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:	National Orthopaedic Hospital Cappagh
Address of healthcare service:	Cappagh Road, Finglas, Dublin 11, D11 EV29
Type of inspection:	Announced
Date(s) of inspection:	20 and 21 November 2024
Healthcare Service ID:	OSV-0001014
Fieldwork ID:	NS_00104

About the healthcare service

Model of hospital and profile

National Orthopaedic Hospital Cappagh (Cappagh Hospital) is a model 2 orthopaedic public voluntary hospital. The hospital was a member of the Royal College of Surgeons of Ireland Hospital Group up to September 2024. Since October 2024, the hospital is under the Dublin and North East health region, and reports to the Integrated Healthcare Area Manager of the Dublin North City and West healthcare area.

Services provided by the hospital include:

- elective orthopaedic surgery for adults and paediatric patients
- rheumatology diagnosis and management
- diagnosis and treatment of musculoskeletal conditions
- sports and exercise medicine
- rehabilitation following an acute medical episode necessitating inpatient care.

The hospital is a national referral centre for bone and soft tissue tumours and the surgical oncology centre for the National Sarcoma Service.

Model of hospital	130
Number of beds	95 inpatient beds 35 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 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.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service

*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.

- 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.

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 plan submitted by the hospital is included in Appendix 2.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
20 November 2024 21 November 2024	09.00 – 17.30hrs 09.00 – 12:30hrs	Nora O' Mahony	Lead
		Aedeen Burns	Support
		Emma Cooke	Support
		Eileen O' Toole	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.[**]

The inspection team visited two clinical areas:

- Cappagh Kids ward (10-bedded paediatric inpatient and six paediatric day ward beds)
- St Teresa's ward (29-bedded adult surgical orthopaedic ward)

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

- representatives of the hospital's executive management team:
  - Chief Executive Officer
  - Director of Nursing
  - Clinical Directors for adult and paediatric services
  - Chief Operations Officer
- Quality Manager, the Clinical Risk Manager and the Health and Safety Officer
- Complaints Manager
- lead representative for non-consultant hospital doctors (NCHDs)
- Head and Deputy Head of Human Resources, the Learning and Development Officer and the Assistant Director of Nursing representative.
- hospital lead representatives 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.

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[‡] Using Early Warning Systems in clinical practice to improve recognition and response to signs of patient deterioration.
[§] 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.

Acknowledgements

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

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

During this inspection inspectors visited Cappagh Kids ward and St Teresa's ward. Inspectors spoke with a number of patients about their experience of the care received in St Teresa's ward. Patients were complimentary about the staff and the care received commenting that '*staff are lovely, very friendly ',* and that staff '*look after you very well*'. When asked what had been good about their stay in the hospital patients commented that – '*communication preoperatively had been very good', 'food very nice' 'catering staff get to know what you like',* and that staff were '*very accessible and visible'.* One patient commented that *'staff work very well together'.* When asked if there was anything that could be improved, patients who spoke with inspectors commented – '*can't think of anything, happy all round,' 'excellent service'.* When asked if they would know how to make a complaint if required, one patient did know that the hospital had a complaints officer, other patients commented that they would be happy to talk to any member of staff if they had an issue as staff were '*very approachable'*.

On Cappagh Kids ward inspectors spoke with both children receiving care and their parents. Both children and parents were very complimentary about staff and care received commenting that – '*staff are fantastic and helpful', 'fantastic here', 'they [staff] respond to our needs'.* When asked what had been good about their stay in the hospital, children and their parents were complimentary about the good preoperative process and how it helped to build connection. Children and parents mentioned the quiet nice atmosphere, the ease of access to staff and medical teams and the good pain management for the children, and that overall it was '*amazing – a great facility'*. When asked if they would know how to make a complaint if required, some parents knew about the '*You Service Your Say',*[††] another commented '*we would figure it out, but we are more about compliments'.*

There was overall consistency between what inspectors observed in the clinical areas visited and what patients or their parents told inspectors about their experiences of care received.

[††] HSE Your Service Your Say is the process to listen and respond to service user's feedback about services. Feedback might be a comment, compliment or complaint.

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.

Inspectors found that there were integrated corporate and clinical governance arrangements in place to assure the delivery of safe, high-quality healthcare services in Cappagh Hospital. Representatives of the senior management team who spoke with the inspectors clearly understood their roles, responsibilities and reporting relationships. Governance arrangements and roles were publicly available. The governance arrangements outlined in the hospital's organisational charts clearly described the reporting structures for disciplines, line managers and hospital committees. These organisational charts were consistent with structures outlined to the inspectors throughout this inspection.

The Chief Executive Officer (CEO) was the accountable officer with overall responsibility and accountability for the governance and quality of the healthcare services delivered in Cappagh Hospital. The CEO reported to the Chair of the Board of Directors. The hospital, via the CEO, reported to the Integrated Healthcare Area Manager for Dublin North City and West since October 2024, having previously reported to the Royal College of Surgeon of Irelands (RCSI) Hospital Group. Responsibility for the governance and oversight of the effectiveness of the patients' clinical care lay with two clinical directorates, a clinical director for adult services and a clinical director for paediatric services. Nursing services were managed and organised by the Director of Nursing. Reporting structures were clearly outlined for all individuals via the CEO to the Board of Directors.

The Executive Management Committee, chaired by the CEO, was the committee with overall responsibility for the management of the hospital. This committee was accountable to the CEO who in turn was accountable to the Board of Directors. From evidence provided throughout this inspection the Executive Management Committee was undertaking its role and function as per the terms of reference which included:

- the consideration of reports presented from executive management team members such as finance, nursing, human resources and facilities
- the review of escalated risks for inclusion onto the corporate risk register
- support and monitoring of the implementation of relevant policies
- leading on the development and implementation of the organisation's business plans

- the monitoring of activity and performance against key performance indicators.

Meetings were action focused with actions assigned to a responsible person. Updates on actions were monitored from meeting to meeting. The evidence provided indicated that the Executive Management Committee was effective in the overall management of the hospital.

The Clinical Governance and Clinical Risk Committee (CGCRC) was responsible for overseeing clinical governance and clinical risk related to clinical services delivered at the hospital. The committee was chaired by the CEO and reported to the Board of Directors via the CEO using the Integrated Governance Monitoring Report. The committee reviewed and considered quarterly reports provided by clinical departments and committees which reported to it. The committee reviewed data and reports related to patient-safety incidents, risks, complaints, audit and monitoring. A list of actions from each meeting was monitored and updated, with an assigned responsible person and time frame for each action. As per the committee's terms of reference it was scheduled to meet quarterly – from minutes submitted to inspectors, the committee had met in November 2023 then in May 2024 and September 2024. From evidence provided it was apparent that there was effective oversight of clinical governance and clinical risk at the hospital.

