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:	Beaumont Hospital
Address of healthcare service:	Beaumont Road Beaumont Dublin 9 D09V2NO
Type of inspection:	Announced Inspection
Date(s) of inspection:	24 and 25 September 2024
Healthcare Service ID:	OSV-001007
Fieldwork ID:	NS_0096

About the healthcare service

Model of hospital and profile

Beaumont Hospital is a model 4* public voluntary hospital. At the time of inspection the hospital was a member of and was managed by the Royal College of Surgeons of Ireland (RSCI) Hospital Group† on behalf of the Health Service Executive (HSE). Since October 1 2024, Beaumont Hospital has been incorporated into the HSE Dublin and North East health region.

The hospital provides emergency and acute care services across medical specialties to a catchment areas of 290,000 people. Beaumont Hospital is a designated cancer centre and the regional treatment centre for ear, nose and throat and gastroenterology. Beaumont Hospital is the national referral centre for neurosurgery and neurology, renal transplantation, cochlear implantation and mechanical thrombectomy, and provides the national poisons information centre.

The hospital also incorporates St. Joseph's Hospital Campus, Raheny, which provides a range of services which includes a rehabilitation unit and a 100-bedded residential Community Nursing Unit.

The following information outlines some additional data on the hospital.

Model of hospital	4
Number of beds	746 In-patient beds(Inclusive of the rehabilitation unit on the St Joseph's Hospital campus) 168 day case beds.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess

*A Model 4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24/7) and an Emergency Department, including a Clinical Decision Unit on site.

† The RCSI Hospital Group comprised seven hospitals. These are Beaumont Hospital, Connolly Hospital, Our Lady of Lourdes Hospital – Drogheda, Louth County Hospital, Cavan General Hospital, Monaghan Hospital and Rotunda Hospital. The Hospital Group's Academic Partner is the Royal College of Surgeons (RCSI).

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 which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
24 September 2024 25 September 2024	09.00 – 17.10hrs 09.00 – 16.10hrs	Nora O'Mahony	Lead
		Aedeen Burn	Support
		Sara McAvoy	Support
		Danielle Bracken	Support

Information about this inspection

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

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

HIQA last undertook an unannounced inspection of Beaumont Hospital's emergency department in 2023 when compliance against four national standards was assessed – 5.5, 6.1, 1.6 and 3.1. The hospital was found to be substantially compliant with all four standards during that inspection.

During this inspection, the inspection team visited:

- the emergency department
- AB Cleary ward (35-bedded haematology oncology ward)
- Laurence's ward (35-bedded medicine for the elderly)
- Hardwicke ward (35-bedded vascular surgery ward)
- The rehabilitation unit on St Joseph's Hospital campus (20-bedded rehabilitation unit for care of the elderly over 65 years of age)

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

The inspection team spoke with the following staff at the hospital:

- representatives of the hospital's executive management team
  - Chief Executive Officer
  - Interim Director of Nursing
  - Lead Clinical Director
- Interim Head of Quality and Safety
- representatives for the non-consultant hospital doctors (NCHDs)
- Human Resource Manager
- Patient Advisory Liaison Service Manager
- Hospital representative from each of the following areas:
  - Infection prevention and control
  - Medication safety
  - Deteriorating patient
  - Transitions of care.

Inspectors also spoke to hospital staff from a variety of professions and disciplines in the clinical areas visited during this inspection.

Acknowledgements

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

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

Inspectors visited the emergency department and four clinical ward areas. The emergency department had 34 trolley treatment areas inclusive of a five-bay resuscitation areas, a six-bay ambulatory assessment area and two-single rooms. On the day of inspection there were eight additional trolleys beside the nurses' station, 10 armchairs around the nurses' station, 12 armchairs in three partitioned sections at the back of the emergency department and six chairs along the passage way between the front and the back of the emergency department. At 11am on the first day of inspection, the emergency department was very busy and overcrowded with over 105 patients registered in the department. All trolleys and chairs outlined above were occupied. There were thirty admitted patients accommodated on trolleys or chairs in the emergency department awaiting an inpatient bed. Thirty patients in the emergency department's waiting area were awaiting medical assessment.

The ward areas visited comprised a mixture of single and multi-occupancy rooms. The multi-occupancy rooms ranged in size between two, four and six-bedded rooms. Most

rooms had en-suite toilet and shower facilities. All ward areas visited were fully occupied at the time of inspection, with one additional bed on two of the clinical areas visited.

Inspectors observed staff actively engaging with patients in a respectful and kind manner. Staff were respectful and considerate in their interactions with each other. Inspectors observed staff promoting and protecting patients' privacy and dignity in the clinical areas visited. However, privacy and dignity was difficult to maintain in large multi-occupancy rooms and for patients accommodated on the corridor in the emergency department.

Inspectors spoke with a number of patients about their experience of the care received in the emergency department. Patients were complimentary about the staff describing them as '*very helpful*', '*fantastic*' and '*lovely people*'. Patients had differences in opinions of care received. One patient outlined how staff had '*explained everything*' while other patients were unsure of their plan of care. Many patients were complimentary about the short time-intervals between their arrival in the emergency department, to being triaged and brought into the department, while other patients outlined long delays. Some admitted patients described to inspectors how they were sitting on armchairs overnight, without pillows or blankets. Patients did outline that they had received breakfast. However, patients who were in the department since the previous evening reported long intervals since they had eaten previously, but told inspectors they could access water.

Patients on wards visited were complimentary about the staff commenting that staff were '*lovely*', '*great*' and '*pleasant*', '*kind*' and '*on the ball*'. Patients did outline that they got the care they needed but '*had to ask for help*' and '*there were long waits for help to come*'. Patients commented that '*nurses are overworked,*' '*staff are under too much pressure*' and that '*they [staff] are run off their feet, but they will get to you when they can*'.

Patients who spoke with inspectors outlined that if they had a complaint they would enquire how to complain or go to the website. Patients did highlight minor complaints that they had brought to staffs' attention which were being addressed. One patient was knowledgeable about the patient advisory liaison service in the hospital, but outlined that he '*wouldn't complain as they [staff] are doing their best*'. Inspectors observed patient information leaflets about the hospital complaints process displayed in all clinical area visited.

Overall, there was consistency between what inspectors observed in the clinical areas visited and what patients told inspectors about their experience of receiving care.

Capacity and Capability Dimension

Findings from national standards 5.2 and 5.5, 5.8 and 6.1 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital.

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

Beaumont Hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of the healthcare services provided. Organisational charts viewed by inspectors detailed the management reporting structures, and the reporting arrangements for the governance and oversight committees. The governance arrangements outlined to inspectors during this inspection were consistent with those detailed in the hospital's organisational charts.

The Chief Executive Officer (CEO) was the accountable officer with overall responsibility for the governance of the hospital. The CEO reported to the Beaumont Hospital Board. The CEO was supported by the Executive Management Group (EMG) which was the senior executive decision-making committee with responsibility for ensuring appropriate governance and oversight of the quality and safety of services at the hospital. The EMG met in line with its terms of reference and reported to the Hospital Board. At the time of inspection, members from the EMG attended monthly performance meetings with the RCSI Hospital Group to report on service delivery against performance expectations and targets.

The Director of Nursing was responsible for the organisation and management of nursing services at the hospital and reported to the Chief Executive Officer. The hospital's lead Clinical Director reported to the Chief Executive Officer.

