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:	St Vincent's University Hospital
Address of healthcare service:	Elm Park Dublin 4 D04 T6F4
Type of inspection:	Unannounced
Date(s) of inspection:	13 and 14 November 2024
Healthcare Service ID:	OSV-0001099
Fieldwork ID:	NS_0105

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

St Vincent's University Hospital is a Model 4* voluntary public acute hospital. The hospital which was previously a member of the Ireland East Hospital Group (IEHG),† was transitioning to the governance structure of Health Service Executive (HSE) Dublin and South-East health region at the time of this inspection. Healthcare services on behalf of the HSE are provided in the hospital through a service level agreement as per Section 38 of the Health Act 2004.

St Vincent's University Hospital is part of the St Vincent's Healthcare Group (SVHG) which also includes St Vincent's Private Hospital and St Michael's Hospital. Acute, chronic, emergency, intensive care, and specialist services across a vast range of medical and surgical specialities are provided in the hospital. Transitional care beds located off site a short distance from the hospital at Caritas (transitional care unit), fall under the governance structures of the hospital.

The hospital is both a major academic teaching centre and a tertiary referral hospital, is a designated cancer centre, and comprises a number of national centres including:

- the national centre for liver transplant
- the national centre for pancreas transplant
- cystic fibrosis
- pancreatic surgical services
- neuroendocrine tumours
- orthopaedic sarcoma services.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	635

* A Model-4 hospital is a tertiary hospital that provides 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 and an Emergency Department which is open on a continuous basis (24 hours, every day of the year).

† The Ireland East Hospital Group comprised eleven hospitals. These were St Vincent's University Hospital, University Hospital Waterford, St Luke's General Hospital Carlow-Kilkenny, Tipperary University Hospital, Wexford General Hospital, St Columcille's Hospital – Loughlinstown, St Michael's Hospital – Dún Laoghaire, Kilcreene Regional Orthopaedic Hospital, National Maternity Hospital, National Rehabilitation Hospital, Royal Victoria Eye and Ear Hospital. The Hospital Group's Academic Partner was University College Dublin (UCD).

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 of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, 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
- 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

‡ 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.*

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

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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
13 November 2024	08.45 – 17.10hrs	Danielle Bracken	Lead
14 November 2024	08.45 – 15.30hrs	Bairbre Moynihan	Support
		Geraldine Ryan	Support
		Marguerite Dooley	Support*
		Mary Flavin	Support
		Mary Redmond	Support
* 13 November 2024 only			

Information about this inspection

An unannounced two-day inspection of St Vincent's University Hospital was conducted 13 and 14 November 2024.

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)[††]

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

[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

- transitions of care.[‡‡]

The inspection team visited a number of clinical areas:

- emergency department
- St Michael's ward (a mixed medical and surgical ward)
- St Paul's ward (a medical ward, specialising in respiratory illness)
- St Helen's ward (a medical ward, specialising in renal and endocrinology)
- St Laurence's ward (a surgical ward, specialising in orthopaedics)
- St Olivia's ward (a general medical ward)
- Caritas (transitional care unit) located off site.

The inspection team spoke with the following staff:

- representatives of the hospital's executive management team
  - interim chief executive officer and chief clinical director
  - director of operations
  - director of nursing
  - director of quality and patient safety
  - director of human resources
- lead non-consultant hospital doctors (NCHDs)
- staff working in the clinical areas visited
- representatives from each of the following hospital committees:
  - quality and patient safety executive
  - infection prevention and control
  - drugs and therapeutics
  - deteriorating patient
  - bed management.

Inspectors reviewed documentation and data while on site and requested additional documentation and data from hospital management which was reviewed following the inspection.

Acknowledgements

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

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

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

A total of 21 patients across a number of clinical areas spoke with inspectors about their experience of care. In general, the patients were positive in their feedback.

Patients in the emergency department told inspectors that they had been triaged quickly, although delays had been experienced in waiting for a review by a specialist doctor. It was mentioned to inspectors that there was no place for patients to go to get something to eat. Inspectors noted that there was no vending machine and limited amount of cups for water in the ambulatory waiting area. This was discussed with management in the department, who replenished cups and explained that the vending machine had gone for repair. However, some patients spoke about being offered light meals and breakfast. Emergency department staff were described by patients as "brilliant" and "empathetic".

In two clinical areas, St Paul's and St Laurence's wards, patients expressed that communication by individual staff members could be improved, while communication by staff in St Olivia's ward was described as "brilliant". Patients in St Helen's ward mentioned that they had been kept informed about their care and treatment, and also commented that they got to see doctors frequently. Others described staff as "very friendly" and that they would "do anything for you".

An issue raised by patients in multi-occupancy rooms (five-bedded room) in St Helen's ward was that the ward could be noisy at times. The environment in Caritas was described by patients as "spotless", and that there was a nice view from the window.

Capacity and Capability Dimension

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

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

Corporate and clinical governance arrangements in St Vincent's University Hospital (SVUH) for assuring the delivery of high-quality, safe and reliable healthcare were integrated, formalised, and clearly defined. Organisational charts clearly outlined responsibilities, accountability and oversight arrangements for management structures and governance committees. This was consistent with what inspectors were told by management and staff.

The hospital had an interim CEO who had been in position since mid-2023. The CEO position was on an interim basis on the previous inspection in August 2022. The interim CEO was also the chief clinical director of St Vincent's Healthcare Group, and in addition, had clinical commitments. At the time of inspection, inspectors were informed that the post had not been advertised. Although no impact of this interim arrangement was identified on the days of inspection, the ongoing vacancy of this leadership role is not sustainable in the long-term in a Model 4 hospital with multiple specialities.

The interim CEO was the accountable officer with overall responsibility for the governance of the hospital, reported to the hospital board and had previously reported to the CEO of Ireland East Hospital Group (IEHG). New reporting structures to the Integrated Healthcare Area (IHA) manager and upwards to the Regional Executive Officer (REO) of HSE Dublin and South-East health region were being implemented at the time of inspection. These evolving reporting arrangements had not yet been reflected in organisational charts. The Executive Management Team (EMT), who reported to the hospital board through the interim CEO, included the director of operations, the director of nursing and the director of quality and patient safety. The EMT, met in line with its terms of reference, and supported the interim CEO.