The Drugs and Therapeutics Committee had responsibility for oversight of medication safety at the hospital. The committee was chaired by a consultant anaesthesiologist and provided update reports at each Clinical Governance and Clinical Risk Committee meeting. The committee was scheduled to meet quarterly as per their terms of reference and had a structured standing agenda. However, the Drugs and Therapeutics Committee had only met twice in 2024 to the date of inspection due to changes in senior pharmacy management. The next meeting was scheduled for December 2024. The agendas of meetings included a review of previous actions. However, the progress on actions from the previous meetings were not clearly outlined in minutes reviewed.

The hospital also had a medication safety committee who met quarterly and was chaired by the senior pharmacist for medication safety. This committee developed and updated the hospital's medication safety programme with oversight by the Drugs and Therapeutics Committee. The evidence provided indicated that there was effective oversight of medication safety at the hospital.

The Infection Prevention and Control Committee had responsibility to oversee the organisation of infection prevention and control and the antimicrobial stewardship programmes at the hospital. This committee was chaired by the consultant microbiologist and reported at each Clinical Governance and Clinical Risk Committee meeting. The agenda of meetings included a review of previous actions. However, the actions required were not clearly outlined in minutes viewed by inspectors. The committee was meeting as scheduled and undertaking the roles outlined in the committee's terms of reference.

The hospital's Deteriorating Patient Committee was responsible for the implementation of the National Clinical Guidelines to support the recognition and management of a deteriorating patient – the Irish National Early Warning system (INEWS), the Irish Maternity Early Warning System (IMEWS) the Irish Paediatric Early Warning Systems (PEWS) and Sepsis Management for Adults. The committee was chaired by the Director of Nursing and reported at each Clinical Governance and Clinical Risk Committee meeting. The Deteriorating Patient Committee was action focused, with actions clearly outlined and assigned to a responsible person with time frames. Actions were monitored from meeting to meeting. The committee had a standing agenda which included sepsis, monitoring of quality indicators and outcome measure and audit, monitoring of mandatory training compliance, incident review, policy updates to meet national standards and quality improvements plans. This committee had effective oversight of the management of the deteriorating patient.

The hospital's Transitions of Care Committee was set up in 2024 to identify transitions in care associated risks and measures in place for all patient pathways. Sub-groups were established for admissions, internal processes and discharge. The committee had met six times to date of inspection.

Overall the hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare with minor exceptions such as:

- the Clinical Governance and Clinical Risk Committee and Drugs and Therapeutics had not met as per their terms of reference
- actions from minutes of the Drugs and Therapeutics Committee and the Infection Prevention and Control Committee were not clearly outlined in minutes reviewed.

Judgment: Substantially compliant

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

The hospital had management arrangements in place in relation to the four areas of known harm which were the focus of this inspection – infection prevention and control, medication safety, the deteriorating patient and transitions of care. Findings related to these areas are discussed below.

The hospital's infection prevention and control (IPC) team comprised two IPC clinical nurse specialists, a 0.25 whole time equivalent (WTE) microbiology consultant and a 0.3 WTE antimicrobial stewardship (AMS) pharmacist. The hospital's IPC team developed an annual infection prevention and control plan that set out the objectives, priorities and work plan for the IPC team for 2024. This plan was overseen by the Infection Prevention

and Control Committee. The IPC team also developed an annual report of activities undertaken for 2023. The AMS pharmacist supported the hospital's antimicrobial stewardship programme and reported on progress to the Infection Prevention and Control Committee and the Clinical Governance and Clinical Risk Committee.

The hospital's pharmacy service was led by the Head of Pharmacy. The medication safety programme at the hospital was guided by the hospital's annual medication safety strategy. This strategy was guided by the World Health Organization Global Patient Safety Action Plan 2021-2030[‡‡] and the Irish Medication Safety Network's[§§] Building a Medication Safety Programme in Acute Care in Ireland: Fundamental Steps. The hospital had a 0.3 WTE senior pharmacist assigned to the role of medication safety which supported the implementation of the medication safety programme at the hospital. The hospital had developed a quality improvement plan (QIP) to track the implementation of the actions required to implement the hospital's medication safety strategy with progress tracked through the Medication Safety Committee with oversight by the Drugs and Therapeutics Committee. Update reports were provided at the Clinical Governance and Clinical Risk Committee. All actions recorded on the QIP were in progress at the time of inspection, with evidence of some progress on actions seen by inspectors such as – ongoing incident management, audit and patient education.

The hospital provided a clinical pharmacy service[***] to all adult areas of the hospital. However, inspectors were told that a dedicated clinical pharmacy service was not provided to the paediatric ward – Cappagh Kids, and the AMS pharmacist did not provide an AMS service to Cappagh Kids ward. However, a clinical pharmacist was available to the paediatric ward on request. This is discussed further under national standards 5.8 and 3.1.

The hospital had formal processes in place for nursing and medical clinical handover. The hospital had admission, discharge and transfer processes in place which were clearly described by staff throughout this inspection. However, no formal admission and discharge policy, procedure or guideline was provided to inspectors. This is discussed further under national standard 3.1. The hospital had a formalised documented transfer policy for the deteriorating patient.

The Transitions of Care Committee had completed a review of the transition of care pathways for admissions, internal processes and discharge. They had developed a quality

[‡‡] WHO Global Patient Safety Action Plan-Toward eliminating avoidable harm in healthcare. The purpose of the action plan is to provide strategic direction for all stakeholders for eliminating avoidable harm in healthcare and improving patient safety in different practice domains through policy actions on safety and quality of health services, as well as for implementation of recommendations at the point of care. Available on line at Global Patient Safety Action Plan 2021-2030

[§§] Irish Medication Safety Network Building a Medication Safety Programme in a Hospital in Ireland: Fundamental Steps. 2023. Available on line from https://imsn.ie/publications-alerts/

[***] 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.

improvement plan for each of the three pathways. An identified responsible person and timeframes were assigned for each action, with all actions completed or in progress at the time for inspection.

The hospital's Deteriorating Patient Committee had developed a quality improvement plan which tracked the committee's progress on the implementation of actions from recommendations arising from reviews and risk assessments. The progress of implementation of outstanding actions was outlined in the QIP, with evidence of completed actions seen by inspectors such as – the monitoring of incidents and review of early warning system audits and training metrics were added as standing agenda items for the Deteriorating Patient Committee. The Deteriorating Patient Committee had oversight of the implementation of the outstanding actions.