The hospital comprised nine clinical directorates – cancer, critical care and anaesthesia, medical, surgical, neuroCent,[‡‡] radiology, laboratory, emergency medicine and transplantation, urology and nephrology directorates. Each directorate had a management team which comprised a clinical director, a directorate nurse manager and a business manager. Each directorate had a Directorate Clinical Governance Committee who reported to the Corporate Clinical Governance Committee twice a year. The clinical directors for each directorate provided update reports at alternate EMG meetings. Examples of Corporate Clinical Governance Committee minutes for the medical and surgical directorates were viewed by inspectors. From evidence provided, the Surgical Corporate Clinical Governance Committee had only twice in the past eighteen months – June 2023

[‡‡] NeuroCent – neurosurgery, neurology, ear nose and throat directorate

and May 2024. The terms of reference (TOR) outlined that meetings should be biannually or more frequently if deemed necessary by the chair.

The hospital's Corporate Clinical Governance Committee (CCGC) promoted and advanced the importance and value of clinical governance and the quality and safety of patient care across the hospital. The CCGC was chaired by the Director of Clinical Governance, or in their absence the Interim Head of Quality and Safety, and met every six to seven weeks in line with its terms of reference. The committee reviewed scheduled reports received from committees which reported to it. These included – the Directorate Clinical Governance Committees, the Infection Prevention and Control Committee, the Drugs and Therapeutics Committee and the Deteriorating Patient Steering Committee. The chair of the CCGC reported monthly on behalf of the committee to the EMG, and annually to the Governance and Risk sub-committee of the Hospital Board.

The Infection Prevention and Control (IPC) Committee provided assurance to the Corporate Clinical Governance Committee, to the Executive Management Group and ultimately to the Hospital Board that the appropriate controls were in place to minimise the transmission of healthcare associated infection (HCAI) in the hospital thus reducing the risk of harm to patients. The IPC Committee met and reported as per its terms of reference. A HCAI oversight group which comprised of senior executive managers was in place to provide guidance and assurance to the IPC Committee. From evidence provided during this inspection, it was clear that the hospital had effective oversight and governance arrangements in place for the hospital's infection prevention and control programme.

Medication safety at the hospital was managed by the Drugs and Therapeutics Committee whose role was to support – evidence-based, safe, effective and efficient use of medications. From evidence provided during this inspection it was clear that the Drugs and Therapeutics Committee operated as per its terms of reference and provided effective management and oversight of medication safety at the hospital.

The Deteriorating Patient Steering Committee's purpose was to guide the management of the deteriorating patients, including sepsis management in Beaumont Hospital. The committee was guided by National Clinical Guidelines for the Irish National Early Warning System (INEWS) version 2, the Irish Maternity Early Warning System (IMEWS) and Sepsis Management for Adults. From evidence provided during this inspection it was evident that the Deteriorating Patient Steering Committee was effective in the management of the deteriorating patients including sepsis at the hospital. However, the implementation of the National Clinical Guideline for Emergency Medicine Early Warning System (EMEWS) to improve the safety and quality of care for patients in emergency departments was not included in the terms of reference of this committee. The EMEWS was included as an additional agenda item and seen discussed in the last two meeting minutes submitted to HIQA.

Overall, the hospital had formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare. Governance committees were well attended by relevant members and had structured agendas. Meetings were action orientated, and the implementation of agreed actions was monitored by the committees. Evidence was provided of formalised reporting structures from each governance committee to the CCGC and EMG as relevant, and onwards to the Hospital Board and to the RCSI Hospital Group.

Judgment: Compliant

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

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of known harm which were the focus of this inspection – infection prevention and control, medication safety, deteriorating patients and transitions of care.

There were management arrangements in place to manage patient flow throughout the emergency department, the hospital and on to the community. However on the day of inspection, the high volume of attendees at the emergency department and the demand for inpatient beds exceeded the emergency department and the hospital's capacity. The operational management arrangements in place were not fully effective in managing the mismatch between demand and capacity. At 11am on the first day of inspection there were 105 patients registered in the emergency department with 30 admitted patients accommodated on trolleys and chairs. This resulted in non-compliance with national patient experience time (PETs).[§§] At 11am on the first day of inspection:

- 57 (54%) patients were in the department for more than six hours after registration — not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 49 (46%) patients were in the department for more than nine hours after registration — not in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.

[§§] Patient experience time (PET) measures the patient's total time in the emergency department, from registration time to emergency department departure time. Targets are set for the percentage of all attendees at emergency department who are discharged or admitted within six hours (target 70%), within nine hours (target 85%) and with 24 hours (target 97%) of registration, and the percentage of all attendees aged 75 years and over at emergency department who are discharged or admitted within six hours (Target 95%), within nine hours (target 99%) and within 24 hours (target 99%) of registration.

- 4 (3.8%) patients were in the department for more than 24 hours after registration — marginally outside the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- 19 patients in the emergency department were 75 years of age and over, 14 of these patients (73%) were in the department over nine hours from registration – not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.
- One patient aged 75 years and over (5%) was in the department over 24 hours – slightly outside the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within 24 hours of registration.

During the inspection, inspectors were informed that the hospital was in 'black escalation[***]' as per the hospital's escalation policy. Some, but not all actions as outlined in the hospital's escalation policy were seen enacted on the day of inspection. For example, escalation meetings were held, scheduled care capacity was used to accommodate admitted patients and patients were allocated to additional beds on clinical ward areas. A hospital escalation status report was circulated to all clinicians to highlight the status of the hospital so that patients' reviews could be prioritised to support discharges. However, evidence of an escalation meeting with the clinical director, emergency medicine consultant and on-call consultant for medicine, as outlined in the escalation policy, was not seen on the day of inspection.

Hospital activity and performance was reviewed at daily patient flow meetings to progress actions to support patient flow. Activity and performance was also monitored at EMG and RCSI Hospital Group meetings. The hospital's Length-of-Stay Committee had oversight of all patients in the hospital over 10 days, to identify potential delays of care and determine the key actions required to progress safe patients' discharges.

The hospital had identified access to diagnostics out of hours and access to rehabilitation beds as issues impacting patient flow. The hospital had reinstated its Winter Planning Committee to consider, scope and develop a plan to support patient flow during the upcoming winter months. The committee was reviewing ways to enhance and expand admission avoidance, hospital pathways and discharge pathways and access to diagnostics by reviewing access to radiology, the use of Beaumont in the home,[†††] the

[***] Over 12 patients admitted in the emergency department, with any patient awaiting admission in exceed of nine hours.

[†††]The 'Beaumont in the Home' was an initiative established under the governance of Beaumont Hospital, in conjunction with the HSE Community Health Organisation area 9 (CHO9) to address gaps in provision of care for people who were medically fit for discharge home and where a care package was being processed but not yet finalised.

frailty intervention therapy team,[‡‡‡] rehabilitation beds and surge capacity to improve patient flow.

Capital projects in progress by the hospital to increase overall hospital capacity were outlined to inspectors. These included – a new 100 bedded ward block, a new emergency department and a new critical care facility. However, many of these projects were still at an early stages of planning.

The hospital had an overarching infection prevention and control programme as per national standards,[§§§] which was managed by the IPC team with oversight from the IPC Committee. The IPC team had developed an IPC plan that set out objectives to be achieved in 2024. Evidence of progress with IPC objectives for 2024 was provided during this inspection – for example, the undertaking of surveillance and outbreak management, ongoing education and training and the provision of IPC advice to staff. The IPC team produced an annual report which outlined the objectives achieved in the previous year. This report was reviewed at the HCAI Committee and the Corporate Clinical Governance Committee.

