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:	Connolly Hospital Blanchardstown
Address of healthcare service:	Mill Road Abbotstown Dublin 15 D15 X40D.
Type of inspection:	Announced Inspection
Date of inspection:	6 and 7 December 2022
Healthcare Service ID:	OSV-001018
Fieldwork ID:	NS_0020

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Connolly Hospital is a Model 3* public acute hospital and is part of the Royal College of Surgeons of Ireland (RCSI) Hospital Group.† It is a major teaching hospital providing a range of services to a diverse population covering the communities of West Dublin, North Kildare and South County Meath. The hospital services are provided under the governance and leadership of five clinical directorates: emergency medicine directorate, medical directorate, peri-operative directorate, diagnostics directorate and radiology directorate. Services provided by the hospital include:

- 24-hour emergency care
- acute medical and surgical services
- long-stay residential care
- day care
- diagnostic and therapeutic services
- outpatient care.

There is a paediatric urgent and ambulatory care centre co-located on the campus of Connolly Hospital. It is managed and governed by Children's Health Ireland (CHI). There is also an acute psychiatric service provided on the campus of the hospital which is under the governance of mental Health services. Neither of these services were part of this inspection at Connolly Hospital.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	336 inpatient beds 40 daycase beds 97 step down/offsite beds

* Model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care.
† RCSI Hospital Group comprises Beaumont Hospital, Cavan & Monaghan Hospital, Connolly Hospital, Louth County Hospital, Our Lady of Lourdes Hospital – Drogheda, Rotunda Hospital and RCSI (academic Partner).

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out an announced inspection at Connolly Hospital to assess compliance with a number of standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, authorised persons [‡](hereafter referred to as inspectors) reviewed relevant information about this healthcare service. This included any previous inspection findings, information submitted by the healthcare service provider, publicly available information and other unsolicited information[§] received by HIQA since the last inspection.

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality

[‡] Inspector refers to an 'authorised person' appointed by the Health Information and Quality Authority (HIQA) under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.
[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

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 received on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how the service performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national 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.

This announced inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
06 December 2022 and 07 December 2022	09.00 – 17.10hrs 09.00 – 16.30hrs	Lisa Corrigan	Lead
		Patricia Hughes	Support
		Nora O'Mahony	Support

Information about this inspection

This inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The five themes were person-centred care and support, effective care and support, safe care and support, leadership, governance and management and workforce. 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 three clinical areas:

- Emergency department
- Cedarwood ward (medical ward – recently opened in response to capacity issues)
- Sycamore ward (care of the older person)

The inspection team spoke with the following staff at the hospital:

- Representatives of the hospital's executive management team
  - General Manager
  - Director of Nursing (DON)

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

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

‡‡ Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

  - Clinical Director
  - Head of Quality and Safety
- Head of Quality and Safety
- Complaints Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager
- A representative from each of the following hospital committees:
  - Infection prevention and control
  - Drugs and Therapeutics
  - Deteriorating patient
  - Transitions of care.

Acknowledgements

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

What people who use the emergency department told inspectors and what inspectors observed in the department

On the first day of inspection, inspectors visited the emergency department, which operates 365 days a year, 24/7.

Attendees to the emergency department presented by ambulance, were referred directly by a general practitioner (GP) or self-referred. The emergency department at Connolly Hospital provides undifferentiated medical care for all patients aged 16 years or more with acute and urgent illness or injuries.

The hospital had a system in place for assessing patients for risk of COVID-19 on arrival at the hospital before entering the emergency department and patients with suspect or confirmed COVID-19 were streamed to a separate area. This will be discussed further in NS 3.1 and NS 5.5.

The waiting area in the emergency department comprised 28 individual partitioned chairs and inspectors observed one metre physical distancing, in line with national guidance. A map on the wall in the emergency department labelled 'your journey through ED' offered valuable information on the emergency department layout and assessment and treatment process for patients.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment (PPE), in line with current public health guidelines and were 'bare below the elbow' in line with national guidance when not wearing PPE. All patients within the main waiting area were observed wearing masks.

The newly refurbished emergency department consisted of three zones incorporating the following;

- two triage rooms
- non-COVID-19 resuscitation area comprising three bays
- COVID-19 resuscitation area comprising two bays and one isolation room
- 10 individual walled cubicles
- four individual minor cubicles
- two individual treatment rooms
- a four-bay clinical decision unit[§§]

[§§] Clinical decision unit- This area was used for patient reviews by a senior decision maker.

- a room which accommodated two patients (previously the plaster room)
- ambulatory care pathway. This area had a separate waiting area with 18 partitioned seats, four patient review areas and a GP room.

Inspectors observed access to toilet facilities in the emergency department. There was also a shower in the emergency department for patients' use.

Inspectors observed staff actively engaging with patients in a respectful and considerate manner. Staff were seen apologising to a patient for the wait time and lowering their voice to speak with a patient on the corridor regarding their treatment update. They were also observed comforting a patient who had received bad news.

On the day of inspection, at 10.30am, the emergency department was crowded with patients and staff, however, the wide corridors facilitate space for movement of patients on trolleys along the corridors. Twenty-two patients were receiving care and treatment in the department and an additional 18 patients were in the waiting area, waiting to be reviewed by the emergency medical team. There was an additional 13 patients on seats on corridors within the emergency department awaiting further medical review.

Inspectors spoke with a number of patients in the emergency department to find out about their experiences of the care received in the emergency department on the day of inspection. Patients who spoke with inspectors said they were waiting from two to 12 hours in the department from time of registration at the hospital. A range of views were provided to inspectors relating to their experiences so far. Staff were described as *'nice', 'very busy, 'flying around'* and a patient described how they *'try to give you as much attention as possible, even though they are dealing with very serious cases'*. Overall, patients were happy with the care they received.

One patient did outline that they had been waiting with an ambulance crew for around 1.5 hours before getting a trolley in the cubicle. All patients reported getting breakfast however, some patients told inspectors that they had no easy access to water once in cubicles but did receive water from staff on request.

Inspectors observed staff promoting and protecting patients' privacy and dignity. Curtains were pulled to ensure privacy and dignity when patients were being clinically assessed and treatment administered. Patients also spoke of how staff attempted to protect and promote their privacy and dignity saying there is *'a curtain around the bay for privacy'*.

Patients who spoke with inspectors were unsure how to make a complaint but outlined that they would speak to a member of staff directly if they had a complaint. All patients who spoke with inspectors were aware of their plan of care.

Overall, there was consistency with what inspectors observed in the emergency department, what patients told inspectors about their experiences of receiving care in the

department and related findings from the 2022 National Inpatient Experience Survey.*** This is discussed in further detail under NS 1.6.

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

Inspectors visited two ward areas, Cedarwood and Sycamore wards. Both of these wards were in one storey standalone units situated on the campus of Connolly Hospital but separate from the main hospital building and from each other.

The Cedarwood ward was an 18-bedded recently refurbished ward consisting of two four-bedded multi-occupancy rooms and 10 single rooms. Two of the single rooms had en-suite bathroom facilities. The ward had adequate shared toilet and bathroom facilities for patients. Access to the ward was via a security fob. The ward was used as an overflow ward for fully mobile patients under the age of 75 years who met specific admission criteria taking account of cognitive ability, level of independence and were clinically stable. At the time of inspection, all 18 beds were occupied. There were no trolleys on this ward and all patients had a means to call for assistance. Feedback received by inspectors included that *'staff are very polite', 'the facility is very clean' and 'overall experience very good'.*

The Sycamore ward was a 28-bedded ward consisting of five multi-occupancy rooms with five beds in each and three single rooms. One of the single rooms had en-suite bathroom facilities and the remaining two single rooms had separate shared bathroom facilities. Access to the ward was via a security fob. The ward had adequate shared toilet and bathroom facilities for patients. The ward specialised in care of the older person. At the time of inspection, all 28 beds were occupied. There were no trolleys on this ward and all patients had a means to call for assistance. When asked what had been good about the care they had received in the hospital so far, patients talked positively about their experience. Patients told inspectors: *'staff couldn't do any more for you'* and said that there were *'nice patients to talk to'.*

Inspectors observed that staff interactions with people using the services on both wards were kind, respectful and attentive to patient needs. This was validated by patients who described staff in the clinical areas visited as *'very polite'* and *'couldn't be nicer'* saying *'staff try their best'*. Inspectors also observed that privacy curtains were drawn around patients at appropriate times.

*** The National Care Experience Programme is a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care.

Staff were focused on ensuring patients' needs were promptly responded to. For example, inspectors observed staff responding in a timely way to colleagues requesting assistance with patients' care needs. Patients recounted how their needs were met quickly, telling inspectors *'staff help me to go to the toilet' and 'I know I can use bell or ask them for help'*. When asked what could be improved about the service or care they received, some patients responded that the food could be improved, noise levels were quite high and expressed a dislike at being admitted to a mixed ward.