The hospital's consultant orthopaedic surgeons and consultant anaesthesiologists for adults and paediatrics were onsite during core hours Monday to Friday, which supported effective clinical arrangement for delivery of quality care and the detection and management of the deteriorating patients. Out of hours, a medical registrar was on call on site for adult patients with access to an on-call orthopaedic registrar off site. There was no formal on-call consultant arrangement for adult patients. However, the hospital had an informal arrangement whereby the on-call registrar or a member of the nursing team, with support from the site nurse manager, could call the patient's admitting orthopaedic consultant or the medical consultant for advice as required. This on-call arrangement was clearly outlined in the 'NCHD on-call procedure' which was provided to inspectors. The 'NCHD on-call procedure' had an issue date of 19 November 2024.

There was an onsite paediatric orthopaedic registrar on call for paediatric services and, through informal arrangements, they could escalate any concerns to the patient's consultant orthopaedic surgeon. There were additional interim formal on-call arrangements in place for children under 18 years of age who had undergone spinal fusion surgery. For this cohort of patients, inspectors were informed that medical issues could be referred to the on-call medical registrar or escalated to an on-call anaesthetist or medical consultant. This on-call arrangement was not outlined in the recently issued 'NCHD on-call procedure'.

There was no paediatric medical consultant or paediatric medical non-consultant hospital doctor at, or available to Cappagh Hospital. The risks associated with this were recognised by the hospital and recorded on the hospital's corporate risk register. An action outlined in the corporate risk register to mitigate any potential risks of a deteriorating paediatric patient was to secure a formal agreement for medical paediatric cover to support the paediatric surgical registrar on call. The Clinical Director for paediatric services was liaising with Children's Health Ireland in an effort to advance the action required to mitigate this risk This is discussed further under national standard 3.1

Overall, the hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services related to

infection prevention and control, transitions of care and medication safety. The hospital had a number of safeguards and procedures in place to mitigate the risk of a child's deterioration during or following surgery.

However:

- the out-of-hours consultant arrangement for adult patients was informal
- there were no paediatric medical consultants or non-consultant hospital doctors at, or available to Cappagh Hospital, however the Clinical Director for paediatrics was liaising with Children's Health Ireland in an effort to advance the action required to mitigate the risk of harm to paediatrics patients from clinical deterioration
- the on-call arrangement for children under 18 undergoing spinal fusion surgery was not outlined in the recently issued 'NCHD on-call procedure'.

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 for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital collated a range of patient-safety indicators, which were reviewed at senior hospital level and at Hospital Group level. These indicators were not being published at the time of inspections. Senior management outlined that this was due to the transition from the RSCI Hospital Group to the new health regions structure.

There were risk management structure in place to proactively identify, manage and minimise risks in line with the HSE's risk management framework. Each department had a local risk register with risks outside the scope of the department escalated to the senior management team for review and addition to the corporate risk register as appropriate. The Executive Management Committee had oversight of the corporate risk register.

The lack of a clinical pharmacy service to Cappagh Kids was identified as a red-rated risk by the pharmacy department and recorded on the pharmacy departmental risk register. Inspectors were informed that all pharmacy risks were held locally at department level, and had not been formally escalated onto the corporate risk register. Senior management informed inspectors that they were unaware that a dedicated clinical pharmacy service was not provided to the paediatric ward as the risk had not been formally escalated. This is discussed further under national standard 3.1.

The hospital had systems and processes in place to proactively identify and manage serious incidents and serious reportable events. The clinical risk department were responsible for ensuring that all patient-safety incidents were reported in line with the National Incident Management System (NIMS)[†††] and managed in line with the HSE's Incident Management Framework, with oversight from the Clinical Governance and Clinical Risk Committee and Executive Management Committee. Incident reports were shared monthly with departments to share learning. Examples of quality improvements put in place in response to incidents were outlined to inspectors and related to issues such as needle stick injuries and skin tears during surgery. Learning was also shared with staff through a quarterly newsletter sent to all departments.

The hospital did not have an agreed annual plan for audit, but evidence was provided of audit and monitoring in the areas that were the focus of this inspection relevant to the size and scope of the hospital. Oversight of performance was provided by the relevant governing committees, with evidence of reporting on performance seen at the Clinical Governance and Clinical Risk Committee.

The hospital collected a range of data on metrics such as – clinical outcomes, patient-safety incidents, complaints, service user feedback, infection prevention and control, emergency transfers to other hospitals, and risks which may impact the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governance committees, and had previously been reviewed at performance meetings between the hospital and the RCSI Hospital Group. At the time of inspection the hospital was transitioning to the new health regions structure and no formal meetings had occurred to date of inspection.

Information from feedback and complaints from people who use the services was shared with staff and at relevant governance committees and at the Clinical Governance and Clinical Risk Committee and the Board of Directors.

Overall, there was evidence of monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services relevant to the size and scope of the hospital.

Judgment: Compliant

[†††] The National Incident Management System (NIMS) is a 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).

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 Cappagh 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. Overall there was a 0.5 WTE unfilled nursing post which was challenging to fill and one WTE consultant post which was at an advanced stage of recruitment. All approved pharmacy and infection prevention and control posts were filled at the time of inspection.

The reported staff absenteeism rate in October 2024 was 4.2%, which was marginally higher than the HSE target of 4% or less. The hospital had a process in place to manage absenteeism with line managers undertaking back-to-work interviews. Staffing numbers (headcount), absenteeism and recruitment was managed and monitored by the human resource department. Human resource management was overseen by the Executive Management Committee. The Head of Human Resources had provided a report at performance meetings with the RCSI Hospital Group up to September 2024. Occupational health supports were available to staff, and staff who spoke to inspectors were aware of a staff counselling service.

Mandatory training was managed by the human resources department and reported at the Executive Management Committee. Relevant governance committees had oversight of training for the deteriorating patient and infection prevention and control. Clinical nurse managers managed mandatory and essential training for nurses and healthcare assistants on the clinical wards visited. Nurses and healthcare assistants attendance at mandatory and essential training at the hospital for standards and transmission-based precautions, hand hygiene and basic life support (BLS) ranged from 91% to 100% compliance. Nurse training compliance for INEWS, IMEWS, PEWS, was 100% and medication safety was 80%.