The hospital's pharmacy service was led by the Head of Pharmacy. The hospital's medication safety programme was led by the Medication Safety Officer and actions to support medication safety practices were set out in the hospital's 2024 medication safety plan. Evidence of progress with the implementation of the 2024 plan was seen during this inspection such as ongoing education, incidents tracking and trending, risk management and audit. The hospital's 2023 Annual Medication Safety Report, had been presented to the Corporate Clinical Governance Committee and was viewed by inspectors. The Medication Safety Officer attended Medical Directorate Governance meetings, and liaised with clinical directors and directorate nurse managers of other directorates, to support safe medication practice and review incidents and medication safety risks specific to each directorate.

The hospital had a deteriorating patient programme to facilitate the early recognition and appropriate treatment of the deteriorating patients, including the management of sepsis, in line with National Clinical Guidelines for INEWS, IMEWS and Sepsis Management. The

[‡‡‡] A Frailty Intervention Therapy (FIT) Team was in place in the emergency department. The FIT team, accepted referrals for all patients aged over 75 years of age with an aim to proactively promote best possible care and maximise admission avoidance for this cohort of patients.
[§§§] 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.

EMEWS was not implemented for all relevant cohorts of patients in line with national guidelines,[****]this is addressed more under national standard 3.1.

There was a consultant lead for the early warning systems and a consultant lead for sepsis, with oversight by the Deteriorating Patient Steering Committee. The committee had developed a quality improvement plan (QIP) which outlined areas for improvement. Each action had an assigned timeframe, responsible person(s) and governance arrangement. Progress on each action was outlined in the QIP. The QIP was monitored by the Deteriorating Patient Steering Committee. Evidence of the implementation of actions was seen by inspectors during this inspection. For example, the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool[††††] had been updated in the Adult Patient Observation chart to support communication of the deteriorating patient.

The hospital had management arrangements in place related to clinical handover for medical and nursing staff. There was a consultant lead for medical handover and the Director of Nursing had overall responsibility for nursing handover. Policies were in place to guide medical and nursing clinical handover.

Overall, the hospital had effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to infection prevention and control, medication safety and clinical handover. The hospital had management arrangements in place to support, manage and respond to increases in service demands. However, these arrangements were not fully effective at the time of inspection to manage the mismatch between service demand and hospital capacity. This resulted in an overcrowded emergency department, non-compliance with HSE targets for PETs and admitted patients accommodated in the emergency department. The hospital had not implemented all the actions as outlined in their escalation policy.

Judgment: Partially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital collected data on a range of different measurements related to the

[****]Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11. Available online from *https://www.gov.ie/en/collection/006e63-clinical-handover-in-acute-and-childrens-hospital-services/*

[††††] Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

quality and safety of healthcare services which was publicly reported on the RCSI Hospital Group's website. The hospital collected and collated data relating to compliance against national metrics, hospital activity, patient-safety incidents, complaints, hospital acquired infections, workforce, training and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governance committee such as the CCGC and the EMG and at performance meetings with the RCSI Hospital Group.

There were formalised risk management structures and processes in place to proactively manage and minimise risks at the hospital. Clinical directors, with support from the quality and risk department, had oversight of the risks within their clinical areas. These risks were documented on directorate risk registers with existing controls and required actions outlined to manage and mitigate these risks. Risks were escalated through the governance structures to the EMG as relevant, and recorded on the hospital's corporate risk register. The Risk Management Committee met every six weeks and were responsible for the oversight of the corporate risk register. Each directorate reported to the Risk Management Committee twice a year to present and review their directorate's risk register.

Patient-safety incidents were reported on the hospital's incident management system and inputted onto the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework 2020. The hospital's quality and patient safety department tracked and trended patient-safety incidents. The hospital's Serious Incident Review Team (SIRT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital. The SIRT were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. Patient-safety incidents relevant to each directorate were reported and discussed at directorate meetings. Feedback on patient-safety incidents was provided to clinical nurse managers by the Risk and Legal Manager.

The Performance and Quality Metric report, which included activity, incidents, complaints and compliance against key performance metrics were presented and discussed at – CCGC meetings, EMG meetings and at performance meetings with the RCSI Hospital Group and at Hospital Board meetings.

The hospital had arrangements in place to monitor the services' performance. Examples of audit and monitoring activities were provided to inspectors, with quality improvement plans and action trackers to monitor implementation of the required actions. Oversight of these monitoring activities was provided at directorate level, with directorate performance reports presented at CCGC meetings. Evidence was provided that information from monitoring was used to improve the quality, safety and reliability of services. The hospital's Clinical Effectiveness Committee, chaired by the lead Clinical Director, provided strategic direction for the hospital's clinical audit programme.

Feedback on complaints and compliments from the people who used the service was shared across the hospital to promote learning. Examples of shared learning were provided to inspectors and 'Effective Communications Road Shows' were held to share learning and support complaints management at ward level. Inspectors were also informed that learning from complaints was shared across the RCSI Hospital Group at group meetings.

The hospital had a Quality and Safety Programme 2022-2027 which outlined the quality and safety priority actions under the themes of – patient centred care, safe, effective care and health and wellbeing. Priority actions in the Quality and Safety Programme 2022-2027 aligned with annual plans reviewed by inspectors. Evidence on progress with the priority actions was seen during this inspection. For example, one priority action completed was the establishment of the Clinical Effectiveness Committee with approved terms of reference, another priority action completed was the implementation of a process for clinical handover with supporting guidance.

Overall, from evidence provided it was clear that the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Judgment: Compliant

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

The workforce arrangements in Beaumont Hospital were planned, organised and managed to provide high-quality, safe and reliable services. At the time of inspection, the hospital was carrying a low overall vacancy rate, with the majority of approved nursing, medical and healthcare assistant posts filled at the hospital.

In the emergency department there was an unfilled approved clinical nurse manager (CNM) 3. All other approved medical, nursing and healthcare assistant posts in the emergency department were filled. On the day of inspection there was one unfilled nursing shift due to short-term sick leave.

The hospital reported some variance in approved and actual whole time equivalent (WTE)[‡‡‡‡]nursing posts filled on the day of inspection. For example, AB Cleary ward had 2.3 unfilled posts (variance of 8%), Hardwicke and Laurence wards and the rehabilitation unit had one or less unfilled post (variance of 3% or less). Staff did report, and rosters

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

viewed confirmed, some unfilled shifts related to unplanned short-term sick leave, which had the potential to impact care provided.

There was a 28% shortfall in the approved pharmacists WTE posts. The shortfall in pharmacists impacted on the hospital's ability to provide a full clinical pharmacy service. The executive management team were aware of the risks associated with the pharmacists staffing shortfall, and these risks were recorded on the hospital's corporate risk register. Efforts to recruit were ongoing and the hospital was undertaking overseas recruitment in a further attempt to address this issue.

The multidisciplinary IPC team comprised 1.8 WTE antimicrobial pharmacist, 0.5 WTE consultant microbiologist, one WTE assistant director of nursing, two WTE CNM 3 posts, five WTE CNM 2/CNS who also cover St Joseph's Hospital, four WTE staff nurse grades allocated to the intravenous team 2 WTE Healthcare Assistants allocated to mask-fit testing and 2.6 WTE admin resources. All roles were filled or in the process of being filled at the time of inspection, and the IPC lead reported that the resources were adequate to meet the needs of the service.

