



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

Name of healthcare service provider:	St James's Hospital
Address of healthcare service:	James Street Dublin 8 D08 NHY1
Type of inspection:	Unannounced
Date(s) of inspection:	18 and 19 September 2024
Healthcare Service ID:	OSV-0001102
Fieldwork ID:	NS_0095

The following information describes the services the hospital provides.

About the healthcare service

Model of Hospital and Profile

St James's Hospital is a Model 4* hospital. It is a statutory body which was established by statutory instrument number 187 of 1971 (as amended) as ordered by the Minister for Health. St James's Hospital is led by Board members, who are appointed by the Minister for Health and who delegate the day-to-day management of the Hospital to the CEO and Executive Management Group, subject to any matters reserved for Board approval. The Board operates under the Code of Practice for the Governance of State Bodies and the Charities Governance Code. The Board has 3 sub committees: Finance Committee, Audit & Risk Committee and Quality, Safety and Risk Committee. At the time of the inspection the hospital was a member of the Dublin Midlands Hospital Group (DMHG)[†] providing healthcare services on behalf of the Health Service Executive (HSE). The hospital provides acute, emergency, specialist services and inpatient care, across a vast range of medical and surgical specialties. Services provided by the hospital include:

- acute medical in-patient services
- elective and emergency surgery
- emergency care
- intensive and high-dependency care
- diagnostic services
- outpatient care.

The hospital is the largest acute academic teaching hospital within the HSE six health regions which were in the process of restructuring to the new Regional Health Authority at the time of the inspection. Additionally, the hospital is one of eight adult designated national cancer centres.

The following information outlines some additional data on the hospital.

Model of Hospital	
	4

* A Model-4 hospital is a 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 hours, every day of the year) and an Emergency Department.

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

Number of beds

1,081 inpatient, 120 day beds and 178 off site beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part 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 publicly available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how the hospital performed in relation to compliance with the 11 national standards assessed during this inspection are presented in the following sections under the two dimensions of capacity and

[†]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.

capability and quality and safety. Findings are based on information provided to inspectors before, during and following the unannounced inspection at the hospital.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 September 2024	08:45hrs-17:30hrs	Elaine Egan	Lead
19 September 2024	08.45hrs-16.05hrs	Denise Lawler	Support
		Geraldine Ryan	Support
		Cathy Sexton	Support
		Sara McAvoy	Support

Background to this inspection

This inspection was unannounced and undertaken to assess compliance of St James' Hospital with the *National Standards for Safer Better Healthcare*. HIQA last undertook an unannounced of the hospital's emergency department and the Acute Medical Unit (AMU) 23 March 2023 and progress on the implementation of the actions outlined in the compliance plan developed by the hospital management following that inspection was also reviewed as part of this inspection.

The inspection focused in particular, on four key areas of known harm:

- infection prevention and control
- medication safety

- the deteriorating patient[§] (including sepsis^{**})
- transitions of care.^{††}

The inspection team visited seven clinical areas:

- Emergency Department and AMAU
- Keith Shaw Ward
- John Houston Ward
- Denis Burkett Ward
- John's Ward
- Patrick Kavanagh Ward.

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

- Representatives of the Executive Management Group (EMG)
 - Chief Executive Officer (CEO)
 - Chief Operating Officer (COO)
 - Director of Nursing (DON)
 - Interim Chief Operations Officer
 - Executive Medical Director
 - Clinical Director for the MED Directorate
 - Clinical Director Strategy and Planning
- Quality and Patient Safety Manager
- Lead Representatives for Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Director
- Representatives from each of the following:
 - Prevention and Control of Healthcare Associated Infections (PCHAI) Committee
 - Pharmacy and Therapeutics Committee (PTC)
 - Medication Safety Committee (MSC)
 - Transitions and Escalation of Care Committee (TEoC).

Acknowledgements

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

[§] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Services 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 hospitals across Ireland.

^{**} Sepsis is the body's 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 <http://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf>

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

Over the course of the inspection, the inspectors spoke with a number of patients in the emergency department who told inspectors *"their experience was very good", "staff are amazing, caring and kind", "staff were doing their best", "staff were always smiling", "called back by a consultant this morning for treatment, I couldn't stay overnight"*. Staff were observed to be actively engaged with patients in a kind, respectful and caring way. Inspectors spoke with a number of patients receiving care in all clinical areas visited. Patients were very complimentary about the nursing and medical staff, *"healthcare assistants were very good", "staff were lovely and kind", "medical team were very attentive"*. Patients stated that there was *"good response from staff to call bells"* and patients observed staff to *"wash their hands and use hand gel"*. Patients told inspectors if they had a complaint they would speak to nursing staff on the ward. None of the patients who spoke with inspectors had a complaint to make. Overall, all patients who spoke with the inspectors were complimentary about the care received.

Capacity and Capability Dimension

This section describes the national standards relevant to leadership, governance, and management in healthcare services and how effective they are in delivering high-quality and safe care (national standards 5.2, 5.5, and 5.8). It also covers the national standard related to the healthcare workforce (national standard 6.1).

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

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. The governance arrangements were consistent with those illustrated in the hospital's organisational charts and aligned with what inspectors were told during the inspection.

Inspectors spoke with members of the EMG who demonstrated a clear understanding of their roles, responsibilities and their individual reporting arrangements. The hospital's CEO was the senior accountable officer and had overall responsibility and accountability for the governance and the quality of health services delivered in the hospital. The hospital's CEO reported to the Chair of the Hospital Board. The CEO and members of the EMG attended meetings and provided reports at performance meetings with DMHG. Hospital management informed inspectors, the hospital receives its funding through a Service Level

Agreement which is the contract for services held with the region. There was a well-established reporting structure from the CEO to the Chair of Hospital Board, extending to the DMHG and structures were evolving with the newly formed Regional Health Authority Dublin and Midlands (RHADAM), which was in the early stages of transition at the time of the inspection. The EMG was constituted by the hospital Board and was the senior executive decision-making body of the hospital. The EMG was chaired by the CEO. The multidisciplinary EMG held senior responsibility for oversight of the quality and safety of healthcare services at the hospital. The EMG met monthly in line with its terms of reference and reported to the hospital Board. The hospital had established seven clinical directorates (covering for example, surgery, anaesthesia, critical care, medicine, medical oncology, research, diagnostics, laboratories, health and social care) which provided governance, management and operational oversight for the functions of the clinical directorates. Inspectors reviewed minutes of meetings and it was evident that all clinical directorates submitted reports to the EMG. However, inspectors noted the terms of reference for EMG were not up to date.