There was opportunity for improvement for mandatory training attendance for non-consultant hospital doctors (NCHDs) at the hospital. NCHD's were 58% compliant with standards and transmission-based precautions and 79% for hand-hygiene training. NCHDs overall were 34% compliant with BLS. Medical NCHD's who provided on-call cover were 83% compliant with BLS training and 67% compliant with advanced cardiac life support (ACLS) training. However, of the orthopaedic NCHDs who provided on-call cover for the paediatric service only 11% of this cohort of staff were up to date with BLS, ACLS and paediatric advanced cardiac life support (PALS). The hospital were aware of the need to improve doctors' training and had developed a quality improvement plan to support improvement and attendance at training. At the time of inspection, 22 of the 25 outstanding actions in the quality improvement plan were completed, and the uptake of mandatory training among doctors had increased from 33% to 52%. Whilst still not at the required level, this had demonstrated an improvement, and a commitment by the hospital

to support the uptake of mandatory training for doctors. Hospital management did outline a plan, to ensure that all paediatric orthopaedic NCHDs on rotation to Cappagh Hospital completed PALS training. This was due to commence in quarter one 2025.

Overall the hospital planned organised and managed and developed their workforce to provide a quality safe and reliable healthcare. Staff vacancies were minimal at the hospital with plans in place to fill the outstanding consultant post.

However,

- there was poor compliance rates for NCHDs mandatory training for BLS, ACLS and PALS, especially for NCHDs covering paediatric services.

Judgment: Partially 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 and 3.1 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 in the clinical area visited by inspectors respected and promoted patients dignity, privacy and autonomy. Staff in the paediatric ward were observed to communicate with their patients in a child friendly manner. Patient's autonomy was protected and promoted, and all family members who spoke with inspectors were kept up to date with their child's plan of care. Privacy curtains were observed in use as required.

On St Teresa's ward, inspectors observed staff maintaining patients' dignity and privacy. Curtains were pulled around patients and staff spoke to patients in lower voices to promote privacy. Patients acknowledged that their privacy was maintained and commented that '*staff will always pull the curtains*'.

In the clinical area visited during the inspection, patient's personal information was observed by inspectors to be protected and stored appropriately.

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. This was consistent with the human rights-based approach to care promoted by HIQA.

Judgment: Compliant

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. Staff were observed to be kind and considerate when interacting with children and their families on the Cappagh Kids ward.

On St Teresa's ward, many examples of kindness, consideration and respect were observed by inspectors. For example, staff were observed providing reassurance to a patient who appeared anxious, this was further confirmed by a patient who told inspectors what staff were '*very reassuring'.* Staff were observed providing directions to patient in a cooperative and friendly manner. Catering staff were observed offering extra snacks to a patient who was due to travel away from the hospital later that day.

Overall, hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

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 hospital had a designated complaints officer who reported directly to the Chief Operations Officer and had responsibility for managing complaints.

The hospital used the HSE's complaints management policy 'Your Service Your Say.' Complaints were resolved where possible at first point of contact, and 'Your Service Your Say' leaflets where available in the hospital. Patients' feedback on their experience of care was sought, and inspectors observed a child friendly feedback sheet available on the paediatric ward. Results from feedback of the Cappagh Kids patient satisfaction survey were collated, and results provided to inspectors for quarter three 2024. 96% to 100% of children or their parents responded that care received was good or excellent related to (1)

notice given for surgery date (2) pre-surgery information provided (3) care for children with additional needs and (4) discharge information provided.

Staff outlined to inspectors that there was a coordinated response to managing formal complaints. The complaints officer would liaise with the managers of the department involved to review the complaint and coordinate an appropriate response.

The Clinical Governance and Clinical Risk Committee had oversight of complaints at the hospital. Minutes of meetings reviewed by inspectors demonstrated that the committee reviewed relevant data and reports relating to complaints and service users feedback. A quarterly complaints report was prepared detailing the following information:

- the total number of complaints received year to date
- the yearly comparison of complaints resolved locally versus complaints that required a formal response
- category breakdown of complaints with trend analysis and comparison to previous years data
- areas for learnings and improvements.

Feedback on complaints was provided to staff on the clinical areas and learning was shared at ward huddles and through the complaints report which was shared with staff twice yearly.

There was evidence that quality improvement plans were developed in response to patients' feedback and complaints. Examples of improvements implemented were outlined to inspectors during the inspection. For example, complaints about delays in getting appointment was one of the top complaints received by the hospital and lack of information regarding same. In response, the complaints officer was working with staff to improve communication with patients so they can better understand the waiting list process and their place on the list. They also introduced a process to improve response to phone call messages left by patients.

100% of complaints received by the hospital were closed out with 35 days. Resolution within 35 days was the target set by the RCSI Hospital Group. Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

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.

On the day of inspection, inspectors visited Cappagh Kids ward and St Teresa's ward. Inspectors observed that Cappagh Kids ward had been recently renovated and was a bright spacious ward which was very clean and well maintained. This ward comprised 10 in-patient beds with one four-bedded multi-occupancy room, one five-bedded multi-occupancy room. These rooms did not have en-suite toilet or shower facilities, but there were two toilet and shower facilities for use by the children situated on the corridors opposite these multi-occupancy rooms. There was one single room with en-suite toilet and shower facilities.

There was one toilet dedicated for the use of parents of children being treated in hospital. Inspectors were informed that parents had access to shower facilities on request, However, parents who spoke with inspectors on the day of inspection were not aware of this arrangement.

St Teresa's ward had an outdated aging infrastructure that was in need of refurbishment, with evidence of bubbling paint and chipped surfaces that impacted effective cleaning. There was a quality improvement plan in progress for non-infrastructural issues identified from the hospital's environmental audit programme. On St Teresa's ward, the need for some painting and general maintenance was identified, with 50% of these actions completed at the time of inspection. Management outlined a plan for a new 72 bed build which would include replacement beds for this ward. The plan was at an advanced stage, with projected onsite building work commencing in 2026.

St Teresa's ward had 29 beds which comprised multi-occupancy rooms with nine beds, seven beds, four beds, three beds, and two rooms with two beds. There were two single cubicles which had en-suite shower and toilet facilities. None of the multi-occupancy rooms had en-suite toilet or shower facilities. There were shower and toilet facilities located on the corridors outside these rooms – however, some of these facilities were located a distance away from the patients' bedrooms. There were two single cubicles which had en-suite shower and toilet facilities. Access to the nine-bedded room was through the seven-bedded room, which increased the risk of hospital acquired infection. The nine-bedded room, if fully occupied, did not have sufficient space to allow easy movement of patients in and out the room for example when returning from theatre. On the day of inspection this room only accommodated eight beds. The restricted space had been risk assessed by the ward management, with an action to keep the room restricted to eight beds when possible. The ward had two single rooms suitable for isolation of patients for transmission based precautions, and patients requiring isolation in a neutral pressure room were moved to another ward with suitable single rooms

There was inadequate space for storage of patient equipment and some patient equipment was incorrectly stored in a toilet, which was then not available for patients' use. During the inspection, some of the bathroom facilities were noted to be very cold. This was brought to the attention of management on the day of inspection. The ward was revisited by inspectors on the following day of inspection and actions taken to address the issue had resulted in a significant improvement in temperature.