The Quality and Patient Safety Executive (QPSE), provided the EMT with assurances in relation to the quality and safety of healthcare services provided at the hospital. A number of subcommittees with formal reporting arrangements to the QPSE were in place, including; Infection Prevention and Control Committee, Drugs and Therapeutics Committee, and the Deteriorating Patient Committee. Committees were meeting according to their terms of reference, with structured agendas in place. Committees were action-orientated and had oversight of the quality and performance of areas within their remit.

The bed management committee reported to the EMT and was meeting in line with its terms of reference. There was no date of sign-off on the terms of reference. The committee was action-orientated with oversight of key performance indicators and activity data within its remit.

Clinical governance in the hospital was provided through a directorate structure with five directorates in place; Medicine and Emergency Medicine, Perioperative, Cancer, Diagnostics, and Liver and Hepato-pancreatic biliary (HPB). Each

directorate had a clinical director in place, who reported to the chief clinical director, providing a verbal report to the EMT at each meeting.

- the CEO position was on an interim basis and this was also a finding on the inspection in August 2022.

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.

Management arrangements were in place in the hospital to support the delivery of high-quality, safe and reliable healthcare services.

Oversight of the day-to-day workings of the hospital's emergency department was the responsibility of the onsite consultants in emergency medicine and clinical nurse manager grade 3 (CNM 3) who reported to an assistant director of nursing (ADON). There was a consultant clinical lead in the department, with oversight provided by the clinical director of the medicine and emergency medicine directorate. Outside core working hours, clinical oversight of the emergency department was provided by the on-call consultant in emergency medicine.

At the time of the inspection, the hospital was experiencing a high number of attendances. A total of 181 people attended the emergency department for care 13 November 2024, the first day of inspection, with 197 people attending the day prior to inspection. The hospital was in stage 2 'amber' escalation on the first day of inspection. Senior management stated that a number of actions, in line with the hospital's escalation policy, had been implemented. These included:

- the use of surge and additional capacity beds
- early identification of patients for discharge and the use of the discharge lounge.

At the time of inspection, the hospital's escalation policy was being revised. The executive management team stated that the reason for this was to implement more hospital-wide measures in response to demands on the emergency department and bed capacity.

At 11.00am on the first day of inspection there were 53 patients in the hospital's emergency department, of these, 18 (34%) were admitted and boarding in the department, awaiting a bed in the main hospital. This is an improvement on a previous inspection in August 2022, where 70% of patients were admitted and boarding in the department. The total number of patients admitted from the

emergency department to the hospital for further care and treatment on the first day of inspection was 39 (21.5%).

A number of initiatives were in place at the hospital to manage patient flow, to provide alternative pathways to the main emergency department and to avoid unnecessary admissions. These included:

- EDITH (emergency department in the home) service
- OPRAH (older persons assessment hub), who assessed frail patients over 60 years of age and made referrals to community services where relevant
- AMAU (acute medical assessment unit) reviewed patients from the emergency department daily
- admission pathways to St Vincent's Private Hospital, St Michael's Hospital and St Columcille's Hospital.

Daily meetings took place to assess the demands on hospital services, such as the emergency department, and the requirement for inpatient beds, these are discussed in more detail in national standard 3.1.

Other clinical areas included St Michael's, St Paul's, St Helen's, St Laurence's and St Olivia's wards, and CNM 2s managed the day-to-day running of these clinical areas.

Caritas, a transitional care unit, located off site, a short distance from the hospital was managed on a daily basis by a CNM 2 with a CNM 3 from the main hospital on site two days a week. A monthly consultant roster was in place, with a consultant visiting once a week and a registrar and senior-house officer on site daily Monday to Friday. Outside of these hours, if a patient required medical review, the E-Doc service or EDITH (emergency department in the home) service was contacted. Two infection prevention and control link nurses worked in Caritas. A pharmacist was on site twice a week.

Management arrangements were in place in relation to the four areas of focus of this inspection; infection prevention and control, medication safety, acutely deteriorating patients and safe transitions of care.

The infection prevention and control team comprised a consultant microbiologist, an ADON for infection prevention and control (IPC), a CNM 3, a CNM 2 and five clinical nurse specialists.

A clinical pharmacy service overseen by the pharmacist executive manager 3, was provided to all clinical areas in the hospital. The clinical pharmacy team included a

medication safety coordinator and antimicrobial stewardship[§§] pharmacists. An anticoagulant[***] stewardship pharmacist had recently taken up post in April 2024.

The deteriorating patient improvement programme had a consultant lead in place. The programme was supported by a CNM 3 from the Nursing Practice Development (NPD) team, and critical care advanced nurse practitioners, who ran an intensive care outreach service seven days a week.

The patient flow team, overseen by the head of bed management also included an ADON, three CNM 2s, five bed managers and three discharge coordinators.

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.

Monitoring arrangements were in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided in the hospital. Data was used by a number of governance committees to compare performance within their remit over time and drive improvement. Performance data for the hospital was publically reported through, for example, the Hospital Patient Safety Indicator Reports (HPSIR).

Performance data was discussed at meetings between the hospital and IEHG, this was noted in minutes reviewed. At the time of inspection, senior management stated that oversight arrangements were transitioning from the hospital group to Integrated Healthcare Area (IHA) structures within the HSE Dublin and South-East health region. Terms of reference for performance meetings with the IHA were in draft format at the time of inspection.

The corporate risk register was reviewed and high-rated risks on the risk register relevant to this inspection included the risks associated with transmission of infection, aging infrastructure and high bed occupancy. Inspectors noted that controls and additional actions were in place to minimise these risks. The risk register, including actions had been reviewed in October 2024. The risk registers for the Medicine and Emergency Medicine directorate and for the emergency department were reviewed. High-rated risks on both of these risk registers included those associated with high attendances in the emergency department. Existing controls and additional assigned actions to minimise risks were in place, although these were not time-bound. Senior management had oversight of risks, with

[§§] Antimicrobial stewardship are a set of measures designed to improve and measure the appropriate use of antimicrobials. Antimicrobials include antibiotics, antifungals and antivirals.
[***] An anticoagulant, commonly known as a blood thinner, is a medication that prevents or reduces blot clots.

evidence of discussion of risk taking place at executive management team meetings.