The hospital utilised an online learning portal to record and monitor attendance at mandatory training. All staff members could access the portal and upload evidence of completion of training and education. Management could access training records and staff received automatic email prompts when training was due to be renewed. Compliance with training KPIs was reported to the Executive Management Group and RCSI Hospital Group.

Training records reviewed by inspector's demonstrated good compliance with mandatory training for nurses in basic life support, medication management, INEWS and infection prevention and control. However improvement was required for nurses' training for the IMEWS at 65% compliance. Training for doctors required improvement for basic life support at 28% compliance, INEWS at 54% and infection prevention and control at 65% compliance.

The reported staff absenteeism rate in July 2024 was 4.28%, which compares well with the HSE target of 4% or less. Occupational Health supports were available to staff, and staff who spoke to inspectors were aware of a staff counselling service.

Overall, the workforce arrangements in Beaumont Hospital were organised and managed to provide high-quality, safe and reliable services. The hospital had low vacancy rates for nurses, medical and healthcare assistant staff overall. However, a shortfall in approved pharmacist's posts impacted on the hospital's provision of a full clinical pharmacy service and there were some unfilled nursing shifts due to long and short-term leave on some clinical areas visited. There was an opportunity to improve compliance with mandatory training for doctors especially for basic life support.

Judgment: Substantially Compliant

Quality and Safety Dimension

Inspection findings related to the quality and safety dimension are presented under national standards 1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3 from the themes of person-centred care and safe care respectively.

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

Staff were aware of the requirement to respect and promote the dignity, privacy and autonomy of service-users. Staff observed by inspectors in all clinical areas visited communicated with patients in a manner that promoted their privacy and dignity.

However, the physical environment in the emergency department did not fully support the delivery of care that respected the dignity and privacy of all patients. Due to high attendance rates, limited facilities within the department and lack of inpatient capacity, admitted patients awaiting transfer to a ward were accommodated on chairs and trolleys in the emergency department, overnight in some cases. Eight patients accommodated on additional trolleys were positioned immediately adjacent to one another, in the middle of the emergency department. Patients were also accommodated on armchairs around the staff work station and on armchairs in the passageway of the emergency department.

Staff in the emergency department did endeavour to maintain patients' privacy as much as possible, albeit within a very challenging environment. Privacy curtains were used to maintain privacy for patients in trolley bays, and privacy screens were available in the department. Inspectors were informed that three emergency department bays were kept available for patient assessments or treatments as required. Staff explained that efforts were made to accommodate elderly patients on trolleys rather than chairs where possible.

To support patients, a healthcare assistant (HCA) was allocated to the emergency department waiting area 10am to 8pm Monday to Friday to communicate with patients awaiting medical review. The HCA provided information about individual wait times and also provided some refreshments. A family room was available within the emergency department to support families of very ill patients.

Patients on the ward areas visited were accommodated in a combination of multi-occupancy and single rooms, all with en-suite toilet and shower facilities although some en-suite facilities in single rooms were not wheelchair accessible. This had the potential to impact on dignity for patients with mobility issues accommodated in these rooms.

Staff in the clinical areas visited who spoke with inspectors outlined how they promoted dignity, respect and autonomy for patients in their care. For example by promoting the 'get up, get dressed, get moving' §§§§initiative, the use of privacy curtains, using soft voices when speaking to patients, and keeping patients up to date with their plan of care. What inspectors were told corresponded with what inspectors observed on wards they visited.

Inspectors observed a family room for private conversations, on one ward. However, significant information was provided on the corridor of another ward, within earshot of people passing by.

The issue of inappropriate use of incontinence wear had been raised as a complaint by patient's families. In response the hospital had developed a continence QIP, which had been rolled out in three wards to support the maintenance of patient's continence and promote patients' dignity. Evidence of this QIP in place was found on one of the wards visited during this inspection. The issue of inappropriate use of incontinence wear was highlighted to inspectors in another ward visited. The continence QIP had not been implemented on that ward. Hospital management outlined plans to review continence practice on all wards – to ensure appropriate continence practice hospital wide.

Patients' healthcare records and patients' personal information was observed to be stored appropriately, in line with relevant legislation and standards.

Overall, staff working in clinical areas visited were observed communicating with patients in a manner that respected their dignity and privacy. Staff endeavoured to support patients with their individual needs in a manner that protected their dignity and privacy. However, the challenging environment in the emergency department did not support the provision of dignity and privacy for all patients. Patients were accommodated on additional trolleys positioned immediately adjacent to one another in the middle of the emergency department, patients on chairs around the nurses' station and on the passage way of the emergency department, and admitted patients accommodated on chairs and trolleys while awaiting transfer to a ward. Single room en-suite toilet and shower facilities that were not wheelchair accessible had the potential to impact on dignity for patients with mobility issues accommodated in these rooms.

The continence QIP rolled out in three wards in response to complaints had demonstrated improvement in care on these wards. Continence practice in other ward areas had not yet been assessed by the hospital to provide assurance of the quality of continence care provided.

Judgment: Partially compliant

§§§§ Get up get dressed get moving campaign to improve patient outcomes after a hospital stay. The campaign is to encouraging healthcare staff and families to support patients to keep active, even while still in hospital, to promote independence and faster recovery.

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care at the hospital. Inspectors observed considerate and respectful interactions between staff and patients in the clinical areas visited. Staff were observed interacting with patients in a kind and respectful manner.

Posters were displayed on hospital corridors detailing the 'Just A Minute' (JAM) initiative promoted by the hospital to support people with a hidden disability or communication barrier to highlight to others that they need extra time and understanding.

Patient information leaflets were available in clinical areas visited promoting the patient advisory liaison service. Posters supporting communication with a multilingual identification tool and a social meet-up for patients with dementia were observed by inspectors.

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.

The complaints procedures in Beaumont Hospital was clear, transparent, open and accessible to patients and their families. The Patient Advisory Liaison Service (PALS) managed the complaints process within the hospital. In addition, the PALS staff provided assistance to patients in relation to difficulties that may arise in relation to services, provided information about the hospital services, listened to complaints and co-ordinated and managed investigations into complaints. The Patient Advisory Liaison Service (PALS) manager reported to the Interim Head of Quality and Safety.

Complaints were tracked and trended and presented at the monthly EMG by the Interim Head of Quality and Safety. The hospital was compliant with national metrics for the acknowledgement and resolution of complaints. The PALS manager provided each of the Directorate Management Teams with directorate specific quarterly feedback on complaint trends for discussion at Directorate Clinical Governance Committee meetings. Complaints metrics were submitted monthly at performance meetings with the RCSI Hospital Group. Inspectors were told that learning from complaints was shared between hospitals at a quarterly quality meeting at RCSI Hospital Group level.

The PALS manager attended and provided a report to the patient engagement committee which met every two months. Examples of shared learning and quality improvements introduced in response to complaints were outlined to inspectors. For example a QIP

implemented to improve the answering of telephone calls was outlined with a subsequent reduction in the number of complaints received related to poor communication.

The PALS team had undertaken an education programme to empower staff to manage complaints with a focus on effective communication. Complaints were shared with the CNM 3 of the relevant clinical area, and inspectors observed complaint metrics displayed in the clinical areas visited. Patient advocacy liaison service information was available on clinical areas and on the Beaumont Hospital website.

Overall, there was evidence provided during this inspection that the hospital was responding promptly, openly and effectively to patient complaints.