Environmental cleaning was carried out by hospital staff. An identified member of staff was allocated to Cappagh Kids ward and St Teresa's ward during core hours, with access to additional cleaners up to 8pm. Cleaning supervisors had oversight of cleaning and cleaning schedules. Clinical nurse managers were satisfied with the level of cleaning resources in place. Environment audits reviewed by inspectors demonstrated high levels of compliance on Cappagh Kids ward on average 94%. Environment audits on St Teresa's ward were on average 81% compliant from audits completed between January and October 2024, with compliance ranging from 92.5% in January to 69.7% in July 2024. Inspector's observation of the clinical environment was consistent with the audit findings.

Cleaning of patients' equipment was undertaken by the healthcare professional who used the equipment, with additional patient equipment cleaning assigned to healthcare assistant staff. The hospital had a labelling system in place to identify cleaned equipment, and this was observed in use by inspectors on the day of inspection. Patients' equipment observed in the clinical area visited was very clean. Equipment audits undertaken throughout the year demonstrated over 90% compliance with cleaning of equipment for Cappagh Kids wards and 86.9% compliance for St Teresa's ward.

Alcohol-based hand-sanitiser dispensers with hand-hygiene signage were located throughout the clinical areas, and there was adequate personal protective equipment available for staff. On Cappagh Kids the hand-hygiene sinks conformed to recommended Health Building Note (HBN) 00-10 part C sanitary assemblies or equivalent standards.[‡‡‡] However, not all sinks on St Teresa's ward were compliant with these standards.

There was evidence that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care in Cappagh Kids ward. However, the physical environment on St Teresa's ward did not fully support the delivery of high quality care as it had:

- aging, outdated infrastructure
- a lack of storage areas for equipment
- hand-hygiene sinks that did not conform to recommended standards
- a multi-occupancy room that was a thoroughfare for access to another room

[‡‡‡] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *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)

- no en-suite toilet and shower facilities in the multi-occupancy rooms.

Judgment: Partially compliant

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

The hospital used a variety of sources such as national performance indicators, audits, clinical outcomes for adult services and experience of care from the perspective of people using the services to measure the quality and safety of care provided.

The IPC team reported on the rate of hospital acquired infections[§§§] monthly, with low occurrence noted on reports reviewed by inspectors for year to date 2024. Quarterly hygiene audits were undertaken by the IPC team covering the areas of waste, linen and environment with monthly audits of equipment and sharps by the IPC team and nursing. All hospital departments and wards were audited quarterly with monthly re-audits if compliance fell below 80% on two consecutive audits. Overall the departments average compliance rates ranged from – 88% to 100% for waste management, 83% to 100% for equipment, 83% to 100% for linen and 87% to 100% for sharps management and 71% to 93% for environment. Evidence of re-audit for areas with poor compliance was seen by inspectors.

Audit findings concurred with what inspectors observed on the day of inspection in that Cappagh Kids ward, which was recently refurbished, scored well for environment elements of the audit. However, the physical environment on St Teresa's ward did not fully support the delivery of high-quality care and scored lower on environmental audits.

A quality improvement plan to address non-infrastructural issues that required action from the hospital environmental audit programme, was viewed by inspectors. Approximately 50% of actions required on St Teresa's ward were completed, with some paintwork and repairs to be completed. Time frames for completion and a responsible person were not assigned for these actions. There was oversight of hygiene audit results and associated quality improvement plan at the hospital's Hygiene Committee. Results were also reviewed on Infection Prevention and Control Committee minutes viewed by inspectors.

[§§§] Methicillin-resistant Staphylococcus aureus, Clostridioides difficile, Norovirus, Staphylococcus aureus, Vancomycin-Resistant Enterococci, Carbapenemase-Producing Enterobacterales, catheter-associated urinary tract infection, central line related infections, COVID-19 and Extended-spectrum Betalactamase.

Hand-hygiene audits were undertaken monthly for high-footfall areas and quarterly on low-footfall areas by locally trained hand-hygiene auditors. The average overall hospital hand-hygiene audit results reviewed by inspectors from January to October 2024 was 91.6% ranging by month from 87% to 95.8%. Audit results were reviewed and monitored by the Infection Prevention and Control Committee, with monthly reporting to the Executive Management Committee and the Hospital Group, and to the Board of Directors via the Integrated Governance Monitoring Report.

The Infection Prevention and Control Committee had developed a hospital wide hand-hygiene quality improvement plan, which outlined actions to promote and sustain the hospital's hand-hygiene compliance at over 90%. All actions were completed at the time of inspection. However, not all individual area were compliant with the 90% target. For example St Teresa ward visited on the day of inspection was overall 79% compliant with hand-hygiene practice in year to date 2024 with monthly audits ranging from 80% to 97%, and Cappagh Kids overall average at 88% ranging 83% to 95% throughout 2024.

Medication safety was monitored by the hospital through audits and through nursing and midwifery quality care metrics. Quarterly allergy audits showed good compliance with documentation of allergy status –100%, nature of allergy recording – 81%, signed – 86%, and dated – 86%. Quarterly audits of high-alert medicines were undertaken to ensure practice aligned to hospital policy, with overall compliance ranging from 87% to 100%. The pharmacy department set key performance indicators (KPIs) for – the undertaking of medication reconciliation for patients within 24 hours of admission, the review of prescription on discharge and the percentage of orthopaedic patients reviewed post operatively. Monthly audits reviewed by inspectors, showed compliance against set KPI's for medicine reconciliation was 100% (target >90%), for discharge prescription was 54% (target >50%) and for orthopaedic patients reviewed post operatively was 100% (target 90%). Medication safety audit results were reviewed and monitored by the Medication Safety Committee.

Evidence of a quality improvement plan completed for nursing clinical handover in 2023 was provided to inspectors, with a re-audit plan to be undertaken in quarter four 2024.

The INEWS and PEWS escalation and response was audited quarterly by the hospital. Compliance level for INEWS audits year to date was high ranging from 94% to 100%, and PEWS audits compliance was 85% to 97.7% year to date 2024.