The serious incident management team (SIMT) had oversight of serious incidents that occurred in the hospital. From a review of meeting minutes, the team had met in October 2024 to discuss relevant patient-safety incidents with documented decisions. The hospital had a Clinical Incident Review Group (CIRG), this was attended by representatives from a number of clinical areas and disciplines. This included representatives from the quality and patient safety department, a pharmacist, nursing, clinicians and clinical support. The group had met in October and November 2024, discussing clinical incidents, recommendations arising from these, and learning arising from complaints.

Patient feedback, including complaints, was discussed as a standing agenda item on the quality and patient safety executive committee. Key performance indicators in relation to complaints management were discussed and documented at this meeting.

The hospital had an infection prevention and control plan for 2024. The IPC team produced a report annually, which outlined infection prevention and control activity for each year. The infection prevention and control committee had oversight of progress with infection prevention and control activity, performance, audit, and risk, as discussed and documented at infection prevention and control committee meetings reviewed by inspectors.

A medication safety strategy for 2024 had been developed, and a medication safety end of year report was produced in 2023. The strategy outlined short, medium and long-term goals in relation to medication safety. The plan included audit and monitoring activity. There was evidence that elements of this strategy, such as medication safety reporting, were discussed at the drugs and therapeutics committee.

Both the drugs and therapeutics and infection prevention and control committees had oversight of antimicrobial stewardship activity. Minutes of meetings reviewed by inspectors showed that data and performance in relation to antimicrobial stewardship, including the antimicrobial stewardship report for 2023 was discussed at both committees. The hospital was awarded Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) level three accreditation in 2024, and was designated a centre of excellence for antimicrobial stewardship, being the first hospital in Ireland to achieve this.

Performance data in relation to the deteriorating patient, such as key performance indicators and audit findings were overseen by the deteriorating patient committee. It was evident that the committee tracked performance in relation to key indicators

such as vital sign monitoring and training compliance, comparing performance from one quarter to another in order to benchmark.

The bed management committee was data driven and had oversight of key performance indicators and organisational activity related to scheduled and unscheduled care activity and patient flow. This included data on length of stay, delayed transfers of care and bed availability and data relating to the emergency department, such as attendances and admissions. Activity and performance data for the emergency department was collated on a monthly basis and compared with previous performance. Comparison data included triage and patient experience times. This data was also discussed at emergency department operational management meetings.

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.

While systems and processes were in place at the hospital to plan organise and manage the workforce, the skill mix on St Michael's ward required review. As discussed under national standard 5.2 the CEO position was filled in an interim capacity since the last inspection in 2022.

At the time of inspection, all emergency medicine consultant and emergency department NCHD positions were filled. There was an uplift from the previous inspection of 1.5 whole-time equivalent (WTE)[†††] emergency medicine consultants. In line with the compliance plan from a previous inspection in 2022, the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland* [‡‡‡] had been implemented. Minimal nursing position vacancies were found on this inspection. The emergency department's approved staff nurse complement (excluding management grades) was 99 WTE with 4.5 WTE (4.5%) nursing positions unfilled. Two additional CNM 3s were in place in the department, however, these posts were temporary. Additionally there was a 4.5 WTE uplift in approved clinical skills facilitator posts for the department. Inspectors were told that interviews to fill a vacant clinical facilitator post were scheduled for the week following inspection. The approved complement for healthcare assistants (HCAs)

[†††] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.
[‡‡‡] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin. Department of Health. 2022.

was 15 WTE with three of these positions vacant. There were no unfilled shifts on the day of inspection.

The overall vacancy rate of nursing positions in the hospital at the time of inspection was 5.6%, and the overall vacancy rate of healthcare assistants (HCAs) was 8.4%. There were no unfilled shifts in the clinical areas visited at the time of this inspection. In responding to the findings of the previous inspection in 2022, hospital management had committed to implementing the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.*[§§§] At the time of this inspection, the framework had been implemented in the majority of wards. Inspectors were informed that implementation in the remaining wards was progressing. The hospital had an uplift of nurses and HCAs since the last inspection, this included additional CNM 2s and a CNM 3 for the Herbert wing, where some of the larger wards in the hospital were located.

St Michael's ward contained 20 single rooms of all specialities. Inspectors were informed that there was a lack of skill-mix, combined with patients with complex needs in this ward. Due to the skill-mix, the CNM informed inspectors that they had to assist less experienced staff, and this took away from management and oversight duties. A risk assessment on staff skill mix for this ward was requested following inspection. Existing controls included twice daily review of staffing levels across the hospital prior to each shift and redeployment of staff if required. Additional actions documented on the risk assessment to reduce this risk included the 'ward based care initiative', reducing the number of specialities and complexity of caseloads in the ward by the end of 2024.

The hospital had an approved complement of 52 WTE pharmacist positions (inclusive of management grades), of these, 9 WTE (17%) were unfilled. Inspectors were informed that the HSE's Pay and Numbers Strategy had impacted on the ability to recruit to these vacant posts. However, the impact of this was not seen on this inspection.

In the compliance plan to address findings from a previous inspection in 2022, hospital management had committed to monitoring mandatory training compliance at EMT meetings. Inspectors noted that mandatory training compliance was a standing agenda item for EMT meetings, was discussed on a quarterly basis and was last discussed in October 2024. Training deemed to be mandatory by hospital management relevant to the focus of this inspection included hand hygiene and basic life support. Hospital training compliance reports provided showed that the overall compliance rate for hand hygiene training was 84% and basic life support was 75%. The compliance target of 80% had been achieved for hand hygiene training but not for basic life support training. The deteriorating patient committee

§§§ Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland*. Dublin: Department of Health. 2018.

tracked performance in relation to online INEWS and sepsis training each quarter. Training compliance levels had improved from quarter one to quarter two 2024, where compliance of 75% for INEWS (nursing) and 54% for sepsis (all relevant employees) had been achieved. These levels were below the target of 85% set by the committee.

In summary, workforce arrangements were in place to support and promote the delivery of quality, safe and reliable healthcare, however;

- there were deficits in the skill-mix in St Michael's ward
- the hospital's compliance target for basic life support, INEWS and sepsis training was not achieved.

Judgment: Substantially compliant

Quality and Safety Dimension

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

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

Inspectors observed that staff generally respected and promoted the dignity, privacy and autonomy of patients. Privacy curtains were used to support privacy while patients received care. There was no bereavement or family room in the emergency department. A designated cubicle was used when patients required privacy with family members and other visitors. Inspectors were informed by staff about initiatives in the emergency department to promote dignity and autonomy, such as the provision of menstruation products.