The Safety and Quality Assurance Governance Committee (SQAGC) provided the EMG and the Hospital Board with assurance that clinical governance structures and processes at the hospital were appropriate. Inspectors reviewed minutes of meetings and it was evident the committee functioned as per terms of reference. Risks were discussed at each meeting, updates were provided with a strong focus on the corporate risk register. All actions were assigned to a responsible person and it was evident actions were progressed from meeting to meeting.

The Hospital's Quality, Safety and Risk Management Committee (QSRMC) met monthly, was accountable to the SQAGC which then reports to Quality, Safety and Risk Board Sub-Committee (QSRBSC). Subcommittees reporting through QSRMC monitor assurance and support improvement in programmes of work in the four areas of focus of this inspection - infection prevention and control, medication safety, deteriorating patient (including sepsis) and transitions of care. These subcommittees of QSRMC had formalised reporting arrangements up to the SQAGC and provided a performance report about their areas of responsibilities every three months.

Inspectors conducted a thorough review of the documentation for all four committees. It was clear that each committee operated to a defined agenda and included relevant multidisciplinary members. Committee members provided regular updates at each meeting, and actions were either assigned to a responsible person or if actions were not called out, it was evident that matters were progressed with attendees taking responsibility for progressing issues. Inspectors noted terms of reference were due for review for Pharmacy and Therapeutics Committee (PTC) and the Access Committee.

Hospital management told inspectors that the hospital had a strategic programme 2021-2025 setting out the strategic objectives for the hospital over a four year timeframe and inspectors observed that this was available on the hospital's website.

In summary, inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. There was a formalised and structured upward reporting process from each governance committee to the QSRMC, SQAGC, QSRBS, EMG to the Hospital Board and to the DMHG. While some committee terms of reference required updating, it was clear from documentation reviewed by inspectors and from meetings with relevant staff, that each governance committee discussed and monitored information on the performance and quality of healthcare services, and of the hospital's compliance with defined quality metrics. All committee membership included representation from the EMG and clinical specialities, had a set agenda, actions assigned or responsibility were assigned to committee attendees.

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. The EMG were responsive and had a strong operational understanding of the issues affecting the quality and delivery of healthcare services at the hospital. Hospital management established several committees to achieve planned objectives and ensure effective management arrangements that involved infection prevention and control practices, medication safety, the deteriorating patient and safe transitions of care. Management systems were established to oversee patient flow from the emergency department through the hospital and into the community.

The hospital's infection prevention and control team (IPCT) promoted and supported staff in implementing infection prevention control practices. The IPCT was led by a consultant microbiologist and reported on the monitoring of surveillance and infection prevention control practices to the PCHCAI committee. Five subcommittees reported into the PCHCAI (Decontamination Reusable Medical devices, Intravenous Device Safety, Outbreak Preparedness, Hygiene Services Committee and Antimicrobial Stewardship). A representative from each subcommittee attended the PCHCAI committee meeting four times a year. The PCHCAI committee devised and approved the hospital's annual infection and prevention and control programme that set out the priorities to focus on for the year. Progress made in implementing the annual plan was formally reported to the PCHCAI, SQAGC, EMG and up to the Hospital Board annually. The annual infection prevention control summary report for 2023 detailed the work undertaken by the IPCT in that year, and the hospital's performance in relation to infection prevention control practices, surveillance and monitoring, compliance with national standards and appropriate key performance indicators (KPIs). The hospital's performance in these areas are discussed further in national standard 2.8 and 3.1.

The hospital's antimicrobial stewardship programme was implemented with oversight by the Antimicrobial Stewardship Committee (AMSC). The AMSC was a subcommittee of the PCHCAI and PTC, and had a dual reporting structure on the level of compliance with antimicrobial stewardship practices to each committee.

The responsibility for quality and safety of the hospital's pharmacy service was designated to the Director of Pharmacy. The purpose of the hospital's PTC was to provide leadership and support in assuring and improving quality and safety in the management and use of medication. The PTC reported on their quality safety assurance and improvement activity to the SQAGC and then the QSRBSC through the QSRMC. The PTC had four subcommittees (Nurse Prescribing, New Drugs, AMSC and Medication Safety) reporting into it with representatives from each committee attending the PTC meetings. Measures to support medication safety practices were set out in the hospital's annual medication safety programme, which was devised by Medication Safety Committee (MSC) and approved by PTC. Medication safety was an agenda item on QSRMC, the MSC provided reports to the QSRMC four times a year, reported on medication safety incidents and the measures implemented to improve medication safety in the hospital. The report also included trends and data analysis, audit results, development of medication guidance, quality improvement initiatives, medication safety alerts and staff training on medication safety completed in the year. The medication safety programme also included a work plan for 2024.

A deteriorating patient improvement programme was implemented under the clinical leadership of two consultants in general medicine to support the timely recognition and management of clinically deteriorating patients. The TEOC was the overarching committee overseeing the quality and safety of transitions of care and clinical deterioration including sepsis in the hospital. The TEOC was a subcommittee of the QSRMC and had defined and formalised reporting arrangements to that committee. The TEOC had four subcommittees (Admission, Discharge & Transfers of Care, Clinical Communication, Escalation of Care, Resuscitation and Sepsis) reporting into it with representatives from each subcommittee attending TEOC meetings four times a year. Inspectors reviewed documentation which included trends and analysis, audits and quality improvement initiatives.

The Access Committee, monitored scheduled and unscheduled care activity to support safe patient flow through the hospital. The committee reported directly to the CEO and up to the hospital Board. Hospital activity, patient acuity, hospital capacity and responsiveness to meet service demand was monitored and managed daily and weekly through a number of formalised meetings. These included daily handover meetings and huddles with senior nurse managers, patient flow and members of the IPCT. Clinical directorate meetings were held as well as weekly meetings with Community Healthcare Organisation (CHO 7), also in the process of transitioning to the new Regional Health Authority Dublin and Midlands at the time of the inspection.