Sepsis audits were also undertaken quarterly. The healthcare records of all patients who triggered an early warning score of three or higher were reviewed to examine if the sepsis protocol was commenced as required. In quarter two, 96% of sepsis forms were commenced when required and 92% of the sepsis forms were completed correctly. For cases where the sepsis forms were not completed correctly – an incident form was completed and feedback and education was provided for ward staff to share learning and reduce the risk of recurrence.

The hospital also monitored adult patients' complications to identify any trend and patterns for learning. The findings were presented and discussed at bi-annual clinical audit morbidity and mortality meetings attended by multidisciplinary staff members from the hospital. A similar process for monitored paediatric patients' complications was not in place at the time of inspection. The Clinical Director for paediatric services outlined that they planned to commence monitoring of paediatric patients complications from January 2025.

Overall, the quality and safety of care provided was monitored by the hospital relevant to the size and scope to the hospital with information from monitoring used to improve care and share learning.

Judgment: Compliant

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

Cappagh Hospital had arrangements in place to proactively monitor, analyse and respond to information significant to the delivery of safe services from a variety of sources such as patient-safety incidents, complaints, concerns, risk assessments, legal claims, audits, patient satisfaction surveys and findings from serious reportable events.

The hospital's risks were reviewed at the Clinical Governance and Clinical Risk Committee with oversight by the corporate risk register at the Executive Management Committee. High-rated patient risks related to the focus of this inspection included – the risk to patient safety and the risk of hospital acquired infection related to the poor hospital infrastructure and limited isolation facilities and the risk of harm to children due to lack of paediatric radiology unit. The existing controls and additional actions required were outlined on the corporate risk register. The phase 3 capital development plan of the paediatric radiology unit was approved and developed with contractors due to be appointed in early 2025.

All patients were screened for *Carbapenemase-Producing Enterobacterales* (CPE) prior to admission in line with national guidelines. This was audited by the hospital and reports viewed by inspectors demonstrated full compliance.

The hospital staff who spoke with inspectors described the management of the last outbreak of infection. A multidisciplinary outbreak team was convened to advise and ensure the management of the outbreak was aligned with best practice standards and guidance. An outbreak report was developed with oversight by the Infection Prevention and Control Committee. Staff in the hospital had access to microbiology advice on a 24/7 basis.

Isolation rooms were limited at the hospital and patients requiring transmission-based precautions were isolated according to the hospital's isolation prioritisation policy with support and advice from the infection prevention and control team. At the time of inspection, inspectors were informed that the availability of single rooms for isolation was adequate to meet demand. All patients requiring transmission-based precautions were accommodated in single rooms at the time of inspection.

The hospital was using the national early warning systems for the various cohorts of patients — the INEWS version 2, IMEWS and the PEWS to support the recognition, response and management of a deteriorating patient. The Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool was used for the escalation of the care of the deteriorating patient. Medical and nurse led 'mock event' scenario training were undertaken by the hospital to support staff in the management of the deteriorating patient.

As outlined under national standard 5.5, there was a lack of a paediatrics medical consultant or non-consultant hospital doctor at, or available to Cappagh Hospital to discuss medical paediatric issue or consult when there was a paediatric deteriorating patient. The existing controls in place to mitigate against risks of medical deterioration for paediatric patients undergoing surgery in Cappagh Hospital were clearly outlined to inspectors throughout this inspection. For example, inspectors were informed that patient selection was restricted to patients with ASA 1 or ASA 2,[****] low-risk patients and low-risk surgeries, with additional safeguards in place for children undergoing spinal fusion surgery as outlined above. The patient selection criteria was clearly articulated by staff during this inspection, but no documented patient selection or surgical admission criteria was available. To further support safe patient selection, a medical questionnaire was sent to the parents or guardians of all paediatric patients planned for admission to Cappagh Hospital for inpatient or day case procedures – The medical questionnaire was reviewed by a consultant anaesthesiologist who indicated if the patient was required to attend the pre-operative anaesthetic clinic. This clinic includes anaesthesiologist and nursing assessment and review of patients' vital signs and selection of diagnostic swabs, bloods and x-rays. Based on review of all assessments and diagnostics result, the anaesthesiologist consultants determines if the child is fit and suitable for surgery in Cappagh Hospital. This pre-assessment procedure is outlined clearly in the hospital's 'Cappagh Kids Outpatient General Operation Procedure' in place since 2 April 2024.

There was a clinical pharmacy service[††††] available to all adult areas of the hospital. Patients admitted for surgery brought in their own medicines and patients for

[****] The ASA (American Society of Anaesthesiologists) physical status classification system is used to assess and communicate a patient's pre-anaesthesia medical co-morbidities. The classification system alone does not predict the perioperative risks, but used with other factors (for example type of surgery), it can be helpful in predicting perioperative risks. ASA I indicates a normal health patient, ASA 2 indicates a patient with mild systemic disease.

[††††] 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.

rehabilitation had medicines dispensed from a community pharmacy. A clinical pharmacist completed medicine reconciliation[‡‡‡‡] for patients on admission, and a medicine review for patients' on discharge when possible. As mentioned under national standard 2.8, medicine reconciliation on admission was above the hospital target of 90%. Medicine reviews for patient on discharge was above the hospital target of 50%. The hospital outlined that they aimed to increase this target to 70%.

As outlined under national standard 5.8, the lack of a dedicated clinical pharmacy service to Cappagh Kids was identified as a red-rated risk by the pharmacy department and recorded on the pharmacy departmental risk register but not formally escalated to the corporate risk register. The additional action required to mitigate this risk as per the pharmacy risk register was the recruitment of more staff to enable a clinical pharmacist with adequate paediatric training to provide a full clinical pharmacy service to Cappagh Kids. Senior management informed inspectors that they were unaware that a dedicated clinical pharmacy service was not provided to the paediatric ward as the risk was not formally escalated to the corporate risk register. Therefore the impact of this risk, the mitigating actions in place or additional actions required to mitigate the risk had not been reviewed or considered at senior management level. The potential of providing this service from within current pharmacy resources was not reviewed by the hospital. The Clinical Director for paediatric services was aware of the lack of clinical pharmacy services for the paediatric ward and they informed inspectors that they were new to the post and had not yet began reviewing this issue to date. The Clinical Director did outline, that at present no risk issues with regards to lack of clinical pharmacy services for paediatric services had been raised. The hospital's 'Provision of the Pharmacy Service' policy issued in 2014 outlined the pharmacy service provided at Cappagh Hospital. Paediatric services were not included in this policy. The 'Provision of the Pharmacy Service' policy was overdue for review since 2016.