People who spoke with inspectors knew how to raise a complaint, if required. Leaflets on how to make a complaint, HSE '*Your Service Your Say'* were available in both clinical areas visited. The HSE *'Your Service Your Say'* poster was on display in Cedarwood ward. A compliments board was also on display in Sycamore ward. There was an advocacy contact support list on the wall at the main entrance to Cedarwood ward.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2022 National Inpatient Experience Survey, where 76.3% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, which was below the national average of 81.9%.

Overall, there was some inconsistency with what inspectors observed in the clinical areas visited, what patients told inspectors about their experiences of receiving care in those areas and the findings from the 2022 National Inpatient Experience Survey. While the 2022 National Inpatient Experience Survey highlighted scores lower than the national average for presence and availability of hospital staff to talk to or for support getting to the toilet in a timely manner this was not reported as a concern to inspectors by patients on the wards.

Capacity and Capability Dimension

Findings from national standards 5.2 and 5.5 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital.

Inspection findings from the emergency department related to the capacity and capability dimension are presented under national standard 6.1 from the theme of workforce.

Inspection findings from the wider hospital and clinical areas visited and related to the capacity and capability dimension, are then presented under national standard 5.8 from the theme of leadership, governance and management.

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

Connolly Hospital had formalised corporate and clinical governance arrangements in place appropriate to the size, scope and complexity of services provided. Organisational charts setting out the hospital's reporting structures were submitted to HIQA, as part of the pre-on-site documentation, data and information request. These charts detailed the direct reporting arrangements for hospital management and hospital management's reporting arrangements to the Chief Executive Officer of the Royal College of Surgeons in Ireland (RCSI) Hospital Group. The governance arrangements defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. The General Manager had overall responsibility for governance and management of the hospital and reported to the Chief Executive Officer of the RCSI Hospital Group. The reporting and accountability arrangements at hospital level and to the RCSI Hospital Group was articulated by staff on the day of inspection as outlined on organisational charts reviewed by inspectors.

The hospital had a clinical directorate model in place and a clinical director was appointed to provide clinical oversight and leadership at the hospital. Each of the hospital's directorates had an assigned associate clinical director (ACD) to provide oversight and the directorates were:

- medicine
- emergency medicine
- perioperative
- diagnostics
- radiology.

The Director of Nursing (DON) was responsible for the organisation and management of nursing services at the hospital. The DON reported to the General Manager.

Executive Management Team Committee

The Connolly Hospital executive management team (EMT) committee was the main governance structure at the hospital. Chaired by the hospital's general manager, the committee met fortnightly and collectively provided oversight and governance over the standard of care to all patients using the service. The EMT were accountable to the RCSI Hospital Group in line with its terms of reference. The membership comprised of the Chief Operation Officer, the Clinical Director, the DON, the Associate Clinical Directors, the Director of Clinical Services, the Human Resource Manager, the Chief Pharmacist and the Head of Quality and Safety. The committee reported directly to the RCSI Hospital Group at monthly performance meetings. Minutes of committee meetings submitted to HIQA, showed that the meetings were well attended and followed a structured format. Progress in implementing actions was monitored from meeting to meeting with some exceptions noted on minutes reviewed. The frequency of meetings was broadly in line with its terms of reference. Minutes provided to HIQA prior to inspection from 27 September 2022 to 8

November 2022 showed that one meeting occurred fortnightly and two occurred tri-weekly.

Quality and Safety Executive

The hospital's Quality and Safety Executive (QSE) was the main committee assigned with overall responsibility for the oversight, coordination, monitoring and advice on quality and safety activities. The aim of the QSE as stated in the Terms of Reference was to facilitate the integration of quality and patient safety into daily working activities at departmental level and continuously improve the quality of service provision throughout the hospital. The committee, chaired by the Clinical Director, met every two months with membership appropriate to the size and scope of the hospital and good attendance at meetings.

The QSE reviewed and considered reports from the various sub-committees that reported to it, including the Drugs and Therapeutics, Medication Safety, Infection Prevention and Control, and the Deteriorating Patient Committees. The chairs of these committees provided update reports on a rotational basis to the QSE using structured ISBAR[†††] format in line with the committee's terms of reference and organisational charts.

In addition to providing oversight of performance of committees that reported in to it, the QSE also reviewed the hospitals' monthly quality and safety performance metrics report which included the hospitals key performance indicators, Carbapenemase producing *Enterobacterales* (CPE) screening, incident trend analysis and the risk register update. The hospital's quality and safety performance metrics were also reviewed and monitored at the hospital's performance meetings with the RCSI hospital group.

The QSE committee also monitored and reviewed complaints, audits, the National Inpatient Experience Survey results and implementation of recommendations from reviews.

Infection Prevention and Control Committee

The hospital's multidisciplinary Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control at the hospital. The Infection Prevention and Control Committee, chaired by the General Manager was accountable to the Hospital Executive Committee through the General Manager and reported to the Quality and Safety Executive through formal reports presented as a standing agenda item at each QSE meeting.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA were action orientated, with actions monitored from meeting to meeting.

[†††] ISBAR =Identify, Situation, Background, Assessment, Recommendation), a technique used to facilitate prompt and appropriate communication in relation to patient care and safety is used for clinical handover.

Membership of the committee was appropriate and meetings were well attended by members, with some exceptions.

The Infection Prevention and Control Committee developed an annual quality improvement plan with a lead person and timeframes assigned to each quality improvement or new initiative. This was documented and reviewed by inspectors in the Infection Prevention and Control Annual Report 2021. Progress of the annual plan was tracked throughout the year by the committee. The committee also produced quarterly reports on key performance indicators.

The hospital had an antimicrobial pharmacist and there was an antimicrobial stewardship (AMS) programme in place. The hospital had an outbreak control team which was responsible for managing outbreaks and for the compilation and sharing of reports at the end of an outbreak. Inspectors were provided with an up-to-date hospital outbreak policy.

HIQA was satisfied with the governance and oversight of infection prevention and control practices, and infection outbreaks at hospital and hospital group levels.

Medication Safety

The hospital's Drugs and Therapeutics Committee promoted safe and effective use of all aspects of the medication management process at the hospital. The committee was chaired by a consultant in geriatric medicine with membership relevant to the size and scope of the hospital. Meetings were due to take place quarterly as per the committee's terms of reference, however, the committee had only met twice in 2022. Inspectors were told that meeting frequency was affected by changeover of key members of the Committee including the Chairperson, Medication Safety Pharmacist, and Chief Pharmacist. The hospital assured inspectors that the committee would now function in line with its terms of reference which were currently overdue for review. The committee was operationally accountable and reported to the Quality Safety Executive through the committee's chairperson and reported formally to the Hospital and RCSI Hospital Group on an annual basis.

Drugs and Therapeutics Committee (DTC) meetings followed a set agenda and were action oriented with evidence of actions followed through from meeting to meeting. Antimicrobial stewardship was a standing agenda item at the DTC and the RCSI Hospital group antimicrobial stewardship committee provided updates at each meeting. Quality improvement plans were reviewed and monitored by the committee.

The hospital also had a Medication Safety Committee established to promote and support the safe use of medications in the hospital. The Committee was accountable to the Quality and Safety Executive (QSE) and provided update reports at the Drugs and Therapeutics Committee. According to the terms of reference this committee was to meet six times a year. However, no meetings had occurred between February and September

due to change of chairperson. The hospital informed inspectors that a new chairperson was now in position and meetings had resumed as per the recently updated TOR.

The Medication Safety Committee had standing agenda items which included education, monitoring and audit, quality improvement plans, medication safety incident analysis, implementation of recommendations from reviews and circulation of items for shared learning. Required actions were outlined with a responsible person assigned and follow up at subsequent meetings.

Overall, HIQA found that the hospital had structures, systems and processes to support medication safety at the hospital. However, the effectiveness of these measures are impacted by the limited access to clinical pharmacy services at the hospital. Furthermore, committees should ensure that they are operating in line with their terms of reference in order to provide adequate oversight of medication safety at the hospital.

Deteriorating Patient Committee

The hospital had a deteriorating patient improvement programme (DPIP). The Deteriorating Patient Committee had oversight of the implementation of national early warning systems, cardiopulmonary resuscitation and sepsis management at the hospital. This committee reported to the Quality and Safety Executive and provided a formal update on an annual basis. Terms of reference reviewed by inspectors outlined the committees' purpose which was to provide oversight and advice about the safety, effectiveness and ongoing improvement of the recognition and response for all Early Warning Systems, CPR and sepsis management processes implemented in Connolly Hospital. The committee was chaired by a consultant in medicine and met quarterly. Meetings were well attended with some exceptions. They followed a structured format and were action orientated with a responsible person assigned to each action. Inspectors were informed that a DPIP project lead appointed for the RCSI hospital group had attended Connolly Hospital DPIP committee meetings.