Judgment: Compliant

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

During this inspection, inspectors visited AB Cleary ward, Laurence's ward, Hardwicke ward and the rehabilitation unit in St Joseph's Hospital campus Raheny. The physical environment of the clinical areas visited was generally clean and well maintained with some exceptions within the constraints of an aging infrastructure. There was evidence of general wear and tear observed on Laurence's ward, AB Cleary ward and the rehabilitation unit which did not facilitate effective cleaning. Hospital staff outlined ongoing refurbishment plans in place, but no definite date was provided for this work for wards visited. Evidence of some refurbishment and environmental improvements were observed on Hardwicke ward, with additional areas still to be further refurbished.

The ward areas visited comprised of a mixture of single rooms and two, four and six-bedded multi-occupancy rooms. Most single rooms had en-suite toilet and shower facilities. Some toilet and shower facilities were noted to be in need to refurbishment, with floor and tile grout discolouration. Some wards visited had a four-bedded and a six-bedded open bay areas near the nurse's station to facilitate observation of patients. However, these open bay areas had potential to increase the risk of HCAI.

The hospital identified the risk of HCAI caused by infrastructure deficits, including dated bathrooms, an aging building environment, insufficient single rooms and airborne infection isolation rooms to meet the demand for isolation. This risk was escalated to the corporate risk register with existing controls in place to mitigate the risk. This included an electronic system for flagging patients with infection control risks, surveillance testing on admission, staff education, IPC team, Beaumont Hospital isolation priority policy and ongoing monitoring and oversight from the IPC Committee and the HCAI Oversight Committee.

The hospital's long term plans for expansions were outlined to inspectors, but these plans were still at an early stage of development and planning.

The clean utility rooms in two wards visited had no doors, which created a potential risk to medicine safety. Mitigating actions were in place to reduce the risks to medication safety – such as locked medicine cupboard, increased vigilance and ongoing monitoring.

Environmental cleaning was undertaken by the cleaning staff allocated to wards. The clinical nurse manager and cleaning supervisor had oversight of cleaning on the wards. Wards visited had dedicated cleaning staff during core hours, with access to additional cleaners out of hours if required. A dedicated terminal cleaning[*****] team was available within the hospital. Staff who spoke with inspectors were satisfied with the level of cleaning resources in place and reported good access to maintenance services.

Inspectors were informed that equipment was cleaned by the nurse or healthcare assistant at time of use. Additional cleaning was undertaken by the healthcare assistants and completed equipment checklists were viewed by inspectors. Equipment observed by inspectors on the day of inspection was noted to be generally clean. The hospital had a labelling system in place to identify cleaned equipment, and this was observed by inspectors on the day of inspection.

Wall-mounted alcohol-based hand-sanitiser dispensers with hand-hygiene signage were strategically located throughout the clinical areas. Inspectors noted that hand-hygiene sinks in wards visited conformed to national requirements, with some exceptions. For example, sinks in the rehabilitation unit and in some clean utility rooms were not all compliant with Health Building Notes (HBN) 00-10 part C sanitary assemblies or equivalent standards required standards.[†††††] Personal protective equipment was available as required on the clinical areas visited.

There was appropriate waste management observed on clinical areas visited. There was appropriate segregation of clean and used linen observed and clean linen was stored appropriately.

Overall, the physical environment of the clinical areas visited on the days of inspection were generally clean and well maintained, with some exceptions, despite infrastructural challenges. Evidence of refurbishment undertaken on some wards visited was observed by staff. Staff outlined that there were ongoing refurbishment plans in place, but no definite date was provided to complete this refurbishment for wards visited.

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

[†††††] *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

Wards visited had evidence of general wear and tear observed which did not facilitate effective cleaning, open observation bays increased potential patient risk of HCAI, and clinical rooms without doors had potential risks for medication safety. Shower facilities in some bathrooms observed by inspectors were in need of refurbishment.

Judgment: Partially compliant.

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

The quality and safety of care and its outcomes were measured by the hospital using national, group and hospital performance indicators and benchmarks. A variety of outcome measures were used by the hospital to evaluate the effectiveness of the healthcare services provided at the hospital. These included key performance indicators for – access and patient flow, infection prevention and control, medication management, patient care and treatment and patient and family experience. The key performance indicators were tracked against set targets and reported and published monthly by the RCSI Hospital Group. Evidence was provided throughout this inspection that information gathered from monitoring and evaluation was used to improve care and share learning. Key performance indicators were monitored through relevant governance committees, at directorate level and also at executive management and group level.

Each directorate had set clinical outcomes which were measured monthly to track the effectiveness of clinical care provided by the service. The hospital's quarterly Clinical Metric Report outlined the suite of clinical outcomes metrics for each directorate. The report also highlighted areas for improvement, especially related to access to ED, elective surgery, radiology and timely ICU support. This report was presented to the Clinical Effectiveness Committee who had oversight of the improvements and actions required.

The hospital's audit department tracked registered audits. Progress on audits was reported to the Corporate Clinical Governance Committee. QIPs were developed based on the recommendations of audits with responsibility for follow up at directorate level. Evidence of audit findings reviewed at the Medical Directorate Clinical Governance meetings was seen by inspectors. However review of audits was not noted on Surgical Directorate Clinical Governance meetings minutes seen by inspectors. Sharing of audit findings was circulated through a quarterly newsletter.

The hospital's infection prevention and control team reported monthly on rates of *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE), hospital-acquired *Staphylococcus aureus* blood stream infections, hospital-acquired COVID-19 and outbreaks monthly. Patients were screened for CPE in line with national guidance and compliance with this guidance was audited, with good level of compliance

across wards (average 91%). Examples of action trackers to reduce incidents of HCAI and outbreaks were viewed by inspectors with timeframes, assigned responsible person(s) and governance arrangements outlined.

A sample of environmental hygiene audits[‡‡‡‡‡] for clinical areas inspected were provided to inspectors. Compliance rates with these audits varied between clinical areas with overall compliance ranging from 82% to 99%. Evidence of QIPs developed and implemented for clinical areas scoring under 90% was seen by inspectors. There was evidence of re-audit to ensure improvement in practice occurred. For example, in July 2024 Laurence ward had an overall environmental hygiene audit compliance of 87%. A QIP was developed by the ward with progress on each actions tracked. A re-audit took place in August 2024 with an increase in the compliance rate to 92%.

The antimicrobial stewardship team also monitored key prescribing indicators for antimicrobial prescribing. Quarterly results year to date were reviewed by inspectors with good compliance with most key metrics, ranging from 87%-97% compliance. However, the overall compliance with choice and duration of agent in line with local policy required improvement at 78%. Results were reported to relevant governance committee, and required actions were outlined to improve compliance. However, no action tracker to ensure required actions were completed was seen by inspectors.

Nursing medication safety was monitored through nursing and midwifery quality care metrics, which were carried out in each ward monthly. There was overall good compliance for medication safety and storage with results ranging from 87% to 100%. Other medication safety audits undertaken by the hospital consisted of unannounced monitoring of medication safety and storage practices, with an average compliance rate of 81.6% with all audits undertaken in 2023. In 2024, the scope of the audit tools was reviewed and expanded by a multidisciplinary team of pharmacists and nursing with support from the Quality and Patient Safety Directorate. In 2024 year to date, the average compliance rate was 73.3%. Compliance by ward and audit questions were tracked to identify areas for improvement. Ongoing interventions to support improvement in practice were highlighted in the audit report at hospital level. However, no individual ward QIPs were provided for wards with poor compliance. Ongoing audits were discussed at the Drugs and Therapeutics Committee.

