare Communication programme.

Surveillance testing for carbapenem resistant enterobacteriaceae (CRE)‡‡‡‡‡‡ was performed for patients on admission as per national guidelines and inspectors saw evidence that the infection control team audited this monthly and that compliance was high. Staff had access to an electronic information system that alerted them if a patient had a previous history of a multi drug resistant organism (MDRO), which facilitated early isolation if needed. In the event that there were insufficient isolation facilities, a risk assessment was performed in discussion with the infection prevention and control team and patients were then cohorted. At the time of inspection, there were no outbreaks of infection ongoing in the hospital. Evidence was seen of previous appropriate response to outbreaks.

The most recent versions of the national early warning systems were used throughout the hospital as appropriate to admitted adults, paediatrics and maternity patient groups. There was evidence that staff were familiar with and used early warning systems and the 'Sepsis 6' standardised approach to suspicion of sepsis. An initiative to improve response times for review of patients with early warning scores above 7 by instigating a rapid response bleep was described by staff and observed on inspection. Documentation provided to HIQA following inspection demonstrated that this quality improvement initiative was being monitored as part of a quality improvement cycle.

On days when the hospital was using surge capacity and at weekends, a second registrar was rostered on duty to provide a more efficient response to the deteriorating patient. Staff were familiar with and used the national ambulance Protocol 37§§§§§§ to expedite the urgent transfers of patients in the event that their care required escalation to a model four hospital. In the case of the transitional care unit, systems were in place to support appropriate care for deteriorating patients. Staff were aware of the procedure, and it was supported by a written policy.

The emergency early warning system (EMEWS), for patients waiting longer for review by a treating clinician than is recommended based on their Manchester triage system (MTS) category, was not used in the emergency department. EMEWS training had commenced and staffing for this function was in place. In the interim, a 'post triage nurse' was allocated to care for patients who had been triaged but were still in the waiting room.

Arrangements were in place to proactively report and manage risks related to medication safety at the hospital. The hospital implemented appropriate safety measures for high-risk medications to protect patients from the risk of harm. This included maintenance of an updated high-risk and sound alike look alike drug (SALAD) list. The hospital's list of high-risk medications aligned with the acronym 'A PINCH.'******* Appropriate actions to limit the

‡‡‡‡‡‡ Guidelines for the Prevention and Control of Multi-drug resistant organisms (MDRO) excluding MRSA in the healthcare setting MDRO - Health Protection Surveillance Centre (hpsc.ie)

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

******* 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.

potential harm from these medications formed part of the medication safety programme of the hospital. Evidence was seen that these actions were part of practice relating to high-risk medications.

Essential information on the safe use of medications was readily available at the point of preparation and administration either on hard copy or on approved medicines information electronic resources. The medication record included features to support safer medication prescription and administration. The medication record was being actively reviewed in conjunction with learning from medication safety incidents for possible improvements. A full clinical pharmacy service was not available throughout the hospital and there was no dedicated medication safety pharmacist. A medication reconciliation service was not provided to all patients due to staffing constraints. This was on the hospital's risk register. This service was provided on a risk basis to patients most at risk of harm or when requested by a nurse or doctor. Pharmacy staff maintained a prioritisation list for this function. The absence of medicine reconciliation for patients is a recognised risk of harm associated with the design and delivery of healthcare services.

There was evidence of systems and standardised documents to support transitions of care, interdepartmental communication and discharge. Safer communication between teams and disciplines was supported by use of the ISBAR tool, and safety huddles or pauses were held regularly to alert staff to risks in the clinical environment. Discharge planning was commenced on admission with use of the SAFER[†††††††] patient flow principles including allocation of predicted dates of discharge and multidisciplinary rounds. The transitional care unit, which accepted patients who had completed the acute phase of admission but were not yet fit for discharge had been opened to improve patient flow within the hospital. The hospital had devised a discharge envelope, which included a prompt to staff to discuss medications, and discuss Know Check Ask[‡‡‡‡‡‡‡] with the patient, it also included a standard checklist to ensure that communication with community links had happened prior to discharge.