Call bells were accessible to patients if they required assistance. Mixed responses were provided by two patients in clinical areas in relation to the number of staff and promptness in answering call bells. A patient told inspectors in St Michael's ward that there were not enough staff and promptness of the response to call bells

depended on the time of day. In contrast, in St Helen's ward, patients stated that staff were "very attentive" and that there was "lots of staff".

In Caritas, patients were observed to be dressed and out of bed with staff assisting patients to mobilise. A poster encouraging patients to 'get up, get dressed, get moving' was displayed on a noticeboard in this area.

In general, the inspectors observed patients' healthcare records and patients' personal information stored in line with best practice.

Judgment: Compliant

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

Inspectors observed kind and friendly interactions between staff and patients in the clinical areas visited. Patients described staff as "so helpful", "very caring", "pleasant" and "kind". Thank you cards were on display in a number of wards.

There was evidence of consideration of specific patient needs in the emergency department. A poster outlining the 'just a minute' (JAM) card initiative was displayed. This initiative involved a JAM card that could be presented to staff to highlight that a patient may require extra time when communicating.

Inspectors observed good use of humour in Caritas where there was a 'comic board' displaying a drawing with an uplifting message. Information on wellbeing was also displayed in the unit.

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.

Overall, the systems and processes within the hospital to respond effectively to complaints were in place. Some areas required action, for example, ensuring that patients had access to information in relation to how to make a complaint.

The hospital had three designated complaints officers. In response to findings from an inspection in 2022, hospital management had committed to employing a patient liaison officer to support communication with patients and families in the emergency department. On this inspection, inspectors found that there was a patient liaison officer designated to the emergency department in post and noted that the patient liaison officer was present in the department on the first day of inspection. Management described plans to introduce a face-to-face complaints clinic in the centre point of the hospital and to establish a patient forum in early 2025.

A local complaints policy was in place and this was aligned with the HSE's 'Your Service Your Say'. Inspectors noted the absence of complaints leaflets, posters, comments boxes, and advocacy information in the areas visited. The exception to this was Caritas which had a comments box and advocacy information displayed. Information on how to make a complaint, including a satisfaction survey and advocacy information were available on the hospital's website. New leaflets on patient advocacy had been delivered to the hospital and were demonstrated to inspectors, however, these had not yet been circulated. Not everyone who spoke with inspectors during this inspection knew how to make a complaint or who to talk to in relation to issues or concerns.

Staff in clinical areas focused on resolving complaints locally. There was an electronic system in place to log complaints. Inspectors were told that communication was one of the most common complaints themes. Inspectors were told about an initiative in place on St Laurence's ward to improve communication for patients at the time of being discharged from the hospital.

The HSE's complaints management system (CMS) was not in use in the hospital, instead, a complaints report was submitted to the HSE. The patient feedback and complaints team have a database to record complaints, including recommendation progress and shared learning (for example through the clinical incident review group), and this was demonstrated to an inspector. Documentation received following the inspection indicated that the percentage of formal complaints responded to within 30 working days year to date in 2024 was 87.4% on average, with 100% achieved from June to September 2024. This was an improvement on the overall average for 2023, which, at 64% was below the national target of 75%. From August 2024, a new performance indicator was introduced — 'percentage of complaints with recommendations that have an implementation plan in place and progressing'. Documentation showed performance of 80% in August and 92% in September of 2024 (target 65%).

Patient feedback, including performance in relation to complaints management was discussed monthly as a standing item at quality and patient safety executive meetings. Quarterly Risk, Quality and Patient Summary Reports were provided to inspectors which showed tracking of the number of locally resolved complaints, formal complaints, performance indicators in relation to complaints resolution and complaints escalated to the hospital group and or ombudsman.

In summary, there were systems in place at the hospital to respond effectively to complaints, with the following requiring attention:

- information on how to make a complaint was not available in all clinical areas.

Judgment: Substantially compliant

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

The physical environment did not fully support the delivery of high quality, safe, reliable care. Some areas visited as part of this inspection had issues with the physical environment, storage and cleaning.

Examples of infrastructural and environmental issues observed on inspection included a dirty utility room in St Paul's ward which was undergoing refurbishment. The cleaner's room was in a state of disrepair. The floor coverings in a number of toilets in this ward were worn and damaged, which did not facilitate effective cleaning. Some environmental issues were identified by patients in St Olivia's ward, including that the temperature in the ward was uncomfortably warm. These issues were brought to the attention of the nurse manager on the ward. Inspectors observed air-conditioning units in St Olivia's and St Paul's ward. These took up space and were noisy. Inspectors discussed these with the IPC team and were informed that the units were necessary to ensure air quality while building works were being carried out on site.

Not all clinical hand wash sinks conformed to the required standard.[****] These included sinks in St Paul's and St Helen's ward and Caritas.

Availability of adequate and sufficient facilities to isolate patients with a multidrug-resistant organism (MDRO) varied between inspected areas. For example, St Michael's ward consisted of 20 single rooms, all of which had en-suite toilet and

[****] Clinical hand wash basins should conform to *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

shower facilities, four of which were negative pressure rooms.[††††] Other wards, such as St Laurence's ward had a low number of single rooms and the single rooms did not have en-suite toilet or shower facilities. St Olivia's ward was being used by staff as a thoroughfare to access St Agnes' and Our Lady's ward. This thoroughfare created potential risks in relation to infection prevention and control. Aging infrastructure as a contributory factor in the transmission of MDROs was a risk on the hospital's risk register. Actions to reduce this risk, which had last been reviewed in October 2024, included refurbishment of ward and toilet facilities.

Inspectors observed that doors to rooms where patients with an MDRO were isolated were open in a number of clinical areas (St Paul's and St Michael's ward and Caritas). This was a finding on a previous inspection and was not in line with hospital policy. Additionally, no formal risk assessment had been undertaken in relation to leaving the doors open for higher visibility of patients.

The environment in the emergency department was clean as observed by inspectors and three patients remarked about the cleanliness of the environment. In general, inspectors found the environment in the other clinical areas visited clean. Exceptions to this included the floor in the dirty utility room in Caritas, and a fridge at the tea station in St Michael's ward, an issue which was identified on a previous environmental audit of this ward. Cleaners who spoke to inspectors were knowledgeable about cleaning processes.