Monitoring and evaluation of the deteriorating patient was provided to inspectors through monthly monitoring of the patient monitoring section of the nursing and midwifery quality care metrics with compliance ranging from 75% to 90% across wards. Audits of the INEWS version 2, sepsis and the use of the ISBAR communication tool were provided to inspectors. However, quality improvement plans were not provided for all audits completed when areas for improvement were identified. Evidence of some improvements in year on year audit results was seen for example the overall INEWS audits results

[‡‡‡‡‡] Environmental hygiene audits included — the general environment, safe handling and disposal of sharps handling of disposal of linen and patient equipment.

demonstrated an improvement in practice from 75% in 2023 to 82.5% in 2024. Oversight of monitoring and audit related to the deteriorating patient was under the governance of the Deteriorating Patient Steering Committee.

Overall, the hospital had systems in place to systematically monitor and evaluate the services with many examples provided of quality improvements, action trackers and re-audits completed to continuously improve practice. However, quality improvement plans were not provided for all audits completed to improve healthcare services and care provided at the hospital.

Judgment: Substantially compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service. The Risk Management Committee was assigned with responsibility to review and manage risks that impacted the quality and safety of healthcare services. Risks that could not be managed at hospital level were escalated to the hospital's Board and as appropriate to the RCSI Hospital Group. Risks were recorded on the corporate risk register with existing controls and additional required actions to manage and reduce these risks. Evidence of active and ongoing management of the additional requirements to mitigate identified risks was provided to inspectors. For example, management outlined well advanced plans to implement the additional actions required to mitigate high-rated risks related to the hospital's information technology system and fire safety system. Advanced plans to build a new critical care facility were also outlined to inspectors to mitigate high-rated risks related to insufficient critical care beds, although this new build was still at planning stage.

The hospital was using national early warning systems for the relevant cohorts of patients to support the recognition, response and management of a deteriorating patient – the Irish National Early Warning Systems (INEWS) and the Irish Early Maternity Warning System (IMEWS). The ISBAR communication tool was used for the escalation of the care of the deteriorating patient. Policies and procedures were in place to support the implemented early warning systems. Advanced nurse practitioners on the critical care outreach team§§§§§ supported the management of clinically deteriorating patients on a 7/7

§§§§§ Critical care outreach team staffed by critical care nurses who review patients at risk of deterioration on the clinical wards. The critical care outreach team provides advice and clinical support to the ward staff by liaising with the primary and anaesthesiology teams as early as possible to respond and deliver the most appropriate management.

basis. Monitoring and audit of this service demonstrated positive impact on patient outcomes and the hospital was in the process of expanding this services to 24/7.

Patients were screened on admission to the hospital for multi-drug resistant organisms (MDROs) in line with national guidelines. Patients were screened for CPE on admission in line with national guidance, with weekly screening on high-risk wards. The hospital's information patient management system alerted staff to patients who were previously inpatients in the hospital with MDROs. Staff who spoke with inspectors were knowledgeable about the management of outbreak of infection. A multidisciplinary outbreak team was convened to advise and ensure that the management of the outbreak was aligned with best practice standards and guidance. Outbreak reports were developed with oversight by the IPC Committee. Staff in the hospital had access to microbiology advice on a 24/7 basis. Infrastructural issues and lack of isolation facilities which impacted infection prevention and control at the hospital were outlined under national standard 2.7. Risks related to infection prevention and control of healthcare associated infection were identified, monitored and reviewed by the IPC team with oversight by the IPC committee and HCAI committee.

Risks of harm and potential for errors arising from medications were identified, monitored, and reviewed by the Medication Safety Officer with oversight by the Drugs and Therapeutics committee. These risks were used to inform the hospital's medication safety programme. The hospital had identified strategies to reduce risks associated with high-risk medications supported by a policy.

Pharmacy staffing shortages impacted on the provision of clinical pharmacy services, with 10 wards which were not allocated a clinical pharmacy service. The pharmacy staffing shortages created medication safety and management risks. These risks were identified by the hospital and escalated to the hospital's corporate risk register. Staff did outline to inspectors that pharmacists when requested would do clinical reviews or medicine reconciliation for patients with complex medications or conditions. Staff had access to medicines information on printed posters, desk top computer, phone applications and portable computers in some wards. However, medicine information was not accessible at point of medicine preparation on all wards visited.

At the time of inspection there was overcrowding and prolonged wait times in the emergency department for triage, medical review, decision to admit and transfer to an inpatient bed. At 11am on the first day of inspection there were 105 patients registered in the department, with 30 admitted patients accommodated in the emergency department awaiting an inpatient bed, and approximately thirty patients awaiting medical review. Annual attendance rates to the department were 6% higher year to date. Attendances from 1 January to 8 September 2024 were 45,755 compared to 43,177 in 2023.

At 11am on the first day of inspection the time from:

- registration to triage ranged from 12 minutes to 1 hour and five minutes. The average time was 20 minutes, slightly higher than the 15 minutes recommended by the HSE's emergency medicine programme.
- triage to medical assessment ranged from 12 minutes to 13 hour 38 minutes for non-urgent patients. The average wait time was 3 hours and 54 minutes.
- The wait time from medical assessment to time inpatient bed requested was 3 hours and 24 minutes to 19 hours 5 minutes.

The risks associated with overcrowding in the emergency department were identified by the hospital and escalated to the corporate risk register. The overcrowding was attributed to a high volume of presentations, insufficient bed capacity and patient pathway blockages. Controls were in place to mitigate the risks related to overcrowding in the emergency department which included – various hospital activity review meetings throughout the day to identify and undertake actions that would improve patient flow, admission avoidance processes such as the frailty intervention therapy team and discharge support systems such as Beaumont in the Home. Additional actions identified to mitigate these risks included capital development projects for a new emergency department and a new bed block – both of which were at early stages of planning. An interim capacity plan developed in July 2024 and continuous performance management were the other actions implemented to mitigate these risks. The hospital had also reinstated its Winter Planning Committee to develop a plan to support patient flow during the upcoming winter months.

The risk that a deteriorating patient in the emergency department might not be recognised and managed in a timely manner with potential for adverse patient outcome was also identified by the hospital. Existing controls in place to mitigate this risk were outlined and observed during this inspection. For example, nurses were trained on the EMEWS which was recently incorporated into the emergency department nursing documentation. EMEWS observations were now commenced on all patients within the assessment areas of the emergency department.

However, full implementation of the EMEWS in line with national guidelines[******] was a further action required to mitigate this risk. EMEWS observations were not commenced for patients waiting longer for review by a treating clinician than is recommended based on their Manchester Triage System category. The time lapse from triage to medical review

[******] EMEWS is recommended for use in emergency departments when patients are waiting longer for review by a treating clinical than is recommended based on their Manchester triage system. The Manchester triage system (MTS), classifies patients based on their main symptoms into five different levels of urgency in terms of the need for first medical assessment ('MTS level 1 = immediate assessment', 'MTS level 2 = very urgent assessment within 10 min', 'MTS level 3 = urgent assessment within 60 min 'MTS level 4 = standard assessment within 120 min, 'MTS level 5 = non urgent assessment within 240 min.

reported on the day of inspection created a risk of non-recognition of a deteriorating patient in the waiting room while awaiting medical review.

Patients were however re-triaged if waiting more than 6 hours for medical review. Re-triage after a six-hour wait for medical review was audited by the department weekly. Compliance with re-triage after six hour wait was only 60% in July 2024. This compliance rate had gradually improved with re-education and support from clinical managers and the emergency department's clinical facilitators, with 97% compliance in August 2024.