There were several patient flow and admission avoidance strategies in use including outreach by the respiratory nursing team, rapid access cardiology clinics and early intervention clinics with the Diabetes CNS. Advanced Nurse Practitioners (ANPs) provided a minor injuries service five days per week and the hospital reported close links with and good utilisation of the community intervention team and the outpatient parenteral antimicrobial therapy (OPAT) service. A frailty team was being established with an ANP and a physiotherapist already in post; recruitment was underway for a full multidisciplinary team. A CNM 2 for admitted patients was in post in the emergency

[†††††††] SAFER is a national tool used to reduce delays for patients in inpatient wards. It consists of the following: S Senior review – all patients will have a senior review before midday; A All patients will have a Predicted Discharge Date (PDD) and Clinical Criteria for Discharge; F Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards; E Early discharge – aim for discharges before 11:00 am each day; and R Review – a systematic, daily MDT review of patients with extended lengths of stay.

[‡‡‡‡‡‡‡] Know Check Ask is a medication safety campaign in line with World Health Organisation Global Patient Safety-Challenge Medication without Harm. The aim of the campaign is to encourage those taking medication and their caregivers to take an active role in managing their medication management.

department and worked closely with the patients' consultants to progress the patients' care towards discharge or movement to an appropriate inpatient bed.

At 11am on the first day of inspection, there were 34 patients registered in the emergency department. The department appeared to be calm and functioning well with assessment and resuscitation spaces available. All patients' wait times complied with the HSE patient experience times (PETS). There were four patients 75 years age or older in the emergency department. One admitted patient was accommodated in the emergency department while awaiting an inpatient bed.

Five patients were admitted into surge capacity§§§§§§§ in the AMSAU, which diminished its capacity to function as an AMSAU. The conversion rate for the emergency department in 2023 was 21%, and 23% year to date 2024. This compared well to other model 3 hospitals.********

The Manchester Triage System†††††††† was in use for adults and the Irish Children's Triage System (ICTS)‡‡‡‡‡‡‡‡ was in use in the paediatric emergency department, with a specific ICTS contingency plan in case of delays in triage. The average waiting time from registration to triage was 15 minutes, which aligns with the HSE's emergency medicine programme KPI. Staff could view the status of all patients in the department, their prioritisation category levels and waiting times, via the hospital's electronic operating system.

There was no early streaming of patients appropriate for the AMSAU, and patients were required to complete the full ED process prior to being referred to the AMSAU. A medical and surgical consultant were allocated responsibility for admissions to the AMSAU on a weekly basis. The AMSAU was the first place used for surge capacity. Surge capacity was used 87% of days from January to the end of May 2024. Patients admitted to surge capacity in the AMSAU were accommodated on trolleys and remained under the care of the admitting specialist consultant on call on the day of their admission.

Since the last inspection, and as per the compliance plan from the 2023 inspection, the hospital provided evidence that formalised arrangements for the bypass or transfer of patients with suspected stroke had been ratified and were functioning. Management of stroke patients was supported by clinical guidelines, and the process was monitored for

§§§§§§§ Surge capacity in use beds/trolleys elsewhere in the hospital to accommodate admitted patients to meet the demands of the emergency department. When a hospital used surge capacity it may impact the functioning of the area used as surge capacity.

******** Comparison with Connolly Hospital, Midland Regional Hospital Mullingar, Sligo University Hospital and Midland Regional Hospital Portlaoise.

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

‡‡‡‡‡‡‡‡ ICTS acknowledges the different issues that arise with emergency presentations of children and incorporates additional triage parameters to reflect age-related physiological differences, children's presenting signs and symptoms, significant paediatric co-morbidities and common Paediatric Emergency Medicine diagnoses.

efficiency and safety. The development or updating of policies procedures and guidelines related to transitions of care, had also formed part of the hospital's compliance plan these had been addressed or were near completion

Overall there was evidence of proactive monitoring, analysis and response to information pertaining to the delivery of safe services, and systems were in place to proactively identify, evaluate and manage immediate and potential risks to people using the service. However, some key deficits persisted. There was an absence of a full clinical pharmacy service that included medicine reconciliation for all patients. EMEWS had not yet been rolled out in the emergency department and the function of the AMASU was impacted by its use as surge capacity.