An existing control outlined on the pharmacy risk register to mitigate the risks associated with a lack of pharmacy services to paediatrics was that pharmacists assisted the paediatric ward staff with – telephone queries related to medicine formulation, administration queries and the sourcing of medicines. This was substantiated by staff during the inspection. Inspectors were informed that most paediatric patients were on few or no medicines. All paediatric patients' medicines were known prior to admission through the medical questionnaire completed by patients or their parents before admission. As outlined above, children prescribed complex medicines were reviewed by a paediatric anaesthesiologist and nurse to determine their suitability for surgery in Cappagh Hospital. There was also no antimicrobial pharmacist services to paediatric services.

Patients brought in their own medicines on admission. Adult patients' medicines were double checked on admission by the pharmacist or by nurses out of hours. Paediatric

[‡‡‡‡] Medication reconciliation: involves using a systematic process to obtain an accurate and complete list of all medications taken prior to admission.

patients had their medicines double checked by paediatric nurses. These medicines were then administered to the patients throughout their stay Checking and administration of patients' own medicines was supported by staff education, a hospital policy and a patient own drugs checklist, completed for all patients on admission.

Overall, Cappagh hospital endeavoured to protect patients from the risk of harm associated with the design and delivery of healthcare services. Where risks did exist the hospital put mitigating actions in place to avoid or reduce the risks.

However:

- there was no documented patient selection or admission criteria available
- there was no dedicated clinical pharmacy or antimicrobial pharmacy service for paediatric patients, although pharmacists did assist the paediatric ward when requested.
- senior management were unaware of the lack of dedicated clinical pharmacy services to the paediatric ward, a red-rated risk on the pharmacy risk register, which had not been formally escalated to the corporate risk register. Therefore the impact of this risk, existing controls in place to mitigate the risk, residual risk rating or additional actions required to mitigate the risk had not been reviewed or considered at senior management level to reduce or eliminate any risk.
- the 'Provision of the Pharmacy Service' policy was overdue for review since 2016.

Judgment: Partially compliant

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

The hospital had a system in place to identify, manage, respond to and report patient-safety incidents. This was supported by local policies which were in line with national legislation, standards, policy and guidelines. Staff who spoke with inspectors were knowledgeable about the system in place and their role in reporting and managing patient-safety incidents.

Incidents were reported on paper or electronic format by staff and sent to quality, safety and risk department. Patient-safety incidents were reviewed and uploaded on the National Incident Management System (NIMS)[§§§§] by the quality, safety and risk department. Incidents were tracked and trended by number, hazard, category and outcome with quarterly comparisons year on year and reported monthly to the Executive Management

[§§§§] 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).

Committee and at Hospital Group meetings. Incident data was also reported to the Board of Directors via the Integrated Governance and Monitoring Report.

The quality, safety and risk department worked with staff at ward and department level to review and manage incidents. Examples of actions taken in response to incidents and incident trends was provided to inspectors. Monthly patient-safety incident reports were provided to wards and departments to share learning. Learning from incidents, was shared through the Health, Safety and Risk Newsletters issued to all departments quarterly, at the daily ward safety pause and at staff meetings. Staff also outlined a process whereby each clinical nurse manager had a cohort of nurses with whom they shared information.

Medication safety incidents were reviewed by a pharmacist who had a medications safety role. All medication safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Medication safety incidents were discussed and managed at the Medication Safety Committee and reported to the Drugs and Therapeutics committee and to the Clinical Governance and Clinical Risk Committee. The medication safety pharmacist liaised with the quality, safety and risk department to ensure timely management of medication related incidents and discussed all medication safety incidents category D and above***** with the Director of Nursing. Medication safety notices were circulated to share learning with clinical staff related to common issues or medication incidents.

Patient-safety incidents inputted into NIMS within 30 days was reported at 98%, in compliance with the HSE's target of 70%. At the time of inspection, there were two incident reviews in progress. One of these reviews had exceeded the target completion date of 125 days.

The Serious Incident Management Team (SIMT) were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Category 1 and 2 incidents had preliminary assessment reports completed and presented to the SIMT for review and to recommend further review if required, or actions that would prevent or reduce the risk of future similar incidents.

Recommendations from incidents and reviews were tracked by the quality, safety and risk department, with a responsible person and timelines outlined for each recommendation. The progress of implementation of the recommendation was managed through the relevant governance committee, with overall oversight at the Clinical Governance and Clinical Risk Committee.

***** NCC MERP Category A to I: Category A: – No harm, Category B,C,D: Error – No harm, Category E,F,G H: Error – harm, Category I: Error – death

Overall, the hospital effectively identified, managed, responded to and reported on patient-safety incidents There was evidence that information from patient-safety incidents was shared with relevant governing committees and staff at the hospital to share learning and promote improvement. There was a process in place to implement recommendation from reviews with oversight by the SIMT and the Clinical Governance and Clinical Risk Committee.
Judgment: Compliant

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	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	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. The hospital's compliance plan

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:

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

1. **Out of Hours consultant arrangement for adult patients was informal**
Actions:

- NCHD On-Call Policy has been renamed to Medical On-Call Out of Hours policy and updated to reflect the arrangement/ process in place for each of the out of hours scenarios and to outline the on-call arrangements for consultants. The policy clearly indicates that in the event that consultant escalation or advice is required for a patient during out of hours, the consultant is called. If the consultant is uncontactable or is on leave, the consultant on call in the admitting consultant's base hospital will be telephoned. The policy lists each Consultant and their base Hospital.
  Responsibility: Head of Human Resources/ Clinical Directors/ Chair of Medical Board
  Due Date: Complete

- The policy has been brought to the attention of medical, nursing and the Site Nurse Management Team and included on their mandatory list of policies for reading.
  Responsibility:
  Due Date: Complete

- Include Medical On-Call Out of Hours policy in the NCHD induction training program
  Responsibility: Clinical Directors of Paediatric & Adult Services
  Due Date: July 2025

2. **There were no paediatric medical consultants or non-consultant hospital doctors at or available to Cappagh Hospital**

   Paediatric Clinical Directors at Children's Health Ireland and NOHC in discussion with key stakeholders in relation to funding and recruitment of two consultant paediatricians to provide a paediatric service to NOHC.
   Responsibility: Paediatric Clinical Director
   Due Date: Ongoing

3. **The on-call arrangement for children under 18 undergoing spinal fusion surgery was not outlined in the recently issued 'NCHD on-call procedure**

- This on-call arrangement was introduced on a temporary basis only which lasted for a 3 month period. This was communicated to relevant personnel (Site Nurse Management, Ward Nursing and NCHD On-Call) therefore the process was not detailed in the NCHD on-call procedure.
- This on-call arrangement has since ceased however when the locum Paediatric Consultants are formally recruited and appointed, this policy will be updated to reflect a new permanent on-call arrangement.