The hospital had introduced a healthcare assistant in the emergency department waiting room to observe and assist patients as required, and to escalate any issue to the triage nurse. This role was in place Monday to Friday 10am to 8pm.

Overall, the hospital had risk management processes in place with controls to mitigate risks of harm. Evidence of progress in the implementation of additional actions to further mitigate identified risks was seen by inspectors throughout this inspection. However, risk still existed in the design and delivery of services for example – Pharmacist shortages impacted provision of clinical pharmacy services to cover all clinical wards. Medicine information was not accessible in areas of medicine preparation. The emergency department was overcrowded with prolonged wait times for triage, medical review, decision to admit and transfer to an inpatient bed. The EMEWS was not fully implemented in the emergency department in line with national guidance.

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. This process was supported by the Beaumont Hospital Incident Management Policy, which was aligned with the HSE Incident Management Framework 2020, and outlined the incident reporting process for staff. Patient-safety incidents were reported directly on the Beaumont Hospital system and then inputted onto the NIMS.

All incidents were categorised by hazard type and severity. Medication related patient-safety incidents were further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported.

The hospital was compliant with the HSE's target of reporting 70% of clinical incidents through the NIMS within 30 days. Concise reports were completed by the hospital within 125 days, however, some external reviews were outside the 125 day HSE's national target.

Incidents were included and tracked in the hospital's monthly performance and quality metric report. Patient-safety incident summary reports were submitted to each directorate for review, discussion and management at Directorate Clinical Governance Committee meetings. The CCGC had oversight of all patient-safety incidents at the hospital and patient-safety incidents were presented at monthly performance meetings with the RCSI Hospital Group.

There was oversight of patient-safety incidents related to the four key areas that were the focus of this inspection at the relevant governance committees such as, the Drugs and Therapeutics Committee, the IPC Committee and the Deteriorating Patient Steering Committee.

The hospital's Serious Incident Review Team (SIRT) had oversight of the management of serious incidents which occurred at the hospital. The purpose of the SIRT was to oversee the reporting, investigation and management of serious incidents including serious reportable events and serious incidents arising from complaints. The SIRT met every two weeks, or more frequently if required.

Learning from incidents was circulated to staff through quarterly *Safety Matters* newsletters, medication safety memos, alerts and medication safety minutes. Inspectors were also informed that learning was shared at directorate and local level meetings and at daily ward huddles on clinical areas. Evidence of quality improvements implemented in response to incidents was provided to inspectors during this inspection.

Overall the hospital effectively identified, managed, responded to and reported on patient-safety incidents.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Beaumont Hospital to assess compliance with 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.

Capacity and Capability

Beaumont Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare.

The hospital had effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. However, these arrangements were not fully effective at the time of inspection to manage the mismatch between service demand and hospital capacity. This resulted in an overcrowded emergency department, non-compliance with HSE targets for PETs and admitted patients accommodated in the emergency department.

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

The hospital had low vacancy rate for nurses, medical and healthcare assistant staff overall. However, a shortfall in approved pharmacist's posts impacted on the hospital's provision of a full clinical pharmacy service. There was an opportunity to improve compliance with mandatory training for doctors especially for basic life support.

Quality and Safety

The hospital promoted a person-centred approach to care. Staff communicated with patients in a manner that respected their dignity and privacy. However the challenging environment in the emergency department did not support the provision of dignity and privacy for all patients.

The hospital responded promptly, openly and effectively to patient complaints. The hospital had systems in place to systematically monitor and evaluate the services with examples of quality improvements, action trackers and re-audits completed to continuously improve practice. The hospital effectively identified, managed, responded to and reported on patient-safety incidents.

The physical environment of the clinical areas visited on the day of inspection were generally clean, but there was some evidence of general wear and tear. Ward areas, such as bathrooms, were in need of refurbishment. Evidence of refurbishment was observed on some wards visited, and staff outlined ongoing refurbishment plans in place.

There were risk management processes in place with controls to mitigate risks of harm. Evidence of progress in the implementation of additional actions to further mitigate identified risks was seen by inspectors throughout this inspection. However, risk still existed in the design and delivery of services such as lack of clinical pharmacy services to all clinical wards. Medicine information was not accessible in areas of medicine preparation. The emergency department was overcrowded with prolonged wait times for triage, medical review and decision to admit and transfer to an inpatient bed. The EMEWS was not fully implemented in the emergency department in line with national guidance.

Following this inspection, HIQA will review the compliance plan submitted by the hospital. As part of ongoing monitoring actively HIQA will continue to monitor the hospital's progress in implementing actions to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the 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	
Overall Governance	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially Compliant

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

Appendix 2 Compliance Plan. Service Provider's Response

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

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

(1) ED overcrowding, response to increased demand in ED, non-compliance with HSE targets for PET times

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

The following details the measures that are being taken to manage increased demand and overcrowding in the Emergency Department and reduce PET times.

Daily processes:

- New daily "Hospital Status" report and 'Live Dashboard'
  - Identification of patients awaiting movement to wards and PET times
  - Reporting of average of time to bed
  - Highlighting of >75 years patients for movement to bed

- PET times monitoring
  - Hourly focus on >75 years PET times
  - 22 hour breach notification for >75 years

- DTOC management review daily
  - The average daily number of patients with a DTOC first 10 days in December average 12 patients .v. first ten days of November average 16 patients equaling a reduction of 4

- LTC management review daily

- Repatriation review daily (new metric monitoring)

- Daily review, support and advocating for patients >75 years in ED awaiting placement when required

Additional actions completed:

- 25.11.2024: Trauma pathway
  - Patient discharge from the ED with direct admit to a protected bed in Finbar's ward
    - 10 days in operation as of 17.12.2024 with 10 patients through the service
    - average length of stay 1 day
    - average length of stay for this group of patients year to date was 3.86 days

- 02.12.2024: GI gastro pathway
  - daily protected emergency slot in place for endoscopy 2.00pm - ED discharge with urgent appointment or inpatient discharge with urgent appointment.

- 02.12.2024: Discharge co-ordinator appointed for pathways to private hospital beds - 100% capacity usage (a temporary increase to 15 beds).

- 02.12.2024: Signposting for persons attending the ED to inform of alternative pathways.

- 10.12.2024: The Discharge Lounge opened in the main hospital corridor with work underway to embed the practice of earlier discharges and the full utilisation of the lounge.

- 20.12.2024: Winters Ward - planned opening of 14 beds for additional surge capacity.

- Utilisation of St. Joseph's for low acuity trauma cases.

- There is currently underway a review of the Escalation and Repatriation policies and these have been presented and circulated to members of the EMG in December 2024 for review with a plan for approval in January 2025.

- There is ongoing engagement with the Dublin & North East Region regarding utilisation of all opportunities in relation to integrated care in the community.

- See 1.6 below for the development of a new ED as part of capital development plans.

(2) EMEWS Implementation
Standard 5.5 - EMEWS National Guideline implementation
'The EMEWS was not implemented for all relevant cohort of patients in line with national guidelines'

and

Standard 3.1 - Deteriorating Patient & EMEWS
'However, full implementation of the EMEWS in line with national guidelines was a further action required to mitigate this risk. EMEWS observations were not commenced for patients waiting longer for review by a treating clinician than is recommended based on their Manchester Triage System category. The time lapse from triage to medical review reported on the day of inspection created a risk of non-recognition of deteriorating patient in the waiting room while awaiting medical review.'