Judgment: Partially Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.
The hospital had patient-safety incident management systems in place to identify report, manage, and respond to patient-safety incidents in line with national legislation, policy and guidelines. The senior accountable officer (SAO) at the hospital was the General Manager. The hospital had a Serious Incident Management Team (SIMT) which met regularly, was chaired by the SAO and reported to the SMT. There was evidence that serious incidents were escalated to group level SIMT and that incidents were discussed as part of performance meetings with the DMHG. The hospital was not compliant with all KPIs for the reporting of patient safety incidents. Patient safety incidents relating to medication safety were reported to the Drugs and Therapeutics Committee. Incidents relating to infection were reported to the HCAI committee. The service provider classified patient safety incidents using an agreed standardised classification in NIMS as outlined in HSE policy that is applied service-wide. National Incident Reporting Forms were used, and patient safety incidents were reported via the National Incident Management System (NIMS). The hospital was compliant with the national target for incidents entered onto NIMS within 30 days of notification. The quality and patient safety department collated quarterly and annual reports of incidents, hazardous events and significant reportable events. These reports were reviewed at the SMT meeting. Compliance with KPIs relating to patient safety incidents was reported monthly. The hospital was not compliant with reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident (Target 70%). Clinical staff who spoke with inspectors were familiar with the requirement to report clinical incidents, and with the procedures and processes in place to do so. As per their TOR submitted post-inspection, QSEC had a monitoring role in ensuring that lessons learned from significant incidents had been shared across the hospital. This committee was not meeting to fulfil this role. Overall, inspectors found that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular in relation to the four key areas of harm. There was evidence that the SIMT and SMT had oversight of serious incidents and reportable events. However, oversight for the sharing of lessons learned from serious incidents was delegated to a committee that was not meeting. The hospital was not compliant with national targets for incidents reviews completed within 125 days of notification.
Judgment: Substantially Compliant

Conclusion

HIQA carried out an unannounced inspection of Midland Regional Hospital Portlaoise to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care under the domains of capacity and capability and quality and safety.

Capacity and Capability

Midland Regional Hospital Portlaoise had formalised corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare. The executive management team demonstrated that they had effective governance and management arrangements in place for the four key areas of harm which were the focus of this inspection. Not all committees were meeting as per TOR and this resulted in possible gaps in the coordination and integration of risk management and quality activities across various committees and departments. The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of services.

The hospital had occupational health and employee assistance support systems in place to support staff in the delivery of high quality, safe healthcare. However, the oversight and uptake of essential and mandatory training required improvement. Vacancies in key posts, such as the quality and patient safety and pharmacy departments, have the potential to impact safe delivery of care and need to addressed to ensure compliance with the provision of high-quality, safe and reliable healthcare services.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital. People who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary about staff. The hospital were aware of the need to support and protect patients that are more vulnerable and were actively promoting feedback from patients through the National In-patient Experience Survey 2024, which was ongoing at the time of inspection. However, management and investigation of complaints was not being performed as per national policy.

Despite increasing numbers of patients attending the emergency department, and the relatively small number of emergency medicine consultants, the emergency department was performing well in relation to national targets for patient experience times.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of isolation facilities which increased the risk of cross-infection. Some six-bedded rooms in clinical area visited by inspected had constricted space, which causes difficulty for patients and staff in those rooms. There are capital programmes in train to address some of these issues.

Inspectors were satisfied that the hospital had systems in place to monitor and improve services and were performing regular audits aimed at improving care in the four known areas of harm which were the focus of this inspection. Systems were in place in the hospital to identify report, manage and respond to patient safety incidents in line with national guidance.

The lack of meetings of the Quality and Patient Safety Executive Committee meant that quality, safety and risks were being managed outside of the hospital's stated processes. This may present a potential gap in the management of information and subsequent learning from complaints, incidents or near misses. The absence of a full clinical pharmacy service including medicines reconciliation increased the risk of patient exposure to a medication error and compromised patient safety. The lack of implementation of the EMEWS in the emergency department, for patients waiting longer for review by a treating clinician than is recommended based on their Manchester triage system category, impeded staff ability to detect and respond to a patient's deterioration in this cohort of patient.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards was 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 (Appendix 2). 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.	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially 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.	Partially Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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.	Partially 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.	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.	Substantially Compliant

Compliance Plan

Compliance Plan Service Provider's Response

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

QPS executive committee meetings.

Specific

QPS will reconvene quarterly Q&S Executive Committee meetings

Reporting/Accountability Relationship between Q&S Committees and the Quality and Safety Executive Committee has been revised

Terms of Reference of Q&S Committees to be updated to reflect the above

Feedback document from Q&S Committees to Q&S Executive Committee will be circulated to each Q&S Committee prior to the Q&S Executive Committee meetings

Measurable

Minutes & Powerpoint Presentation of Q&S Executive Committee Meetings

Reporting/Accountablity Structure Chart (Chart 5)

Terms of Reference of Q&S Committees

Feedback document and Powerpoint Presentations of Q&S Executive Committee meetings

Achievable

Meeting dates will be agreed at the beginning of the year

Q&S Executive Committee meeting took place in Q3 2024 - (25/07/24)

Date of next meeting of Q&S Executive Committee meeting is 21st November, 2024

Q&S Executive Committee members will be notified a month in advance of the meeting.

Realistic

In absence of QPS Manager (vacant post), the Partnering with Patients Co-Ordinator will be responsible

Timebound

The next meeting is scheduled for 21st November, 2024

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially Compliant

Nursing, Midwifery and HCA mandatory Training Compliance.

Specific

Mandatory Training to be prioritised within all in-service training
Review and re-circulation of mandatory training course list.
Communication at Nurse Managers meetings and departmental meetings re-focus on mandatory training compliance.
Support of staff on duty as activity allows to engage in mandatory training both face to face and e-learning.
Circulation of Training schedules
Staff to be identified on rosters to attend scheduled mandatory training when scheduled.
Reintroduction of hand hygiene champions

Measurable

Certificates of completion inputted into Nursing and Midwifery and HCA Training and Medical staff Records
Review and monitoring of compliance monthly with Departmental ADONs and CNMs
Feedback compliance monthly to Nurse Managers and Departmental meetings.
Utilise HSEland reports to support compliance monitoring.
Review compliance with mandatory training at staff PDP meetings.
Individual staff and department PIP where required.
Monitor progress through hand hygiene audits

Achievable and Realistic

Supporting the CNM and staff to prioritise mandatory training will achieve the above actions
Agenda item on Nurse Managers/Medical/Support services/Allied Health meetings

Timebound

Actions to commence immediately with all departments to have achieved compliance within the required KPIs across all training within 6 months
Hand Hygiene Champions will be in place / trained within 3 months

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Hospital management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients.

Specific The hospital has a workforce and recruitment plan in place to recruit for vacancies in all disciplines at MRHP, inclusive of rolling campaigns for specialist areas and International Recruitment for Nursing and HCSPs.

Measurable All vacancies have a Business case and Hire form created, they are reviewed by MRHP HR/Finance when received from Line Managers and submitted to the DMHG bi-monthly pay bill. Further approval is now required from the REO as part of the implementation of Pay and Numbers Strategy 2024 to progress the filling of posts. WTE Ceiling limit applied to MRHP as at 31/12/2023 and no approval to exceed this WTE limit at year end or any point in between. 3 stage control process in place for management of recruitment and on boarding.

Achievable If derogation is received for critical posts , MRHP can prioritise posts and the Approved posts can be progressed to existing panels or new recruitment campaign is commenced and progressed with DMHG HR Department.

Realistic Recruitment is actively progressed by MRHP to DMHG for advertisement and contracting.

Time bound

Ongoing.