Inspectors were told that training was in progress covering use of the early warning systems and the identification and management of sepsis. Inspectors viewed audits conducted on the use of Irish National Early Warning Score (INEWS) version 2 with associated recommendations and a time bound action plan.

Transitions of Care

The hospital had a number of personnel and established committees to support transitions of care of people requiring admission into hospital and their subsequent transfers or discharge from the hospital. The patient flow department were operationally responsible for transitions of care within the hospital and included a designated lead for patient flow.

Inspectors were told that Connolly Hospital had a 'length of stay (LOS) greater than seven days committee' which was established under the joint governance of the Hospital

Operations and Nursing Executives and met weekly to support co-ordinated, safe and timely discharge or transfer of care of patients in Connolly Hospital to their home or other healthcare settings.

The hospital also had an Unscheduled Care Committee which met monthly chaired by the General Manager where monthly unscheduled care reports were reviewed and actioned. The meeting was action oriented to support patient flow from the emergency department through the hospital and onward to the community. The monthly reports provided to HIQA covered a number of areas including but not limited to emergency department attendances, admission conversion rates, compliance with patient experience times (PET) and off-site bed usage. HIQA recommends that clear terms of reference are drawn up for these meetings.

The management of the hospital had oversight of the main issues inspected under this programme, which impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital. As an area for improvement, inspectors found that the Drugs and Therapeutics Committee and the Medication Safety Committee meetings should be meeting in line with their terms of reference. In summary, the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring quality and safety of the services provided.

Judgment: Substantially compliant

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

Findings relating to the emergency department

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. There was evidence of strong clinical and nursing leadership in the emergency department. Operational governance and oversight of day-to-day workings of the department was the responsibility of the associate clinical director for the emergency department — a consultant in emergency medicine, who reported to the hospital's clinical director and general manager. Outside core working hours,[‡‡‡] medical oversight of the emergency department was provided by structured on-site consultant presence 8am to 9am and 5pm to 8pm Monday to Friday and flexible five hour consultant on-site cover on Saturdays. Outside these hours and core working hours, on-

[‡‡‡] Core working hours is considered to be Monday to Friday 9am to 5pm.

call cover was provided via an on-call rota of five WTE[§§§] consultant posts (six employees). Additional on-site 24-hour medical cover was provided through a rota of non-consultant hospital doctors (NCHDs).

At 11am, there were 65 patients in the emergency department. Of these, 35% had arrived via ambulance, 12% had been referred by their GP and 54% had self-referred. Of the 65 patients, ten patients (15%) were aged 75 years or older. One patient was on a trolley and the remainder were placed either on trolleys in cubicles or were seated in the main waiting area or sub waiting areas in the emergency department. All patients had been triaged and prioritised in line with the Manchester Triage System.[****] The average waiting time from registration to triage was 31 minutes (Target is 15 minutes recommended by the HSE's emergency medicine programme). Staff could view the status of all patients in the department — their prioritisation category levels and waiting times via the hospital's electronic emergency department dashboard.

Staff in the emergency department advised inspectors that they had a system in place for assessing patients for risk of COVID-19 on arrival at the hospital before entering the emergency department and confirmed that patients with suspect or confirmed COVID-19 were streamed to a separate area. However, on the days of inspection this system was not observed to be in use. On both days of inspection HIQA inspectors noted that the designated healthcare assistant was not at the front door to complete this function. Instead this was being undertaken at triage. At the time of inspection the longest waiting time for triage was two hours and ten minutes. National guidance[††††] sets out that all patients must be promptly assessed for COVID-19 risk on arrival at a healthcare setting. Inspectors highlighted the potential patient safety risk of delay in assessing for signs and symptoms of COVID-19 until triage with hospital management on the first day of inspection. Hospital management confirmed that the practice of promptly screening patients for COVID-19 on arrival to the hospital and the streaming of confirmed or suspected cases of COVID-19 to an isolation area would be carried out as per the national guidance on COVID-19.

In 2021, the overall attendance rate at the hospital's emergency department was 47,765, which equated to an average attendance rate of 3980 each month or 131 attendances every day. Data for the eight-month time frame January to August 2022 showed that there was 33,095 attendances to the emergency department, which represented a four per cent increase year to date on 2021 levels.

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

[****] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

[††††]Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting V2.16 03.11.2022. For Implementation 09.11.22

The conversion rate which refers to the percentage of persons who presented to the emergency department and who were admitted to hospital was 23% in 2021. It was noted to be 24% from January to August 2022 while acknowledging that activity levels had increased by eight per cent in that time period.

At the time of inspection, the emergency department was busy and staff were responding to a surge in the urgency of acute emergency care due to time critical patient presentations. At 11am on the first day of inspection, the waiting time from:

- registration to triage ranged from three minutes to two hours and 10 minutes. The average waiting time was 31 minutes.
- triage to medical review ranged from zero minutes to 12 hours eight minutes. The average waiting time was one hour 52 minutes
- decision to admit to actual admission in an inpatient bed ranged from seven minutes to five hours 36 minutes. The average waiting time was two hours and five minutes.

Accepting the surge in urgent time critical activity at 11am the registration to triage performance was reviewed again at 2pm and was found to be improved.

The waiting time from triage to medical review, from decision to admit to admission in an inpatient bed was tracked and trended by the Unscheduled Care Committee, with feedback on performance provided to staff in the emergency department and reported at monthly performance meetings.

At 11am, the hospital was not compliant with the HSE's key performance indicators for patient experience times[‡‡‡‡] for all patients in the department. At that time, eight patients were admitted and were waiting to be admitted to a bed on a ward.

The hospital had systems and processes in place to support continuous and effective patient flow through the emergency department. Inspectors noted however that the systems and processes were not always functioning in the way they should.

A number of hospital admission avoidance pathways and other measures to improve surge capacity and patient flow through the emergency department were in place at the time of inspection. These included:

- Staff reported GP access where 1.2 WTE GP's reviewed 10-12 patients per day within the ambulatory care pathway 8am to 8pm Monday, Wednesday and Thursday and 12pm to 8pm on Tuesday.
- An ambulatory care pathway staffed by advanced nurse practitioners in minor injuries. This offered rapid access to and treatment for minor injuries as well as access to a GP. Patients screened in the emergency department, deemed as less urgent cases and likely to go home had access to ambulatory care. The ambulatory

[‡‡‡‡] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

emergency department had a planned capacity for 16 patients and operated Monday to Friday, between the hours of 8am to 8pm. At 8pm, patients in the ambulatory emergency department were transferred to the hospital's main emergency department, where their care had not yet been concluded plus or were waiting on an inpatient bed. On the day of inspection at 12pm, there were 12 patients receiving care in the ambulatory emergency department.

- a frailty team to improve the experience of the 'frail older person' aged 75 years and over in the emergency department and onward patient flow through the hospital.
- a six-bedded clinical decision unit (CDU) where patients could be admitted for 24 hours under the care of an emergency medicine consultant for observation and treatment.
- a transit care day unit accommodated up to eight patients from the wards or the emergency department who were preparing for discharge, to free up beds and trolleys and support patient flow. It was open Monday to Friday, 7am to 6pm.

The safe inter-departmental and external transfer of patients within and outside the hospital was supported by a formalised clinical handover policy as reported to inspectors by staff. In relation to transitions of care, staff were told that the hospital uses the ISBAR (Identify, Situation, Background, Assessment and Recommendation) technique when transferring patient care between health care professionals as in clinical handover.

Overall, it was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department and that operationally, the department was functioning well. On the days of inspection however, the hospital's COVID-19 streaming practices were not functioning in line with local and national guidance. Inspectors raised these findings with the executive management team and were assured that the DON was addressing and following up this concern.

Findings relating to the wider hospital and two clinical areas inspected

The hospital had management arrangements in place in relation to the four areas of known harm for the clinical areas inspected and the wider hospital and these are discussed in more detail below.

Infection, prevention and control (IPC)

The hospital had an infection prevention and control team comprising:

- 2.0 WTE consultant microbiologist
- 1.0 WTE assistant director of nursing (ADON)
- 3.0 WTE IPC clinical nurse specialists
- 1.5 WTE surveillance scientists

- 1.0 WTE antimicrobial pharmacist

The hospital had an overarching infection prevention and control programme[§§§§] as per national standards.[*****] The infection prevention and control team had developed an infection prevention and control service plan that set out objectives to be achieved in relation to infection prevention and control in 2022. These objectives were time bound and focused across all eight themes from the *National Standards for Safer Better Healthcare*. They included quality improvement plans related to communication, antimicrobial stewardship, education and training, IPC guideline updates as per national guidance, IPC audits and IPC staffing. Inspectors found that the hospital were also completing outbreak management reports, in line with guidelines following outbreaks of infection at the hospital.

Inspectors were told by the IPC lead that the hospital had an antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship programme.[†††††] Antimicrobial Guidelines published in Q1 2022 were viewed by inspectors. According to documentation provided to inspectors antimicrobial stewardship rounds led by either the Antimicrobial Pharmacist or Consultant Microbiologist took place twice a week on Laurel & Redwood wards and once a week on Beech, Elm & Maple wards.

In relation to prevention and control of COVID-19, inspectors were informed that the hospital had a system in place for assessing patients on arrival at the hospital. However, on the morning of inspection, and on two other occasions during the inspection, inspectors observed a desk at the entry door to the emergency department with a clipboard and questionnaires related to COVID-19. There was no member of staff at this desk to support completion of the questionnaire as patients arrived at the emergency department. HIQA inspectors were told by both the ADON and clinical nurse manager 3 (CNM3) in the emergency department that the staff member allocated to the COVID-19 risk assessment had been re-assigned to other duties when a number of emergency situations arose within the emergency department within a short period of time of each other. The absence of this initial level of screening was raised by HIQA inspectors with the IPC lead, DON and EMT, and assurance was sought that the screening system was being

[§§§§] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

[*****] Health Information and Quality Authority. *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services.* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

[†††††] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

adhered to. The DON assured HIQA that this was being investigated and managed. This is discussed further under standard 3.1.

Patients with suspected or confirmed COVID-19 were streamed to a separate newly refurbished area of the department which contained one HBN4 negative pressure room[‡‡‡‡‡] (with an ante room)[§§§§§] and two resuscitation rooms. All other patients were directed to the main waiting area. Further assessment for communicable infectious diseases including COVID-19 was undertaken during triage.

Medication safety

- The hospital had a clinical pharmacy service,[******] which was led by the hospital's chief pharmacist. During inspection HIQA were told that the hospital had:
- 32.29 WTE approved pharmacy posts and 8.9 WTE vacancies, which included the chief pharmacist, clinical pharmacists, medication safety pharmacists, AMS pharmacists and pharmacy technicians. Post inspection data shared with HIQA reported 42.1 WTE pharmacy posts and 10.3 WTE vacancies. Considering both figures this represents a 24-27% vacancy rate.

The hospital had management arrangements in place to support the delivery of medication safety however inspectors were told that deficits in the available pharmacy resources compared to the approved and funded posts were impacting on the provision of a comprehensive clinical pharmacy service across all departments and ward areas. Medication safety risks and incidents were tracked and trended by a medication safety pharmacist. Risks were also escalated to hospital group level where indicated. Incidents were reported directly onto the National Incident Management System (NIMS). There was evidence of risk reduction strategies in place at the hospital such as the use of automated medication dispensing systems, a high risk medicine list with reduction strategies, APINCH[††††††] lists and SALAD[‡‡‡‡‡‡] lists. The HSE leaflets '*Know, Check, Ask'*[§§§§§§] were

[‡‡‡‡‡] Negative pressure rooms refer to isolation rooms where the air pressure inside the room is lower than the air pressure outside the room. Therefore, when the room door is opened, potentially contaminated air or dangerous and infective particles from inside the room will not flow outside to non-contaminated areas.
[§§§§§] Anteroom, is an airlock room that provides a safe area for healthcare professionals to change into or out of protective clothing, transfer or prepare equipment and supplies, and can protect other rooms from contamination if pressure is lost within the negative pressure room.
[******] 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.
[††††††] APINCH list: acronym for high risk medicines including **a**nti-infective agents, anti-psychotics, **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy, **h**eparin and other anticoagulants
[‡‡‡‡‡‡] SALAD list: **S**ounds **A**like, **L**ooks **A**like **D**rugs
[§§§§§§] The 'Know, Check, Ask' is a campaign led by the HSE, aimed at encouraging health care professionals to discuss medication and empowering people to become more informed about their medication and its use.

noted to be on display in one of the clinical areas inspected. A medication safety bulletin for November 2022 was also noted to be on display on Sycamore ward.

Deteriorating patient

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. There was a Deteriorating Patient Committee (DPC) in place to provide oversight and advice about the safety, effectiveness and ongoing improvement of the recognition and response for all Early Warning Systems, CPR and sepsis management processes implemented in Connolly Hospital. The hospital had implemented the INEWS version 2 early warning system. The escalation protocols were in line with national guidance with a system wide framework and escalation procedure. There were posters on display in the medical ward relating to the INEWS version 2. There were assigned nurse leads for each of the early warning systems. Staff reported satisfaction with the use of this version.

Inspectors noted evidence of monitoring compliance with the use of warning systems and corrective actions being taken. Staff reported that monthly metrics were reported to the DON and QPS manager. Risks and incidents associated with the deteriorating patient were tracked and trended as reported by the clinical lead for the deteriorating patient committee.

Transitions of care

HIQA was satisfied that the hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. The term 'transitions of care' incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. The hospital's 'length of stay (LOS) greater than seven days' committee and patient flow co-ordinator had oversight of scheduled and unscheduled care activity and issues contributing to delayed discharges at the hospital. Inpatient bed capacity, patient discharge and transfers into and out of the hospital were discussed at hospital executive level between the general manager, DON, patient flow manager and a senior emergency department representative Monday to Friday at 9am. If 'in-surge'******* at weekends, an on-call member of the hospital executive team met with representatives from bed management and the emergency department.

The average length of stay (AvLOS) in November 2022 for medical patients was 10.06 days (above the HSE national target of 7 days) and AvLOS for surgical patients was 4.05 days (below the HSE national target of 5.2 days). On day one of the inspection there were nine delayed transfers of care recorded (no HSE target).

******* 'In surge' was defined by the patient flow manager as a situation whereby the number of admitted patients in the hospital was above the hospital's capacity, which was reported as 318 beds.

To support patient flow, Connolly Hospital had access to a total of 130 beds located in five external step down facilities. Inspectors were informed that on transfer patients remain under the care of their consultant from Connolly Hospital to support continuity of care for the patient.

A number of systems were also in place to enhance the safe transfers of patients within and from the hospital. Inspectors were informed by the lead for patient flow that these included:

- daily bed management meetings
- length of stay meetings twice weekly
- meetings between the GM, lead for patient flow and the ADON for patient flow three times weekly
- safety huddles
- a patient discharge leaflet highlighting the discharge process and availability of off-site facilities.

Inspectors were informed that the 'Communication (Clinical Handover) in Acute and Children's Hospital Services: National Clinical Guideline No. 11' was in use throughout the hospital to support patient flow.[†††††††] Staff told inspectors that a communication log was maintained on Sycamore ward to inform family members of the patient's progress towards discharge and a predicted discharge date was also documented on all patient charts on Cedarwood ward.

The hospital monitored compliance with the HIQA National Standards for a Clinical Summary (Patient Discharge) using datasets contained within discharge correspondence and found that there was a 93% compliance as reported in its most recent published data October 2022. The hospital used the Integrated Patient Registration and Management System (iPMS) to complete discharge summaries on each patient. Notwithstanding this, HIQA were informed during inspection of delays in the issuing of discharge summaries to primary healthcare services. Inspectors noted that the hospital's Operational Plan 2022-2024 had stated an aim to implement improvement actions based on the findings from a discharge summary audit. An audit reported in documentation provided to HIQA on a hospital wide eDischarge Project Proposal dated October 2022 identified that overall, 45% (18/40) of patients had a discharge summary recorded in both the medical notes and on iPMS, however 25% (10/40) of patients had no discharge summary in either their medical notes or on iPMS. In the interest of safe transitions of care, discharge summaries should be available for each patient's primary health care team or for the patient at the point of discharge.

It was clear that existing hospital avoidance pathways and the access to additional off-site beds supported transitions of care for patients out of the hospital. This was evident in the

[†††††††] Department of Health. Communication (Clinical Handover) in Acute and Children's Hospital
Services. National Clinical Guideline No. 11 November 2015. ISSN 2009-6259

use of lower numbers of admitted patients awaiting a bed on a ward, in the hospital's conversion rates and in the lower numbers of delayed discharges at the hospital on the day of inspection (which totalled nine) when compared to the data for other similarly sized model 3 hospitals. However delays in completing discharge summaries require improvement.

Nursing, medical and support staff workforce arrangements

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

The hospital's Director of Human Resources (HR) reports to the RCSI Hospital Group HR Director and is operationally accountable to the general manager. The HR department tracked and trended staffing levels and absenteeism rates, which were reported at monthly performance meetings with the RCSI Hospital Group. Inspectors were informed that absenteeism rates at the hospital in October 2022 were 5.4% (HSE's target 4%).

The hospital's total approved complement of staff at the time of inspection was 1579.54 WTE. This included 86 WTE vacancies (5% vacancy rate overall). Inspectors were satisfied that the hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, the deteriorating patient and transitions of care. HIQA were informed of hospital wide attempts to support medication safety despite challenges of a 24-27% vacancy rate in the pharmacy department.

The hospital's approved complement of nursing staffing was 580.7 WTE. At the time of inspection, 532.75 WTE nursing positions were filled, which represented a variance of 47.95 WTE posts or an 8% shortfall between the approved and actual nursing complement. Hospital management told inspectors that they were actively recruiting nursing staff to address the variance and interviews were taking place weekly. It was reported that the hospital had 80 nurse candidates with clearance that they were actively seeking to employ.

The hospital had an approved complement of 81.87 WTE consultants. 79.87 WTE consultant staff were on the specialist register with the Irish Medical Council. HIQA were assured that consultants who were not on the specialist register received both supervision and mentorship in line with national guidance. HIQA inspectors were told that the recruitment of a further 3.0 WTE consultants was in progress. The consultant staff were supported by 157.45 WTE non-consultant hospital doctors at registrar, senior house officer and intern grade. At the time of inspection, the human resources manager reported notable improvements in recruitment of NCHDs with just 3.0 WTE vacancies.

The hospital's approved complement of health and social care professionals (HSCPs) was 187 WTE. At the time of inspection, 160.7 WTE HSCP positions were filled, which represented a variance of 26.3 WTE posts or a 14% shortfall between the approved and

actual HSCP complement. Inspectors were told that management were actively recruiting although this was challenging especially in the occupational therapy profession.

Inspectors viewed a comprehensive RCSI Hospital Group workforce plan for 2021–2023, with an associated time-bound action plan to facilitate implementation. Some of the key priorities were recruitment, retention, employee experience and investment in technology.

Staff training and education

HIQA were provided with a copy of the uptake of mandatory and essential training at the wider hospital level across all staff groups. A deficit that was highlighted by HIQA inspectors to the EMT during inspection was the uptake of basic life support training. This had already been identified by the clinical director for the hospital and raised at the DPC meeting as documented in the DPC meeting minutes viewed by inspectors. Nursing and healthcare assistant staff attendance at mandatory and essential training was monitored at clinical area level by clinical nurse managers. Inspectors were told that access to a learning hub was provided for all staff. Inspectors were informed during inspection that essential and mandatory training attendance by non-consultant doctors was recorded on the National Employment Record (NER) system.[‡‡‡‡‡‡‡] Inspectors were also provided with documentation showing sample induction timetables for both NCHDs and interns and dates and numbers of attendees for nursing induction programmes.

Uptake of mandatory and essential training

On the day of inspection, there was evidence that CNMs had oversight of the uptake of training for their clinical area. The hospital had mandatory training programmes for infection prevention and control, medication safety and the national early warning system. Nursing, medical and support staff who spoke with inspectors confirmed to HIQA that they had received induction training and had completed training on a variety of topics on the HSE's online learning and training portal (HSELanD).

Training for infection prevention and control included mandatory training on hand hygiene and standard and transmission based precautions and documentation provided to HIQA showed that:

Staff uptake of mandatory training in hand hygiene in the last two years was above the HSE target of 90% except for medical staff:

- 99% for nursing staff
- 98% for healthcare assistants
- 73% for medical staff
- 98% for health and social care professionals.

[‡‡‡‡‡‡‡] National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

Staff uptake of mandatory training in standard and transmission based precautions and donning and doffing PPE in the last two years was:

- 99% for nursing staff
- 98% for healthcare assistants
- 73% for medical staff
- 98% for health and social care professionals.

During inspection training records for the clinical areas inspected shared with inspectors showed that:

Staff uptake of mandatory training in hand hygiene in the last two years was as follows:

- 100% for nursing staff (Sycamore ward)
- 60% for nursing staff (Cedarwood ward)
- 100% for healthcare assistants (Sycamore ward)
- 0% for healthcare assistants (Cedarwood ward)

Staff uptake of mandatory training in standard and transmission-based precautions and donning and doffing PPE in the last two years was:

- 100% for nursing staff (Sycamore ward)
- 80% for nursing staff (Cedarwood ward)
- 100% for healthcare assistants (Sycamore and Cedarwood wards)

The uptake of mandatory training in medication safety in the last two years in both the clinical areas inspected was:

- 100% of nursing staff

The hospital's overall uptake of mandatory training in INEWS and sepsis in the last two years was:

- 98% of nursing staff - above HSE target of 85%, 96% sepsis
- 71% of medical staff - above HSE target of 85%, 82% sepsis.

In summary, HIQA was assured that the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm in the emergency department, wider hospital and clinical areas visited on the day of inspection. Hospital management had implemented a number of hospital admission avoidance pathways which was having a positive impact on hospital conversion rates, trolley numbers and discharges. HIQA acknowledges hospital management's efforts to recruit medical, nursing and pharmacy staff. Nevertheless, at the time of inspection there were particularly high vacancy levels within nursing, clinical pharmacy services and the health and social care professions.

Efforts were made by hospital management to provide mandatory training in all areas. Notwithstanding this, staff attendance at and uptake of mandatory and essential training is an area that could be improved. The hospital wait time for triage requires particular attention and efforts should be made to improve this. Contingency arrangements should also be reviewed to ensure that triage continues in a timely manner during time critical events. It is important that patient discharge summaries are provided for each patient at the point of discharge. The COVID-19 management pathway should be regularly reviewed and monitored to ensure it is functioning in line with national guidance.
Judgment: Partially compliant

Inspection findings relating to the Emergency Department

The following section outlines findings from the inspection as they related to the Emergency Department. Findings and judgments are presented under three of the four national standards (6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare* relating to the themes of: workforce; person-centred care and support; and safe care and support.

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.
Connolly Hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. Medical staffing levels in the emergency department were maintained at levels to support the provision of 24/7 emergency care. At the time of inspection, the emergency department had 5.75 WTE consultants in emergency medicine made up of seven consultants. One of the consultants in emergency medicine was the assigned clinical lead for the department who was responsible for the day-to-day functioning of the department. The consultants were operationally accountable and reported to the hospital's Clinical Director. All permanent consultants in emergency medicine were on the specialist register with the Irish Medical Council. A senior clinical decision-maker,§§§§§§§ consultant or registrar, was available on site in the emergency department 24/7. Consultants were on site 8am to 8pm Monday to Friday and for five hours every Saturday with one consultant providing on-call cover during evenings,

§§§§§§§ Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

nights and weekends. Non-consultant hospital doctors provided medical cover in the department 24/7.

The consultant in emergency medicine at Connolly Hospital was supported by 30 non-consultant hospital doctors (NCHDs). The hospital was an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine. HIQA were informed by staff that NCHDs often come back to the hospital as consultants.

Hospital management discussed the active measures they were taking to improve the recruitment of non-consultant hospital doctors to the hospital's emergency department. Staff reported an increase in the uptake of NCHD positions in the emergency department.

The emergency department had an approved complement of 65 WTE nursing staff, with 59 WTEs (91%) nursing positions filled on the day of inspection. The variance between the approved and actual nurse staff complement was 6.0 WTEs (9%). Staff told HIQA that emergency department nursing shortages are addressed through the use of redeployment of nursing staff from areas less busy at the time.

The emergency department approved nursing roster was 14 nurses per day shift, Monday to Friday and 13 nurses per day shift at weekends with eleven nurses per night shift. A review of the emergency department nursing rosters for the four week period prior to the inspection demonstrated that the emergency department was on average short one to three nurses per day shift. Night shifts were fully covered for two of the four weeks reviewed with one nursing shift unfilled per night for the remaining two weeks reviewed. Over the four weeks rostered reviewed, approximately 19.5% of day shifts and 8% of night shifts were unfilled. Documentation on nursing rosters provided to HIQA demonstrated that this level of cover was maintained through the use of agency staff and staff working additional shifts.

The department did not have its full complement of nursing staff on duty on the day of inspection. There were 12 nurses on duty and two nurses on unplanned sick leave. Of the 12 nurses on duty, HIQA were advised that two of those were allocated to Walnut ward leaving the emergency department with 10 nurses. Walnut ward was a 7-bed unit for admitted patients, used to manage surge capacity in the hospital. Inspectors were told that Walnut ward previously operated as an acute medical assessment unit (AMAU) in which GPs could directly refer patients meeting specific criteria to support patient flow through the emergency department. It was staffed by the emergency department, however in this alternative configuration, the ward operated as a short-stay ward for patients who presented through the emergency department and were admitted under the care of specialty consultants. The patients previously attending the AMAU for assessment now presented to the emergency department instead. On the day of inspection HIQA inspectors were told that of two nurses on duty on Walnut ward one had been transferred permanently to the ward and the other nurse on duty was agency staff. Nursing staff in the

emergency department were supported by five healthcare assistants on the day shifts with four healthcare assistants on night shifts.

A CNM3 had responsibility for the nursing service within the emergency department and worked Monday to Friday. The CNM3 reported to the ADON for the emergency department. Issues such as staffing shortages were escalated to the nursing office. A CNM 2 was on duty each shift, and had responsibility for nursing services out-of-hours and at weekends. The CNM 2 escalated issues to the nursing office out-of-hours. An additional CNM 2, working core hours was responsible for admitted patients boarded in the emergency department. An ADON for patient flow is also specifically assigned to the emergency department.

The staff in the emergency department had access to an infection prevention and control nurse and HIQA were told staff could call or email and get a response very quickly and a risk assessment if required. Staff also had access to clinical pharmacy to check stock Monday to Friday. HIQA were told that an antimicrobial pharmacist was available to review the drugs list and make updates as needed. Inspectors noted that security staff were on duty in the emergency department on the day of inspection.

Attendees to the emergency department were assigned to the consultant on-call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and remained within the emergency department while awaiting allocation to an inpatient bed in the hospital. Inspectors were told that if the patient's clinical condition deteriorated while in the emergency department awaiting award bed, staff in the emergency department provided the necessary emergency response.

Uptake of mandatory and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice. The emergency department had a system in place to monitor and record staff attendance at mandatory and essential training, and this was overseen by the CNM 3.

HIQA found that staff attendance and uptake at some mandatory and essential training could be improved, especially training on basic life support which was documented as an issue in the Deteriorating Patient Committee meeting minutes viewed by inspectors. Inspectors were informed that the Clinical Director had a remit to improve this and this was under review.

Training records for nursing staff in the emergency department supplied to HIQA inspectors by the CNM 3 on the day of inspection showed that:

- 100% of nurses were compliant with hand hygiene practices – above the HSE's target of 90%
- 64% of nurses were up to date in basic life support training

- 100% of nurses were up to date with training on the national early warning system (INEWS)[********]
- 85% of nurses were up to date in training on the Manchester Triage System.[††††††††]

Mandatory training records for doctors in the emergency department provided to HIQA inspectors dated October 2022 showed that:

- 73% of all hospital doctors were compliant with hand hygiene practices – below the HSE's target of 90% (this represented all hospital doctors not solely the emergency department doctors)
- 84.5% of doctors were up to date with infection prevention and control training (100% of consultants)
- 28% of doctors were up to date in basic life support training
- 84.5% of doctors were up to date with training on the national early warning system (100% of consultants)
- 88% of doctors were up to date in training on sepsis (100% of consultants).

At the time of inspection the hospital had not commenced training on the roll-out of the Emergency Medicine Early Warning System (EMEWS) and this was documented in the training records provided by the hospital.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare, however nursing staff resources should be reviewed in light of the reconfigured service whereby there is no longer an AMAU and there is now an in-patient ward. The hospital should ensure that its staffing of the service is in line with national guidance.[‡‡‡‡‡‡‡‡]

Attendance at and uptake of mandatory and essential training for staff in the emergency department could be improved, especially training on basic life support. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

[********] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission/readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

[††††††††] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

[‡‡‡‡‡‡‡‡] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings from the emergency department, related to the quality and safety dimension are presented under two national standards (1.6 and 3.1) from the themes of person-centred care and support and safe care and support.

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[§§§§§§§§] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department, and to be responsive to their individual needs. Staff provided assistance and information to patients in a kind and caring manner. Communications observed between staff and patients were respectful. Curtains were secured around patients to provide privacy and protect their dignity when providing personal care.

Patient's privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles. This was validated by patients who spoke with inspectors and consistent with the 2022 National Inpatient Experience Survey, where with regard to privacy when being examined or treated in the emergency department, the hospital scored 8.4, above the national score of 8.1. However, it was clear that the privacy, dignity and confidentiality of patients accommodated on chairs in the corridor and multi-occupancy areas was compromised.

[§§§§§§§§] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

In 2022, the hospital achieved higher than the national average score in survey questions related to the emergency department. More specifically, with regard to:

- privacy when being examined or treated in the emergency department, the hospital scored 8.4 (national average – 8.1)
- being treated with respect and dignity in the emergency department, the hospital scored 8.9 (national average – 8.7)
- communication with doctors and nurses in the emergency department, the hospital scored 7.9 (national average – 7.9).

On the day of inspection, all patients were accommodated in designated bays or cubicles with privacy curtains provided around each individual space. Toilet and shower facilities were located within the emergency department.

Due to the high number of patients within the department, staff were overheard providing updates on clinical care to patients on corridors. Staff apologised to patients for the long waits and the lack of privacy.

Inspectors were informed that a patient at end-of-life would be accommodated in the single room within the emergency department. The department also had a relatives rooms for privacy and sharing of bad news.

On the day of inspection one patient appeared confused and was mobilising around the department. Staff provided special assistance to this patient and were heard speaking kindly in lowered tones to support and orientate the patient. However, a busy emergency department was not a suitable environment for this patient and did not support the provision of dignity and respect.

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 in the emergency department and this is consistent with the human rights-based approach to care supported and promoted by HIQA. However, the physical environment in which care was delivered did not always promote and protect confidentiality for the patients in the emergency department.

Judgment: Partially 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 systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the

emergency department in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times.

Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at the Unscheduled Care Committee meetings which took place on a monthly basis. Data was also reviewed at executive management group meetings and at monthly performance meetings with the RCSI Hospital Group.

Performance data collected on the day of HIQA's inspection showed that at 11am the hospital was not fully aligned with all of the national key performance indicators for the emergency department. Performance data over a 10-month time frame submitted to HIQA showed that 70% of patients who attended the department between January to October 2022 waited less than nine hours after registration to be discharged or admitted to an inpatient bed.

At that time, 65 patients were in the emergency department, of which

- 35 (54%) patients were in the emergency department for more than six hours after registration — not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 24 (37%) patients were in the emergency department for more than nine hours after registration — not in with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- one (1.5%) patient was in the emergency department for more than 24 hours after registration — compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- 9 (14%) attendees to the emergency department were aged 75 years and over and were in the emergency department greater than six hours of registration- not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within six hours of registration.
- 9 (14%) attendees to the emergency department were aged 75 years and over and were in the emergency department greater than nine hours of registration-not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.
- all attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration — compliant with the national target that 99% of patients aged 75 years and over are discharged or admitted to a hospital bed within 24 hours of registration.

Similar to other emergency departments inspected by HIQA, the hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes (HSE target 95% in 30 minutes). In 2021, 41.8% of ambulances that attended the hospital's emergency department had a time interval of 30 minutes or less, which

suggests that ineffective patient flow in the emergency department affects the timely offload of patients arriving to the department via the national ambulance service. At the time of the inspection 33.5% of ambulances that attended the department had an interval of 30 minutes or less.

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at department level with oversight of the process assigned to the CNM 3 and ADON for the emergency department. Incident reports were sent to the risk manager in quality and patient safety. Feedback was provided on all risks including an annual report that was shared with all staff.

At the time of inspection, three risks specifically related to the emergency department were recorded on the hospital's corporate risk register — adverse patient outcomes due to non-compliance with the 9-hour patient experience time (PET) in the emergency department, delay in accessing historical patient emergency department records due to a time delay in scanning paper records onto the hospital's electronic storage system and infection control risks in the emergency department due to limited availability of isolation facilities.

All three risks were risk-rated high (red) and the risk register detailed the existing controls, actions required, review date and status of the risk. Inspectors were informed that risks specific to the emergency department were discussed at local level at the Unscheduled Care Committee meeting and that the executive management team had oversight of the hospital's overall risk register.

While inspectors were assured that the hospital had systems and processes in place to identify, evaluate and manage risks, it was noted that the last date for formal review of PET in the emergency department by the EMT was May 2022. Hospital management should ensure that systems in place to monitor, manage and evaluate risk are effective and operating in line with the hospital's risk management processes in order to provide assurance that risks are being managed appropriately.

Other risks on the risk register that also impacted the emergency department included: risk of missed and or delayed diagnosis due to delays in radiological reporting; risk of delayed diagnosis due to limited access to Radiology Diagnostic Services (CT/MRI;) and risks associated with poor clinical handover or communication of information during transitions of care.

Inspectors were informed that risk issues were discussed and managed at Safety Huddles which occurred three times a day at 10am, 1pm and 6.30pm.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were screened by a healthcare assistant at the door

for signs and symptoms of confirmed or suspected COVID-19. If symptomatic or COVID-19 positive, the attendee was immediately referred to a designated COVID-19 waiting area. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single cubicles and isolation room. Staff confirmed that terminal cleaning[*********] was carried out following suspected or confirmed cases of COVID-19. On both days of inspection HIQA inspectors noted that the healthcare assistant was not at the front door to complete this function as outlined under standard 5.5. This was highlighted by inspectors during the meeting with the lead for infection prevention and control and at the executive management team meeting and subsequently addressed.

Self-presenting attendees then checked in at reception, were allocated a waiting area and waited to be called for triage. During triage any further screening took place for CPE or methicillin-resistant Staphylococcus aureus (MRSA) in line with national guidance at the time of inspection. Inspectors were informed that there was an alert on the computer system to prompt staff to screen for CPE (green flag) and MRSA (red flag) and that this could not be bypassed. Minimum physical spacing of one metre was maintained in the waiting area and emergency department, in line with national guidance. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. All patients within the main waiting area were observed wearing masks.

The emergency department environment was generally clean and well maintained and had recently been refurbished. Staff reported that quality improvement plans were developed to improve any areas of non-compliance and gave a recent example of working with the infection prevention and control team to improve hand hygiene compliance in the emergency department.

Medication safety

No clinical pharmacist was assigned to the emergency department but inspectors were informed that a pharmacist came to the department when available or requested. A pharmacy technician did visit the department every Monday, Wednesday and Friday to replace pharmacy stock. Inspectors observed evidence of risk reduction strategies in place in the emergency department such as the use of automated medication dispensing systems, a high risk medicine list with reduction strategies, APINCH[†††††††††] and SALAD[‡‡‡‡‡‡‡‡‡] lists.

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

[†††††††††] APINCH list: acronym for high risk medicines including **a**nti-infective agents, anti-psychotics, **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy, **h**eparin and other anticoagulants

[‡‡‡‡‡‡‡‡‡] SALAD list: **S**ounds **A**like, **L**ooks **A**like **D**rugs

There was evidence that some medication safety practices were audited in the department and quality improvement plans were developed to improve areas of non-compliance.

Inspectors were informed that there was no formal medicine reconciliation by a clinical pharmacist taking place for patients in the emergency department.

Deteriorating patient

The emergency medicine early warning system (EMEWS) was not used in the emergency department. The hospital was using the Irish National Early Warning System (INEWS 2).

The hospital were auditing compliance with national guidance on INEWS throughout the hospital. Inspectors were informed that staff are supported to complete training on INEWS and sepsis.

Inspectors observed the use of the INEWS observation chart to support the recognition and response to a deteriorating patient in the emergency department. Staff reported that the ISBAR communication tool was used in the emergency department.

Three multidisciplinary safety huddles, at 10am, 1pm and 6.30pm were held in the emergency department to discuss the status of all patients in the department and identify patients that were of concern.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers from the emergency department. The hospital had also introduced a discharge leaflet for patients to support safe transitions of care from the emergency department. Delayed transfers of care impacted the availability of inpatient beds at the hospital and affected waiting times in the emergency department. On the day of inspection, the hospital had nine delayed discharges. Hospital management attributed the delay in transferring patients due to the complexity of patients and access to nursing home placements and this was documented in the October 2022 Unscheduled Care Report for the hospital.

Staff reported efforts to communicate with families through a communication log and they also had support from 1.5 WTE (three part-time) patient liaison officers (PLO).

Management of patient-safety incidents

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported to the National Incident Management System (NIMS),[§§§§§§§§§] in line with the HSE's incident management framework. Feedback on patient-safety incidents was provided to the CNM 2 by the quality and risk manager.

[§§§§§§§§§] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

The hospital's Serious Incident Management Team and executive management team had oversight of the management of serious reportable events and serious incidents that occurred in the emergency department.

Inspectors were informed that feedback on emerging trends and themes from patient-safety and serious reportable events was shared with staff in the emergency department via clinical handover and safety huddles. Documentation provided to inspectors showed that in the emergency department there was one serious reportable event recorded in 2022.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally, in line with the hospital's complaints policy by nurse management with oversight from the CNM 3 and ADON. Inspectors were told that complaints relating to the department were tracked and trended by the hospital complaints manager and feedback on emerging trends and themes was provided to the nurse manager who shared it with all staff. Complaints management training was provided to staff in the emergency department. Of note, on the day of inspection, the patients who spoke with inspectors did know how to make a complaint.

In summary, HIQA found that while the hospital had structures and systems in place to protect patients from the risk associated with the design and delivery of the service, these were not always effective. The COVID-19 management pathway should be regularly reviewed and monitored to ensure it is functioning in line with national guidance. Furthermore, the hospital must ensure that identified risks are being appropriately managed, evaluated and updated in line with risk management processes in order provide adequate oversight of risks. The hospital needs to ensure that plans outlined to implement the emergency department early warning systems are progressed. Improvements are needed in the emergency department PET and ambulance turnaround times to support optimal patient care. Staff uptake of mandatory and essential training could also be improved. Hospital management need to introduce sustainable improvements to protect patients receiving care in the department from harm and hospital management need to be supported to do this from the wider hospital group.

Judgment: Partially compliant

Inspection findings relating to the wider hospital and clinical areas

This section of the report describes findings and judgments against selected national standards (from the themes of leadership, governance and management (5.8), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3).

Capacity and Capability Dimension

Inspection findings from the wider hospital and clinical areas visited and related to the capacity and capability dimension are presented under national standard 5.8 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital.

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. These arrangements were outlined in the Hospital's Operational Plan 2022-2024.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the RCSI Hospital Group Quality Assurance Programme key performance metrics. The performance metrics reported for the hospital cover the areas of access and patient flow, infection control and management, medication management, patient care and treatment, patient and family experience and staff.

The hospital collated performance data for unscheduled and scheduled care, including data on emergency department attendances and patient experience times, bed occupancy rate, average length of stay, scheduled admissions and delayed transfers of care. The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at fortnightly meetings of the executive management team and at monthly performance meetings between the hospital and RCSI hospital group. Inspectors reviewed the monthly quality and safety performance metrics report for the hospital for June to September 2022 and there was evidence of KPI review, incident trend analysis, infection control management, risk register review and complaints trend analysis.

Risk management

There were risk management structures in place to proactively identify and minimise risk. Risks outside the control of the services were escalated to the corporate risk register. The executive management group had oversight of the management of risks recorded on the hospital's corporate risk register. The corporate risk register was reviewed monthly by the

Executive Management Committee (EMC), with updates provided at the monthly performance meetings with the RCSI Hospital Group.

Risk management was also a standing item agenda at quality and patient safety committee meetings. Inspectors were informed that each directorate also had their own risk register and risks that could not be escalated at directorate level were escalated to the corporate risk register. High-rated risks not managed at hospital level were escalated to the RCSI Hospital Group.

Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to mitigate the risks, in relation to the four key areas of known harm were recorded on the hospital's corporate risk register. These risks are outlined further in NS 3.1.

At ward level, CNMs were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential patient safety risks. Inspectors observed a member of staff drafting a risk assessment and they were provided with examples of risks at ward level related to the four key areas of known harm.

Audit activity

The quality and patient safety committee were the governing committee for audit activity at the hospital. The hospital had a clinical audit coordinator, Grade 7 who was accountable to the Head of Quality and Safety. Audit activity was centrally controlled at the hospital and a formal process was in place for staff wanting to undertake audit activity.

Management of serious reportable events

The hospital's Local Incident Management Team (LIMT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. Chaired by the hospital's general manager, the LIMT meetings were held on a scheduled basis to monitor and gain assurance in relation to the ongoing management of all open reviews and reviews for closure. The LIMT committee's membership comprised of the General Manager, Clinical Director, Head of Quality and Safety, Associate Clinical Director(s), Director of Operations, DON, Director of Clinical Services, Chief Pharmacist, Quality and Safety Patient Liaison Officer and the Quality & Safety Advisor.

The LIMT committee reported to the Quality and Patient Safety Executive through the Quality & Safety Performance Metrics Report issued monthly. The LIMT also had a reporting relationship to the RCSI Group through the Senior Incident Management Forum (SIMF) held on a quarterly basis attended by the Head of Quality and Safety, DON and Clinical Director.

The purpose of the LIMT was to (i) agree the review approach for any clinical and non-clinical serious incident, (ii) agree methodology of review and (iii) appoint a review team. Minutes of LIMT committee meetings submitted to HIQA, showed that the meetings were well attended and followed a structured format. Progress in implementing actions was monitored from meeting to meeting and there was a named responsible person for new actions. Serious reportable events and serious incidents were reviewed, tracked and trended by the risk manager and discussed and updated at the LIMT.