Since the unannounced inspection of the hospital's emergency department in March 2023, hospital management continued to develop additional admission avoidance and early

discharge pathways. These initiatives were designed to enhance patient flow from the emergency department through the hospital and into the community by improving both scheduled and unscheduled care. Furthermore, the ongoing progression of the Digital Visual Hospital project supported measures to address patient flow issues within the emergency department and the broader hospital. The hospital had access to private medical beds and additional sub-acute beds at an off-site facility (as discussed further under Standard 3.1). Hospital management continued to monitor delayed transfers of care (DTOC) and the average length of stay (ALOS) at the monthly Access Committee meetings and daily bed management meetings. Hospital management informed inspectors that it continues to make progress in these areas, with plans to implement additional pathways to further enhance patient flow.

Hospital management outlined the progress of a number of long, medium and short term building projects from the previous inspection compliance plan, all which were at a various stages of progress. For example, the building of a new critical care and burns facility, expansion and reconfiguration of the emergency department and plan for new beds onsite as well as expanding sub-acute beds in an off-site facility.

Overall, on the day of inspection it was evident that the hospital had defined management arrangements in place. Measures implemented since the previous inspection to oversee patient flow from the emergency department through the hospital and into the community were established and functioning well and this was an improvement on the previous inspection.

Judgment: Compliant

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

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

Risk management structures were established in alignment with HSE's risk management framework, which facilitated the proactive identification, assessment, evaluation, tracking and escalation of reported risks. The hospital's patient safety and risk manager were responsible for overseeing the effectiveness of the hospital's risk management processes. They reported to the director of quality and safety improvement directorate. Patient safety

reports were regularly delivered at QSRMC and SQAGC. Local risk registers with mitigating actions documented were observed in the clinical areas visited by inspectors. Reported risks were managed by the clinical nurse managers (CNMs) and assistant directors of nursing (ADONs). It was evident that CNMs implemented actions to mitigate both actual and potential risks to patients. Risks that could not be effectively addressed within clinical areas were escalated to the CEO through the clinical directorate EMG process. Risks rated as high were escalated by the CEO to SQAGC or directly to the hospital board as deemed appropriate and documented on the corporate risk register.

Clinical directorates and other governance committees such as the PTC, IPCT, MSC and TEOC, supported by the Quality and Safety Improvement Directorate (QSID) Team, overseeing the effectiveness of the risk management process for the clinical services within their scope of responsibility. Risks assessments with a high rating were reviewed by the SQAGC twice a year and escalated to the Quality Safety Risk Board Sub-Committee (QSRBSC) to the Hospital Board. Significant high rated risks were reviewed at the monthly performance meeting between the hospital and the DMHG.

The hospital had established structures and processes in place designed to proactively identify and address patient-safety incidents. The QSID and the Serious Incident Management Team (SIMT) were responsible for ensuring all serious reportable events and serious incidents were reported onto the National Incident Management System (NIMS)^{##} and managed in line with HSE's Incident Management Framework. The SIMT, SQAGC and EMG tracked the timelines and effectiveness of managing adverse events and reported patient-safety incidents. SIMT approved recommendations from patient-safety reviews and recommendations were logged onto an electronic register, reviewed by SQAGC and quality improvement plans developed were monitored via SQAGC. The implementation of recommendations and sharing of learning from reviews lay with clinical directorates and governance committees.

Systematic monitoring arrangements were in place to ensure a collaborative approach to auditing, monitoring, and improving healthcare services at the hospital. Both clinical and non-clinical audits were overseen by the QSID, Audit and Risk Subcommittee of the Board, and the EMG, with reports submitted to the hospital Board. Hospital management informed inspectors that Directorate Management Teams in collaboration with their Service Leads were responsible for implementing quality improvement plans arising from audit activities within the hospital. The Lean Transformation team's role was to support and enable improvement work in the Hospital. A Quality and Patient Safety Improvement Strategy for 2022-2025 was in place, dedicated to enhancing patient experiences and outcomes within the hospital.

^{##} The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

Findings from the National Inpatient Experience Surveys and related quality improvement initiatives were reviewed at QSRM, SQAGC team meetings, lean management team meetings and clinical directorate meetings, with updates provided to the CEO and the Hospital Board. Inspectors found evidence that quality improvement plans were devised following the most recent National Patient Experience Survey (2022) to improve patient experiences, for example, updated information and instructions were now provided to patients on discharge. Additionally, the hospital had implemented a new key performance indicator (80%) following the National End of Life Survey (2023) so that end-of-life-care was provided in a single room.

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 hospital's workforce arrangements were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. At the time of the inspection, hospital management stated that the vacancy rate was very low across all categories of staff in the hospital.

Hospital management confirmed that except for four whole time equivalent (WTE)^{§§} posts, all the hospital's funded medical consultant positions were filled. Hospital management told inspectors that the vacant posts were in specialist areas making them more challenging to fill. Specialist vacancies included medical scientists, oncology specialist, breast surgery and dialysis posts. All permanent medical consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC). Medical consultants at the hospital were supported by a total of 429 WTE non consultant hospital doctors (NCHDs), 122 WTE registrars (approved for 124 WTE), 111 WTE senior house officers (SHOs) and other 196 WTEs (interns, specialist registrars (SPRs) and international trainees). The approved number of NCHDs was 431 WTE. On the day of the inspection, 98% of NCHD posts were filled with the deficit filled by regular agency staff.

The emergency department was approved and funded for eight WTE permanent consultants in emergency medicine. At the time of the inspection, the eight WTE consultant in emergency medicine posts were filled – five WTEs on a permanent basis and three WTEs on a locum basis. Consultants in emergency medicine were supported by a total of 36 NCHD (17 registrars, 16 SHOs and three interns). Emergency medicine consultants provided 24/7 medical cover in the emergency department. This was an improvement on HIQA's previous inspection (one consultant in emergency medicine post was unfilled).

^{§§} Whole-time equivalent (WTE): allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

The hospital was funded for a total of 82.47 WTE pharmacy posts and 38.02 WTE pharmacy technician posts. On the day of inspection, 33.99 WTE (92%) of pharmacy technician posts and 74.17 WTE (90%) of pharmacist posts were filled. The 10% deficit impacted on the ability to provide a comprehensive clinical pharmacy service and on the surveillance and promotion of medication safety practices across the hospital. However, staff informed inspectors they could access clinical pharmacy when required. This risk along with mitigating actions was recorded on the hospital's risk register and escalated to DHMG.

