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 Luke's Radiation Oncology Network
Address of healthcare service:	Oakland Drive Highfield Road Dublin 6 D06 HH36
Type of inspection:	Announced
Date(s) of inspection:	22 and 23 January 2025
Healthcare Service ID:	OSV-001104
Fieldwork ID:	NS_0111

Model of hospital and profile

About the healthcare service

St. Luke's Radiation Oncology Network (the hospital) is a model 2[1] hospital and the largest radiation therapy centre in Ireland. Established in 1954, the hospital serves the Dublin area, but also adjacent counties, Dublin and surrounding areas. Under the Health (Miscellaneous Provisions) Act 2010, the hospital became part of the HSE and later, part of the St Lukes's Radiation Oncology Network. The network operates from three locations – St Luke's in Rathgar, St. Luke's Radiation Oncology Units located in St. James Hospital and Beaumont Hospital and also provides a radiation day case service for paediatrics patients from Crumlin Hospital. The hospital is a member of Dublin Midlands Hospital Group[2] and managed by a Network Executive Management team reporting directly to the Chief Executive Officer (CEO). At the time of the inspection, six new regional health areas were being established by the HSE and as part of that process, the CHO 7 and Dublin Midlands Hospital Group were being aligned to the HSE Dublin and Midlands Regional Health Area.

The hospital accommodates 123 beds, made up of four in-patient acute wards (one in-patient ward (29 beds) currently closed to inpatients but two beds were utilised for day cases, a day unit and a five-day unit (Oakland's Lodge), which accommodates independent patients receiving treatment. Two in-patient wards, managed under separate governance structures in the hospital, provide transitional (step down) beds for patients from St James's Hospital (Ward A) and Tallaght University Hospital (Ward C) through formalised service level agreements. Services provided by the hospital include:

- comprehensive radiotherapy and oncology services
- day case procedures
- diagnostic services
- outpatient care.

The hospital provides post-graduate training in radiation oncology to a wide range of disciplines including doctors, nurses and physicists. The hospital also provides clinical

[1] 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

[2] The Dublin Midlands Hospital Group comprises seven hospitals. These are St James's Hospital, Tallaght University Hospital, Naas General Hospital, Midland Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, The Coombe Hospital, Regional Hospital Mullingar, St Luke's Radiation Oncology Network. The Hospital Group's Academic Partner is Trinity College Dublin.

education facilities for specialist registrars, radiation therapists and oncology nurses, amongst others and has an active research and development programme.

The following information outlines some additional data on the hospital.

Number of beds	56 inpatient beds 16 day case beds 51 beds in Oakland's lodge

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[3] 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.

[3]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-centered 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 January 2025	13.00- 17.15hrs	Elaine Egan	Lead
		Geraldine Ryan	Support
23 January 2025	08.45hrs – 13.40hrs	Angela Moynihan	Support

Information about this inspection

This announced inspection was undertaken to assess compliance of St Luke's Radiation Oncology Network compliance with the *National Standards for Safer Better Healthcare*. HIQA last undertook a medication safety thematic inspection in 2017.

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

- infection prevention and control
- medication safety
- the deteriorating patient[4] (including sepsis)[5]
- transitions of care.[6]

The inspection team visited Ward D.

The inspection team spoke with the following staff:

- Representatives of the hospital's Network Executive Management Team
  - General Manager (GM)
  - Director of Nursing (DON)
  - Interim Clinical Director
  - Assistant Director of Nursing (ADON)
  - Radiation Services Manager
  - Operations Manager
- Quality Patient Safety and Risk Director
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Interim Human Resource Manager

- Representatives from each of the following:
  - Hygiene Infection Prevention and Control and Decontamination (HIPCAD)
  - Drugs Advisory Committee (DAC)
  - Irish National Early Warning System (INEWS) and Sepsis lead
  - Bed Utilisation Committee.

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.

[4] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[5] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[6] 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

Over the course of the inspection, the inspectors spoke with a number of patients in the clinical area. Patients expressed positive feedback, stating "staff are great" and "food is great". One patient mentioned being "happy to be afforded daily leave over Christmas to go home and see family". Staff were observed to be actively engaged with patients in a kind, respectful and caring way. Patients were complimentary about the level of help and support received from staff and told inspectors if they had a complaint they would speak with nursing staff.

Capacity and Capability Dimension

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

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

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. While the governance arrangements were mostly consistent with those illustrated in the hospital's organisational charts, they did not align with information provided to inspectors on the day of inspection. Management acknowledged this and gave an undertaking to update organograms.

Inspectors spoke with members of the Network Executive Management Team (NEMT) who demonstrated a clear understanding of their roles, responsibilities and their individual reporting arrangements. The hospital's general manager (GM) was the senior accountable officer and had overall responsibility and accountability for the governance and the quality of health services delivered. The NEMT, chaired by the network director or the GM, met fortnightly and comprised senior management and clinicians in the hospital. Their role was to review network operations, performance, and the implementation of the network strategy. Minutes of meetings reviewed clearly indicated alignment with the terms of reference. There were two radiation centres on the campus of Beaumont and St James's Hospitals, which along with the hospital, operated as a single network with a single

executive management team directly reporting to Dublin Midlands Hospital Group CEO. There was a well-established reporting structure from the NEMT to the Group. While these structures were evolving with the newly formed Regional Health Authority Dublin and Midlands, which were at the early stages of transition at the time of the inspection, inspectors were told that the Integrated Health Area (IHA) manager had met members of Quality, Patient Safety and Risk Management (QPSRM) committee as part of the new structure.

The hospital had established two clinical directorates - physics and regulation service, which provided governance, management and operational oversight for their respective functions. The DON was a member of the NEMT and was assigned with responsibility for the service and management of nursing staff at the hospital.

The hospital's Quality, Patient Safety and Risk Management (QPSRM) committee, chaired by the director of quality patient safety and risk, met quarterly and reported to the NEMT. As outlined in the terms of reference, the QPSRM committee provided assurances to the NEMT that clinical governance structures and processes at the hospital were appropriate. Subcommittees of the QPSRM oversaw the effectiveness and the quality of practice in the four areas of focus of this inspection - infection prevention and control, medication safety, deteriorating patient (including sepsis) and transitions of care. Inspectors met with representatives of the QPSRM, reviewed minutes of meetings and it was evident the committees functioned as per terms of reference. Risks were discussed at each meeting, updates were provided and the risk register was discussed. All actions were assigned to a responsible person and it was evident that actions were progressed from meeting to meeting.

Inspectors conducted a review of the documentation for the three committees of the Clinical Risk Committee (the Drugs Advisory Committee (DAC), and the Hygiene, Infection and Control and Decontamination (HIPCAD) Committee). It was clear that each committee operated off a defined agenda, included relevant multidisciplinary members and all had terms of reference, except for the discharge committee. Inspectors met with representatives of the above committees, reviewed minutes of meetings and noted that regular updates were provided at each meeting and actions were assigned to responsible persons and were either time-bound or the status was monitored.

In summary, inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. There was a formalised structure upward reporting process from each governance committee to the NEMT and up to the Dublin Midlands Hospital Group. It was clear from the documentation reviewed and from meetings with relevant staff, that each governance committee discussed and monitored information on performance and quality of healthcare services, and of the hospital's compliance with defined metrics. All committee membership

included representation from the NEMT and clinical specialities, had a set agenda and actions were assigned to a responsible person.

Judgment: Compliant

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

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. The NEMT demonstrated a strong operational understanding of the issues affecting the quality and delivery of healthcare services. Hospital management had established several committees to achieve planned objectives and to ensure effective management arrangements for infection prevention and control practices, medication safety, and safe transitions of care.

The hospital's infection prevention and control team (IPCT), in line with its terms of reference, promoted and supported staff in implementing infection prevention and control practices. The IPCT was led by a consultant microbiologist and reported on the monitoring of surveillance and infection prevention control practices to the HIPCAD committee. Five subcommittees reported into the HIPCAD (Decontamination, Hygiene Services, Infection Prevention and Control, water safety and water management). A representative from each subcommittee attended the HIPCAD committee meetings held every second month. The IPC CNM 2 stated that the HIPCAD committee devised and approved the hospital's infection prevention and control programme which set out the priorities to focus on for the year.

The hospital's antimicrobial stewardship programme was implemented and overseen by the consultant microbiologist and the pharmacy team. The antimicrobial stewardship team reported into both the HIPCAD and DAC, which was evident in the minutes of meetings reviewed by inspectors.

The hospital's pharmacy service was led by the chief pharmacist and the DAC was the overarching committee overseeing the quality and safety of the pharmacy service and also supported medication safety practices. The DAC was a subcommittee of the Clinical Risk committee (CRC) and had defined and formalised reporting to that committee. Hospital management stated that the establishment of a formalised medication safety committee or medication safety programme was not in place due to staffing deficits in the pharmacy. However, inspectors observed medication safety was an agenda item on DAC, meeting held every six weeks. Medication safety was also discussed at the QPSRM under quarterly committee updates, which included trends of medication prescribing errors and

the measures taken to improve prescribing, and staffing deficits in pharmacy department. From evidence provided during this inspection, it was clear that there was oversight of medication safety at the hospital.

While the hospital did not have a deteriorating patient committee, a lead was in place (an ADON) who described their oversight of sepsis and INEWS in the hospital. Hospital management informed inspectors that the ADON attended the Dublin Midlands Hospital Group Deteriorating Patient Programme meetings. It was evident that sepsis audit results and deteriorating patient incidents were discussed at QPSRM committee quarterly meetings with improvements and learnings noted and shared. From evidence provided during this inspection it was clear that there was oversight of sepsis and INEWS in the hospital.

The hospital convened a Bed Utilisation meeting every two weeks and membership was multidisciplinary. The members had oversight of the management of hospital beds to ensure availability for newly admitted patients. The terms of reference reviewed did not clearly outline the reporting structure for the meeting. However, inspectors were informed that nurse management attended the bed utilisation meeting and any issues that could not be resolved were escalated by the director of nursing to the NEMT. It was evident from minutes of meetings that actions were assigned to a responsible person and status of actions were reviewed from meeting to meeting. Additionally, waiting lists and delayed transfers of care were reviewed. Inspectors were informed and documents reflected that any issues related to transitions of care were discussed with the DON, the clinical lead and the medical team. It was also evident that transitions of care were discussed at CRC and QPSRM committee meetings. Hospital management stated that a discharge committee was recently set up in response to complaints and incidents occurring during and following patient discharge. At the time of the inspection the committee had held seven meetings since 2023 and inspectors were told they planned to meet every second month, membership was multidisciplinary and inspectors were told the committee reported directly to the NEMT. Hospital management stated, and it was evident from review of minutes of the meeting that a number of improvements occurred or were in progress, for example, updating a number of documents for patient discharge including letters, discharge information leaflets, discharge against medical advice policy and discharge medication prescriptions. From evidence provided during this inspection it was clear that there was oversight of transitions of care in the hospital.

In summary, on the days of the inspection it was evident that the hospital had defined management arrangements in place.

Judgment: Compliant

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

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

Risk management structures were established in alignment with the HSE's Risk Management Framework policy. The hospital's director of quality, patient safety and risk was responsible for overseeing the effectiveness of the hospital's risk management processes, chaired the QPSRM committee and reported to the NEMT. Inspectors were informed and evidenced that risk assessments within the clinical area were documented in patients' care plans, overseen by the CNM 2. Risks that could not be managed in the clinical area were escalated to the QPSRM committee for review and inclusion on the corporate risk register. Inspectors were informed of plans to implement local risk registers in 2025, in accordance with the HSE's Enterprise Risk Management policy. Minutes of meetings reviewed indicated that all high-rated risks were escalated to the NEMT and discussed at the monthly performance meetings with the Dublin Midlands Hospital Group. From meeting with management representatives, a review of meeting minutes it was evident that clinical directorates and other governance committees such as HIPCAD, DAC and CRC supported by the director of quality, patient safety and risk, oversaw the effectiveness of the risk management process for the clinical services within their scope of responsibility.

The hospital had established structures and processes in place to proactively identify and address patient-safety incidents. The QPSRM and the NEMT were responsible for ensuring all serious reportable events, and serious incidents were reported onto the National Incident Management System (NIMS)[7] and managed in line with the HSE's Incident Management Framework. Hospital management stated that a Serious Incident Management Team (SIMT) meeting was organised as needed and that each committee had overall responsibility of implementing recommendations and sharing learning following reviews with the support of the director of quality, patient safety and risk. The

[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).

hospital had a Quality Patient Safety Program for 2024/2025, which aimed at improving patient experiences and outcomes.

Findings from a recent patient experience survey were mostly positive. Related quality improvement initiatives had either been implemented or were in the process of being implemented at the time of inspection. Further discussion on this topic can be found under national standards 1.7 and 1.8.

Overall, there were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Judgment: Compliant

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

The 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 the vacancy rate was low across all categories of staff in the hospital (7% - 8% deficits across all disciplines including nursing, catering, physics, pharmacy, radiotherapy and administration).

Hospital management confirmed that the hospital was funded for 25.73 WTE radiation oncology consultant posts and all positions were filled. All radiation oncology consultants were on the relevant specialist division of the specialist register with the Irish Medical Council (IMC). Radiation oncology consultants were supported by a total of 37 WTE non consultant hospital doctors (NCHDs), 17 WTE specialist registrars, 1 WTE senior registrar, 11 WTE registrars and 8 WTE senior house officers. On the days of the inspection, there were no deficits in medical posts in the hospital.

The hospital was funded for a total of 7 WTE pharmacy posts which included 4 WTE pharmacist posts and 3 pharmacy technician posts. At the time of inspection, there were 3 WTE (75%) of pharmacy posts 2 pharmacy technician posts were filled. Hospital management informed inspectors the 28.5% deficit impacted on the ability to provide a comprehensive clinical pharmacy service and on the surveillance and promotion of medication safety practices across the hospital. However, staff informed inspectors they could access clinical pharmacy when required. This risk along with mitigating actions was recorded on the hospital's risk register and escalated to the Dublin Midlands Hospital Group.

IPCT comprised 0.2WTE microbiologist, 1 CNM2 and 0.5 WTE AMS Pharmacist. The 0.5 WTE for the AMS Pharmacist was vacant at the time of inspection.

There was a total of 82.5 WTE approved nursing posts (inclusive of management and other grades). On the days of the inspection, 71.0 WTE (86%) nursing posts were filled and 11.5 WTE (14%) nursing posts were vacant. The specialities with higher levels of vacancy were in theatre, the day ward and radiotherapy nursing outpatients department. The delivery of nursing care was supported by healthcare assistants (HCAs) The hospital was approved for 31.5 WTE HCA staff. On the days of inspection 26.5 WTE posts were filled. In addressing the nursing and HCA staffing deficit, hospital management stated that ward B was closed, except for two isolation rooms. Patients were being cared for by staff from ward D, which was in close proximity and inspectors observed this during the inspection. The staffing deficits were also noted on the corporate risk register and escalated to the Dublin Midlands Hospital Group. Hospital management expressed that agency nurses, familiar with the hospital, covered any shortfalls in nursing staff when required and had completed the hospital's induction training program. The ward visited had a full complement of nursing staff on the day and a second CNM 2 post was awaiting approval.

Inspectors were informed that staff absenteeism current rate was 5.6% which was above the HSE target of 4% or less. The human resource department was tracking absenteeism rates and reported to the NEMT and the Dublin Midlands Hospital Group. Management stated that succession, recruitment and retention planning were an ongoing focus of the NEMT. An induction programme was provided to all new staff and this was confirmed by staff who had attended the induction programme.

Hospital management confirmed that two members of the NEMT provided an on-call rota for the hospital seven nights a week. Management agreed with inspectors' observation that this arrangement was unsustainable and presented inspectors with a plan to develop a rota in collaboration with all members of the NEMT, a draft policy to support same, both of which were pending approval at the time of inspection. Additionally, there was a plan to provide training for non-clinical staff to provide on-call cover.

Hospital management outlined how each department was responsible for overseeing staff attendance at mandatory training and described a plan to centralise training records through the human resources department in the near future. Department managers were responsible for monitoring the uptake of essential and mandatory training by staff. Attendance of NCHDs at essential and mandatory training sessions was recorded in the National Employment Record (NER) system, with copies also sent to the human resource department in the hospital. Radiation oncology consultants were responsible for monitoring the uptake of staff training by NCHDs.

Training records reviewed by inspectors showed deficits in the attendance and uptake of mandatory and essential training in for example, basic life support, standard and

transmission based precautions across all disciplines of staff in the hospital, hand hygiene for doctors and HSCPs and INEWS training for HCAs were noted. Staff who spoke with inspectors during inspection confirmed they were up to date on essential and mandatory training.

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

- the current on-call arrangements for senior management staff at the hospital were unsustainable
- deficits in the attendance and uptake of mandatory and essential training in for example, basic life support, standard and transmission based precautions across all disciplines of staff in the hospital, hand hygiene for doctors and HSCPs and INEWS training for HCAs were noted
- staffing deficits in pharmacy, nursing and HCA posts were noted.

Judgment: Partially compliant

Quality and Safety Dimension

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

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

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity.

There were 16 en-suite single rooms and three four-bedded bays in the ward. Each bay had a toilet and a shower and disposable privacy curtains were in place around each bed space. Patients had access to individual call bells, oxygen and suction points at all bed spaces.

Healthcare records were stored securely in a room behind the nurse station. A whiteboard with minimal patient information was also located in a secure location in the ward. However, patients' personal information was displayed over beds and this was brought to the attention of the CNM who addressed same. CCTV was used to observe patients accommodated in single en-suite rooms and who required particular treatment. Inspectors observed that the CCTV was in a secure location in the ward. The hospital had a policy for the use of CCTV, which included that verbal consent is to be taken but the policy did not include that verbal consent was to be documented in the patient notes. Additionally, while inspectors were informed that patients' consent was sought and documented in their healthcare records, inspectors found no evidence of this in the patients' records reviewed.

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

- documentation regarding seeking a patient's consent for the use of CCTV was not observed in the healthcare records reviewed by inspectors.
- The hospital's policy for the use of CCTV did not include that patient's consent for the use of CCTV was to be documented in the patient's notes.

Judgment: Substantially compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care. Inspectors observed staff to be respectful, kind and caring towards patients and were communicating in an open and sensitive manner. Patients were highly complementary about their interactions with staff. Patients told inspectors they were "happy with the level of support from staff", "staff are great" and another patient told inspectors they were "happy to be afforded daily leave over Christmas to go home and see family".

There was a significant focus on providing a patient-centred approach to care in the ward. Each patient had their own care plan with a strong focus on continence and skin care. Care bundles were in place for peripheral venous catheter[8] (PVC) and central venous

[8] A central venous catheter is a long, flexible, y-shaped tube that is inserted through one of the central veins found in your neck, chest or groin to allow access to the bloodstream. A CVC is much longer than the standard IV and is placed deeper in the body into larger blood veins. The CVC is also able to remain in the body for a longer period of time than the standard intravenous line.

catheter[9] (CVC) lines. Management stated that there was a focus on enhancing person-centred care and clinical communication skills. Various disciplines of staff had attended a National Healthcare Communication Programme education session. This was confirmed by staff and noted in training records. Management informed inspectors that additional sessions were planned for later in the year. Inspectors noted that staff had access to a multilingual manual in the ward and staff stated that patients had access to interpreter services. A family sitting room was available for visitors.

Call bell audits conducted from April to August 2024 assessed patients' knowledge, awareness, and access to call bells on the ward. The results indicated that call bells were functional on every occasion. Patients' access to call bells improved from 82% in April to 92% in August 2024, and patient awareness of using the call bell to request assistance increased from 88% in April to 100% in August 2024.

A patient survey was conducted in the hospital from July to September 2024. A feedback report provided, detailed patient responses on a range of themes. Overall, the feedback was positive. This is discussed further under national standard 1.8. Information leaflets on a range of health topics were available and accessible to patients.

Judgment: Compliant

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

Inspectors found that there were systems and process in place in the hospital to respond to complaints and concerns. The complaints manager was supported by the patient safety manager and the director of quality patient safety and risk. The hospital's complaints policy was an adapted version of "*Your Service Your Say"*.[10] Complaints management training was provided for all staff. Point of contact complaints resolution was promoted and supported in line with national guidance.

[9] Peripheral venous catheter, is a catheter (small, flexible tube) placed into a peripheral vein for venous access to administer intravenous therapy such as medication fluids.

[10] Your Service, Your Say' is the name of the HSE's complaints process for all users of HSE funded services. In addition to being a complaints process, "Your Service, Your Say" is also a way to provide feedback to the HSE

It was evident that complaints were discussed at the CRC, QPSRM committee and the NEMT meetings. Hospital management expressed how they had a close working relationship with the Dublin Midlands Hospital Group and had no requirement to escalate any complaints recently. It was evident that the hospital was compliant with HSE's target to resolve 75% of complaints within 30 days in 2024. Inspectors observed that information leaflets and a poster on advocacy services were available in the ward.

Inspectors observed feedback leaflets in the ward and were informed that verbal complaints were documented in patients' healthcare records. Due to the low number of complaints reported in 2024, a track and trend analysis of complaints was not available for the ward. In 2024, St. Luke's received over 500 compliments from patients. Quality improvements implemented in response to complaints included the introduction of a taxi companion service to support patients during transfers.

Staff on the ward told inspectors they received feedback on the patient survey completed in 2024. Quality improvement plans following the survey included providing more choice of food for patients. Hospital management described how additional improvements included a new virtual OPD appointment letter and delay time information displayed on screens within the radiotherapy waiting area. Management outlined how they were in the process of implementing a plan to reduce delays in appointment times in the outpatient department. This initiative was also evident in the feedback report reviewed.

Patients who spoke with inspectors were not familiar with the hospitals complaints process but informed inspectors if they had a complaint they would speak to a member of staff.

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.

The physical environment in the ward was generally secure, well maintained and clean. All single rooms had en-suite bathroom facilities. In the multi-occupancy rooms, patients shared an en-suite bathroom within each bay. Inspectors noted that shared en-suite bathrooms were clean and cleaning checklists were completed on the day of inspection. Adequate physical spacing was observed between beds in multi-occupancy rooms.

Inspectors were told that privacy curtains were changed on patient discharge or as required.

The ward had a dedicated cleaner each day. Management and staff in the ward told inspectors that any cleaning required overnight was carried out by HCAs. The CNM stated that they and the cleaning supervisor had oversight of the cleaning on the ward. The hospital employed an external cleaning company for environment and terminal cleaning[11] and inspectors were told there was good access to the cleaning supervisor and maintenance when required.

Generally, the cleaning of equipment was assigned to HCAs. Inspectors observed a system in place to identify when equipment was cleaned. There was appropriate segregation of clean and used linen. Hazardous materials were safely and securely stored, however, waste material was not disposed as per policy and this was brought to the attention of the CNM for action.

Wall-mounted alcohol hand sanitiser dispensers were strategically located and readily available to staff. Additionally, hand hygiene signage was prominently displayed in the ward. Inspectors observed that not all hand hygiene sinks were HBN compliant.

Patients requiring standard and transmission-based precautions were accommodated in single rooms on the ward and the single isolation room doors were closed. Personal protective equipment was available outside single rooms and all multi-occupancy rooms. The correct and appropriate use of infection prevention and control signage in relation to standard and transmission-based precautions was observed in the ward visited.

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

- not all hand hygiene sinks were compliant with HBN requirements
- waste material was not disposed as per policy.

Judgment: Substantially compliant

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management confirmed that information from a variety of sources was used (KPIs,

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

findings from audit activity, risk assessments, patient-safety reviews, patient and family feedback) to support the continual improvement of healthcare services. The hospital had an audit schedule in place for 2025, which included weekly hygiene audits, monthly nursing activity, sepsis, INEWS audits and INEWS escalation audit every second month, safe surgery audit twice a year and decontamination audit three times a year.

Infection prevention and control

As per the HSE's reporting arrangements, hospital management reported monthly on rates of *Clostridioides difficile*[12] infection, *Carbapenemase-producing Enterobacterales*[13] (CPE), hospital acquired *Staphylococcus aureus*[14] blood stream infections, hospital acquired *methicillin-resistant Staphyloccus aureus* (MRSA), COVID-19 and infection outbreaks. The IPCT reported every second month at the HIPCAD committee meeting on surveillance (*Clostridioides difficile*, CPE, *Staphylococcus aureus, central line associated infections, catheter related blood stream infections and COVID-19)* and the HIPCAD reported quarterly to QPSRM committee. Inspectors were informed that a summary report of the hospital's healthcare-associated infection surveillance was submitted annually to the QPSRM and NEMT. Actions taken to reduce rates of *Staphylococcus aureus* included updating care bundles, staff education and implementing a new dressing for PVC/CVC lines.

Clinical equipment audits were carried by the infection prevention and control CNM2 using a computerised system. A review of minutes of meetings indicated that audit findings were discussed at the HIPCAD committee meetings. A sample of clinical equipment audits completed in the ward from April, July and November 2024 scored 55%, 77% and 84% respectively. Inspectors were told that actions were assigned to the ward CNM 2, however, while results improved over time only one action was assigned to a responsible person in the documents reviewed by inspectors.

The environmental audits were carried out by the members of the Hygiene committee using a digital system provided by the external; contracted cleaning company. A sample of audits were reviewed from August, November and December 2024 and scored 96%,

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

[13] Carbapenemase-Producing Enterobacteriales (CPE), are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat.

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

96% and 95% respectively. A review of minutes of meetings indicated that audit findings were discussed at the HIPCAD committee meetings.

Hand hygiene audits were carried out by the infection prevention and control CNM 2. A review of minutes of meetings indicated that audit findings were discussed at the HIPCAD committee meetings. Inspectors reviewed results of hygiene audits submitted to HIQA for the ward completed in August, September and October 2024 scoring 83%, 37% and 85% respectively. The IPC representative stated when results fell below the expected standards additional hand hygiene training was provided and this practice was re-audited. As part of a quality improvement initiative, a hand hygiene scanner was installed on the ward to enable staff to conduct self-assessments of their hand hygiene practices. A hand hygiene audit completed in December of three clinical areas included the ward visited by inspectors had an overall result of 82% with ward D scoring 67%.

Nursing and midwifery metrics monitored healthcare associated infection prevention and control in the ward and good levels of compliance ranging from 90%-100% in October, November and December 2024 were noted.

Medication safety

There was some evidence of monitoring and evaluation of medication safety practices at the hospital. The storage and custody of medicines was monitored in the ward. Recent audits reviewed included a pharmacist dispensing and documentation practices audit, specifically identifying missing signatures on pharmacy drug requisitions. The audit results were disseminated to all pharmacists for educational purposes and immediate corrective action. A follow-up audit was planned to assess the implementation of the recommended improvements.

An audit was conducted on discharge summaries within the electronic system due to the pharmacy's inability to provide discharge review services. In the absence of pharmacy staff, registrars were responsible for reviewing prescriptions. A total of 30 discharge summaries were reviewed February to March 2024. The findings indicated a prolonged timeframe for the completion of discharge summaries, extending up to 24 days. Additionally, 35% of prescriptions were not reviewed by a pharmacist and/or a registrar prior to discharge. The recommendations included reporting all errors as patient-safety incidents, and while actions were assigned to a responsible person, actions were not time-bound. Hospital management detailed other quality improvement initiatives arising from medication audits which included the implementation of the "10 Rights of Medication" to enhance staff awareness regarding medication safety.

Medication practices were monitored monthly as part of the nursing and midwifery care metrics. A review of the documentation indicated a high level of compliance in the ward for medication safety, with results ranging from 93% to 98% in October, November, and December 2024. Medication storage and custody results ranged from 86% to 94%. It

was evident when results fell below 90%, an action plan was developed, assigned to a responsible person, and time-bound to ensure timely resolution.

A medication management audit was completed monthly on the ward by the education coordinator and patient flow coordinator. The audit focused on assessing the competence of nurses in medication management and medication safety on the ward. A review of medication management audits completed in September, October, and November 2024 indicated that resulting action plans included nurses participating in the hospital's chemotherapy study day and wearing red aprons during medication rounds (as observed on inspection). Actions were assigned to each individual nurse but were not time-bound.

The hospital's antimicrobial stewardship practices were monitored and evaluated. These included participating in the European Centre for Disease Prevention and Control[15] point prevalence of hospital-acquired infections and antimicrobial use. The findings from 2024 were not published at the time of this inspection. However, hospital representatives outlined that there was a focus on changing from intravenous antibiotic use to oral use, and that antimicrobial rounds had not recommenced due to the current pharmacy staffing levels. Inspectors were informed that reserve antibiotics were dispensed only when recommended by the microbiology team. Inspectors were told, when staffed with an AMS pharmacist, a weekly report was given to the assigned microbiology consultant on antimicrobial usage in the hospital and reported to the DAC and HIPCAD. The antimicrobial stewardship plan for 2025 included prescriber feedback, antimicrobial stewardship rounds, audits, surveillance, reviewing incidents, KPIs, education, updating guidelines and quality improvement projects.

Deteriorating patient

Inspectors were informed that compliance with the national early warning system escalation and response protocol and sepsis were audited monthly by the ADON (the sepsis lead). Inspectors found that compliance rates in the months preceding the inspection ranged from 91% - 100% in the ward.

A hospital sepsis audit conducted in September, October and November 2024 scored 50%, 70% and 60% respectively. Inspectors were told that feedback on audit results were given to staff at the time of audit and feedback was also presented at the CRC meeting and this was evident in the minutes of meetings reviewed and confirmed by ward staff. Inspectors were informed that a quality improvement action plan had been implemented, with a focus on staff education. Additionally, efforts were currently in progress to update the fluid balance chart. However, actions were not time-bound. The

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

hospital participated in the National Sepsis 6 audit in December 2024 and was waiting feedback at the time of the inspection.

Transitions of care

Clinical handover occurred twice a day in the ward. The clinical handover communication tool, Identify, Situation, Background, Assessment, Recommendation/Readback/Risk (ISBAR2[16]) was recently introduced.

Overall, the hospital was monitoring and evaluating healthcare services provided to improve care. Nonetheless:

- actions implemented from audit findings were not all assigned to a responsible person (HIPCAD) and not all actions implemented were time-bound (medication management, sepsis).

Judgment: Substantially compliant

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

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

Risk Management

There were systems in place to proactively identify, assess and manage immediate and potential risks to patients. Risks with associated controls and assigned actions to mitigate the risk to patients were recorded on the corporate risk register viewed by inspectors and high-rated risks documented included, ageing equipment, aspergillus, the requirement for additional capacity and staffing. Risks associated with the four areas of harm were documented on the corporate risk register and included medication reconciliation and low pharmacy staffing levels (high-rated risks), infection prevention and control (medium rated risks), sepsis and clinical handover (low rated risk). It was noted that all risk assessments had assigned, time-bound actions and were regularly reviewed. Management stated and staff confirmed that quality, patient safety and risk training was provided to all staff included incident management and risk management. There was a plan to introduce departmental risk registers in 2025 in line with the national Enterprise Risk Management policy. Staff in the ward were knowledgeable about

[16] ISBAR communication tool stands for Identify, Situation, Background, Assessment and Recommendation. The tool is a structured framework which outlines the information to be transferred. ISBAR is a versatile and effective tool which can be used in a variety of situations, such as bedside handover, internal or external transfers (e.g. from nursing home to hospital, from ward to theatre) communicating with other members of the multidisciplinary team, and upon discharge/transfer to another health facility.

risk assessments and risks associated with radioactive iodine treatment. It was noted from a review of meeting minutes and from discussions with management that all high-rated risks were reviewed fortnightly by the NEMT and at monthly HSE performance meetings. Risks discussed included risks associated with lack of staff (nursing, engineering and pharmacy), ageing equipment, and a recent COVID-19 outbreak. While risk was a standing agenda at all governance and committee meetings, the NEMT meeting agenda required updating to reflect this.

Infection prevention and control

In line with national guidelines patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs). The hospital's electronic system alerted staff to patients previously confirmed with MDROs at St James and Beaumont hospitals. Management stated that compliance with MDRO screening was audited by the IPCT . Progress made on implementing the annual plan was formally reported to the HIPCAD, QPRSM and NEMT. The annual IPC report for 2024 had not yet been completed at the time of inspection. Inspectors reviewed the 2024 and 2025 IPC annual programs, which outlined the quality improvement initiatives undertaken by the IPCT in 2024 and plans for 2025, which included refurbishment of toilets in the multi-occupancy bays in ward D, ongoing education to all staff in hand hygiene and mandatory infection prevention control training. Staff stated that patients requiring transmission-based precautions were placed in a single room on admission or at diagnosis, in line with national guidance and hospital policy, this was evident on the day of inspection. If isolation facilities were not available, suitable patients were cohorted in multi-occupancy rooms. On the day of the inspection there was no infection outbreak in the hospital. Inspectors noted that staff demonstrated a strong understanding of outbreak management protocols. Hospital management confirmed that staff had access to a microbiologist 24/7 based at St Vincent's University Hospital for advice when required. Members of the antimicrobial stewardship team infomed inspectors of their participation in the 2024 National Point Prevalence Survey of antimicrobial use and indicated that they were awaiting the results of the survey.

Medication safety

A limited clinical pharmacist service[17] was available for essential services (dispensing and chemotherapy). Until recently, the hospital provided a full medication reconciliation service however, medication reconciliation was currently not delivered by a pharmacist due to staffing deficits in the pharmacy department. Inspectors were told that SHOs were encouraged to complete medication reconciliation on admission and discharge. Staff stated they could contact the pharmacy department for advice when required. There was a process in place to source medications required outside of core working

[17] 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.

hours. Staff stated that they applied risk reduction strategies with high-risk medications aligned with APINCH[18]. A list of sound-alike-look-alike medications underpinned by a hospital policy was available. Prescribing guidelines including antimicrobial guidelines and medication information were available and accessible to staff at the point of care, however, a small number of infographics were not up to date, and this was brought to the attention of the CNM for action. Inspectors observed that medication was stored securely and in line with national guidance. A small number of medications stored in the fridge required discarding due to being opened, not labelled, and stored for more than 28 days. This issue was brought to the attention of staff, and the medications were discarded immediately. Medication fridge temperature records reviewed reflected that temperatures were monitored.

Deteriorating patient

Staff used the most recent version of the INEWS for all patients on the ward. The 'Sepsis 6' care bundle[19] was available to support staff to recognise and respond to the deteriorating patient. The hospital recently introduced the $ISBAR_2$ as a communication tool for clinical handovers. Staff were knowledgeable about the INEWS escalation and response protocol to ensure timely management of patients with a triggering early warning score. Inspectors reviewed a number of patients' healthcare records and noted that the INEWS was appropriately recorded and at the required frequency. Emergency equipment was readily available, such as a resuscitation trolley, a manual defibrillator and an emergency trolley, all which were checked daily. Oxygen points were at each bedside. Sepsis (including neutropenic sepsis) management guidelines were available to staff.

Transitions of care

There was a system and policy in place to support discharge and the safe transfer of patients within and from the hospital during and outside of core working hours. The hospital had a defined criteria for admission and consultants reviewed and assessed all referrals. Patients were admitted via the admissions office close to start date of radiotherapy treatment. Hospital management informed inspectors the hospital very rarely experience delayed transfers of care (DTOC), and the average length of stay (ALOS) for a patient was 22 days. Key performance indicators (KPIs) for DTOC and ALOS were monitored monthly on the hospital's KPI balance scorecard. The hospital did not access community beds. A social worker was available to engage with patients and their

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

[19] Sepsis 6 care bundle, components are blood cultures, check full blood count and lactate, IV fluid challenge, IV antibiotics, monitors urine output and give oxygen.

families regarding any discharge issues. Referrals to the public health nurse were completed prior to patient discharge. A discharge committee was recently established as part of a quality initiative in response to complaints about lack of information on discharge and delays in receiving discharge summaries and prescriptions. Management described the implementation of a new electronic mailing system and a new alert introduced on the hospital's IT system to identify patients for daily discharge. A policy was available to staff at the point of contact on discharging patients from the wards.

Policies procedures and guidelines

Staff had access to a range of up-to-date infection control, medication safety, transitions of care and deteriorating patient policies procedures, protocols and guidelines via a document management system and in hard copy format. A small number of policies required updating, such as transmission-based precautions, clinical pharmacy medication reconciliation and management of outage. Hospital management stated that the hospitals' policies on incident management and management of patient feedback were in draft format and currently under review.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm. However:

- medication infographics and a small number of hospital policies were not up to date
- the NEMT meeting agenda required updating to reflect that risk was an item discussed at every NEMT meeting.

Judgment: Substantially compliant

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

The hospital had systems in place to identify, manage, respond to and report patient-safety incidents in line with national legislation and standards, policy and guidelines. All patient-safety incidents were reported on a local electronic system and the NIMS. Staff who spoke with inspectors were knowledgeable about how to report a patient-safety incident.

Patient-safety incidents were reported to NIMS in line with national guidance and reporting onto NIMS was timely, and in line with national targets. No serious reportable events or comprehensive reviews of adverse incidents were open at time of inspection. This was also evident in the annual report reviewed by inspectors. Data on patient-safety incidents was included in the quality and patient safety report submitted to the NEMT and the Dublin Midlands Hospital Group.

It was evident that reported incidents were tracked and trended by the quality patient safety and risk team and shared with the relevant committees. The most common trends in patient-safety incidents reported in 2024 related to slips, trips and falls, medication errors and healthcare associated-infections. Inspectors were informed that tracking and trending of patient-safety incidents were shared with CNMs on the ward by ADON at staff meetings. The CNM who spoke with inspectors shared the lessons learned and the mitigating actions taken following a recent patient-safety incident on the ward. Hospital management told inspectors that learning from patient-safety incidents was also shared via email, at the excellence awards and at staff meetings.

Inspectors were informed that the implementation of recommendations from reviews of patient-safety incidents was the responsibility of the relevant governance committees, monitored by the QPSRM committee. Inspectors were told all relevant infection prevention and control incidents were reviewed with the associated corrective actions outlined. This was also evident in the annual report on incident management and learnings 2024 reviewed by inspectors. Medication-related patient-safety incidents were categorised and logged on NIMS. All medication incidents and corrective actions were reported and reviewed at the CRC meetings and reported at QPSRM quarterly meetings. This was also evident in the annual report on incident management and learnings 2024 reviewed. A sample of the quality, patient safety and risk reports submitted to the NEMT reviewed by inspectors contained information about the four areas of harm focussed on this inspection.

Hospital management stated that while they did not have a formal SIMT meetings schedule, if a serious incident occurred management would convene an urgent SIMT meeting.

Overall, the hospital had systems and processes in place to identify, manage, respond to and report patient-safety incidents using an agreed taxonomy, in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

Conclusion

An announced inspection of St Luke's Radiation Oncology Network was carried out to assess compliance with national standards from the *National Standards for Safer Better Healthcare*. Overall, the hospital was found to be compliant in six national standards (5.2, 5.5, 5.8, 1.7, 1.8 and 3.3), substantially compliant in four national standards (1.6, 2.7, 2.8, and 3.1) and partially compliant in one national standard (6.1).

Capacity and Capability

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 hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital's workforce arrangements were managed to ensure the delivery of high-quality, safe and reliable healthcare. However, the current on-call arrangements for senior management staff at the hospital were unsustainable. Staffing deficits in pharmacy, nursing and HCA posts were noted and there was deficits in the attendance and uptake of mandatory and essential training.

Quality and Safety

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care. Inspectors found that there were systems and process in place in the hospital to respond to complaints and concerns. The physical environment in the ward was generally secure, well maintained and clean. Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. Arrangements were in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care. The hospital had systems in place to identify, manage, respond to and report patient-safety incidents in line with national legislation and standards, policy and guidelines.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is

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

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	**Compliant**
Standard 5.5: Service providers have effective management arrangements to support and promote	**Compliant**

the delivery of high quality, safe and reliable healthcare services.	
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	**Partially compliant**
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Substantially compliant**
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	**Compliant**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Compliant**
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	**Substantially compliant**
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	**Substantially compliant**
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	**Substantially compliant**

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

Compliance Plan for St Lukes's Radiation Oncology Network OSV:1104

Inspection ID: NS_0111

Date of inspection: 23 and 24 January 2025

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

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

1) On-call arrangments for Senior Management

The current draft procedure, as referred to within the report, is being finalised. A timeline for completion and issue of the procedure is the end of Q2 2025.

2) Deficits in attendance and uptake of mandatory and essential training

St. Luke's Radiation Oncology Network will implement a training compliance and monitoring system. The timeline for configuration and implementation of the system is the end of Q4 2025. As an interim measure, line managers will continue to maintain records of training and monitor compliance on a local level.

Outstanding IPC training will be provided to the appropriate staff groups and the induction will have additional IPC training included, particularly in the area of standard and transition-based precautions.

Each staff group will be reviewed to assess training needs and gaps, training schedules will be planned accordingly.

The timeline for the assessment of training needs and subsequent additional training is the end of Q3 2025

3) Staffing Deficits

Pharmacy – A recent recruitment campaign resulted in a panel of canidates to fill vacant positions. We are working with the HSE Dublin South City and West IHA to move to the next stages in the recruitment pathway. Timelines will be determined by the HSE recruitment processes.

Nursing -A recent recruitment campaign resulted in a panel of canidates to fill vacant positions. We are working with the HSE Dublin South City and West IHA to move to the next stages in the recruitment pathway. Timelines will be determined by the HSE recruitment processes.

HCA's - A recent recruitment campaign resulted in a panel of canidates to fill vacant positions. We are working with the HSE Dublin South City and West IHA to move to the next stages in the recruitment pathway. Timelines will be determined by the HSE recruitment processes.