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

N/A

Timescale: As specified above

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

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. **Poor compliance rates for NCHDs for BLS, ACLS and PALS, especially for NCHDs covering paediatric patients**

   Note: NCHDs do not complete PEARS

   Actions

- Introduction of additional Induction days for CHI doctors
  Responsibility: Head of Human Resources
  Due Date: Complete

- BLS – NOHC are arranging internal BLS dates for NCHD's who's BLS training is outstanding.
  Responsibility: Head of Human Resources
  Due Date: 10th April 2025

- ACLS & PALS – Additional dates for both ACLS and PALS were sought and provided to all relevant NCHD's for February, March & April. HR have verified with each

relevant NCHD if they are booked to attend. Clinical Director for both services are being updated on progress.
Responsibility: Head of Human Resources/ Clinical Director
Due Date: 10th April 2025

- Review of all NCHD mandatory training each Clinical Director with HR Business Partner on a monthly basis, agree actions and follow up with individuals as required.
  Responsibility: Clinical Directors for Paediatric and Adult Services/ Head of Human Resources
  Due Date: 8th Jan 2025

- Continue to monitor training compliance rates and presented at relevant committee e.g. deteriorating patient, IPC committee, Training committee etc.
  Responsibility: Head of Human Resources/ Paediatric Clinical Director
  Due Date: Complete

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

N/A

Timescale: As specified 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.

Aged, outdated infrastructure

Action:

- NOHC are listed on HSE's Major Capital Development Plan. There is a plan (Phase 1) in place to build a new 76 bed ward block build which will replace 46 existing beds and provide additional capacity with 30 new beds. This project is currently at Preliminary Design Stage to provide the following:
  - 76 Bed Ward Block including storage and support rooms/space.
  - 10 bed HDU including storage and support rooms/space.
  - 5 Surgical Theatres including storage and support rooms/space.

- As an interim measure NOHC are planning to carry out minor upgrade works in 2025 including doors, flooring and wall replacement in St Teresas Ward where there are IPC risks.

Responsibility: Head of Engineering

Due Date:

1. Major Upgrade 2028 / 2029 completion pending each stage approval.
2. Minor Upgrade works Q4 2025 completion.

A lack of storage areas for equipment

Sufficient Equipment storage will be provided in the new building as highlighted above.

Lack of storage facilities for clean linen

- St. Teresa's ward has a designated storage facility on the corridor opposite St. Teresa's ward and clean linen is stored in designated closed linen trolleys.
- No action required.

Hand hygiene sinks that do not confirm to recommended standards

Action:

1. Replace 2 sinks on St. Teresa's ward with IPC compliant sink units
2. Upgrade Bathroom facilities

Responsibility: Head of Engineering

Due Date:

1. Sink replacements now complete.
2. Bathrooms to be upgraded as part of 2025 Amric / Minor Capital HSE Infrastructural upgrade funding. (Q4 2025 completion).

A multi-occupancy room that was a throughfare for access to another room

Action:

- St Teresas Ward will be repurposed as part of the NOHC Masterplan and the new Ward Block Development (Phase 1). Major infrastructural upgrade works required to St Teresas Ward for ongoing use. The objective for repurposing is yet to be confirmed. It is likely Radiology will expand into St Teresas Ward area in future phases of the NOHC Masterplan.
- Responsibility: Head of Engineering
- Due Date: TBC pending HSE Funding

No en-suite toilet and shower facilities in the multi-occupany rooms

Action: St Teresas Ward will be moving into the new build which will have single occupancy rooms.

Responsibility: Head of Engineering

Due Date: TBC pending HSE Funding

No single rooms for isolation of patients for transmission based precautions

- The ward has two single rooms suitable for isolation of patients for transmission based precautions.
- Patients requiring isolation in a neutral pressure room can be moved to another ward with suitable single rooms.
- No action required.

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

NOHC are on the HSE Major Capital Development Plan. There is a plan in place for a new 76 bed ward block build (Phase 1) which will address all concerns highlighted above.

Responsibility: Head of Engineering
Due Date: 2028 / 2029 completion (pending each stage approval)

Timescale: As specified 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:

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

1. **There was no documented patient selection or admission criteria available**

   All NOHC patients are assessed via a Medical Questionnaire which is completed and returned to NOHC by the patient/ parent in advance of their surgery. The

questionnaire is triaged by the nursing team who are then assessed by the consultant anaesthetist team as needed (based on MQ triage) to determine their suitability for surgery at NOHC.

2. **There was no clinical pharmacy or antimicrobial pharmacy service for paediatric patients**

   Action:

   Provision of a Clinical Pharmacy Service (including antimicrobial pharmacy service) to Paediatric Ward

   Actions:

   While there is presently no dedicated clinical pharmacy service provided to the paediatric ward, a pharmacist is available on request for queries in relation to sourcing and administration of medicines. The current clinical pharmacy service is being reviewed with a view to providing a dedicated clinical paediatic pharmacy service.

   Responsibility: Chief Pharmacist
   Due Date: 31/05/2025

3. **Senior Management were unaware of the lack of a dedicated clinical pharmacy service to the paediatric ward, a red-rated risk on the pharmacy risk register. The impact of this risk, existing controls in place to mitigate the risk, residual risk rating or additional actions required to mitigate the risk had not been reviewed or considered at senior management level to reduce or eliminate the risk.**

   Actions:

- Review of Pharmacy risk register and escalate red-rated risks to Executive Management Team using the 'Proposed Risk for Inclusion to the Corporate Risk Register' form as per the hospital Risk Management process.
  Responsibility: Pharmacy Executive Manager
  Due Date: Complete

- The Pharmacy Executive Manager in collaboration with the Senior Executive Team are reviewing the paediatric clinical pharmacy service. Following this review, if required, a business case will be submitted for funding of a trained paediatric clinical pharmacist (at the relevant grade and WTE), a role which would include medication clinical guideline development and review.
  Responsibility: Pharmacy Executive Manager/ Senior Executive Team
  Due Date: ongoing

4. **The 'Provision of the Pharmacy Service' policy was overdue since 2016**

   Actions:

- Policy to be updated to reflect current service provided by Pharmacy and to include the service provided to the paediatric ward
  Responsibility: Chief Pharmacist
  Due Date: 31/03/2025

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

N/a

Timescale: