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 Michael's Hospital
Centre ID:	OSV-0001100
Address of healthcare service:	George's Street Lower Dún Laoghaire Co Dublin A96 P902
Type of Inspection:	Unannounced
Date of Inspection:	15/01/2025 and 16/01/2025
Inspection ID:	NS_0117

About the healthcare service

Model of hospital and profile

St Michael's Hospital is a Model 2[*] voluntary public acute hospital. The hospital was transitioning to the governance structure of Regional Health Area HSE Dublin and South-East[†] at the time of inspection. Healthcare services on behalf of the HSE are provided in the hospital through a service level agreement under Section 38 of the Health Act 2004.

St Michael's Hospital is part of the St Vincent's Healthcare Group (SVHG) which also includes St Vincent's University Hospital and St Vincent's Private Hospital. Services provided by the hospital include:

- acute medical inpatient services
- elective surgery
- emergency care
- high-dependency care
- diagnostic services
- outpatient care.

The hospital also has a multidisciplinary clinic for the assessment and management of pelvic floor[‡] dysfunction.

[*] A Model 2 hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, and a range of diagnostic services.

[†] The Regional Health Area HSE Dublin and South East provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

[‡] The pelvic floor is a layer of muscles that runs from the pubic bone to the lower spine.

The following information outlines some additional data on the hospital.

Number of beds	98 inpatient beds 20 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 (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

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

[§]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.

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 inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
15/01/2025	13:08 – 18:00	Mary Redmond Bairbre Moynihan	Danielle Bracken
16/01/2025	08:45 – 15:20	Mary Redmond Bairbre Moynihan	Danielle Bracken

Information about this inspection

This inspection focused on 11 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:

- St Joseph's Ward (general medical ward)
- Surgical Ward (medical ward at the time of inspection)

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 (CEO)
  - Director of Nursing (DON)
  - Quality and Risk Manager
  - Clinical Director
  - Chief Clinical Director of SVHG

- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Director
- Representative(s) for
  - Infection Prevention and Control
  - Pharmacy
  - Irish National Early Warning System (INEWS) and Sepsis
  - Delayed Discharge and Bed Management

Acknowledgements

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

** 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 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.

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

Inspectors greeted and chatted to a number of patients over the two days of inspection and in more detail with six patients to elicit their experiences of being a patient in St Michael's Hospital (SMH). Overall, patients were complimentary about the staff and the care they received. Patients described their experience as "amazing", "well looked after" and everything is "grade A".

Inspectors visited two clinical areas – St Joseph's Ward, a general medical ward and Surgical Ward which was in use as a general medical ward on the days of inspection. Some patients were aware of their plan of care and a patient informed an inspector that if you leave the room you are asked if you require assistance.

The majority of patients had access to call bells within reach, however, one patient highlighted how the call bell was not working. This was escalated to management while inspectors were on the ward and rectified. Patients described how staff were busy but the call bell was answered in a timely manner.

Inspectors asked patients if there was anything that could be improved and the majority of patients stating that there was not, comments included they "care about you" and "staff are very informative". Patients informed inspectors that they had no complaints to make and some patients highlighted who they would make a complaint to if they had to.

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

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standard related to workforce. St Michael's Hospital was partially compliant with one standard (6.1), substantially compliant with one standard (5.2) and compliant with two standards (5.5 and 5.8).

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

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. The governance arrangements were mostly consistent with those illustrated in the hospital's organisational charts, however, the organogram provided on inspection reflected the relationship with the hospital group and had not been updated to reflect the arrangements with the newly established regional health area (RHA) of Dublin and South East. Following inspection an updated organogram was submitted to HIQA.

During the course of the inspection, inspectors followed up on findings from the inspection in August 2022. Overall, inspectors identified that hospital management had actioned some of the actions. For example, a mandatory training working group was established, swipe access was installed in St Columba's Ward and the lack of en-suite rooms was escalated via the corporate risk register to St Vincent's Healthcare Group (SVHG). Notwithstanding this, the lack of en-suite rooms remained an issue and poor compliance levels were identified in some areas of staff training. These will be discussed under national standards 2.7 and 6.1.

The chief executive officer (CEO) was the senior accountable officer and had overall responsibility and accountability for the governance and the quality of health services delivered. The CEO reported to the director of operations of SVHG. The CEO outlined that there was no direct reporting relationship with the integrated health manager for the RHA of Dublin and South East, however, the CEO stated that there is a working relationship which includes monthly meetings where performance data is reviewed and discussed.

The reporting structures in the hospital were unchanged since the inspection in August 2022. The key corporate governance structures assigned with the

responsibility for ensuring the quality and safety of healthcare services at the hospital were the Executive Committee and the Quality and Safety Executive Committee (QSEC).

The Executive Committee, chaired by the CEO, met monthly and was responsible for the overall governance of the hospital. Meeting minutes reviewed indicated that meetings were action focused with actions assigned to a responsible person. Updates on actions were monitored from meeting to meeting.