A formalised system to ensure oversight of equipment cleaning was not in place in all areas visited. An equipment checklist system in St Laurence's ward and Caritas to document equipment cleaning were in use. Issues with equipment cleaning observed by inspectors included a commode in Caritas, glucometer boxes and a medication trolley in St Michael's ward. Issues with cleaning of equipment was an issue identified during a previous inspection in 2022.

In general, management of waste, including hazardous was appropriate with some exceptions, which were discussed with management on the day of inspection.

Inappropriate storage of equipment and supplies included an intravenous[‡‡‡‡] (IV) cannulation trolley on the corridor of St Olivia's ward and IV trays stored in the sluice room of St Michael's ward.

Overall, while clinical areas were observed to be generally clean, some issues identified by inspectors require attention:

- infrastructural issues which included single rooms with no en-suite toilet and shower facilities, some areas, such as toilets, required repair and refurbishment

†††† Negative pressure rooms, also called isolation rooms, are a type of hospital room that keeps patients with infectious illnesses, or patients who are susceptible to infections from others, away from other patients, visitors, and healthcare staff.
‡‡‡‡ Intravenous means taking place within or administered into a vein or veins.

- not all hand hygiene sinks conformed to the required standards
- room doors in a number of ward areas where patients were isolating with an MDRO were open, which was not in line with hospital policy
- environmental and equipment hygiene and appropriate storage was inadequate in some clinical areas.

Judgment: Partially compliant

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

While there were systems and processes in place at the hospital to systematically monitor, evaluate and continuously improve the effectiveness of the healthcare provided there, not all audit findings were being addressed through a time-bound quality improvement plan with individually assigned actions.

Nursing quality-care metrics were measured every two to three months. Results from September 2023 to September 2024 reviewed showed that all areas visited as part of this inspection had achieved over 80% overall compliance (range 82% to 99%). Results for each ward were benchmarked. Nursing metric results were clearly displayed in a number of clinical areas.

A suite of 18 infection prevention and control performance indicators was in place in the hospital, and provided to inspectors. Indicators were measured every three months and included rates of infection acquired in the hospital and hand hygiene compliance rates. Hand hygiene results for Q3 2024, showed that overall compliance of 91% was achieved.

An IPC audit schedule for 2024 was in place. The IPC team were benchmarking performance across a number of audits in clinical areas within the hospital, including hand hygiene and patient care equipment hygiene.

Environmental hygiene audit results for St Michael's ward in October 2024 showed compliance of 89.2%. At that time, the floor beside the tea station required cleaning, this was also a finding by inspectors as discussed under national standard 2.7. A re-audit of the ward a week later, showed compliance of 98.8%.

Recent results of patient care equipment audits viewed showed good compliance in general. Audit results for January 2024 for St Laurence's ward showed compliance of 62%. This was addressed through a quality improvement plan which was provided to inspectors. A re-audit in October 2024 showed that compliance had increased to 87%.

In general, glucometer[§§§§] audit results viewed showed high compliance. A glucometer audit for St Helen's ward in April 2024 showed compliance of 85%, one finding was that there was dust on a glucometer box. This issue was found by inspectors in St Michael's ward also, as discussed in national standard 2.7.

Medication storage audits had been carried out in all clinical areas visited (April to September 2024), results showed high levels of compliance, although exact percentage compliance was not calculated for these audits. Additionally, as part of this audit, information on medications that were within six months of the use by date was gathered. Inspectors found out-of-date medication in St Helen's ward and this is discussed under national standard 3.1.

A number of performance indicators related to the recognition and response to deteriorating patients were collated in the hospital on a quarterly basis, this included data on outcomes, and compliance with the Irish National Early Warning System (INEWS) version 2 and sepsis protocols.

Results of INEWS audits completed in quarter three of 2024, showed compliance with chart completion of 90%. Overall hospital compliance showed that frequency of measuring vital signs was an area for improvement having disimproved from 92% in quarter two to 80% in quarter three of 2024. An INEWS escalation and response audit was last carried out in December 2023, with overall compliance of less than 80% achieved, the plan was to re-audit again in three months. Following inspection, inspectors requested an updated audit, however, this was not received.

A sepsis audit from June 2024 in the emergency department showed that the percentage of patients commenced on the sepsis pathway fell from 54% of relevant cases to 45%. A sepsis audit from October 2024 of patients transferred from a ward setting to the intensive care unit showed that the sepsis form had been commenced in only 50% of cases. For both audits, a date for re-audit was established, however recommendations arising from the audit were not assigned to individuals for action, or time-bound.

The critical care outreach team produced an activity report each year. The report for 2024 was reviewed and indicated that the INEWS score at the time of referral, whether sepsis was suspected and time to review for unscheduled referrals was being tracked. So far, in 2024, 97% of patients referred to the team had been reviewed within one hour or less.

A range of key performance indicators in relation to scheduled and unscheduled care activity was collated by the hospital on a monthly basis. Inspectors viewed a report of October 2024 data. The report included performance data in relation to the emergency department patient experience time and the number of delayed discharges in the hospital. Monthly activity and performance data for the emergency department was collated and this information was displayed in the

[§§§§] A glucometer is a medical device for measuring the amount of glucose in the blood.

department. Data included the number of attendances and admissions, performance in relation to the OPRAH and EDITH teams, and triage times.

Handover practices were audited in the hospital in December 2023. Compliance with the 'Ward Patient Handover' form, was audited, all areas visited as part of this inspection achieved 100% with the exception of one ward inspected (St Laurence's). A repeat audit in September 2024 found 100% compliance in all clinical areas.

In summary, a range of data from a number of sources was used within the hospital to measure and benchmark performance. While systems and processes were in place at the hospital to measure and improve the effectiveness of healthcare services, the following was identified:

- a re-audit of INEWS escalation and response was not received on request
- quality improvement plans with assigned time-bound actions to address both audit findings and findings from performance with metrics were not always in place.

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's systems and processes to identify, evaluate and manage immediate and potential risks to patients were not fully effective. Areas for action included staff knowledge and understanding of risk in some clinical areas visited and minimising the risks posed by long patient experience times in the emergency department.

As discussed in national standard 5.8, high-rated risks on the corporate risk register related to the four areas of harm inspected as part of this inspection included the potential for transmission of infection, the risks associated with aging infrastructure and the risks associated with high bed occupancy.

Staff in the emergency department were knowledgeable in relation to risk identification and management. Safety rounds were conducted in the department by the emergency medicine consultant and nurse managers at 12.30pm on days of increased demand. Findings were documented and where risks were identified, a risk assessment was sent to the business manager, and director of operations and director of nursing when relevant. Inspectors reviewed samples of risk assessments from October and November 2024 and noted that actions to reduce risk were documented. A structured handover day report was in place where issues such as

high attendances were documented. Actions taken to reduce these issues such as deployment of staff to the emergency department were also documented.

Knowledge and understanding of risk identification and management in other clinical areas visited by inspectors varied. Staff in St Paul's, St Helen's and St Olivia's wards were unsure of the hospital's risk management approach, for example, there was uncertainly in relation the use of risk registers and how to carry out risk assessment. Staff in St Michael's ward and Caritas demonstrated a good understanding of risk. Approaches to reduce risk included daily safety pauses in St Michael's ward and monthly safety walk rounds with senior management in Caritas.

'Care rounds' was a quality improvement plan introduced by the nursing department in 2024. These were carried out by CNMs and ADONs in clinical areas. The purpose of these rounds were to provide additional support to staff and increase oversight of care provision. Staff who spoke to inspectors about this initiative were positive and felt more supported since they commenced.

The infection prevention and control team maintained a risk register, risks were last reviewed in August 2024. To minimise the risk of spread of infection, patients admitted to the hospital were screened on admission and as required as documented in policy. Screening for multidrug-resistant organisms (MDRO) included Carbapenemase-Producing *Enterobacterales* (CPE), Vancomycin-Resistant *Enterococci* (VRE) and Methicillin-resistant *Staphylococcus aureus* (MRSA). Antimicrobial stewardship rounds were in place. These rounds helped to identify patients on antibiotics which put them at higher risk of an infection with an MDRO.

A summary report on outbreaks of infectious diseases in the hospital was produced on a yearly basis. The report detailed the type, number and location of outbreaks. A CPE outbreak report for February 2024 was provided and included a detailed time-bound action plan to address areas of non-compliance. Outbreaks of norovirus and COVID-19 had occurred in Caritas in quarter two 2024. Staff demonstrated how they could access an outbreak report on the computer. The report included potential contributing factors and control measures to minimise outbreaks. CNMs in St Paul's ward told inspectors they had not received feedback in relation to outbreaks that had occurred there. Outbreaks and their management were discussed at infection prevention and control meetings as documented in meeting minutes reviewed.

As discussed in national standard 5.8, a medication safety strategy for 2024 was completed. A clinical pharmacy service was provided to all areas of the hospital that required this. Inspectors found evidence of medication reconciliation[*****] in samples of medication prescribing and administration records reviewed. Risk

[*****] Medication reconciliation is the process of comparing a patient's medication prescriptions to all of the medications that the patient has been taking. This process aims to avoid medication errors and can be carried out by pharmacists, doctors and nurses.

reduction strategies were in place to reduce the risk of harm from high risk medications. Staff who spoke with inspectors were able to describe these risk reduction strategies and information posters were displayed. Information on sound-alike, look-alike drugs were also displayed. Inspectors found multi-dose vials of insulin with no date of opening in St Michael's and St Helen's wards. Additionally, out-of-date medication was also found in St Helen's ward. In St Laurence's ward the date of discontinuation of some medications had not been recorded on medication prescribing and administration records. These issues were discussed with ward managers and a pharmacist as relevant. Most staff who spoke with inspectors knew how to access medicines information. This could be accessed through an application available on computers and smartphones.

Staff who spoke with inspectors were knowledgeable in relation to recognising and responding to patients that were deteriorating. Early warning systems were in place in the hospital to facilitate staff in recognising and responding to an acutely deteriorating patient. In response to findings from a previous inspection in 2022, hospital management had committed to implementing the Emergency Medicine Early Warning System (EMEWS). On this inspection it was found that EMEWS was partially implemented since October 2024 in the emergency department. Patients in the ambulatory care area were monitored using this system with EMEWS observation charts demonstrated to inspectors.

St Paul's ward was one of three wards that had implemented a digital early warning system. INEWS observations and escalations were recorded electronically for patients. St Paul's was a respiratory ward and staff stated that there was no flexibility to adjust the digital INEWS system for the patient's baseline. As a result, the digital early warning system frequently alarmed for patients that were admitted on oxygen. Inspectors noted one patient that was escalated on the day of the inspection of the ward, who did not have parameters set on the electronic system despite these being documented in the healthcare record. Staff in Caritas did not use INEWS. If a patient was for transfer back to the main hospital then INEWS was commenced prior to transfer. Information on what to do in the case of a deteriorating patient, in the form of a policy and flow chart, including who to call and transfer arrangements were available in Caritas. A resuscitation trolley and oxygen were available in the event of an emergency.

Processes were in place to support safe transfer within the hospital and safe discharge from the hospital such as multidisciplinary team meetings in clinical areas. Clinical handover processes in a number of clinical areas visited made use of the Identify, Situation, Background, Assessment, Recommendations (ISBAR)[†††††] tool to facilitate effective communication. Additionally, ISBAR communication stickers to place into patient charts to facilitate effective communication were

[†††††] The ISBAR clinical communication tool is a structured framework which outlines the information to be transferred when communicating information verbally and in writing between healthcare professionals.

available. The stickers were not being used in all clinical areas in which they were available. For example, inspectors observed a patient's healthcare record in St Paul's ward where the patient required escalation, however, the sticker was not used. Management on the ward informed inspectors that the sticker was not in use in this ward. However, senior management stated that the sticker was meant to be used throughout the hospital. Admission criteria for Caritas were in place with patients requiring assessment prior to acceptance to the unit. A handover process and the patient's healthcare record accompanied the patient on transfer to the unit.

Daily meetings to manage patient flow included a safety huddle every morning at 7.30am where senior management planned what actions would be needed each day in order to respond to service demands. This was followed by a hub meeting at 8.30am to discuss patients suitable for discharge. Additional operational patient flow hub meetings which included the emergency department took place at 10am and 4pm to identify discharges, barriers to discharge and confirm bed availability.

The average length of stay (ALOS) reported by the hospital for medical patients year to date 2024 was 10.9 days (national target ≤7.0) and for surgical elective inpatients was 6.6 days (national target ≤5.0). On the first day of inspection, the hospital had 17 patients with a delayed transfer of care (DTOC). Monthly delayed transfers from January to July of 2024 ranged from 15 to 26. This was a reduction compared to the previous inspection when monthly delayed transfers of care from January to July 2022 had ranged from 28 to 44.

Inspectors noted improvement in patient experience times since the last inspection of those in the department less than nine hours and less than 24 hours after registration. However, data on the emergency department patient experience times collected on the first day of inspection, showed that there was non-compliance with all of the HSE's targets. Patient experience times in the emergency department were as follows:

- 60% of patients were in the department for less than six hours after registration. (HSE's target 70%)
- 66% of attendees were in the department for less than nine hours after registration. (HSE's target 85%)
- 96% of attendees were in the department for less than 24 hours after registration. (HSE's target 97%)
- 41% of the attendees aged 75 years and over were in the department for less than six hours after registration (HSE's target 95%)
- 65% of the attendees aged 75 years and over were in the department for less than nine hours after registration (HSE's target 99%)
- 94% of the attendees aged 75 years and over were in the department for less than 24 hours of registration. (HSE's target 99%).

Additionally, waiting times for patients were as follows on day one of inspection:

- registration to triage ranged from 0 to 37 minutes (average 2 minutes).
- triage to medical assessment ranged from 2 to 91 minutes.

Patient flow from the emergency department to the wards was not always effective:

- at 11am on the first day of inspection, a high percentage (34%) of the patients in the emergency department were boarded there while awaiting an inpatient bed.

Staff had access to policies, procedures, protocols and guidelines (PPPGs) on computers in local areas. The majority of staff could readily access these. PPPGs viewed by inspectors were up to date.

In order to come into compliance with this national standard, the following areas require review:

- although patients were triaged and medically reviewed promptly in the emergency department, none of the HSE's patient experience time targets were met on the first day of inspection
- staff knowledge and understanding of risk management in some clinical areas visited was limited
- inspectors found out-of-date medications, medication with no date of opening, and decisions to discontinue medications were not always dated
- the use of ISBAR communication stickers was not consistent amongst the clinical areas inspected.

Judgment: Partially compliant

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

Systems and processes were in place in the hospital to ensure that patient-safety incidents were identified, managed, reported and responded to effectively. The HSE target for entering patient-safety incidents into the National Incident Management System (NIMS)[‡‡‡‡‡]was not consistently achieved throughout 2024.

Performance data for 2024 provided to inspectors showed that the average monthly rate of clinical incidents per 1,000 bed days used (BDU) from January to July of 2024 was 36.7.

‡‡‡‡‡ 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).

The percentage of incidents reported onto NIMS within 30 days of notification of the incident in 2024 for the hospital was 54.6% for quarter three 2024. This was below the national target of 70%, however the target was achieved in quarter one 2024 (79.7%). Compliance with serious incident reviews being completed within 125 days of notification, was 56% in 2024 which was below the HSE target of 70%.

Quality and Patient Safety Executive reports provided a summary in relation to the numbers of reported incidents, the clinical incident rate, incidents that met the threshold of a serious reportable event and the main themes identified in relation to the reported incidents. These reports were discussed at quality and patient safety executive meetings.

An annual report of infection prevention and control-related incidents was produced at the hospital. Inspectors reviewed the quarter two 2024 report which categorised the incidents and tracked them from one quarter to the next for comparison. IPC incidents were a standing agenda item and were discussed at each IPC meeting as documented in meeting minutes.

A detailed overview of medication incidents that had occurred in the hospital was provided in the annual Medication Safety Report. In the report, medication incidents were categorised using the NCC MERP§§§§§ classification system. Incident data such as the number and type of incidents were tracked over time and compared to data from previous years. Inspectors observed medication safety bulletins in clinical areas visited. One bulletin from June 2024 provided to inspectors provided an overview of incidents that had occurred in 2023 along with learning in relation to these. Inspectors were told that the medication safety pharmacist discussed incidents with staff. A clinical nurse manager in one area described an analysis that had been carried out in response to a medication incident.

Staff were knowledgeable in relation to the hospital's incident reporting process and familiar with how to report incidents in electronic format. CNMs in some areas could access tracked and trended incident information from the local incident reporting system, although not all CNMs knew how to do this. Learning in relation to incidents was shared locally in different ways, these included weekly 'learn and share' sessions, through safety pauses and handover.

In summary, processes in place in the hospital to manage patient-safety incidents required improvement:

- HSE targets for entry of patient-safety incidents on to NIMS and completion of serious incident reviews had not been consistently achieved in 2024

§§§§§ The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body composed of 27 national organisations.

- not all clinical nurse managers knew how to access tracked and trended information on incidents in clinical areas inspected.

Judgment: Substantially compliant

Conclusion

An unannounced two-day inspection of St Vincent's University Hospital was conducted 13 and 14 November 2024. 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 and safe transitions of care.

Capacity and Capability

At the time of this inspection, new reporting structures to the HSE Dublin and South-East health regions were being implemented. The CEO position was filled on an interim basis, which was a finding on a previous inspection in 2022. Corporate and clinical governance arrangements within the hospital were integrated, formalised and clearly defined. There were systematic monitoring arrangements in place within the hospital to measure performance and identify areas for improvement. Governance committees such as infection prevention and control, drugs and therapeutics, deteriorating patient and bed management committees were data-driven and used this data to measure performance. Additionally, a wide range of activity and performance data was captured and reported on by clinical leadership within the emergency department. Inspectors identified a deficit in the skill-mix in St Michael's ward. Following inspection, a risk assessment was requested and provided to HIQA.

Quality and Safety

Inspectors spoke with a number of patients about their experiences of care in the hospital, in general, patients were positive in their feedback. Care rounds by senior nurse managers had been introduced in the hospital to provide support to staff and oversight of the care provided in a number of ward areas. Dignity, privacy and respect for patients was generally promoted by staff. Systems were in place at the hospital to respond effectively to complaints, although information on how to make a complaint was not available in all clinical areas inspected. The emergency department and wards inspected were generally clean, although inspectors noted infrastructural and environmental and equipment hygiene issues on this inspection that require attention. Patients in the emergency department were being triaged

and medically reviewed promptly, although their overall patient experience time did not meet HSE targets. There were processes in the hospital to ensure that patient-safety incidents were identified and managed appropriately, although HSE reporting targets were not always met.

