Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of healthcare service provider:	St Mary's Hospital, Rehabilitation and Community Inpatient Healthcare Service
Address of healthcare service:	Acres Road Phoenix Park, Dublin 20 D20TY72
Type of inspection:	Announced
Date(s) of inspection:	16 and 17 January 2025
Healthcare Service ID:	OSV-0007277
Fieldwork	NS_0115

About the healthcare service

Model of hospital and profile

St Mary's Hospital in the Phoenix Park is a rehabilitation and community inpatient healthcare hospital. It is owned and managed by the Health Service Executive (HSE) and under the governance of Older Persons Services covering Integrated Health Areas (IHA) of Dublin North County (DNC) and Dublin North City and West (DNCW) (Previously Community Health Organisation (CHO) 9). From here on referred to as IHA DNC DNCW. At the time of inspection, the organisation was in a period of transition from CHO 9 structures to IHA structures.

The hospital provided 101 rehabilitation beds. Patients were admitted from referring acute hospitals following an episode of acute care for rehabilitation, including stroke rehabilitation. Additionally, the hospital admitted individuals for rehabilitation from the local community and from the Integrated Care Programme for Older Persons.* On the day of inspection, 91 beds were occupied.

Care in the hospital was delivered by a multidisciplinary team of doctors, nurses and allied healthcare professionals including physiotherapists, occupational therapist, speech and language therapists and dieticians, led by a Lead Consultant Geriatrician.

The Phoenix Park Community Nursing Unit also onsite did not form part of this inspection.

Number of beds	101 rehabilitation beds.

* The aim of the integrated Care Programme for Older Persons is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.

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 publically 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-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.

The inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
16 January 2025 17 January 2025	09.00 – 16.45 09.00 – 14.45	Aedeen Burns	Lead
		Sara McAvoy	Support
		Robert Mc Conkey	Support

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:

- Achill Ward (stroke and general rehabilitation)
- Skellig Ward (general rehabilitation)

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

- Representatives of the hospital's Executive Management Team
  - Operations Manager (Deputising for Hospital Manager)
  - Director of Nursing for Older persons services IHA DNC and DNCW
  - Lead Geriatrician
  - General Manager for Older Persons Services IHA DNC and DNCW
- Quality and Patient Safety Advisor
- Representative for the non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager for IHA DNC and DNCW
- A representative for each of the following areas
  - Infection Prevention and Control (IPC)
  - Drugs and Therapeutics
  - The deteriorating patient
  - 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 spoke with patients on two wards and observed care being delivered over the course of the two days of inspection.

Patients expressed satisfaction with the care provided on both wards visited in the hospital offering positive feedback on their experiences. Comments included, being "thrilled with the care" and staff were described as "very caring." Patients demonstrated awareness of their care plans and reported no complaints. Inspectors observed staff interacting with patients in a manner that was kind, respectful, and considerate. Staff were seen providing support and assistance tailored to the individual needs of patients.

Information on the HSE '*Your Service Your Say'* (YSYS)[‡‡] complaints process was displayed on the wards and suggestion boxes for concerns and compliments were available on the wards. Patients who spoke with inspectors were not aware of the complaints procedure but voiced no concern about approaching staff if they had a complaint. Information was also displayed on advocacy services available to patients.

In the clinical areas visited patients were accommodated in multi-occupancy single-gender rooms, or single rooms. Each of these rooms had a toilet and shower room. Each ward visited had six single rooms with en-suite shower and toilet facilities.

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 standards related to workforce, use of resources.

[‡‡] Your Service Your Say is the HSE service process to listen and respond to feedback about services
Make a complaint or give feedback - Your Service Your Say - HSE.ie

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

St Mary's hospital had formalised governance arrangements in place, however inspectors identified areas which required improvement in order to fully ensure the provision of high quality safe and reliable healthcare.

Organisational charts setting out the hospital's reporting structures including governance and oversight committees that were submitted to HIQA did not accurately reflect the reporting arrangements for hospital management and the accountability relationship upwards to the IHA manager. Key hospital committees and their reporting relationships were absent from these diagrams. Similar findings were identified during the hospital's inspection in 2023 and had not been addressed. The hospital committee on nutrition and hydration had not met in six months.

The Interim Hospital Manager was responsible for the operational management of the hospital and reported to the general manager for older persons' services IHA DNC DNCW, who in turn reported to the Head of Older Persons Services, and upwards to the IHA manager. The post of hospital manager had not been filled on a permanent basis since prior to the previous inspection in 2024. Inspectors were informed that a permanent hospital manager had been appointed and was due to take up post in February 2025.

The position of Director of Nursing (DON) for the hospital had been vacant for 18 months despite two competitions being held for the post. The Director of Nursing for Older Persons Services for IHA DNC DNCW described holding the responsibilities of this post in addition to their own post. Inspectors found that these arrangements were not sustainable in the long term and hospital management should progress to fill the position of a permanent DON at the hospital.

Medical governance for the hospital was led by a Lead Geriatrician for the facility who also had full time clinical commitment. The necessary arrangements were in place to ensure that there was a named consultant clinically responsible and accountable for the patients' care throughout their admission.

The Hospital Manager and DON for Older Persons for IHA DNC DNCW were members of the Older Persons Management Team for IHA DNC DNCW. This team met monthly at Integrated Health Area (IHA) level. As per their terms of reference this was a forum to provide information on operational matters. Reports discussed covered finance, human resources, activity, capital and estates projects and quality and safety. Meetings of the Older Persons Management Team followed a set agenda and evidence was seen that reports were collated and circulated prior to each meeting for review.

The Senior Management Team (SMT) at St. Mary's Hospital were responsible for overseeing the hospital's operational activities. The SMT's responsibilities included reviewing matters related to staffing, quality and patient safety, infection prevention and control and financial management. According to the terms of reference submitted to HIQA, the SMT was chaired by the Hospital Manager and should meet weekly. The terms of reference did not outline reporting and accountability arrangements and the group was not represented on organisational charts. Meeting minutes reviewed by HIQA indicated that meetings were not held in line with the frequency outlined in the terms of reference, action points were not time-bound, and were not consistently monitored from one meeting to the next. Meetings did not follow the set agenda submitted. It was noted that senior nursing representation at SMT for the rehabilitation wards was not consistent.

The Quality and Patient Safety Committee (QPSC) was responsible for development and delivery of the quality and safety programme for the service and, as per their current terms of reference, reported to the hospital SMT. Terms of reference for the QPSC were under review, and as described to inspectors and seen in draft terms of reference, the QPSC had a dual reporting relationship to both the hospital Senior Management Team and the Head of Older Persons Services via the Quality, Safety & Service Improvement Department (QSSI) at IHA level. It was chaired by a consultant geriatrician. Evidence was seen that the QPS committee had oversight of the implementation of recommendations from reviews, oversight of complaints management and the management of the risk register. The QPSC received and reviewed reports from the Clinical Review Committee, Falls Committee, Infection Prevention and Control and Antimicrobial Stewardship Committee, and Safeguarding Committee. The QPSC also reviewed data on complaints and compliments and from quality and safety walk-round [§§] events. The hospital had a Quality and Patient Safety Advisor who was a member of the QSSI department at IHA level and provided updates to and from the QSSI department relating to quality, patient safety and risk at QPSC meetings. Meeting minutes reviewed by inspectors indicated that meetings of the QPSC followed a set agenda and were held with the frequency outlined in the terms of reference. Action points were clear, allocated to individuals, time-bound, and consistently monitored from one meeting to the next. However, it was noted some core members as identified in the terms of reference did not attend consistently.

The Drugs and Therapeutics Committee (DTC) provided governance over medication safety at the hospital. It aimed to provide assurance on the provision of safe, effective medication treatment in the hospital. The DTC was chaired by a consultant geriatrician and reported to the QPSC on a quarterly basis. Pharmacy representation on the DTC was provided by a private external provider which supplied medications to the hospital. As per their terms of reference this committee was supposed to meet every two months,

[§§] Structured process to bring senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent, detect and mitigate patient/staff harm

however, records reviewed indicated that the committee was not meeting in line with this frequency. Terms of reference for the DTC described shared governance of medications over five key disciplines including medical, nursing, hospital management, quality & safety and pharmacy, however key members were not consistently in attendance.

The hospital had an Infection Prevention, Control and Antimicrobial Stewardship Committee (IPCAMSC), the aim of which was to provide leadership and direction on infection prevention and control activities across the hospital and to ensure compliance with the national standards for infection prevention control and antimicrobial stewardship. According to their terms of reference, the IPCAMSC had reporting relationships at hospital and IHA level. The committee to which they reported at hospital level, as outlined in terms of reference, was not reflected in organisational charts. Membership of this committee was broad to reflect the cross campus multidisciplinary approach required for IPC. As per its terms of reference, the IPCAMS committee should be chaired by the Director of Nursing (for rehabilitation beds) and was required to meet monthly. Records of meetings provided to inspectors showed that this committee was not meeting in line with the frequency required and records for only two meetings in 2024 were provided to inspectors. Attendance of committee members was not consistent and in line with terms of reference and this had not been acted upon by senior management.

Overall, while there were governance structures in place, improvements were necessary to assure the delivery of high quality, safe and reliable healthcare as evidenced by:

- the SMT and hospital committees responsible for oversight of medication safety and, infection prevention and control were not meeting as per their terms of reference.
- attendance by key members at relevant oversight committee meetings was not consistent and in line with terms of reference
- minutes of committee meetings reviewed did not always have time-bound actions
- organisational charts were not representative of all committees. This had also been noted in 2023.
- leadership roles were filled on an interim basis for extended periods or held as dual roles.

Judgment: Partially 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 sufficient management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services as they related to the four key areas of known harm which were the focus of the inspection - infection prevention and control, medication safety, deteriorating patient and transitions of care.

Medical cover was available in the hospital 24/7. A consultant and registrar were onsite Monday to Friday 9am - 5pm. Outside of these hours a doctor at senior house officer grade was available onsite and a registrar was on call from home. All medical posts in the hospital were filled, with consultants having contractual obligations across sites within the IHA. A named consultant was clinically responsible and accountable for the patients' care from admission to discharge.

The position of Director of Nursing remained vacant at the time of inspection, with the DON for Older Persons Services for IHA DNC DNCW assuming responsibility as the senior nurse for the service. This DON was supported by an Assistant DON (ADON) who deputised as the senior nurse when present onsite three days per week. The role of senior nurse was covered by CNM2s from the wards on a rotational basis four days per week and out of hours.

Bed management was coordinated by the bed manager, the DON and the infection prevention and control (IPC) CNM2. The senior nurse on duty met with the bed manager twice daily and IPC nurse daily to manage patient flow through the hospital. Referrals were received from consultants in referring hospitals, and the patients were then assessed for suitability by a consultant from St. Mary's. Inclusion and exclusion criteria for acceptance to St. Marys formed part of the admissions policy for the hospital. This policy was out of date but inspectors were informed that a new draft policy was under review at the time of inspection. Bed occupancy for April - December 2024 showed occupancy rates that were frequently below the HSE KPI of 90%.

The hospital had an allocation of one WTE nurse at CNM2 grade in infection prevention and control (IPC). This nurse was allocated by the Quality, Safety & Service Improvement Department (QSSI) at IHA level to St. Mary's, and coordinated IPC activities for the hospital. The IPC nurse had daily meetings with both ADON and bed manager to identify potential IPC issues and discuss patient placement. Ten IPC link practitioners had been trained on-site in St Marys and acted as local resources for infection prevention and control expertise within their areas. Quarterly reports produced for the QPSC provided evidence that the management of monitoring and surveillance, audit and education objectives of the IPC and Antimicrobial Stewardship committee were progressed through the actions of IPC nurse and AMS pharmacist with oversight by the QPSC. The hospital

did not have formal access to a microbiologist and reported seeking advice from the patients' referring hospital when such advice was needed.

The Drugs and Therapeutics Committee (DTC) had developed a medication safety strategy 2022 -2025. There was evidence that the aims and objectives of the DTC, outlined in their strategy, were progressed through monitoring and management of risks, development and approval of medication related policies procedures and guidelines and staff education. The hospital had access to pharmacy supply during daytime hours 7 days a week. All admissions to the unit were planned and processes were in place to ensure that patients' medications were available to them on arrival. In the week preceding the inspection, a new service was commenced where an external provider was contracted to provide 15 hours per week of a clinical pharmacy service to the wards. The limited availability of clinical pharmacy will be further discussed under national standard 3.1.

The hospital were using Irish National Early Warning Score (INEWS) V2.[***] The lead geriatrician and ADON in nurse practice development (NPD) were responsible for the oversight and implementation of INEWS in the hospital. This was consistent with evidence seen by inspectors on the day of inspection. The implementation of INEWS was audited monthly through the patient monitoring and surveillance element of the nursing care metrics. It was evident that audit results were discussed at the clinical review committee and meetings between NPD and CNMs, with opportunities for learning noted and shared. Medical staff were available onsite 24/7. There was a process in place to support the critical transfer of patients in the event of clinical deterioration.

Overall the hospital had effective management arrangements in place, reflective of the size and complexity of the hospital to manage the delivery of safe reliable healthcare.

Judgment: Substantially compliant

[***] INEWS V2 (Irish National Early Warning Score) forms part of National Clinical Guideline 1 and applies to the non-pregnant adult (≥ 16 years) patient in an acute setting, inclusive of Model 2, 3 and 4 hospitals. Its aim is to ensure a response is in place to anticipate, recognise and respond to the clinically deteriorating patient.

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 monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital collected data on measurements related to the quality and safety of healthcare services. Data was collected relating to, bed occupancy, length of stay, patient-safety incidents, nursing metrics, and infection prevention and control. Patient feedback was collected but not collated and key data that could inform the quality, safety and reliability of the service, although collected was not collated.

The hospital had established risk management structures and processes designed to proactively identify, manage, and minimise potential risks. Any risks that could not be effectively managed at local level were escalated through local governance structures and onwards to the IHA. The risk register as it related to the four key areas of harm which were the focus of this inspection (infection prevention and control medication safety the deteriorating patient (including sepsis) and transitions of care demonstrated existing controls and required actions outlined to manage the risk. Inspectors saw evidence of these controls and actions in practice. Ward staff spoken with on inspection were familiar with the processes involved in the management of risk within the hospital.

Opportunities for improvement were identified in relation to the monitoring and evaluation of data associated with referrals and discharge. For example, hospital management reported that transfer to the hospital after referral was timely, but this was not being collected or monitored. Patients' destination of discharge was recorded, but this was not related to their planned destination of discharge. Furthermore, the hospital was not tracking and trending unplanned readmission to acute facilities. While the physiotherapy department used recognised tools to measure individual rehabilitation outcomes for patients, the hospital had not developed a set of local key performance indicators (KPIs) tailored to their service for assessing rehabilitation outcomes for their patient cohort.

Each ward had an agreed annual plan for audit in relation to medication safety and infection prevention and control. Metrics relating to the management of medication safety, infection prevention and control, the deteriorating patient were collected through the patient monitoring and surveillance element of the nursing care metrics. Transitions of care at nursing handover and the use of ISBAR for this was audited. Oversight of these improvement cycles was provided by the relevant governing committees, with evidence of reporting seen at the Quality and Patient Safety Committee. There was evidence that quality and safety walk-rounds afforded the opportunity for senior managers and frontline staff to address local issues to prevent, detect and mitigate risks to patient safety, and that actions were taken because of these discussions.

The experience of a small sample of patients was captured through Quality and safety walk-rounds and suggestion boxes were available for patients to provide feedback on their experience. However, there was no recent survey of patient experience and no process in place for the collation or trending of information received in suggestion boxes.

Overall, there was evidence that systematic monitoring arrangements for identifying and acting on opportunities to improve the quality safety and reliability of care were in place at the hospital. However,

- patient feedback was not collated and used to inform service development
- data relevant to the quality, safety and reliability of the service when collected was not consistently collated to inform service improvements
- KPIs specific to the rehabilitation service had not been developed to facilitate identification of opportunities to continually improve the quality, safety and reliability the services.

Judgment: Substantially compliant

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

Inspectors identified that workforce arrangements were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare. Similar to previous inspections, there remained a significant deficit in health and social care professionals. The ongoing deficit was having an impact on the provision of services to patients.

At the time of inspection, all medical posts within the hospital were filled. The hospital had five consultant geriatricians who had clinical commitments in St. Marys and across services in the IHA. One consultant assumed the role of lead geriatrician for the site. All of these consultants were on the specialist register with the Irish Medical Council. Consultants were present onsite from 9am to 5pm Monday to Friday and were rostered offsite for call outside of these hours. Consultants were supported by 13 non-consultant hospital doctors (NCHDs) comprising seven senior house officers and six registrars, one of whom was a specialist registrar.

Apart from the vacancy in the DON post, management reported that nursing staffing levels were sufficient with six nursing vacancies in the rehabilitation service. Clinical areas visited had their full nursing compliment. Senior management reported that any gaps in rosters due to short-term sick leave were covered by agency or overtime.

The hospital employed 12.5 WTE physiotherapists. However, a deficit in physiotherapists had been placed on the risk register and the requirement for an additional 3.8 WTE posts had been escalated to the Head of Older Persons Services, two of these posts had been

approved. Staff reported that due to a shortage of physiotherapists there was a reduction in frequency and duration of interventions being afforded to patients. Patients were prioritised, based on need. Agency staff were used to fill one WTE and another WTE physio was due to commence employment imminently. Physiotherapists were supported by four WTE physiotherapy assistants.

The hospital employed 6.16 WTE occupational therapists (OT). Staff reported that prior to the recruitment embargo and subsequent pay and numbers strategy[†††] the department had an approval for 13.5 occupational therapists and a horticultural therapist. The shortfall of occupational therapists had a direct impact on patients whereby a referral process within the hospital, instead of universal access to occupational therapy for all patients, had been introduced. Staff reported that this had the potential to lead to inefficiencies in transitions of care as therapies were not concurrent. The ability of the OT department to support staff attendance at MDT meeting was also reported to be impacted. Figures from 2024 showed an eight-fold decrease on the number of OT patient contacts per month when compared with the same period in 2023. Services such as seating assessment and provision of equipment to facilitate discharge were prioritised. Occupational therapists were supported by two WTE occupational therapy assistants. The deficit in HSCPs had been placed on the risk register and seven posts had been escalated to the Head of Older Persons Services, four of which had been prioritised. There was no estimated timescale as to when these posts would be filled.

The absence of a dietetic manager was noted as a factor in the lack of meetings for the nutrition and hydration committee for the hospital.

The reported staff absenteeism rate was 5.5% which was higher than the HSE target of less than or equal to 4%. The hospital had a process in place to manage absenteeism with line managers undertaking back-to-work interviews, and regular management meetings which addressed absenteeism. Staff had access to employee assistance programmes and occupational health referral. Staffing numbers (headcount), absenteeism and recruitment was managed and monitored by the human resource department at IHA level.

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice. Training records provided to inspectors for the hospital demonstrated that improvements were required in staff training compliance across a number of areas. Attendance at training relating to IPC for nurses was 67%-76% percent with the exception of infection outbreak management where only 32% of nurses had attended training in the past 24 months. Evidence was seen of regular education being provided to staff on medications relevant to the area of practice

[†††] Pay and Numbers Strategy in the HSE National Service Plan 2024. This included all pay costs, such as direct pay, agency, and overtime. It set out the workforce numbers and associated costs for both existing and new service development resources for the year. HSE National Service Plan 2024

in the hospital. Records of attendance for these were not available but inspectors were told that uptake was good. 75% of doctors had attended HSE medication safety training in the past 24 months. Only 58% of doctors and 64% of nurses had training on early warning scores. Basic life support training compliance was 83% for doctors and 75 % for nurses. Hand hygiene for doctors, nurses and HCAs was below the HSE 90% target. Complaints management training levels were 85% for nurses and 86% for HCAs. No records were supplied for doctors or nurses relating to clinical handover training. HSCPs had between 91-100% compliance for all training records requested.

In summary, while the hospital had good medical staffing levels and low nursing vacancy levels, inspectors found that current workforce arrangements did not enable the hospital to fully achieve service objectives for high, quality and reliable healthcare. Further action was required as evidenced by the following findings:

- deficits in HSCP staffing were impacting the ability to achieve the service objectives for high quality, safe and reliable healthcare
- attendance at training, requires improvement, in particular doctors and nurses uptake of early warning score training and outbreak management training nurses.

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.

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

Inspectors observed that staff demonstrated a commitment to respecting and promoting patient dignity. Staff were observed interacting with patients in a compassionate and considerate manner. Patients reported having been involved in their plan of care. Patients spoke about how they were afforded autonomy and dignity with personal hygiene needs and how independence was promoted with their activities of daily living. Patients were up and dressed in their own day clothing. Patients also reported that staff responded quickly when they used the call bell.

Multi-occupancy rooms were allocated to patients of the same gender and limited to three beds. Curtains were used to provide privacy around beds and patients were bought to bathrooms for personal care.

A meeting room was available on each ward to facilitate private conversations and meetings between families and service users and the multidisciplinary team.

No patients were receiving end-of-life care on the wards that were visited. Staff indicated that, in such cases, patients would be given priority for a single room.

Evidence was seen that patient information was managed and stored in a manner that complied with relevant legislation and standards and supported confidentiality.

Judgment: Compliant

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

There was evidence of a commitment to fostering kindness, consideration, and respect in patient care. This was consistently observed throughout the inspection process, including through direct observations, meeting with staff interviews, and patient feedback. Patients reported being treated with kindness and respect by staff, expressing high levels of satisfaction with the courtesy and attention they received. Observations indicated that

staff communicated clearly and empathetically, ensuring patients understood their care plan.

Staff spoken with demonstrated an awareness of human rights-based care principles, with staff providing examples of integrating kindness and respect into their daily practices. Feedback boxes were provided on the wards. However there was no process in place to collate or action the feedback received.

Overall, the organisation exhibited a culture of kindness, consideration, and respect in its patient care practices.

Judgment: Substantially 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 established systems to ensure that complaints and concerns were addressed promptly, transparently, and effectively.

The ADON and an operations manager were the designated complaints officers for the hospital. The Health Service Executive's (HSE) complaints management policy, *'Your Service, Your Say (YSYS),'* had been implemented. The hospital was supported in complaints management by a complaints officer at IHA level, who collaborated with the hospital to support the management of any serious complaints.

Evidence was seen that complaints were a standing item agenda of the Quality and Patient Safety Committee and were discussed at quarterly meetings. Evidence was seen that they were also discussed at the older persons' services management meetings at IHA level. The complaints process and availability and access to information was also assessed as part of quality and safety walk-rounds. A small sample of patients were spoken with on quality and safety walk-rounds in relation to their knowledge of YSYS and the hospital's complaints process, these patients were also invited to give feedback or voice complaints at that time.

On the day of inspection, management and staff described a complaints process that was consistent with the HSE policy *'Your Service, Your Say'* information was prominently displayed in the ward.

Management and staff reported that verbal complaints were addressed locally, focusing on point-of-contact resolution. This was confirmed by the year-end 2024 complaints and compliments report submitted by the QPSC. The report detailed the number of complaints and compliments received, audits conducted, quality and safety walk-rounds performed, and progress on quality improvement initiatives and the priorities of the QPSC. In 2024, the hospital received 33 compliments and seven complaints (with all but one resolved at stage one).

Training was provided for complaints officers and other staff throughout the year. Records reviewed demonstrated good compliance levels for nursing, healthcare assistant and HSCP grades as described under standard 6.1. Staff in the clinical areas inspected confirmed that complaints were tracked and analysed, with findings shared during staff handover meetings and safety huddles and actions taken to avoid recurrence.

Overall, there was evidence that the hospital had effective systems and processes in place to respond to complaints and concerns raised by service users.

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 wards visited on this inspection were Achill and Skellig. Clinical areas inspected were clean, bright well maintained and comprised both single rooms and multi-occupancy rooms with three beds. All single rooms were equipped with ensuite toilet and shower facilities, and each three-bedded room had a toilet and shower room.

Clean utility rooms were accessed using swipe access and medications, including controlled medications, were stored appropriately. Waste management and the segregation of clean and soiled linen were handled correctly. General areas were clean, with appropriate storage for sterile supplies and patient equipment. Wards had dedicated cleaning staff present during core hours, outside of these times staff had access to onsite cleaners. Staff reported good availability and access to cleaning staff, and cleaning equipment was stored appropriately. Staff described an efficient method of requesting maintenance and were satisfied with response times.

Environmental hygiene audits for inspected clinical areas were provided to inspectors, with overall compliance rates ranging from 81-100%. Actions were taken on any identified issues. Quality and safety walk-rounds by executive management were used to review and improve the environment, with quality improvement plans (QIPs) and resulting actions observed by inspectors.

Inspectors were informed that cleaning of equipment was the responsibility of the staff who used it. Inspectors observed the use of a labelling system in place to indicate clean and ready-to-use equipment. Extra cleaning of frequently used patient equipment was conducted weekly by healthcare assistants, this process was to be overseen by the CNM of the wards; however, evidence of this oversight was only provided on one ward. Regular flushing of outlets to minimize the risk of legionella was undertaken, and a monitoring system was in place to ensure compliance with the flushing protocol.

Alcohol-based hand sanitiser dispensers were readily available throughout the ward, and hand-hygiene signage was prominently displayed in clinical areas. Inspectors noted that hand hygiene sinks in the clinical areas inspected met the required specifications.[‡‡‡]

There were five single rooms on Achill ward and six on Skellig. The hospital overall had 16.8% single rooms. These rooms were sometimes used for isolation purposes but did not have anterooms and did not have managed ventilation to facilitate negative pressure or positive pressure. The hospital used its admission policy and AMRIC guidelines for placement of patients requiring isolation. This, along with daily bed management meetings, was used to manage the risk associated with limited access to single rooms for isolation purposes. No patients who required isolation were accommodated in multi-occupancy rooms on the day of inspection.

Overall, it was evident that the clinical areas visited during this inspection provided a clean and well-maintained physical environment, supporting the delivery of high-quality, safe, and reliable care. However, the limited isolation facilities available at the hospital necessitate the continued careful management of the risk of transmission of communicable disease.

Judgment: Substantially compliant

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

The hospital monitored a number of parameters to evaluate care and inform improvement in the quality of care related to the four key areas of known harm which were the focus of the inspection (infection prevention and control, medication safety, the deteriorating patient (including sepsis) and transitions of care.) This was predominantly

[‡‡‡] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

achieved using national Quality Care-Metrics[§§§] which provide a standardised system to measure the fundamentals of care as they relate to nursing care. This includes a suite of metrics which include infection prevention and control, medication safety custody and storage, nursing documentation and patient monitoring and surveillance. This activity was coordinated by the Nurse Practice Development Unit.

Clinical areas inspected had an agreed audit schedule for 2024 and 2025. There was evidence that audits measuring quality and safety of care were being performed as per this schedule. CNMs had access to results which were shared with staff via notice boards in staff areas however; these results were not on display in public areas. Audits were performed regularly for quality of nursing documentation, hand hygiene compliance, medication storage and environmental cleanliness. Results seen by inspectors showed compliance levels were generally good for the areas visited on inspection.

The quality and safety of care relating to infection prevention and control was assessed using relevant indicators and benchmarks as follows:

- national Quality Care-Metrics
- local hand hygiene audits
- performance of environmental and equipment audits
- infection prevention and control training
- performance of quality and safety walk-rounds
- reporting of antimicrobial consumption rates

Monthly audits of the environment, equipment, and hand hygiene were conducted at the hospital using a standardised approach. Environmental hygiene audits performed by the provider of cleaning services within the hospital and submitted to HIQA for 2024 noted scores of 93-94%. Time-bound action plans, with identified responsible persons, were developed to address identified issues and oversight of these action plans and actions by nurse practice development was seen in evidence provided to inspectors. Equipment hygiene audit results were reviewed in clinical areas inspected and high levels of compliance were also noted. Since mid-2024 antimicrobial usage was compiled on a monthly basis and submitted to the national point of prevalence survey.

Monthly observational hand hygiene audits were performed by CNMs in clinical areas. Compliance results seen by inspectors for the three months preceding the inspection were between 80% and 100%. CNMs reported that non-compliance was addressed on the day and that results were discussed at daily huddles. Training rates for staff for hand hygiene

[§§§] Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidenced based standards and agreed through national consensus in healthcare settings in Ireland National Guideline for Nursing and Midwifery Quality Care Metrics Data Measurement in Acute Care 2018

were 79% for nurses 68% for healthcare assistants, 83% for doctors and 100% for HSCPs.

Testing for transmissible and multi-resistant organisms was in line with current national guidance and assessed as part of the acceptance for referral to the hospital. Overall scores for the hospital for national Quality Care-Metrics for healthcare-associated infection prevention and control for 2024 were between 83 -100%

The hospital had a medication safety strategy 2022-2025 and used a number of tools to monitor progress on the objectives of this strategy such as:

- national Quality Care-Metric
- medication safety audits
- reporting of medication safety incidents

Progress on goals from this strategy were evident on inspection. Evidence of QIPs and changes in practice, relating to storage of concentrated potassium and administration of vancomycin, as a result of audits were observed. In addition, the hospital had, in the week preceding the inspection, instigated a process whereby medicines reconciliation was performed by a pharmacist which was also aligned with their strategy goals.

The hospital's overall score in national Quality Care-Metric for medication safety was 95-100% and 98-100% in medication storage and custody in 2024.

The hospital were using the Irish National Early Warning System (INEWS) (version 2) observation chart. Compliance with the use of the NEWS document was monitored through the patient monitoring and surveillance element of national Quality Care-Metrics. Additional audits relating to the process for escalation of care to the medical team were also performed. Compliance rates for the hospital for this element of care as measured in national Quality Care-Metrics was 94-97% in 2024. Audit results for escalation of care also showed good compliance with evidence seen of allocated time bound actions for areas requiring improvement. Critical transfers back to the acute setting, were monitored, however further opportunities for improvement were noted in relation to tracking and trending.

The hospital had adopted $ISBAR_3$[****] to enhance safety during transitions of care at nursing handover, and had developed a handover tool aligned with ISBAR. The implementation of this tool was audited. Audit results demonstrated high levels of

[****] The ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework, endorsed by the World Health Organisation, provides a standardised approach to communication which can be used in any situation it is promoted by the HSE as part of National Clinical Guideline No.1 INEWS and Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11

compliance with use and content of ISBAR handover sheet. No evidence was supplied that this audit had been repeated since 2023.

Overall, it was clear that healthcare at the hospital was monitored, assessed, and improved, in relation to the four areas of harm targeted during the inspection in a manner that reflected the hospital's size and complexity. However, while data was being collected, inspectors noted missed opportunities in relation to the tracking and trending of data which could further improve the quality and safety of the healthcare provided in the unit.

- Quality data collected on the wards was not shared publically.
- Clinical handovers outside of nursing handover were not audited.

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 measures in place to protect service users from risk of harm associated with the design of the health service. However limited pharmacy services and lack of formalised access to a microbiologist meant that there were some risks that remained unmitigated.

Processes were in place to identify and mitigate risks. A risk register was maintained and reviewed regularly. Risks that could not be managed at hospital level were escalated through IHA structures.

The risk of suboptimal medication management due to absence of a clinical pharmacy service was on the corporate risk register. The hospital did not employ a pharmacist and did not supply a comprehensive clinical pharmacy service. The hospital had a service level agreement (SLA) with an external provider who supplied medications for the hospital. This SLA included provision of pharmacist representation and expertise on the drugs and therapeutics committee. In the week preceding the inspection, the service had been expanded to provide 15 hours per week pharmacy service on the wards in order to provide medicines reconciliation for patients on admission. Prior to this medicines reconciliation was performed on admission by doctors. Inspectors were informed that this service would, in the near future, be expanded to include a stock control function performed by a pharmacy technician. As this was a new service, it was not yet evident whether this allocation would be sufficient to provide a clinical pharmacy service to the hospital. Inspectors were informed that the hospital intended to gather data on the value and sufficiency of this innovation. Over 25% of medication incidents for 2024 were in some way related to stock provision. In addition issues identified during audits performed by the external provider noted issues with stock rotation. The implementation

of these new services was in mitigation of the risk posed by the absence of a clinical pharmacy service as stated on the risk register. The hospital was recording incidents relating to medication errors and in 2024 reported 14 medication incidents. All 14 incidents were classified as having a severity rating of negligible (category 3) as per HSE classification of risk impact.[††††]

The Drugs and Therapeutics committee had approved a list of high-risk and sound- alike look-alike medications for the hospital. Inspectors observed the use of some risk reduction strategies to support their safe use and staff were familiar with procedures surrounding these medications. The medication administration record in use in the hospital had no risk reduction design features common in modern medication administration records. Inspectors were informed that a redesign of the current record was at an advanced stage and that the new medication administration record would be based on the national template[‡‡‡‡], and incorporate safety features pertinent to the service.

The hospital had access to an antimicrobial stewardship (AMS) pharmacist who advised on antimicrobial usage and compiled data for submission regarding AMS within the hospital. The project for redesign of the medication administration record was being undertaken in conjunction with the antimicrobial pharmacist for the service.

Evidence was provided that patients were assessed for safety for, and supported in, self-administration of medications as part of their rehabilitation and education. This was supported by hospital policy procedures and guidelines as recommended in specialist geriatric services model of care, however there was no pharmacist involved in this process.

On the day of inspection, in the areas visited, medications were noted to be stored securely. Medication fridges were used solely for the storage of medications and monitored appropriately. Staff had access to approved, current medicines information at the point of preparation and administration and agreements had been made with a model four referring hospital to allow access to their antimicrobial prescribing guidelines under the guidance of the antimicrobial pharmacist.

[††††] Incidents are categorised as follows: 1. Category 1 Major/Extreme – Clinical and non-clinical Incidents rated as major or extreme as per the HSE's Risk Impact Table. 2. Category 2 Moderate – Clinical and non-clinical incidents rated as moderate as per the HSE's Risk Impact Table. 3. Category 3 Minor/Negligible – Clinical and non-clinical incidents rated as Minor or Negligible as per the HSE's Risk Impact Table. HSE - Incident Management Framework and Guidance 2020

[‡‡‡‡] The templates were designed under the guidance of National Medication Safety Advisory Group and are intended to be used as an aid in the development or revision of local Medication Records. Ensuring that each hospital's Medication Record is designed, tested, revised and used appropriately and safely is the responsibility of that hospital.

Risks relating to IPC which were on the risk register included:

- risk of respiratory outbreaks
- risk of legionella
- risk of delay in clinical diagnosis due to reduced or unavailable microbiology laboratory services on weekends and bank holidays
- risk of spread of infection to patients, staff and visitors due to lack of isolation rooms where demand exceeds capacity.

With the exception of the risk relating to microbiology laboratory access, all of these risks had ratings revised to amber with controls in place. Control measures for these risks, as described on the risk register, were seen to be in place during the inspection, supported by policy and procedures.

Testing for transmissible and multi-resistant organisms was in line with national guidance and assessed as part of the acceptance for referral to the hospital. Patients were tested for Influenza and COVID-19 if they developed symptoms during their admission. Evidence was seen that outbreak reports were completed following outbreaks. Reports seen by inspectors for 2024 demonstrated that outbreaks had been managed according to national guidelines. Policy and procedures were in place to minimise the risk of legionella. Staff on the day were familiar with these procedures and records were seen that controls had been implemented. Controls to mitigate the lack of microbiology laboratory to process swabs out of hours included the isolation of suspected cases and antigen swabbing by nursing staff. There was evidence that there were controls in place to address IPC risks. The effectiveness of these controls were discussed at the Infection Prevention, Control and Antimicrobial Stewardship Committee. Staff could access advice from IPC nurses as to the allocation of patients to incur the least risk possible.

The hospital did not have formalised access to clinical microbiology advice. The lead geriatrician reported that microbiologists in the referring hospital provided advice when needed, but this arrangement was not formal. Arrangements were in place with a model four referring hospital to allow access to their antimicrobial prescribing guidelines under the guidance of the antimicrobial pharmacist.

Safe transitions of care into, within and out of the hospital were supported by the use of standardised forms. Consultant geriatricians reviewed all referred patients and used a validated tool to determine their suitability for rehabilitation services. Close communication with referring hospitals and an admission policy outlining safe acceptance criteria for the hospital ensured safe transitions of care from the acute setting. Inspectors were informed that the policy supporting this process was being reviewed at the time of inspection. The hospital implemented $ISBAR_3$ to improve safety during nursing handovers.

The hospital had adopted INEWS to improve recognition and response to signs of patient deterioration. Medical staff were available onsite 24/7. In the event of the patient requiring urgent transfer to a higher level of care, this was arranged with the National Ambulance Service using 999/112. Non-urgent transfers to referring hospitals were also facilitated following liaison with the referring hospital and team. Staff spoken with on the day of inspection were familiar with emergency protocols to respond to the care of the deteriorating patient, and documentation seen as part of the inspection process provided assurance that the INEWS escalation processes were being followed.

While the hospital was taking measures to protect service users from the risk of harm associated with the design and delivery of healthcare services, the following areas for action were identified;

- the pharmacy service should be evaluated to assure that it is sufficient to provide a clinical pharmacy service to ensure safe and effective management of medication
- the hospital should progress with the implementation of the new medication administration record
- there were no formal arrangements for access to microbiologist advice.

Judgment: Partially compliant

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

The hospital had effective systems in place to identify, manage, respond to and report on patient-safety incidents.

The Assistant DON for the service was the local accountable officer for management of patient-safety incidents. The Senior Accountable Officer was at IHA level. Evidence reviewed by inspectors demonstrated that from January to November 2024 the hospital reported 292 patient-safety incidents, of which 282 were Category 3 incidents, which include near misses and incidents that resulted in no harm or minor harm to the affected person. Ten of these incidents were Category 2, where the affected person experienced moderate harm. Preliminary assessments were completed for all Category 2 incidents and reviewed by the Assistant Director of Nursing (ADON) and the Quality and Patient Safety (QPS) Advisor.

Evidence was provided that a SIMT was held for serious events that occurred. No major or extreme Category 1 patient safety incidents were recorded in the past year. All clinical incidents, including medication incidents, were reviewed monthly at the Clinical Review

Committee which provided oversight of all clinical incidents and reviews of incidents which were ongoing in the service.

Evidence was seen that incidents were tracked and trended; with the majority of incidents relating to slips trips and falls. These meetings were held with the frequency outlined in their terms of reference and with appropriate representation across the organisation.

Evidence was seen of the management of recommendations from incidents and the cascading of learning from incidents throughout the organisation. Appropriate actions to manage the risks identified in incidents was evidenced in minutes of meetings, tracking of actions from recommendations and policy procedure and guideline development. Staff in clinical areas were aware of changes made to practice as a result of incidents.

The hospital met HSE KPIs associated with the entry of incidents into the National Incident management System (NIMS).

Overall, the hospital implemented effective systems in place to detect, address, respond to, and document patient safety incidents.

Judgment: Compliant

Conclusion

Capacity and Capability

St Mary's hospital had formalised governance arrangements in place, however inspectors identified areas which required improvement in order to ensure the provision of high quality safe and reliable healthcare. Management arrangements in place were reflective of the size and complexity of the hospital and were appropriate to manage the delivery of safe reliable healthcare relating to the four key areas of harm which were the focus of this inspection (infection prevention and control medication safety the deteriorating patient - including sepsis- and transitions of care).

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Opportunities for improvement were identified in relation to development of KPIs specific to the rehabilitation service and use of patient feedback to inform improvements.

The hospital had good medical staffing levels and low nursing vacancy levels, however a deficit in health and social care professionals meant that current workforce arrangements were not fully effective in supporting and promoting the delivery of high-quality, safe and reliable healthcare.

Quality and Safety

Hospital management and staff fostered a culture of kindness, consideration, and respect for individuals accessing and receiving care. This was confirmed by patients who spoke with inspectors.

The hospital had effective mechanisms to address feedback and complaints from patients and their families. The physical environment of the clinical areas visited on the days of inspection were clean and well maintained. The hospital used a number of metrics to evaluate the effectiveness of its healthcare services and inform improvements.

The hospital had risk management processes with controls to reduce harm. Management was aware of service risks and proactively identified and managed them. A number of areas for action were identified to ensure that service users are protected from the risk of harm associated with the design and delivery of the service.

The hospital effectively identified, managed and responded appropriately to patient-safety incidents.

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	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially 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.	Substantially 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.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Substantially 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.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for St Mary's Hospital

Inspection ID: NS_0115

Date of inspection: 16 and 17 January 2025

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

a) Organisational charts setting out the hospital's reporting structures including governance and oversight committees that were submitted to HIQA did not accurately reflect the reporting arrangements for hospital management and the accountability relationship upwards to the IHA manager

Action: A review of the organisational chart has been completed and updated to accurately reflect the reporting arrangements for hospital management and the accountability relationship upwards to the IHA Manager.

b) Key hospital committees and their reporting relationships were absent from these diagrams

Action: The hospital committee diagram has been reviewed and updated to include key hospital committees and their reporting relationships.

c) Nutrition & hydration committee had not met in 6 months

Action: A nutrition and hydration working group was established on the 6th March 2025. This working group will continue to meet on a monthly basis or more frequently if required. The Nutrition and Hydration Steering Group reconvened on the 20th May 2025. This committee will meet quarterly. TOR are under review and will be ratified at the next meeting on 2nd September 2025. Dates for 2025 have been set and circulated to the Steering Group.

d) The post of hospital manager had not been filled on a permanent basis since prior to the previous inspection in 2024. Inspectors were informed that a permanent hospital manager had been appointed and was due to take up post in February 2025

Action: Hospital Manager position has now been filled full time and permanently since the 4th February 2025.

e) Hospital management should progress to fill the position of a permanent DON at the hospital. Leadership role filled on an interim basis for extended periods or held as dual roles

Action: An application has been made to the Regional Employment Control Committee (RECC) Dublin North East, for consideration at their May 2025 meeting to recommence recruitment for this role.

f) Senior management team meetings were not held in line with the frequency (weekly) outlined on their TOR, SMT committee not represented on organisational charts, SMT meeting TOR did not outline reporting relationships and accountability arrangements, Action points from the SMT meetings were not time bound and consistently monitored from one meeting to the next, Senior nursing representation at SMT was not consistent -

Action: The TOR for the Senior Management Team meetings have been updated to state that the frequency of meetings are held fortnightly. The TOR now outline reporting relationships and accountability arrangements. The TOR have been circulated to the SMT for review and will be ratified at the next meeting, 3rd June 2025. The organisational chart has been reviewed and updated to include the SMT meetings.

The template for minutes has been reviewed and updated to include a due date for completion of actions. A review of action points from the previous meeting has been added as an agenda item for the meeting to ensure consistent monitoring of actions.

Senior nursing representation at SMT has been addressed with the nursing management and assurances given that there will be representation as per the terms of reference.

The Hospital Manager has commissioned a review of all hospital committees which is underway and will include membership, terms of reference (TOR), minutes with actions and associated dates for completion. The review will conclude by end of Quarter 3 2025.

g) Core members of the QPSC did not attend consistently

Action: All core members attended the QPS committee held on the 20th March 2025. Assurances have been provided that core members or relevant representation will attend the QPS committee meetings going forward as per the terms of reference.

h) Frequency of D and T meetings not in line with the committee terms of reference

Action: The TOR for the Drugs and Therapeutics Committee have been updated to state that the frequency of meetings are held quarterly. The TOR have been circulated to the D and T committee for review and will be ratified at the next meeting, 19th June 2025.

i) Key members of the D and T did not attend consistently

Action: Assurances have been provided that core members or relevant representation will attend the D and T committee meetings going forward. The next meeting is scheduled for 19th June 2025.

j) IPCAMSC reporting relationship absent from organisation chart, Frequency of IPCAMSC meetings not in line with its TOR, Key members of the IPCAMSC did not attend consistently

Action: The organisation chart has been updated and now details the reporting relationship for the committee. IPCAMSC held meetings on 23rd January 2025 and 12th May 2025. The TOR for the IPCAMSC have been updated to state that the frequency of meetings are held quarterly. The TOR will be circulated to the committee and ratified at the next committee meeting on 23rd July 2025. Assurances have been provided that core members or relevant representation will attend the IPCAMS committee meetings going forward.

Timescale:

a) Organisation Charts - 27/05/2025 - Enclosed

b) Key Hospital Committees' included on Organisation Charts - 27/05/2025 - Enclosed

c) Nutrition & Hydration Committee reconvened on 20/05/2025

d) Hospital Manager appointed full time and permanently since 04/02/2025

e) An application to recommence recruitment of the DON role sent to the RECC for their consideration at their May 2025 meeting.

f). SMT TOR to be ratified on 3/06/2025. The Hospital Manager has commissioned a review of all hospital committees which is underway and will include membership, terms of reference (TOR), minutes with actions and associated dates for completion. The review will conclude by end of Quarter 3 2025.

g) Complete

h) D&T TOR to be ratified on 19/06/2025

i) Complete

j) IPCAMS Committee TOR to be ratified on 23/07/2025

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

a) Deficit in Health and Social Care Professionals to be addressed:

Action: All HSE posts that fall vacant are submitted through the IHA's established paybill process for backfilling. Once approved at pay bill level, as per current process, they are submitted to the Regional Employment Control Committee (RECC) for approval in line with the Pay and Numbers Strategy and financial control limits.

b) Absence of a Dietician Manager

Action: The Dietetic Manager position was submitted to paybill on 19th May 2025 and now awaiting outcome.

c) Reported staff absenteeism rate was 5.5% which was higher than the HSE target of less than or equal to 4%.

Action: Line managers undertake return to work interviews in line with the HSE's Managing Attendance Policy. Absenteeism is a standing item on the Senior Business Review meeting agenda and a fortnightly report is issued to the team for monitoring at these meetings.

d) It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice. Training records provided to inspectors for the hospital demonstrated that improvements were required in staff training compliance across a number of areas.

Action:

Infection Outbreak Management - Training was provided to nurses by the IPC CNM2. The current compliance rate for this training is 73% for nurses. The ADON will request additional outbreak management training sessions to be provided by end of August 2025.

Medication Safety - In person medication safety training is provided to staff by the ADON Practice Development including medications and falls, psychotropic medication and drugs at end of life. Sign in sheets are held with the ADON for this training.

Medication Safety Education Sessions are provided to the medical team at induction by an external pharmacy. A request will be sent for records of attendance at this training.

Early Warning Scores Training (INEWS) - Further training has been provided ant the current compliance rate for this training is 80% for nurses and 67% for doctors. The

DON and Lead Clinician to review and audit all nursing and medical staff training records and to ensure mandatory training is completed by end of October 2025.

Basic Life Support & CPR - 100% of doctors have now completed this training. Training has been organised for staff yet to complete this training for the 27th June 2025. The current compliance rate for nursing is 80%.

Hand Hygiene - Training has been provided on each ward by the IPC CNM2. The current compliance rate for doctors is 75%; nurses is 88% and HCA's 61%. The DON and Lead Clinician to review and audit all nursing and medical staff training records and to ensure mandatory training is completed by end of July 2025. A request will be sent to the IPC CNM2 for additional training dates for June 2025.

Complaints - The current compliance rate for nurses is 94% and HCA's is 89%. Further training for stage 2 complaints by the Service Feedback Manager is scheduled for the 11th June 2025 with the Lead Clinician and the complaints officers.

Clinical Handover - Local handover arrangements are incorporated at induction for the medical team. These records are held through the shared service HR department. The compliance rate for ISBAR training for nurses is currently 69%. A request will be sent to nurse management to ensure training is completed by end of October 2025.

Timescale:

a) Recruitment is ongoing through the paybill process in line with the Pay and Numbers Strategy and financial control limits.

b) Awaiting a decision from the paybill May 2025 meeting with regard to the Dietician Manager post

c) Complete

d) All training listed above to be completed by end of October 2025.

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

a) The risk of suboptimal medication management due to absence of a clinical pharmacy service was on the corporate risk register. The hospital did not employ a pharmacist and did not supply a comprehensive clinical pharmacy service.

Action: Along with the Pharmacist who took up post on the 9th January 2025 subsequently a pharmacy technician has taken up post since 7th February 2025. Part of their role includes stock control and stock rotation of medications that maybe utilised on other wards prior to expiry. This is reported weekly to the Hospital Manager and the Lead Clinician.

b) The medication administration record in use in the hospital had no risk reduction design features common in modern medication administration records. Inspectors were informed that a redesign of the current record was at an advanced stage and that the new medication administration record would be based on the national template[§§§§], and incorporate safety features pertinent to the service.

Action: D and T committee has reviewed and redesigned Kardex in line with national templates and with the guidance of Antimicrobial Pharmacist, Pilot date is set for implementation in June 2025 on one ward with a plan to roll out across the whole hospital in July 2025.

c) Evidence was provided that patients were assessed for safety for, and supported in, self-administration of medications as part of their rehabilitation and education. This was supported by hospital policy procedures and guidelines as recommended in specialist geriatric services model of care, however there was no pharmacist involved in this process.

Action: Since 9th January 2025 a new pharmacist is in post and now involved in self administration education and has oversight.

Timescale:

a) Already in place.

b) July 2025.

c) Already in place.

[§§§§] The templates were designed under the guidance of National Medication Safety Advisory Group and are intended to be used as an aid in the development or revision of local Medication Records. Ensuring that each hospital's Medication Record is designed, tested, revised and used appropriately and safely is the responsibility of that hospital.