The hospital's Quality and Safety Executive Committee (QSEC), reported to the Executive Committee, met quarterly and was chaired by the CEO or the quality and risk manager. Inspectors identified on the inspection in August 2022 that attendance at these meetings by consultants was an area for improvement. On this inspection, inspectors were informed that this had not improved. This was confirmed in meeting minutes reviewed. However, inspectors were informed that a clinical director was appointed on the weeks preceding the inspection, was awaiting an official commencement date and that an improvement should be observed following this.

Subcommittees of the QSEC oversaw the effectiveness and the quality of practice in three out of the four areas of focus of this inspection - infection prevention and control, medication safety and the deteriorating patient (including sepsis). The organisational chart and meeting minutes indicated that the deteriorating patient committee now had a reporting relationship to QSEC which was actioned since the inspection in 2022. However, the terms of reference (TOR) of this committee indicated that the committee reported to the health and safety committee. While the hospital had no transitions of care or equivalent committee in place, it was evident from meeting minutes reviewed that issues relating to this were discussed at governance meetings.

Through a review of meeting minutes, agendas and terms of reference for the three committees above, it was evident that the committees operated to a defined agenda with multi-disciplinary representation. However, actions from the deteriorating patient committee and drugs and therapeutics committee were not time bound and in some instances no action owner was assigned.

Overall the hospital had formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare with the following findings identified:

- discrepancies were observed in the documentation as to the reporting relationship of the deteriorating patient committee
- actions from meetings did not always have assigned action owners and were not time bound.

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 effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of focus for this inspection.

The Senior Management Committee (SMT), chaired by the CEO, reported to the Executive Committee and met fortnightly. Membership included for example, the director of nursing (DON), director of human resources and quality and safety manager. This committee provided a forum for the escalation of issues from the hospital. Agenda items included nursing updates, operations update, HR and communications. Assigned action owners were evident on the meeting minutes, however theses were not time bound.

As discussed under national standard 5.2 a clinical director was appointed on the weeks preceding the inspection and was waiting to commence in the post. The hospital had an on-call roster for consultants and non-consultant hospital doctors (NCHDs) were on site 24/7.

Nursing services in the hospital were managed and organised by the DON who was supported in the role by two assistant directors of nursing. St Joseph's Ward and Surgical Ward each had a clinical nurse manager (CNM) 2 and CNM 1 in position who were responsible for the management and oversight of the wards and were operationally accountable to a CNM 3 and upwards to the ADON.

The hospital's infection prevention and control team (IPCT) was led by a consultant microbiologist who had a shared post with St Vincent's University Hospital (SVUH) and was on site five hours per week. Outside of this time microbiology advice was available via telephone and on-call arrangements were via SVUH. In addition, there was one whole time equivalent (WTE)[***] CNM 3 and a 0.5 WTE clinical nurse specialist (CNS). At the time of inspection one WTE CNM/CNS post was vacant. This will be discussed under national standard 6.1. On the inspection in 2022, the IPCT did not have an annual audit plan in place. This has since been actioned and the annual programme for 2024 was provided to inspectors.

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

The hospital's antimicrobial stewardship (AMS) programme was implemented and overseen by the consultant microbiologist and pharmacists. AMS was a standing agenda item and discussed at the Infection Prevention and Control/Hygiene Committee meeting two monthly.

The hospital's pharmacy service was led by the chief pharmacist. Medication safety was underpinned by a five year medication strategy 2019-2024. A medication safety report was an agenda item at the Drugs and Therapeutics committee meeting (DTC) and meeting minutes reviewed indicated that this was provided at each meeting.

The hospital had identified consultant leads for both the early warning score and sepsis. In addition, two consultants were nominated consultant leads for the Deteriorating Patient Governance group. They were supported by an early warning score co-ordinator. Meetings were held quarterly and well attended with at least one consultant lead attending at each meeting. Updates were provided on for example, early warning scores, sepsis and resuscitation. Inspectors were informed that the hospital had anaesthetic cover from 8am-8pm seven days a week. Outside of these hours the hospital contacted an on-call anaesthetist from SVUH. Inspectors were informed that no incidents had occurred and that they had timely access to the on-call anaesthetist. Executive Committee meeting minutes indicated that the CEO was meeting the anaesthetists in SVUH to discuss this arrangement. At interview the chief clinical director provided assurances that the current arrangement was sufficient.

Hospital management had recently appointed a patient flow co-ordinator on a three month contract while awaiting funding for a permanent role. The hospital did not have a committee in place in relation to transitions of care, however, it was evident that issues relating to transitions of care were discussed at the Senior Management Team and Executive Committee meetings. Furthermore, representatives from the SMT attended the monthly SVUH bed management meeting where an update was provided by senior management from St Michael's Hospital on issues impacting patient flow between the two hospitals.

At the time of inspection the hospital was in escalation in order to assist SVUH with capacity. The hospital had suspended all elective surgery. Eighteen beds in the Surgical Ward accommodated medical patients. Inspectors were informed that the hospital was in escalation since 31 December 2024.

Judgment: Compliant

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

The hospital had 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 management level. This information provided the Executive Committee and relevant governance committees with assurances about the quality and safety of healthcare services provided in the hospital.

Formalised risk management structures were in place. These structures supported the proactive identification, analysis, management, monitoring and escalation of reported clinical and non-clinical risks. The hospital's quality and safety manager oversaw the effectiveness of the risk management processes and the management of reported patient safety incidents. The hospital had two risk registers in place, a corporate and hospital risk register. Risks that could not be managed by the hospital were escalated to the corporate risk register. Inspectors were informed that a sub-committee of the board of SVHG had oversight of this risk register. Risks in relation to the four areas of focus on the risk register will be discussed under national standard 3.1.

The hospital had systems in place to proactively identify and manage patient-safety incidents. It was evident from meeting minutes reviewed that incidents and trending of incidents were discussed at the Executive Committee, QSEC and SMT. Additional findings will be discussed under national standard 3.3.

A hospital audit plan was provided to inspectors. This outlined the audit title, frequency of the audit and the responsible department. Examples of audits relating to the four areas of focus for this inspection included monthly high alert medications, quarterly hand hygiene, and monthly Irish National Early Warning System (INEWS). These will be discussed further under national standard 2.8. Results were discussed at the relevant committee and this was confirmed in meeting minutes reviewed. The hospital collected a range of data on metrics such as patient-safety incidents, complaints, service user feedback, infection prevention and control, delayed discharges and the numbers of beds offered to SVUH and the number of patients transferred. Collated performance data was reviewed at meetings of the relevant governance committees, and were an agenda item at performance meetings between the hospital and IEHG and now with the HSE Dublin and South East region.

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

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

The hospital's workforce arrangements were managed to ensure the delivery of high-quality, safe and reliable healthcare.

At the time of the inspection, hospital management stated that there were 23 vacancies which were at the recruitment stage, 11.8 of those posts were nursing positions at different grades. The pharmacy department was fully staffed in line with its approved WTE. As discussed under national standard 5.5 there was one CNM/CNS post vacant in infection prevention and control. Assurances were provided by senior management that this post would be filled.

St Joseph's Ward was fully staffed on the day inspected and Surgical Ward had an unfilled shift due to unplanned leave. Inspectors were informed that the CNM2 assisted with patient care and contacted the CNM3 if additional support was required. As the hospital was in escalation, Surgical Ward was open as a seven day ward instead of five. To support the additional days of opening, theatre staff were allocated to the ward as theatres were not running during the escalation period. Staff identified particular challenges with this arrangement due to the lack of familiarity of staff with the patient cohort, however, inspectors did not identify any impact as a result of this arrangement on the day it was inspected. Inspectors were informed that support was provided by senior nursing management.

The reported staff absenteeism rate in November 2024 was 5%, which was 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 and an attendance management policy in place. Staffing numbers (headcount), absenteeism and recruitment was managed and monitored by the human resource department. Human resource management was overseen by the Executive Committee. Inspectors identified on the inspection in August 2022 that staff did not have access to an Employee Assistance Programme (EAP). Senior management stated that since then they had engaged with an employee assistance programme and this was confirmed

in Executive Committee minutes. This service was accessible via occupational health. Staff spoken with were aware of occupational health support but some staff were unaware of the EAP in place.

Following the inspection in August 2022, senior management, through the compliance plan outlined a number of key interim actions to improve the oversight of mandatory training. Senior management committed to establishing a Mandatory Training Governance Committee. Inspectors were informed that this working group was formed which met quarterly. Meeting minutes reviewed indicated that the group had discussed and reviewed compliance rates of, for example, hand hygiene and basic life support. Oversight of mandatory training was provided by the Executive Committee. In addition, 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.

Training compliance records provided following inspection indicated that there was good compliance with training for standard and transmission-based precautions and hand hygiene training amongst medical staff with 100% compliance. However, poor uptake of basic life support (BLS) training was noted with 58% of nursing staff and 19% of medical staff trained in this area. In addition, poor uptake of training was observed in medication safety training with 47% of nursing staff having completed this training and INEWS training was 58%. Standard and transmission based precautions was 54% for both nursing and healthcare assistant staff.

Overall, hospital management planned, organised and managed their workforce to provide quality, safe and reliable healthcare, however, inspectors identified that while the oversight of mandatory training had improved, poor compliance levels of the training remained. The following was identified:

- poor uptake of BLS training was observed amongst nursing and medical staff, medication safety for nursing staff, INEWS and standard and transmission based precautions training for nursing and healthcare assistant staff
- some staff were unaware of the EAP programme in place
- the absenteeism rate was above the HSE target of 4%.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

The hospital was partially compliant with two standards (1.6 and 2.7), substantially compliant with three standards (2.8, 3.1 and 3.3) and compliant with two standards (1.7 and 1.8).

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

Inspectors observed that staff working in the hospital were committed and dedicated to promoting a person-centred approach to care. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. However, inspectors observed instances where patient privacy and dignity was not fully maintained or protected.

Patients with limited mobility were assisted by staff to walk on the corridor. Staff were aware of the importance of encouraging patients to mobilise and enabling them to be as independent as possible. A patient described how they were encouraged to improve by the physiotherapists and how grateful they were.

There was evidence of staff respecting individual patient's privacy and dignity such as the provision of a single occupancy room for a patient who required additional privacy and arrangements to promote privacy in multi-occupancy areas, for example; privacy curtains. However, patient's right to dignity and privacy was not consistently respected in St Joseph's Ward. Inspectors observed a patient attending to their own toileting needs without curtains in use within a multi-occupancy room. In addition, a portable camera monitor was observed in a four bedded bay. Both these findings were escalated to the clinical nurse manager who confirmed that the receiver of the monitor was located in the nurses' station. The use of the portable camera monitor was not risk assessed and no policy was in place to support this practice. On day two of inspection, inspectors escalated this finding to hospital management. Inspectors were informed by hospital management at the end of the inspection that the monitor was removed. Assurances were provided that appropriate measures were in place to adequately supervise patients on St. Joseph's ward.

Overall, while staff were communicating with and providing assistance to patients in a timely and respectful manner that respected their autonomy, the following findings were identified that impacted on patient's rights to privacy and dignity:

- a camera monitor was in use in a patient area with no policy in place to support this practice
- inadequate use of privacy curtains in a multi-occupancy area where a patient was attending to their own toileting needs.

Judgment: Partially Compliant

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

Inspectors observed staff communicating in an open and sensitive manner with patients and being assisted in a kind and supportive manner. Patients told the inspector that some staff were "too good" and that "you're not a number in a bed". Patient's reported that staff were aware of their individual needs. Staff were wearing "Hello My Name Is" identification badges and these were clearly displayed on their uniforms.

There was evidence that management and staff were actively seeking and respecting service user's views and preferences. Comment boxes and comment cards were available in both wards. Overall, a culture of kindness, consideration and respect was promoted in both wards.

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 systems in place to respond effectively to complaints. The quality and safety manager was the designated complaints officer. It was evident from a review of meeting minutes that complaints was an agenda item at the QSEC meeting and a report provided to the Executive Committee.

The hospital had an up-to-date local policy in place that aligned to the HSE's complaints management policy '*Your Service Your Say.*' Information on how to make a complaint was observed in both wards and staff described how they would manage a complaint or guide a patient to make a formal complaint. In addition, the quality newsletter from Q3 2024 described this process. Information on patient advocacy services was on display.

Hospital management aimed to resolve complaints at the first point of contact in line with hospital policy. Inspectors were informed that 47 written complaints were received in 2024. The QSEC report for 2024 was submitted following inspection. This outlined the tracking and trending of complaints to identify emerging themes. The majority of complaints in 2024 were themed into safe and effective care. A monthly compliance audit of complaints indicated that in 11 months of 2024 the hospital closed all complaints within 30 working days. Complaints were discussed at handover in both clinical areas.

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.

Inspectors identified that the physical environment did not always fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users.

St Joseph's ward was an 18 bedded medical ward. The ward was separated into two areas, with a nurses' station centrally located. A long corridor linked both areas which were named red and blue. The ward layout consisted of two multi-occupancy bays of four beds each and 11 single occupancy rooms. Only one of the single rooms and one multi occupancy bay had en-suite facilities. Four toilets and two showers were available for the rest of the ward.

The Surgical Ward consisted of 18 beds, of which six were single occupancy rooms and three multi-occupancy areas with four beds in each. None of the single or multi-occupancy rooms had en-suite facilities. Four toilets and one shower were available for use on the ward.

In total 10 patients between both wards, during the days of inspection required transmission based precautions. Doors to single rooms were closed with exception, when supported by a risk assessment. Signage on the use of personal protective equipment (PPE) was displayed and PPE was readily available. Inspectors observed staff in one area incorrectly doffing PPE outside a patient's room where contact precautions were displayed as no yellow clinical risk waste bin was available within the single room. This practice is not in line with national guidelines. None of the 10 patients had access to en-suite facilities. Inspectors were informed that commodes were used in single rooms to prevent the spread of infection.

Staff reported that the bedpan washer in St Joseph's Ward was not functioning efficiently. As a result staff had to manually decant the contents of urinals and bedpans into the sluice prior to washing utensils in the bedpan washer. Manual decanting posed a risk of environmental contamination.

The majority of clinical hand-wash sinks observed throughout both clinical areas conformed to requirements[†††] with the exception of the dirty utility and treatment room in St Joseph's Ward. Hand-washing technique posters were on display. Wall-mounted alcohol-based hand sanitiser dispensers were readily available for staff and visitors.

Inspectors observed that the clinical environment was clean with few exceptions. Contract cleaners were employed and cleaning supervisors and CNMs had oversight of cleaning in their respective areas. CNMs who spoke with inspectors were satisfied with the level of cleaning resources. Patient equipment observed was clean. Cleaning checklists were in place to ensure equipment was cleaned, however, commodes were omitted from the cleaning checklist in Surgical Ward. Linen and waste was appropriately stored and segregated.

General wear and tear was observed throughout both wards. For example, chipped paint on walls, skirting and doors. The flooring in a shower room and the dirty utility in St Joseph's Ward were worn and torn. Inspectors were informed that this was escalated to maintenance. The damaged paintwork was identified on an environmental audit carried out on St Joseph's Ward in May 2024 and remained an issue.

Both wards were challenged by lack of storage space. The corridor in the blue area in St Joseph's Ward was narrow and was used to store some large pieces of equipment. Inspectors observed a catering trolley and a large waste bin were difficult to manoeuvre through the corridor and fire doors. In addition, the layout

[††††††] 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.

may impede the movement of a resuscitation trolley in the event of a patient deteriorating. A risk assessment was completed while inspectors were on site. This will be discussed under national standard 3.1. Inspectors were informed that Surgical Ward had extra stock at the time of inspection as medical patients were on the ward instead of surgical patients. Inspectors observed excess stock of syringes and PPE in the clean utility. In addition, inappropriate storage of clean equipment such as a patient transfer board and unused sharps bins were observed in the dirty utility. This was brought to the attention of management.

Both St Joseph's Ward and Surgical Ward were clean on the days of inspection. However, hospital management were challenged by the design and layout of the environment. The following was identified:

- lack of en-suite single rooms posed a risk of transmission of infection
- narrow corridors in St Joseph's Ward led to a cluttered environment that could impede access to resuscitation equipment in the event of a patient's deterioration
- storage was a challenge in both wards with inappropriate storage of equipment and stock on corridors and in sluice rooms
- the bedpan washer in St Joseph's Ward was not functioning efficiently resulting in staff manually decanting the contents of urinals and bedpans into the sluice prior to washing utensils in the bedpan washer
- wear and tear was noted in both wards with similar findings identified in an audit in May 2024 and were awaiting action
- the hand hygiene sink in the dirty utility and treatment room in St Joseph's Ward was not compliant with the required specifications.

Judgment: Partially Compliant

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

Inspectors identified that the hospital had assurance systems in place to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management used information from a variety of sources (including KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, complaints and patient experience surveys) to measure the quality of care provided.

The IPCT reported on the rate of hospital acquired infections[‡‡‡] monthly, with low occurrence noted on the QSEC report for 2024. The IPC annual report indicated that quarterly hygiene audits were completed in all clinical areas. Inspectors identified that these were completed in both wards inspected. Results ranged from 86.1% to 93.5%. Overall, compliances of 84.9% to 95% in environmental and equipment audits were achieved in both areas. However, the general environment scored 80% in St Joseph's and 65% in sharps management in Surgical Ward. Actions arising from the audits were identified, however, these were not assigned and inspectors identified some of the issues remained in St Joseph's Ward, for example, walls were chipped and peeling.

Medication safety was monitored by the hospital through audits. The medication safety strategy indicated that monthly audits were completed on for example, high alert medications and quarterly audits on controlled drugs and antimicrobial stewardship. Results were provided on overall compliance with high alert medication scoring on average 95.3% from January to December 2024 and 86.8% in a Sound-Alike Look Alike (SALADs) medication audit during the same period. No time bound action plan accompanied this audit. Documentation indicated that quarterly key performance indicators (KPIs) were completed on antimicrobial stewardship. KPI results for 2024 indicated that improvement was required in adding a documented review date in the medication record and documenting the indication. However, no time bound action plan accompanied the audit. Notwithstanding this, meeting minutes of the DTC indicated that KPI results were discussed.

Inspectors were informed and meeting minutes confirmed that INEWS audits were completed quarterly and reported at performance meetings. Two audits for 2024, were submitted to HIQA. Both audits included the medical and surgical wards. One audit indicated an overall compliance of 89.1%. A time bound action plan accompanied the audit with assigned action owners. The second audit was completed in January 2024 to assess the compliance of the utilisation and accuracy of completion of the INEWS adult patient observation chart. The audit report contained recommendations, however, no time bound action plan accompanied this audit. Results of monthly audits of the Identify, Situation, Background, Assessment, Recommendation, Read back Risk ($ISBAR_3$)[§§§] tool indicated compliance of 50% in September 2024, 29% in October 2024 and 75% in November 2024. Information provided to HIQA indicated that actions were implemented for example, results were

[‡‡‡] *Methicillin-resistant Staphylococcus aureus, Clostridioides difficile, Staphylococcus aureus blood stream infections, Vancomycin-Resistant Enterococci, Carbapenemase-Producing Enterobacterales*

[§§§] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

discussed with CNMs which was communicated to staff during safety pauses after handover.

A sepsis audit was completed in November 2024 which included recommendations and status of the actions. Staff informed inspectors that a number of initiatives were implemented for sepsis awareness and detection. These included HSE information leaflets on sepsis that were provided to surgical patients on discharge and two education sessions were held on the deteriorating patient. This was confirmed in documentation reviewed. In addition, a quality improvement plan was recently introduced where sepsis stickers were introduced in the Emergency Department (ED) to prompt the recognition of sepsis. This was evolving at the time of inspection.

Data in relation to hospital activity and performance was measured by the hospital monthly, for example; the average length of stay, delayed discharges and the number of beds offered to SVUH and the number of beds accepted. In 2024, 534 beds were offered to SVUH and 193 patients were accepted who met the criteria for suitability for transfer. This was a significant increase from 2023 where 286 beds were offered and 61 patients met the criteria.

Quality and safety staff had undertaken an audit on National Incident Management System (NIMS)**** incident entry between August and October 2024 to review that incidents were logged correctly and in a timely manner. While the audit did identify areas for improvement, no time bound action plan accompanied the audit.

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

- when practices fell below expected standards, action plans were not always developed to improve healthcare services and care provided at the hospital
- ongoing poor results from ISBAR audits.

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

The hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services. Arrangements were in place to ensure the proactive identification, evaluation, analysis and management of significant information and risks to the delivery of safe healthcare services.

The risk register was an agenda item at the QSEC and meeting minutes indicated that risks were discussed at the SMT meeting. Examples of risks included on the corporate risk register relating to the focus of this inspection included the potential for the spread of hospital acquired infections due to insufficient numbers of en-suite single rooms for appropriate isolation of patients and challenges to keep pace with repairs, maintenance and upgrades. An additional risk will be discussed later in this standard. Existing controls and additional controls were outlined on the risk register.

Inspectors were informed that local risk registers were not in place in St Joseph's or Surgical Wards. Management stated that this was a focus for the hospital for 2025. Staff stated that risks were escalated to nursing management. However, there was lack of clarity amongst staff in both wards on risks, risk assessments and how they differed from an incident.

Quality boards were in place in both wards and contained information on sepsis, audits, screening for multi-drug resistant organisms, a medication alert and a shared learning notice.

Inspectors were informed that all patients admitted overnight to the hospital were screened for *Carbapenemase-Producing Enterobacterales (CPE)* and compliance with this was audited. Management stated that the hospital was compliant with this however, the audit was not submitted to HIQA. In addition, patients who had a previous history of *Methicillin-Resistant Staphylococcus Aureus (MRSA)* and or *Vancomycin Resistant Enterococcus (VRE)* were screened. The IPCT informally monitored compliance with this screening but no formal audit was completed.

Antimicrobial stewardship (AMS) rounds were in place. The AMS programme was supported by a consultant microbiologist and pharmacists. Staff informed inspectors that a member of the IPCT attended the wards daily and they had timely access to advice if required. Furthermore, staff had access to microbiology advice on a 24/7 basis.

The IPC annual report indicated that there were four outbreaks in the hospital in 2024. Outbreaks were discussed at IPCC meetings. Multi-disciplinary outbreak teams were convened to advise and ensure the management of the outbreak was aligned with best practice standards and guidance.

A clinical pharmacy service[††††] was provided to all wards and staff in both wards visited confirmed this. A clinical pharmacist completed medicine reconciliation[‡‡‡‡] for patients on admission, and a medicine review for patients on discharge when possible. A sample of healthcare records reviewed indicated that medication reconciliation was completed in the majority of cases. This process was underpinned by an up-to-date policy.

St Joseph's and Surgical Wards had a list of high-risk medications, and sound-alike look-alike medications (SALADs) on display. Up-to-date polices were available to support practice in both these areas. Prescribing guidelines, antimicrobial guidelines and medicines information were available and accessible to staff. Staff had access to a medication fridge in St Joseph's ward, however, no fridge was available on Surgical Ward. At the time of inspection, staff used the fridge in another ward.

The $ISBAR_3$ communication tool was used for the escalation of the care of the deteriorating patient, at handover and on transfer of patients. ISBAR stickers were used in healthcare records when a patient was escalated and inspectors observed examples of this. Posters and prompts were placed on or near the phones. An interdepartmental transfer form aligned to the ISBAR tool was available. 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.

Staff informed inspectors that scenario based training was done in the clinical areas on the use of the resuscitation trolley. This along with oxygen and suction were available if required, if a patient deteriorated. As discussed earlier in the report, the corridor in St Joseph's Ward was narrow, contained equipment and had the potential to impede the timely transport of the cardiac arrest trolley in the event of a patient's deterioration. A risk assessment was completed while inspectors were on site. This was risk rated as a high rated risk. Controls in place were identified and additional controls included for example, consideration of purchasing of a second cardiac arrest trolley and or an Automated External Defibrillator (AED) and creating a storage room to store equipment located on the corridors with a review date of quarter 2, 2025. The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe discharge planning. Hospital management identified a risk in relation the potential risk of delay in transferring patients to SVUH due to lack of ambulance availability.

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

This was on the corporate risk register. Inspectors were informed that management met with the National Ambulance Service to discuss the service needs with an improvement noted since then.

Hospital management attended and facilitated a number of meetings to aid the timely and safe transfer of patients. For example, weekly meetings were held with the director of nursing, assistant director of nursing and principal social worker to discuss complex discharges, a multi-disciplinary weekly hub meeting to discuss discharges and a daily call with SVUH to identify patients that are suitable for transfer within the defined inclusion and exclusion criteria.

The hospital had access to beds in public and private residential and rehabilitation facilities in the region to enable patients' timely discharge from the acute hospital. In addition, the hospital had access to a hospital bus to transfer patients and an accompanying staff member to SVUH for diagnostics.

Inspectors were informed and documentation was provided following inspection to confirm that a pilot project was commencing in St Joseph's Ward in relation to discharge information for patients. This was a quality improvement plan developed as a result of the National Inpatient Experience Programme (NIES). A document called a "SMART "document was developed, and a discharge journal that will provide patients with the information they require after discharge such as "Signs, Medication notes, Appointments, Results and Talk". The document also contained hospital phone numbers.

Staff had access to policies, procedures, protocols and guidelines (PPPGs) on computers in local areas and in folders. The majority of staff could readily access these. PPPGs viewed by inspectors were up to date with the exception of the early warning score (EWS) policy which was out of date since 2016.

Overall, as evident by the findings presented above, there were arrangements in place in the hospital to ensure there was proactive monitoring, analysis and response to information. However,

- lack of understanding amongst staff of risk registers, risk assessments and how these differed from incidents was evident on the days of inspection
- the EWS policy on the computer was out of date since 2016.

Judgment: Substantially 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.

The Serious Incident Management Team (SIMT) oversaw the management of incidents ensuring that an appropriate investigation of the incident was conducted in line with the HSE Incident Management Policies and Guidelines. TOR indicated that the SIMT reported to the CEO. These had not been updated since 2020. Meeting minutes provided evidence that they had oversight of serious incidents and preliminary assessments were completed for Category 1 and 2 incidents. However, the TOR of the SIMT indicated that the SIMT would "arrange for expeditious implementation of recommendations of investigations as part of the organisations risk management work". There was no evidence from minutes reviewed that recommendations for reviews were discussed at this forum. Furthermore, on review of meeting minutes from QSEC, SMT and the Executive Committee recommendations from reviews were not discussed.

Incidents were reported at point of entry onto NIMS which was introduced in April 2023. Trending of incidents was carried out by quality and safety staff.

A medication safety report was presented at the DTC which included trending of medication safety incidents. The Quality and Safety Executive 2024 annual report outlined the medication themes and trending for the year. 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.

The annual report included the rate of clinical incidents per 1000 beds days used which had decreased in 2024 from 2023. This was also identified at the QSEC in April and July 2024 with an improvement noted in November 2024.

Patient-safety incidents inputted into NIMS within 30 days was 96% between Q4 2023 and Q3 2024, in compliance with the HSE's target of 70%. During the same period two incident reviews exceeded the target completion date of 125 days.

Staff who spoke with inspectors were knowledgeable about the system in place and their role in reporting and managing patient-safety incidents. Inspectors were informed that that incidents were discussed after handover. Learning was shared through shared learning notices which was observed on a quality board in Surgical Ward. A quality newsletter with examples of a "good catch" and "near miss of the

month" was circulated. The Christmas newsletter outlined the number of incidents reported in 2024 compared to 2023 with a decrease noted in reporting.

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

- arrangements to implement recommendations from reviews of patient-safety incidents and to monitor the effectiveness of the action taken was not in place
- the hospital was not meeting the HSE target of the completion of reviews within 125 days.

Judgment: Substantially Compliant

Conclusion

An unannounced inspection of St Michael's Hospital, Dún Laoghaire was carried out to assess compliance with 11 national standards from five of the eight themes from 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.

Overall, the inspectors found that three standards were partially compliant (6.1, 1.6 and 2.7), four were substantially compliant (5.2, 2.8, 3.1 and 3.3), and four were compliant (5.5, 5.8, 1.7 and 1.8).

Capacity and Capability

Corporate and clinical governance arrangements within the hospital were integrated, formalised and clearly defined. The hospital had recently integrated into the newly established HSE Dublin and South East region and these structures were evolving at the time of inspection. The management arrangements supported the operational functioning of the hospital and promoted the delivery of safe, high-quality healthcare services. Monitoring arrangements in place in the hospital enabled the identification of opportunities to continually improve the quality, safety and reliability of healthcare services and were systematic. The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, gaps in the uptake of mandatory training were identified. This was also a finding on the inspection in August 2022.

Quality and Safety

Inspectors spoke with patients about their experiences of care in St Michael's Hospital. Patients were complimentary about the staff and care they received. Staff promoted a person-centred approach to care and the inspectors observed staff being respectful, kind and caring towards patients. It was evident that the majority of staff respected and promoted the dignity, privacy and autonomy of patients, however, inspectors identified the inappropriate placement of a portable camera monitor in a patient bay. In addition, an instance were observed where a patient's dignity was not fully protected.

The hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. The physical environment did not fully support the delivery of high-quality, safe and reliable care. Multiple findings were observed in both wards as outlined in the report. Assurance systems were in place to monitor, evaluate and continuously improve the healthcare services. However, time bound action plans were not always developed. The hospital

protected service users from the risk of harm associated with the design and delivery of healthcare services with some opportunity for improvement identified. Systems were in place to identify, manage, respond to and report patient-safety incidents. Evidence was provided of tracking and trending of incidents and shared learning. However, the arrangements to implement recommendations from reviews of patient-safety incidents and to monitor the effectiveness of the action taken was not in place.

HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with mandatory training, the physical environment and patients' dignity and privacy.

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

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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	
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
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
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	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for St Michael's Hospital

Inspection ID: NS_0117

Date of inspection: 15 and 16 January 2025

Introduction

This document sets out a compliance plan for healthcare service providers to outline action(s) completed or intended to be completed following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare Version 2 (2024)*. Any substantially compliant judgments indicate that some action is required to bring the service into full compliance. These actions can be managed locally and do not form part of this compliance plan.

This compliance plan only relates to:

- standards that were deemed **partially compliant or non-compliant** by HIQA

The compliance plan should be completed and authorised by a representative of the service provider with responsibility to act on behalf of the service, for example the service's Chief Executive Officer, Chief Officer, or other relevant designated manager.

It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the national standards.

Instructions for use

The healthcare service provider must complete this plan by:

- outlining how the service is going to come into compliance with the relevant national standard(s)
- outlining timescales to achieve compliance.

The provider's compliance plan should be SMART in nature:

- **Specific** to the non-compliance identified with the national standard(s)
- **Measurable** so that progress towards compliance can be monitored
- **Achievable**
- **Relevant**

- **Time bound** – The proposed actions outlined in the compliance plan should be accompanied by clear delivery dates and key milestones (where appropriate)

Healthcare Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems that they have, or will put, in place to ensure compliance with a particular national standard, under which a partially compliant or non-compliant judgment has been made.
- Service providers should change their systems as necessary to bring them into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent action and plans for improvement related to urgent risks already identified by HIQA during the inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Continued non-compliance

Continued non-compliance with the national standards resulting from a failure by a service provider to put in place appropriate action(s) to address the areas of risk previously identified by HIQA may result in increased monitoring activity including further inspection activity, seeking compliance plans and assurance reports from the provider. It may also result in further escalation in to the relevant accountable person(s) in line with HIQA policy.

Long-term and medium-term work to meet compliance with the standards

HIQA recognises that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium- and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the

service provider plans to improve the level of compliance with the relevant national standard.

HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on short- and medium-term mitigation measures to manage risks and improve the level of compliance with standards
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance plan provider's response:

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.

Use of the EAP will be further promoted through the Occupational Health Department, Heads of Department meetings and the Health and Safety committee. The usage of EAP will be monitored at the Health and Safety committee through session utilisation.

The working group for mandatory training will be further developed with new terms of reference, refreshed membership and a reporting line to the Executive committee. Responsibility for actions arising will be allocated to the relevant Executive Manager for each discipline. Compliance will be monitored monthly and additional actions to increase uptake will be developed. More trainers for manual handling will be created. Opportunities to enhance the NCHD lead role in SMH will be assessed with a view to improving NCHD lead attendance at the mandatory training committee and supporting training uptake across the NCHD workforce.

St. Michael's Hospital is committed to maintaining the safety, health and welfare of staff while at work and doing all that is reasonably practicable to assist staff members who are absent from work due to injury or ill health to return to work as soon as possible through effective attendance management.

To address and improve compliance with the HSE absenteeism target of 4% or less, Hospital Managers will continue to carry out Return to Work meetings post absence with a view to identifying trends and to offer timely supports to staff.

The Attendance Management policy was reviewed and updated via the Policy Committee on April 1st 2025.

Employee Wellbeing: A key focus for 2025 will be the enhancement of employee wellbeing initiatives to complement the existing Occupational Health services. The 'policy to support the psychological health and wellbeing of staff at work' will be refreshed in Q3

2025. Work to enhance awareness of the EAP programme will also support this and may assist in reducing the rate of absenteeism.

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

SMH will develop a business case detailing the requirement for a learning and development role for the hospital and will submit this to the HSE as funders for the service.

Timescale: 30/09/2025

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

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

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

Monitors are currently not in use. A risk assessment regarding the use of monitors will be undertaken and will inform a new policy for the use of monitors where required. This policy will include the requirement for consent and a specific consent form for this purpose.

St Michaels Hospital is committed to ensuring that patient privacy and dignity is maintained at all times.

An awareness programme has taken place with the Nursing and HCA staff of St Joseph's ward in relation to the use of privacy curtains and ensuring that patient privacy and dignity is protected. Use of privacy curtains will continue to be monitored to ensure that the education has been effective and awareness is maintained.

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

Timescale: 29/05/2025

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.

St Michaels hospital has placed an emergency kit on St Joseph's ward to mitigate the potential risk of impeded access to the emergency trolley; the contents of this kit ensure and allow for early intervention should an emergency situation occur. The kit contains prompt cards, airways, Ambu bag and additional equipment. An AED machine will also be placed in this area until the delivery of the planned purchase of an additional defibrillator machine.

SMH management will ensure adequate provision of clinical waste bins for all single isolation rooms.

SMH senior management, together with HSE capital and estates will undertake an assessment of storage in ward areas to develop new solutions.

HSE capital and estates will undertake a walk-through of St. Michaels hospital with senior management to develop a plan for further addressing wear and tear. AMRIC funding for 2025 has been allocated to the installation of wall panels in a number of areas including St Joseph's ward and the Surgical ward which will address some of the current requirements. These panels will provide a more sustainable solution than repainting. Efforts to address wear and tear will continue in 2026 and will be ongoing.

Staff education will take place regarding the timely escalation of issues with equipment such as the bedpan washer. Staff awareness of the facilities committee will be enhanced through additional communication at Heads of Department and town hall (all staff) meetings.

The sinks in St. Jospeh's ward will be replaced with compliant sinks.

Storage

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

The ability to install en suite rooms is constrained by the current infrastructure. SMH management will request an assessment of potential options for long term solutions by HSE capital and estates.

Timescale:

Actions regarding resus trolley access (emergency kit in place and AED to be installed by 31/5/25)

Actions regarding clinical waste bins, storage, education sinks and infrastructure 01/03/2026