The IPCT comprised 4.5 WTE microbiologists, 2 WTE antimicrobial stewardship pharmacists, 1 ADON and 7 WTE clinical nurse specialists (CNS). Inspectors were informed there were no deficits in posts.

Inspectors were told there were no deficits in nursing posts. There was total of 1,794.44 WTE (inclusive of management and other grades) funded nursing posts with 1,980.37 WTEs in place, an excess of 185 WTE nursing posts in the hospital. The delivery of nursing care was supported by healthcare assistants (HCAs) and the hospital had more than its' approved complement of HCA staff. At the time of inspection, 389.53 WTE posts were funded and 519.84 WTEs were in actual post (130.31 WTE additional posts). On the day of inspection, the clinical areas visited had their full complement of nursing staff with the exception of one clinical area reporting one short term leave. Inspectors were informed that this had no impact on patient care. Hospital management stated that short-term absences and statutory leave were reported. The nursing adaptation programme was in place to improve skills and this also had reduced the costs associated with the employing agency staff at the hospital.

Inspectors were informed that staff absenteeism current rate was 5.7% which was above the HSE's target of 4% or less. The human resource department was tracking absenteeism rates and reported to the EMG and directorate levels. Succession, recruitment and retention planning were ongoing areas of focus overseen by EMG. An induction programme was provided to all new staff, a digital online system allowed staff complete some pre-learning before induction and there was an adaptation programme for staff recruited from overseas. This was confirmed by staff who had attended the induction programme. An occupational health department was located onsite and an employee assistance programme was available to all staff.

The hospital had an electronic system in place to track and oversee staff participation in mandatory and essential training. Attendance at mandatory and essential training for NCHDs was recorded on the National Employment Record (NER) system. Hospital management informed inspectors that this data was integrated onto the hospital's electronic system. Training reports were generated, shared and monitored by the QSAGC, EMG and reported to the Hospital Board.

Training records reviewed by inspectors showed that the uptake of essential and mandatory training for nurses in hand hygiene ranged from 93%-100% in the clinical areas

visited with the exception of John Houston (65%). Basic life support training records ranged from 90%-100% with the exception of Denis Burkett ward (74.5%) and John Houston ward (55%). Not all nursing staff in the emergency department had attended training in standard based precautions, transmission based precautions, medication safety and Irish National Early Warning System (INEWS) and the Emergency Medicine Early Warning System (EMEWS) training was not yet in place. This will be followed up on the next inspection.

Inspectors reviewed the training records provided for HCAs. Keith Shaw ward documented 100% attendance for transmission based precautions, hand hygiene and basic life support training. Denis Burkett ward attendance for all mandatory training was 93% and above with the exception of basic life support (71%). Not all HCAs attended training in standard based precautions and transmission based precautions in the emergency department, John Houston and Patrick Kavanagh wards. This will be followed up on the next inspection.

Inspectors were provided with mandatory training records for doctors from two clinical areas visited Patrick Kavanagh ward and John Houston ward. There was 100% attendance documented with standard based precautions, transmission based precautions in both wards, with gaps seen in hand hygiene and basic life support training.

Overall, workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare and staff shortfalls were relatively small. Notwithstanding this:

- there were some gaps in the attendance and uptake of mandatory and essential training among nursing staff in the emergency department as well as gaps in HCA training in the emergency department, John Houston and Patrick Kavanagh wards. This will be followed up on the next inspection.

Judgment: Substantially compliant

Quality and Safety Dimension

This section discusses the themes and national standards relevant to the dimension of quality and safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) related to the care and support provided to people who used the service and if this care and support was safe, effective and person centred.

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

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity.

A staff survey conducted in August 2024 regarding nursing attitudes towards the increase in healthcare assistants in the emergency department revealed that staff observed an improvement in patient care.

Patients in the emergency department were complimentary of the care received and stated *"staff were always around"* and another patient said *"he was seen immediately, with no delay, had bloods taken and given pain relief"*.

The physical environment in the other clinical areas visited generally promoted the privacy, dignity and confidentiality of patients receiving care. However, in one clinical area patients' personal information was visible and this was brought to the attention of the CNM who immediately addressed same.

Privacy curtains were used in multi-occupancy clinical areas when patients were receiving personal care arrangements. In one clinical area, inspectors were informed that a private room was designated for care needs for example, changing patient wound dressings. The patients explained how they were kept up to date with their plan of care by *"very attentive medical staff who tell you everything"*. Other patient comments included *"staff very responsive"* and *"a nice choice of food"*.

Management stated, and staff confirmed, that there was a significant hospital-wide focus on ensuring that patients' end-of-life care occurred in single occupancy rooms. A KPI was set at 80%, and this target was successfully exceeded at the time of the inspection. Inspectors were informed that the ten patients boarded on trolleys in the emergency department corridors had a staff nurse assigned their care. Inspectors observed that the patients were independent and that nursing and healthcare assistant staff were present and providing care.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. However:

- accommodating patients on trolleys in the emergency department did not promote dignity and privacy and was not consistent with a human rights-based approach to care supported and promoted by HIQA.

Judgment: Substantially compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care. Inspectors observed staff to be respectful, kind and caring towards patients and were communicating in an open and sensitive manner. Patients were highly complementary about their interactions with staff, and were aware of their plan of care. Patients described staff as “*kind and caring*”, “*excellent staff who go above and beyond*”, “*very attentive medical staff who tell you everything*” and “*very good nursing and healthcare assistant staff*”.

There was a significant focus on providing a patient-centred approach to care in the clinical areas visited. The hospital had introduced the DAISY^{***} and Being Extraordinary Everyday⁺⁺⁺ (BEE) Awards. These awards, presented by the director of nursing were based on feedback received from a patient, a family member or any staff member who experienced or observed extraordinary compassionate care provided by a nurse or a healthcare assistant.

Additionally, in response to patient feedback aimed at improving patient experiences, and emphasising the need for additional time to ensure effective communication with hospital staff, the hospital introduced ‘Just a Minute’ (JAM⁺⁺⁺) cards.

Patient information leaflets on a range of health topics were available and accessible to patients.

Judgment: Compliant

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

Inspectors found that there were systems and processes in place in the hospital to respond to complaints and concerns. The complaints manager was supported by two patient experience coordinators, two complaints officers and one administration staff member. The hospital’s complaints policy was an adapted version of “*Your Service your Say*”^{§§§} Complaints management training was provided for all staff at in-service training, study days and at corporate induction training.

*** The DAISY Award is a recognition program to celebrate and recognise nurses by collecting nominations from patients, families, and co-workers. It is a way to thank nurses for the care and kindness they provide.

+++ The BEE award stands for “Being Extraordinary Every day” and recognise non-nursing staff.

+++ The JAM card is a free, discreet and easy device that supports people with learning difficulties, autism, hidden disabilities or communication barriers by alerting others that they just Need a Minute

§§§ Your Service, Your Say’ is the name of the HSE’s complaints process for all users of HSE funded services. In addition to being a complaints process, “Your Service, Your Say” is also a way to provide feedback to the HSE

Staff in the emergency department stated that they received regular feedback on complaints at departmental feedback sessions which focussed on patient stories and learning from complaints. Point-of-contact complaints resolution was promoted and supported in line with national guidance. Effective communication skills training for staff was provided as part of the complaints training with a recent focus on how to manage distressed callers.

In the clinical areas visited, feedback leaflets were either seen or inspectors were informed that information was provided to all patients on discharge. However, on days of inspection, patients who spoke with inspectors were not familiar with the hospital's complaints process, but outlined that if they had a complaint they would speak to a member of staff which was in line with the hospital's complaints policy. Complaints were tracked and trended to identify emerging themes, categories and departments involved. Management stated that complaints were discussed with the clinical nurse manager and feedback was provided to staff at huddles and this was confirmed by the staff.

It was evident that complaints were discussed at Quality Safety Improvement Directorate (QSID), Safety and Quality Assurance Governance Committee (SQAGC), Quality, Safety and Risk Board Sub-Committee (QSRBS) meetings. Patient feedback directorate dashboards and BI dashboards seen by inspectors, went live recently, providing directorate teams with real time oversight of their complaints and feedback. Inspectors were told each directorate was responsible for implementing timely recommendations following complaints, utilising access of the BI dashboards.

There was evidence that quality improvement plans were developed following complaints. Examples included an improved focus on hygiene and cleaning in the emergency department (evident of the day of inspection), as well as additional palliative care education for staff.

Inspectors were informed the hospital was compliant with the HSE's target to resolve 75% of complaints within 30 days last year and this was also confirmed in the Quality and Safety Summery Report 2023 reviewed. Staff confirmed that arrangements were in place to ensure that support services such as advocacy services were available to patients. Inspectors were informed that information on advocacy services was provided to all patients along with their discharge information and this was evident in the documentation reviewed by inspectors.

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

Judgment: Compliant

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

Inspectors observed that the physical environment in the clinical areas visited was generally secure, well maintained and clean. While the numbers of toilet and shower facilities in the emergency department were not adequate for the number of patients attending the department, inspectors did not observe this to be an issue on the day of inspection.

In the clinical areas visited, all single rooms had en-suite bathroom facilities and in multi-occupancy rooms, patients shared en-suite bathroom in each bay. Inspectors observed that the shared en-suites were clean on the day of inspection and cleaning checklists were completed.

Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. The clinical areas visited had dedicated cleaners, with hospital cleaners allocated to cover cleaning requirements out of hours. The CNM2 and cleaning supervisors had oversight of the standard of cleaning in their areas of responsibility. Staff told inspectors there was sufficient cleaning staff in the clinical areas. Environment and terminal cleaning**** was carried out by hospital cleaning staff. Staff stated that bed curtains were changed regularly by an external company in line with policy and that there was good access to maintenance when required.

Generally, cleaning of equipment was assigned to healthcare assistants. Inspectors were informed that there was a system in place to identify equipment that was cleaned. However, inspectors found that during the inspection there was inconsistency in the application of this system but noted that equipment in all areas visited was clean.

Hazardous material and waste were safely and securely stored. Inspectors observed appropriate segregation of clean and used linen. Rooms that required restricted access were not always closed and secured and this was brought to the attention of staff on the day who addressed same.

Signage in relation to the correct and appropriate use of standard and transmission based precautions was displayed. Personal protective equipment (PPE) was available outside single isolation rooms and multi-occupancy rooms where patients requiring transmission-based precautions were accommodated. Inspectors observed wall mounted alcohol-based hand sanitiser dispensers strategically located and readily available to staff. Hand hygiene signage was clearly displayed throughout the clinical areas visited.

In summary, inspectors found the physical environment supported the delivery of high quality, safe, reliable care.

Judgment Compliant

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

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management used information from a variety of sources (KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, accreditation programmes, patient and family feedback) to compare and benchmark the quality of their healthcare services with other similar hospitals in and outside DMHG, and to support the continual improvement of healthcare services. At the time of the inspection hospital management informed inspectors that the hospital had a Clinical Audit Programme that included a Clinical Audit Strategy (2023-2025), Clinical Audit Policy and an annual Clinical Audit Plan. An report for 2024 would be due at the year end and hospital management informed inspectors the hospital work continuously to expand and improve this programme.

Infection prevention and control

As per HSE's reporting arrangements, hospital management reported monthly on rates of *Clostridioides difficile* ⁺⁺⁺⁺infection, *Carbapenemase-producing Enterobacterales* (CPE), ^{****}hospital acquired *Staphylococcus aureus* ^{§§§§} blood stream infections, hospital-acquired COVID-19 and infection outbreaks. The PCHCAI committee reported quarterly on organism surveillance (*Clostridioides difficile*, CPE, *Staphylococcus aureus*, central line associated infections, catheter related blood stream infections and COVID-19) to QSID, QSRMC and to SQAGC. Inspectors were informed that a summary report of the hospital's healthcare-associated infection surveillance was submitted annually to the QSID, SQAGC and QSRBSC. Actions taken to reduce rates of CPE included using a new drain cleaning foam to cleanse drains to reduce transmission and ongoing analysis of *Clostridioides difficile* rates identified no transmission occurred within the hospital. There was evidence of ongoing reviews of *Staphylococcus aureus*, central line associated infections and catheter related blood stream infections.

⁺⁺⁺⁺ *Clostridioides difficile* was formerly known as *Clostridium difficile* and is often called C. *difficile* or C. *diff* for short. C. *difficile* are bacteria/bugs that are normally found in the large intestine (bowel) and C. *difficile* is the primary cause of antibiotic-associated diarrhoea and C. *difficile* infection (CDI).

^{****} Carbapenemase-Producing Enterobacterales (CPE), are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat.

^{§§§§} *Staphylococcus aureus* (S. *aureus*) commonly colonises the skin and nose. Methicillin-resistant *Staphylococcus aureus* (MRSA) infection is caused by a strain of bacteria that has become resistant to the antibiotics commonly used to treat ordinary staphylococcal infections. In the right setting MRSA can cause severe and at times fatal infections such as bloodstream infection (BSI), infective endocarditis, pneumonia and skin and soft tissue infections (SSTI).

Environment and patient equipment audits were carried out using a computerised system, and a review of minutes of meetings indicated that audit findings were discussed at the PCHCAI committee. A sample of environment and patient equipment audits reviewed indicated that there was a good level of compliance with environment and patient equipment hygiene standards in all clinical areas visited. Actions were assigned a responsible person however, time-bound actions were not evident. Additionally, it was not clear if actions carried over from meeting to meeting were reviewed with a small number of actions outstanding on the previous audit completed.

Hand hygiene audits were carried out by the IPCT. HIQA requested results of hand hygiene audits post inspection and as a lot of the data submitted was not current, it was unclear to inspectors if the hospital was auditing hand hygiene on a regular basis, for example in two clinical areas it was not clear if hand hygiene audits were completed since 2022 and results were not submitted for one clinical area. Inspectors observed minutes of meetings which reflected that further audits were required when results fell below the expected standard. However, time-bound actions were not evident.

Medication safety

Medication audits were carried out and audit findings were reported to the MSC and PTC. A medication audit on insulin prescribing was conducted in the month prior to the inspection resulting in additional information being included on the insulin pen. Medication practices were also monitored quarterly as part of the nursing and midwifery quality care metrics with good levels of compliance in the clinical areas visited.

Hospital antimicrobial stewardship practices were monitored and evaluated. Management stated that the hospital had participated in the European Centre for Disease Prevention and Control**** point prevalence of the hospital-acquired infections and antimicrobial use. The findings in 2023 found prevalence of antibiotic use in the hospital was 38.3% in comparison to rates of 40.8% in participating hospitals nationally. In Quarters 1 and 2 of 2024, a re-audit of antimicrobial consumption was conducted. The results indicated a decrease in the use of ciprofloxacin and tazocin. Additionally, inspectors saw in the minutes of a meeting that the hospital intended to participate in a point prevalence study scheduled for October 2024.

Deteriorating patient

Inspectors were informed that compliance with the early warning system escalation and response protocol was audited quarterly as part of the nursing and midwifery quality care metrics. Inspectors found that compliance rates in the months preceding the inspection

**** The European Centre for Disease Prevention and Control (ECDC) is an agency of the European Union aimed at strengthening Europe's defences against infectious diseases. It provides scientific advice, data analysis, and support for disease prevention and control measures across EU member states

ranged from 80%-100% in four clinical areas visited. There was no evidence seen by inspectors that time-bound actions were implemented to improve compliance rates. A recent clinical audit completed on patients who had an INEWS score equal to or greater than 7, was presented to TEOC Improvement Program Committee to inform improvement, however, actions documented were not time-bound. A sepsis audit conducted in October 2023 revealed that 82% of patients were appropriately screened for sepsis, with a slight improvement in the timeliness of receiving diagnostic results within the hour. While recommendations were made for a quality improvement plan, no time-bound actions were evident. However, inspectors were told and noted in meeting minutes that there were plans for further sepsis audits in 2024.

Transitions of care

Clinical handover occurred twice daily in clinical areas and inspectors had the opportunity to attend same. Compliance with national guidance on clinical handover and the use of Identify, Situation, Background, Assessment, Recommendation/Read back/Risk (ISBAR2) communication tool was audited as part of a research project funded by National Quality Patient Safety Division in the HSE from November 2023 –January 2024. Twenty-six hours of handovers involving 226 staff and 309 patients were observed over two months. The audit results indicated that electronic healthcare records were utilised 100% to support clinical handovers, and a checklist was applied for all clinical handovers.

Overall, while there were assurance systems in place to monitor and evaluate healthcare services:

- not all actions associated with quality improvement plans were time-bound (environment and patient equipment audits, INEWS and sepsis management audits) and hand hygiene audits were not completed on a regular basis.

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 arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care.

Risk management

There were systems in place to proactively identify, assess and manage immediate and potential risks to patients. Risks with associated controls and assigned actions to mitigate the risks to patients were recorded on local risk registers viewed by inspectors included, emergency department overcrowding, violence harassment and aggression, COVID-19, medication safety and transfer of patients out of hours. All local risk registers were

reviewed and updated by CNMs who informed inspectors that the Safety and Risk team advised and supported them. CNMs stated that they were responsible for implementing and overseeing the effectiveness of actions and risks that could not be managed at clinical area level were escalated to the relevant department head and committees for review. Risks that could not be managed locally were escalated to the SQAGC where controls and mitigating actions were assessed and approved by the EMG. It was evident that risk was a standing agenda item at all directorate and executive meetings. Hospital management stated that risks and mitigating actions recorded in the corporate risk register were reviewed twice a year by SQAGC and the by hospital Board and inspectors observed this in the minutes of meetings reviewed. Risks escalated to the HSE monthly performance meetings included the risk associated with delayed transfers of care and access to community beds. High-rated risks associated with the four areas of harm were documented on the corporate risk register and included infection prevention and control with potential IT interruptions, transitions of care and medication safety. Inspectors observed that all risks had assigned, time-bound actions that were regularly reviewed.

Management stated that the Safety and Risk team provided education sessions to enhance safety to all professional groups in the hospital, and educational videos were also available for staff.

Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. On the day of inspection, inspectors were informed that the hospital was in a low level of escalation with 52 patients in the emergency room (56 in previous inspection) 21 of which were admitted. The waiting times for this inspection ranged from:

- registration to triage ranged from 3 minutes to 36 minutes. The average waiting time was 12 minutes, (HSE emergency programme target: 15 minutes) which was an improvement on previous inspection findings (52 minutes)
- triage to medical assessment ranged from 0 minutes to 6 hours and 5 minutes for non-urgent patients. The average wait time for medical assessment was 1 hour and 7 minutes, which was an improvement on previous inspection findings (2.5 hours) decision to admit to admission to an inpatient bed ranged from 3 hours and 21 minutes to 42 hours and 35 minutes. The average wait time was 17 hours and 2 minutes, similar to previous inspection (17 hours and 40 minutes).

Data on the emergency department PETS collected at 11.00am on the first day of inspection, showed that while the hospital did not align with all of HSE targets for the emergency department, there was an improvement compared to the previous inspection. At 11.00am:

- 42% patients in the emergency department were in the department for more than six hours after registration (HSE target 70%). This was an improvement from the previous inspection (57%).

- 38% patients in the emergency department were in the department for more than nine hours after registration (HSE target 85%). This was an improvement from the previous inspection findings (54%).
- 10% patients in the emergency department were in the department for more than 24 hours after registration (HSE target 97%). This was a slight increase on the previous inspection (7%).
- 4% patients aged 75 years and over were in the emergency department greater than six hours of registration. (HSE target 95%). This was an improvement on previous inspection.
- 2% patients aged 75 years and over were in the emergency department greater than nine hours of registration (HSE target 99%). This was an improvement on previous inspection findings.
- No patients aged 75 years and over were in the emergency department greater than 24 hours of registration and this was the same as the previous inspection findings.

Infection prevention and control

In line with national guidelines patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs). The hospital's electronic healthcare records system and the information patient management system alerted staff to patients who were previously inpatients with confirmed MDROs. Management stated that compliance with MDRO screening was audited by the IPCT and this was evident in the quality and safety improvement report 2023 and inspectors also observed screening instructions were available to staff in the clinical areas. Staff stated that patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance and this was evident on the day of inspection. If isolation facilities were not available, suitable patients were cohorted in multi-occupancy rooms. On the day of inspection there were no infection outbreaks in the hospital. Inspectors noted that the staff demonstrated a strong understanding of outbreak management protocols. Staff also stated that they have access to a microbiologist for advice when required.

Medication safety

A clinical pharmacy service⁺⁺⁺⁺ was provided in the majority of clinical areas however, while some clinical areas did not have this service (the emergency department, surgical day ward, ambulatory care and ward), staff stated that they could contact the pharmacy department who would then come to the clinical areas. Medication reconciliation was undertaken on all patients on admission and patients were prioritised according to risk, which was in line with the hospital's medication reconciliation policy. Staff stated that a pharmacist for non-stock medicines was contactable by phone and bleep. Medication stock replacement was carried out by pharmacy technicians. Staff stated they applied risk-

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

reduction strategies with high-risk medicines aligned with APINCH.**** There was a list of sound alike look alike drugs (SALADS) underpinned by a hospital policy. The medication management policy was in draft and due to be signed off. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care. Inspectors also observed that medications were stored securely and in line with national guidance for example, insulin, potassium and opioids. Medication fridge temperatures were monitored and recorded.

Deteriorating patient

Staff used the most recent version of the national early warning system for various cohorts of patients. The Irish National Early Warning System (INEWS) and the 'Sepsis 6' care bundle were used to support staff to recognise and respond to the deteriorating patient. The ISBAR₂ communication tool was also used for clinical handovers. The Emergency Medicine Early Warning System (EMEWS) was not yet implemented in the emergency department. However, inspectors were informed that efforts were underway to integrate EMEWS into the electronic healthcare record system. Staff were knowledgeable about INEWS escalation and response protocol to ensure timely management of patients with a triggering early warning score. In one of the clinical areas visited by inspectors, INEWS was not in use, however, the formalised process for monitoring and managing patient deterioration was described and a draft standard operating procedure outlining how to respond to and escalate care in the event of patient deterioration was available. Inspectors were informed the critical outreach team supported clinical areas with patients requiring admission to the intensive care unit (ICU) and also with patients following discharge from ICU to the clinical areas.

Transitions of care

There were systems and processes in place to support discharge planning and the safe transfer of patients within and from the hospital. A bed management committee was in place and a number of ambulatory pathways were also implemented to take pressure off the emergency department. The patient flow lounge was used to improve patient flow through the hospital. Each patient had a planned date of discharge. Inspectors were informed that daily and weekly bed management meetings were held with representation from the hospital and community services. Inspectors attended one of these daily meetings. A review of minutes of meetings reflected that issues impacting on the discharge process, complex discharge cases and actions required to enable the safe discharge of patients were discussed. The hospital had access to an additional 178 off-site beds for medical step down, convalescence and or rehabilitative care beds in community or private healthcare settings. Hospital admission avoidance initiatives such as the Frailty 'Home

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

First', §§§§§ Community Intervention Team***** (CIT), new link with community outreach nurses, ICPOP, +++++ the Medical Ambulatory Suite (MAS) for intravenous infusions, headache pathway, endoscopy and Outpatient Parenteral Antibiotic Therapy (OPAT)***** were used. Inspectors were informed patients were referred to the AMU by GPs. Hospital management stated there was daily interaction with staff in off-site wards regarding the availability of step-down beds and weekly MDT meetings were held there also. On the day of inspection the hospital was in amber escalation and it was evident that actions aligned with the level of escalation were being implemented to manage service demand. These included utilising surge beds in the day ward to admit patients from the emergency department. In minutes of meetings reviewed by inspectors it was evident that patients' surgeries were cancelled on a number of occasions due to surge capacity with an ongoing impact to scheduled care and day surgery care. Hospital management told inspectors the surgical hub was expected to be ready for use by year end 2024.

At the time of inspection, the hospital had a total of 42 delayed discharges (19 acute beds and 23 non-acute beds). This was an improvement on the previous inspection (66 delayed discharges). Hospital management attributed the delay in transferring patients mainly due to acuity and the complexity of patients requiring care. The average length of stay for medical patients was 10.4 days (HSE's target ≤ 7.0 days) and the average length of stay for surgical patients was 8.25 days (HSE's target ≤ 5.6 days) with 2.5% of surgical readmissions within 30 days of discharge to date of inspection 2024.