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

Complaints Management

Specific

Reponses to 2024 complaints are/will be issued when all responses are/have been received

Holding letters issue/will issue to complainants in the event that there is a delay in issuing a response and complainants will be advised of the reason for the delay

Complaints containing matters of concern are highlighted at the Senior Management Team meetings

Measurable

Complaint Responses

Minutes of SMT meetings

Complaint & Compliment Data

Achievable:

Complaints Clerical Officer hours have been increased from 17.5 to 35 hours per week for 6 months (for review at 31/1/25)

Partnering with Patients Co-Ordinator and Complaints Clerical Officer meet on a daily basis to review complaints received; to clarify queries and to agree when responses will issue to complainants

Realistic

In absence of the Consumer Affairs Manager (vacant post), the Partnering with Patients Co-Ordinator will be responsible

Time bound

Commenced and ongoing

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

Storage of Cleaning Products

Review of Domestic Service rooms has been completed and locked presses in place for storage of products

Physical Environment and Space

3PG Guideline to support prioritisation of the placement of patients requiring transmission based precautions to be updated

Specific

3PG allocated to IPC team for prioritisation of review and update with wider stakeholder input

3PG update to be added to HCAI committee agenda and action plan

IPC supported by Nurse Practice Development in the review

Risk assessment in place on deficits in bed spacing

Business case developed for flat mopping system

Measurable

Update on action progress tracked as agenda item at HCAI committee meeting

Surveillance on use of dedicated isolation facilities daily with use of prioritising guideline

Update on flat mopping system introduction agenda item for update at HCAI meeting

Achievable and Realistic

Achievable within the available resources.

Await update on funding allocation

Time bound

Q4 2024/Q1 2025.

Inadequate spacing in the 6 bedded room on Dunamaise Ward.

Specific

Dunmaise Ward is a 33 bed unit with 4 wards containing 6 beds. The 6 bed wards have no ensuite facilities.

On hospital Risk register.

Measurable

Requirements for 20 single ensuite rooms and 13 single ensuite rooms with donning and doffing facility are included in the current Development Control Plan.

Achievable

HSE Estates appointed Architects to develop design brief based on the Development Control Plan to enable future development of the hospital Q3 2023.

Realistic

HSE Estates, IHA and SMT responsible for progressing future development of the hospital.

Timebound

Design brief presentation to new IHA lead scheduled for Q4 2024.

Limited access to isolation facilities in the hospital.

Specific

39 rooms available in MRHP/21 ensuite/14 ante room/8 negative pressure which has increased from 15 prior to 2020
On hospital Risk Register

Measurable

Requirements for additional isolation rooms are included in the current Development Control Plan.

Achievable

HSE Estates appointed Architects to develop design brief based on the Development Control Plan to enable future development of the hospital.

Realistic

HSE Estates, IHA and SMT responsible for progressing future development of the hospital.

Timebound

Design brief presentation to new IHA lead scheduled for Q4 2024.

The majority of hand hygiene sinks throughout the hospital conformed to national requirements.

Specific

Work schedule in place under the schedule of minor capital works

Work ongoing with most departments completed.

Measurable

Within the minor capital work schedule

Achievable

As per the minor capital work plan

Realistic

Based on minor capital funding approval.

Timebound

Q4 2024

Cleaning equipment was not stored in line with national guidance leading to a risk of contamination, and a flat mop system was not used in line with nationally recommended practice.

Specific

Constraints with storage through the hospital on the hospital risk register**.**

Awareness with line managers with appropriate storage of equipment

Appropriate review of schedule of accommodation with rooms appropriately designated to storage with signage.

Measurable

- Daily monitoring by the line manager
- Schedule of Health and Safety audits

Achievable

Oversight by line managers.

Work schedule commenced to introduce flat mop system

Realistic

Constraints with storage through the hospital on the hospital risk register**.**

Timebound

Q2 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

Implementation of EMEWS

Specific

Allocated to lead-Clinical Skills Facilitator and Nurse Practice Development Co-ordinator

Development of working group June 2024

Adapting NCG to MRHP

Adopting EMEWS chart to MRHP.

Supporting education at department level and completion of E-learning

Measurable

Agenda item on ED Governance meeting and Quarterly Deteriorating Patient Committee. To be added to TOR of Deteriorating Patient Committee

Monitoring of compliance with e-learning

Support from Nurse Practice Development

Audit of practice and compliance post rollout

Achievable and Realistic

Achievable through implementation of NCG and networking with other services.

Timelines set for 3PG development and governance processes.

Monitored through TOR Deteriorating Patient Committee

Timebound

Launch date set November 11th.