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

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

Interim / ongoing actions:

- Patients triaged in the *'Orange'* category, based on the Manchester Triage System, are not placed in the ED waiting room;
- There are monthly audits of sepsis screening and adherence to the sepsis 6 bundle in the ED and these are reported at IHA performance meetings, with QIPs developed where areas for improvement area identified;
- The Massimo remote Digital Patient Monitoring System was introduced in the ED on 02.12.2024 to further support the recognition and management of deteriorating patients awaiting review by medical staff
    - Audit and evaluation of the Massimo digital patient monitoring system is planned for Q1 2025 to inform impact and further expansion of the system;
- In the Out-of-Hours period - patients awaiting medical review are re-triaged during this time period;
- Management of the deteriorating patient risk is included on the Corporate Risk Register which includes the implementation of EMEWS as a control for action;
- Engagement with the National Clinical Care Programme regarding the introduction of EMEWS, is necessary to ensure implementation is consistent with safe staffing guidelines. A meeting is scheduled to take place with the leads of the Emergency Medicine Programme on 07.01.2025.

Timescale: As detailed above

National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant

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

(1) ED Physical Environment

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

- There is continued vigilance on the placement of patients in the ED, the use of cubicles and rooms as necessary and required;
- Daily review, support and advocacy provided by the PALS Department focusing on the > 75 years of age category;

Pending construction of major capital developments, a number of interim capacity plans have been advanced in parallel to reduce congestion and enable transition of admitted patients from the ED to more appropriate clinical in-patient facilities. The aim is for patients to be cared for in a less crowded environment which will promote their respect their dignity, privacy and autonomy.

These measures include:-

- A new CT Scanner for the Emergency Department to enable timely access to diagnostics and decision to admit/discharge (EDD March/April 2025);
- A new ED Resuscitation Unit which will provide up to an additional 3 rescuss bays;
- Establishment of a 14 bedded Winters Ward as surge capacity; December 2024
- Establishment and development of a 9 bedded Medical Day Unit to enable transfer of ambulatory patients from the Emergency Department post-triage - Q1/Q2 2025;
- entralisation of the Discharge Lounge to support early access to inpatient beds - December 2024

There are additional interim capacity plans in development which will further address identified shortcomings.

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

- A new Emergency Department and Ward Block have been identified as the key priorities by the HSE for advancement in Beaumont Hospital. Both projects have been submitted for planning at this juncture and will advance to detail design in Quarter 1, 2025 leading to significant improvements in capacity and the quality of care provided to patients. At circa 6,000 square meters, a new Emergency Department will represent a threefold increase in current physical capacity.

- The Ward Block development will deliver an additional 95 medical beds.

- In the shorter term, construction has commenced on a new Cystic Fibrosis Facility which is on schedule for completion in Q 4, 2025. The facility will deliver 20 additional medical beds to the Hospital.

(2) Ward wheelchair accessibility bathroom facilities:

Future capital developments of the new ward block has ensured building regulations 2000 compliance.

(3) Inappropriate use of incontinence wear:

- A Continence Committee is to be established in Q1 2025 with a terms of reference developed and which will incorporate an already existing Continence Working Group;
- An audit in relation to appropriate continence practice commenced Q4 2024 and will be included on the nursing audit plan for 2025 with the development of QIPs where areas for improvement area identified;
- An education module relating to continence promotion is now available for staff on the hospital's e-learning platform BORIS;
- The hospital is exploring funding options to have a full time continence CNS post approved. This will further enable expansion of quality initiatives across all wards;
- In the NeuroCENT directorate, the clinical practice support nurse is focusing on ensuring training is complete for all staff on continence promotion and this approach in promoting and monitoring education will be rolled out to all Directorates;

• A quality improvement initiative 'Targeted Toileting' is due to commence in Q1 2025 where healthcare staff ensure that patients are continuously offered opportunities for toileting throughout the day.
Timescale: As detailed above

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

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

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

(1) Aging Infrastructure:

- All maintenance / repair requests are logged with the Technical Services Department helpdesk;
- There is ongoing monitoring and auditing of hygiene and environmental standards with QIPs in place to address any actions arising;
- The Technical Services Department have an ongoing programme of works to address local refurbishment issues where required to include wear and tear, toilet and shower facilities etc. This programme will continue throughout 2025.

(2) Risk of HCAI

Patients are located in the 4-bedded and 6-bedded areas of wards to facilitate observation. In these situations the risk in relation to controlling the environment / increased risk of HCAI is balanced against the risk of patients' clinical need i.e. the requirement for increased observation.

- There is, at all times, a focus on infection prevention and control practices and measures to prevent HCAI in these areas.
- Each Directorate has an Infection, Prevention and Control risk assessment undertaken and this is represented on all Directorate Risk Registers with ongoing monitoring and management.
- These risks are presented and reported at the Hospital Risk Management Committee to provide assurance that existing controls remain in place and are effective, and provide an update on the action status of additional required controls that have been agreed in

order to further mitigate. A schedule of presentations to the Risk Management Committee is completed for 2025.

(3) Clean utility rooms

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

There is continued reinforcement of current control measures including:

- Ensuring all medicines are locked at all times in drug trollies and medication storage presses;
- Continued emphasis on the importance of enhanced vigilance by all staff, at all times, in relation to access and security of medications within the clean utility rooms;
- The Clean utility areas are located behind the main nurses station in high observation areas where staff are positioned at all times;
- There is an ongoing audit programme of medication safety practices via medication safety audits, 'Ready Every Day' audits and safety huddles/walkarounds. QIPs are developed and actioned where areas for improvement area identified. This audit programme will continue in 2025.

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

- All future build designs will have doors to clean utility rooms with controlled access.

(4) Compliance with Health Building Notes (HBN) 00-10 Part C

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

- The replacement of sinks on the Rehabilitation ward in St Joseph's Hospital will commence in January 2025.
- There are a number of sinks to be replaced (13) and this replacement programme will be completed by the end of March 2025.

Timescale: As detailed above

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

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

(1) Pharmacy Staffing:

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

The national talent pool is limited, and although every effort is being made to maximise the pool through links with academic partners and through networks, there remains a significant deficit nationally in the availability of Pharmacists. This has been compounded by headcount ceilings as per HSE Pay & Numbers Strategy.

The Hospital is endeavouring to attract and retain staff to the Pharmacy Department through the following initiatives and this work remains ongoing:

- Sponsoring further education programmes with a learning contract in place to encourage participant to remain for a defined period following successful completion;
- The roll out of Performance Achievement & Development Policy;
- The provision of flexible working arrangements;
- To supplement the national pool, the Hospital has, and will continue, to attempt to source candidates from the international market.
- As the current complement of Pharmacists is successfully recruited into, business cases for additional resources to support service developments will continue to be developed and submitted.

There has been a slight reduction in overall vacancy rates to just under 22% to year-end.

(2) Medication Information:

The following will be re-iterated and put in place in all ward areas:

- At the point of medicine preparation staff will have access to a mobile device whereby medication information is available;
- Beaumont Clinical Guideline APP is available on all ward PCs;
- Mobile ward workstation on wheels (WOW) are available on all wards and can be moved to medication preparation locations providing easy access to medicines information;
- The Drugs & Therapeutics Committee are committed to seeking additional resources for dedicated devices i.e. a tablet for drug trolleys or dedicated PC in the clean utility/drug treatment room.

(3) ED Overcrowding

Please refer to 5.5 for detail

(4) Deteriorating Patient in ED

Please refer to 5.5 for detail
Timescale: As detailed above