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 hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
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.	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.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Partially compliant

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

Appendix 2 – Compliance plan — service provider's response

Compliance Plan for St Vincent's University Hospital

OSV-0001099

Inspection ID: NS_0105

Date of inspection: 13 and 14 November 2024

Service Provider's Response

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

Infrastructural issues which include single rooms with no en-suite toilet and shower facilities, some areas, such as toilets, required repair and refurbishment.

- Active bed management and patient flow teams to ensure appropriate allocation of patients especially those with infectious status, e.g. patients with MDROs
- Whiteboard system in place with specific Alert ICON for patients with Infectious status.
- Funding approved for upgrade to toilets/shower facilities in Herbert Wing
- Funding approved for improved toilet facilities in AMU
- Recent completion of Dirty Utility room upgrade in Herbert Wing
- Planning and design phase of New Surgical Ward Block in progress which will include single occupancy accommodation for patients (planned for 70 additional inpatient beds)

Not all hand hygiene sinks conformed to the required standards.

- Engagement with Lease holders for Caritas in relation to upgrade of facilities required including hand hygiene sinks
- Any non-compliant Hand wash basin, a request to Estates Strategy Group (ESG) will be submitted to support replacement
- Estates Strategy Group in place to review and prioritise all estates applications for upgrades and allocation of funding accordingly (high dependency on Minor Capital budget issued by HSE)

Room doors in a number of ward areas where patients were isolating with an MDRO were open, which was not in line with hospital policy

- Daily rounds by IPC (Infection Prevention and Control) Team to reinforce Hospital policy
- Risk assessments will be conducted on case-by-case basis to assess lack of visibility of vulnerable patients versus risk of transmission of infection
- Ward based education regarding transmission-based precautions to be provided
- Use of Alert ICON on white board to note infectious status of patients
- Patients who require increased visibility due to acuity/vulnerability will be highlighted to Bed Management and will be prioritised for transfer to ward which can support increased visibility due to viewing panels on doors

Environmental and equipment hygiene and appropriate storage was inadequate in some clinical areas.

- Equipment checklist system in place. Plan to re-audit to confirm compliance and identify/ address any gaps
- Cleaning contract in place with Noonan's to ensure implementation of a robust cleaning roster
- Dedicated Discharge cleaning team in place to facilitate timely cleaning post patient discharge and ensure efficient patient flow
- On-going FMS (Facilities Management System) Audits in place in conjunction with facilities, IPC team and Ward manager
- Risk assessments completed for areas with poor storage and submissions to ESG for funding
- Use of the Medical Equipment Library is encouraged to reduce volume of equipment stored at ward level and minimise clutter
- IPC complete regular audits of equipment and cleaning of patient care equipment which is then fed back directly to Ward CNM
- Electronic ordering system in place to encourage staff at ward level not to overstock
- Facilities team available daily via bleep to arrange removal of faulty or broken equipment.

Timescale: End Q3 2025

National Standard	Judgment

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

Although patients were triaged and medically reviewed promptly in the emergency department, none of the HSE's patient experience time targets were met on the first day of inspection.

- Regular monitoring of PET times in Emergency Department and also reviewed monthly at EMCOG (Emergency Medicine Clinical Oversight Group) including benchmark against other level 4 Hospitals
- OPRAH (Older Persons Rapid Assessment Hub) for patients over 75years – early initiation of treatment and subsequent discharge
- On going review of rosters and allocation of staff to match times of higher attendance to ED
- EDITH 2 to be implemented to support pre-hospital care of patient residing in Nursing Homes. Aim to reduce conveyance to Hospital.
- AMAU pathway in pilot phase for direct transfer of patients from ED to AMAU
- Additional staff to be recruited for the Patient Flow Team to support discharges from hospital and enhance patient flow from ED
- Additional diagnostic lists will be provided when funding available to alleviate pressure.
- Availability of Virtual Ward to reduce length of stay and encourage early transfer home. Plan for expansion from 25 beds.
- Revision of the Hospital Escalation policy to reduce volume of inpatients boarded in ED and enhance flow of admitted patients to wards
- Revision of duties and responsibilities of the ADON for Patient Flow to facilitate focus on discharge planning and complex cases.
- Rehab pathway from SVUH to Leopardstown Care Centre recently established which allow timely egress for appropriate patients
- Increased approval for Marlay convalescence beds for Winter 2024/25 from 50-70 beds
- Increased collaboration with IHA (Integrated Healthcare Area) to develop further egress pathways for patients from acute site into community.
- Inclusion Health Manager liaising with SVUH to support discharges of IPAS & homeless patients
- Reconfiguration of Patient Flow Team, Discharge Coordinators and Bed Management teams to optimise patient flow efficiency.
- Installation of new information screens in ED to improve communication with patients.

Staff knowledge and understanding of risk management in some clinical areas visited was limited.

- Plan for dissemination of Directorate Risk Registers to all wards to ensure their availability for staff
- Training and education regarding risk and use of DATIX reporting system, including running of individual ward area reports, will be provided to CNM2s in each area/ward.
- Regular "Leadership walks" to be expanded to include all ward areas

Inspectors found out-of-date medications, medication with no date of opening and, decisions to discontinue medication were not always dated.

- Findings with regards to medication will be shared with the Drugs and Therapeutics committee and additional actions will be identified, advised and implemented
- Safety notices to be circulated quarterly
- Planned audit of medication documentation to be completed by Pharmacy
- Ongoing education of staff regarding compliance with policy on use of multi dose vials. Audit to be completed by The Nursing Department to ensure compliance and identify/ address any noncompliance.

The use of ISBAR communication stickers was not consistent amongst the clinical areas inspected.

- Further education on the use of ISBAR communication tool and the use of the ISBAR communication sticker to all areas
- Quarterly audit of the use of the ISBAR communication stickers to determine compliance and identify/ address areas of non- compliance
- Deterioration patient simulation study days to be offered to each area/directorates.

Timescale: End Q3 2025