Policies procedures and guidelines

Staff had access to a range of up-to-date infection control, medication safety, transitions of care and deteriorating patient policies, procedures, protocols and guidelines. All policies procedures were accessible to staff via a document management system and in hard copy format. Inspectors were informed that the hospital's policy on medication safety, the hospital's escalation policy and chaperone policy were in draft format and currently under review.

Overall, while the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm and the patient experience times in the

§§§§§ Home First is a hospital admission avoidance service comprising a multidisciplinary team that are dedicated to caring older patients that attend for emergency care with follow –up by community services.

***** Community Intervention Team is a nurse–led measure supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.

+++++ Integrated Care of the Older Persons is delivering integrated care for older people across communities and hospitals in a multifaceted collaborative process between providers, patients and carers. The focus is on patient experience, outcomes and quality care.

***** Outpatient Parenteral Antibiotic Therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.

emergency department had improved from the previous inspection some times were still lower than the national HSE targets.

Judgment: Substantially compliant

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

Inspectors found that the hospital had systems in place to identify, manage, respond to and report patient-safety incidents in line with national legislation and standards, policy and guidelines.

Patient safety incidents were reported to the NIMS in line with national guidance. Hospital management provided monthly reports on the hospital patient safety indicator report, detailing the number of clinical incidents per 1,000 bed days used (BDU) to NIMS. Patient-safety incident reporting onto NIMS was timely, and in line with national targets. However, inspectors were told that it was a challenge to complete comprehensive reviews of adverse events within the national key performance target of 125 days due to availability of subject matter expertise.

Lead representatives from the QSRMC stated they received monthly patient-safety incident reports from all clinical directorates and this was evident in documentation reviewed. Monthly detailed incident reports seen by inspectors, were shared with directorate leads, service leads, quality and safety programme leads and the executive management team. Hospital management stated that all clinical directorates submitted annual incident management review progress reports to the QSRMC. Management stated that the SIMT and SQAGC were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Hospital management also told inspectors that patients were supported and kept informed on the review process. Inspectors were informed that a number of staff had recently completed system analysis review training and consequently, it was expected the 125 day KPI to improve in the near future.

The Safety and Risk team had overall responsibility for the management of the electronic platform and validation of dashboards for all quality and safety committees. The team stated they attended directorate meetings to advise on safety and risk matters. Recommendations from incident management reviews were logged on an electronic register by the quality and risk team. Quality improvement plans developed from recommendations were monitored by SQAGC. The implementation of recommendations from reviews lay with clinical directorates and governance committees.

The infection prevention control team stated that all relevant infection prevention and control patient-safety incidents were reviewed with associated detailed corrective actions

outlined. This was also evident from minutes of meetings reviewed. The infection prevention control team presented a report to the PCHAI committee.

Medication-related patient-safety incidents were categorised according to the severity of outcome in line with the National Coordinating Council for Medication Error Reporting^{§§§§§§} and Prevention (MERP) and also logged on NIMS. Documentation reviewed indicated that all medication incidents were reviewed weekly by the MSC and escalated to the SIMT where necessary. A medication safety incident report was submitted to the PTC, QSRMC and SQAGC.

Inspectors were informed, and it was also observed in minutes of meetings, that the TEOC reviewed, tracked and trended adverse incident reports regarding the deteriorating patient (including sepsis) and handover related issues. These incidents were escalated as required to the SIMT. A detailed report with quality improvement plans was also submitted to QSRMC and SQAGC.

Inspectors observed in documentation provided that weekly education notices were sent out to all staff via intranet and email to share information from patient-safety incidents and staff confirmed this. Hospital management informed inspectors that quality and safety newsletters were distributed to all staff and services within the hospital and inspectors observed hot board posters displayed with key safety messages for both patients and staff.

Line managers informed inspectors they reviewed patient-safety incidents which occurred in their area with the patient safety manager. Management stated that feedback on patient-safety incidents and review reports were disseminated at clinical directorate meetings and governance committee meetings and shared with CNMs who circulated to staff in the clinical areas. Clinical nurse managers stated that information on patient-safety incidents were shared with staff at huddles and this was confirmed by staff working in the clinical areas. Staff who spoke with inspectors were knowledgeable about what and how to report patient-safety incidents. Overall, the hospital had a system in place to identify, manage, respond to and report patient-safety incidents using an agreed taxonomy, in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

§§§§§§ The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body composed of 27 national organizations. In 1995, the United States Pharmacopeial Convention (USP) spearheaded the formation of the National Coordinating Council for Medication Error Reporting and Prevention: Leading national health care organizations are meeting, collaborating, and cooperating to address the interdisciplinary causes of errors and to promote the safe use of medications.

Conclusion

An unannounced inspection of St James's hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. Overall, the inspectors found good levels of compliance with the national standards assessed.

Capacity and Capability

There was evidence of the corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However, terms of reference for a number of committees were not up to date. The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services, which was an improvement on the previous inspection in March 2023. The EMG had a strong operational understanding of the issues affecting the quality and delivery of healthcare services at the hospital. Hospital management had established several committees to achieve planned objectives and to ensure effective management arrangements in relation to infection prevention and control practices, medication safety, the clinically deteriorating patient and safe transitions of care. There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of the hospital's healthcare service. Information from different clinical and quality sources was collected, compiled and published in accordance with HSE's requirements. Quality improvement plans were devised to improve patient experiences. The workforce arrangements were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. Nursing and HCA staff attendance at and uptake of mandatory and essential training should be an area of focused improvement.

Quality and Safety

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity. Patients were highly complementary about their interactions with staff, and were aware of their plan of care. There were systems and processes in place in the hospital to respond to complaints and concerns. The physical environment in the clinical areas visited was generally secure, well maintained and clean. There were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided, but not all actions associated with quality improvement plans were time-bound and hand hygiene audits need to be completed more frequently. The hospital had arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care. There was a

management system in place to identify, manage, respond to and report patient-safety incidents in line with national legislation and standards, policy and guidelines.

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 national 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

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.

Compliant

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

Compliant

Theme 6: Workforce

National Standard

Judgment

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

Substantially compliant

Quality and Safety Dimension

Theme 1: Person-Centred Care and Support

National Standard

Judgment

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

Substantially compliant

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

Compliant

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

Compliant

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