Management of patient-safety incidents

There were systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System (NIMS),†††††††† in line with the HSE's Incident Management Framework. The executive management team and Quality and Patient Safety Committee had governance and oversight of reported patient-safety incidents. Patient-safety incidents were also discussed at performance meetings with the RCSI Hospital Group. Patient-safety incidents related to the four areas of known harm are discussed further in NS 3.3.

Feedback from people using the service

Findings from the National Inpatient Experience Survey were reviewed at meetings of the Quality and Patient Safety Committee and updates were provided to the executive management team. The hospital had developed a number of quality improvement initiatives in response to the National Inpatient Experience Survey findings (2021). The quality improvement plans focused on:

- development and roll out of a ward level communication log
- design and implementation of a hospital-wide patient discharge leaflet
- increased choice in relation to food options for patients

In summary, at wider hospital level, the hospital were monitoring performance against key performance indicators in the four areas of known harm and there was strong evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvement initiatives were implemented in response to audit findings, patient safety incidents and feedback from people using the service. Overall, inspectors were assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital.

Judgment: Compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

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

During the inspection, inspectors were assured that the staff of the hospital promoted and respected the dignity and privacy of the people who use the service. Staff promoted a person-centred approach to care by communicating with patients in a respectful manner. Inspectors were informed that a communication log was used in the clinical areas inspected to maintain communication with the patients' family. Nonetheless inspectors on talking with patients identified that some patients required additional support to access the hospital shop where they could buy phone credit to support communication with family and this was not always readily available impacting on patient autonomy. This related to patients in the wards which were located on the campus but were remote from the main hospital block.

Staff promoted independence by displaying the 'get up, get dressed, get active' mission statement on one of the clinical areas inspected.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and autonomy of patients receiving care. For example inspectors observed access to single rooms, en-suite facilities and privacy curtains. However, inspectors observed that some multi-occupancy rooms accommodated people of mixed gender which had the potential to impact on patients' privacy and dignity.

Patient's personal information in the clinical areas visited, during the inspection, was not always observed to be fully protected and stored appropriately. Inspectors noted patient nursing observation charts with personal information being left on windowsills outside of single rooms along the main corridor in one of the clinical areas inspected. This was highlighted by the inspector and a staff member advised that these notes should be on the bed end and said the chart holders for this were on order but had not yet arrived. The charts were then moved into the main office by the ward staff. Inspectors observed whiteboards in both clinical areas and patients personal information was discretely recorded and protected using whiteboard cover doors.

The clinical areas had single rooms — one clinical area visited had two isolation rooms with en-suite bathroom facilities and the other clinical area had three single rooms one

with a toilet and two with a shared toilet. Multi-occupancy rooms within clinical areas inspected also had en-suite facilities.

These findings were consistent with the overall findings from the 2022 National Inpatient Experience Survey, where with regard to:

- privacy in the clinical area, the hospital scored 8.5 (national average – 8.6)
- staff introducing themselves when treating and examining the patient, the hospital scored 8.6 (national average – 8.7).

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 and this is consistent with the human rights-based approach to care promoted by HIQA. However, patient's personal information should always be protected as a priority.

Judgment: Substantally Compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors. Staff were described by patients as '*'very polite', 'very good' and 'couldn't be nicer'.*

HIQA found evidence of a person-centred approach to care that included meal choices. An example of good practice observed by inspectors was the placement of writing desks within the multi-occupancy rooms enabling staff to complete their clinical notes. This ensured a visible presence for patients if they needed support.

The hospital promoted a culture of kindness, consideration and respect through the development of quality improvements which enhanced consideration and respect for patients and their families. For example, there was a 'communication log' on wards to enable staff to liaise with patients' families on their progress and needs. Inspectors observed a compliments board on display on one of the clinical ward areas inspected.

The hospital promoted a culture of kindness, consideration and respect through their interactions with each other. All management and clinical staff interactions observed during the two day inspection were respectful and considerate. Inspectors were informed of the 'Daisy Award' initiative in the RCSI hospital group which was highlighted in one of the inspected wards, whereby patients and or their families could provide testimonials for staff who were considered to be providing compassionate care. A member of staff on one of the inspected wards had received the Daisy Award on two occasions.

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

Judgment: Compliant

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

The hospital had systems in place to respond to complaints and concerns in an effective manner in line with national guidance. The complaints manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of complaints resolution in the clinical areas visited and staff told inspectors that they always endeavour to resolve complaints locally.

There was oversight and monitoring of the timeliness of responses and the management of complaints by the relevant governance structures — Clinical Governance and Quality and Safety Executive (QSE) and the executive management team. The complaints manager met weekly with the Clinical Director to discuss complaints. Inspectors were told that the hospital supported and encouraged point of contact complaint resolution in line with national guidance. Complaints which could not be resolved at the point of contact were escalated to the quality and patient safety department to be managed at that level. HIQA were told that any risk to patient safety was escalated appropriately to the LIMT to investigate locally or the RCSI Hospital group Serious Incident Management Team (SIMT).

The hospital had a complaints management system (CMS) and used the HSE's complaints management policy '*Your Service Your Say*'.********** There was tracking and trending of all complaints, to identify the emerging themes, categories and departments involved. Inspectors were informed that the hospital QSE provided reports on complaints via the monthly Quality and Safety Performance Metrics report. Documentation provided to HIQA showed a monthly trend analysis of complaints including timeliness of responses.

The rate of complaints investigated and responses sent to the complainant within 35 days was monitored monthly by the hospital and hospital group. Data reviewed for nine

********** Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

months in 2022 indicated that the hospital was below the RCSI Hospital Group target of 75% for two months and in full compliance for seven months of the year.

Information related to 'Your Service Your Say'[††††††††††] was observed on clinical areas and was also included in the patient information folder viewed by inspectors. The majority of patients who spoke with inspectors were satisfied that they could make a complaint if required. Inspectors were informed that the hospital had a dedicated patient advice and liaison service. In hospitals that have such a service, the service supports patients, their families and carers to provide feedback or make a compliant about the care patients received at the hospital. They ensure that the patient voice is heard either through the patient directly or through a nominated representative. Inspectors observed an advocacy contact support list on display in one of the clinical ward areas inspected.

Staff who spoke with inspectors reported that they had access to feedback on tracking and trending of complaints for their services and that learning was shared at the clinical nurse manager's forums and ward meetings.

The HSE 'Your Service Your Say' annual feedback report[‡‡‡‡‡‡‡‡‡‡] (2021) showed that of the 126 formal complaints received in 2021 (excluding withdrawn or anonymous complaints), 95 (75%) of them were resolved within 30 working days, which is compliant with the national HSE target of 75% for investigating complaints.

Overall, inspectors were assured that Connolly Hospital had processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, management at the hospital need to review mechanisms to ensure that responses to complaints are sent to complainants within 30 days in line with HSE guidance.

Judgment: Substantially Compliant

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

During inspection, inspectors observed that overall, in the clinical areas visited, the physical environment was generally well maintained and clean with a few exceptions. While hand hygiene sinks in one of the areas inspected conformed to requirements those in a second area inspected did not and all sinks in that area required attention to grouting

[††††††††††] The Health Service Executive system for management of service user feedback for comments, compliments and complaints

[‡‡‡‡‡‡‡‡‡‡] Health Service Executive. *Managing Feedback within the Health Service. 'Your Service Your Say'*: 2021. Available on line from: https://www.hse.ie/eng/about/who/complaints/ncglt/your-service-your-say-2021.pdf

and splash backs.§§§§§§§§§Inspectors also identified that the storage area in one of clinical areas inspected was limited and cluttered and required reorganisation.

Environmental cleaning was carried out by an external contract cleaning agency. Cleaning supervisors and clinical nurse managers had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal********** cleaning was carried out by designated cleaning staff. CNMs who spoke with inspectors said that they were satisfied with the level of cleaning resources in place both during core and outside core working hours.

Inspectors observed cleaning schedules and checklists in place for cleaning the environment and patient equipment, with oversight at local and supervisor level. The hospital had a tagging system to identify clean equipment and this was observed by inspectors. In all clinical areas visited, the equipment was observed to be generally clean.

Hazardous material and waste was mostly safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available. Hand hygiene signage was clearly displayed throughout the clinical areas visited. Infection prevention and control signage in relation to transmission-based precautions was observed and hand hygiene signs†††††††††† were clearly displayed.

There were adequate supplies of PPE. PPE was available outside isolation rooms where patients with confirmed or suspected infections were accommodated. Staff were also observed wearing appropriate PPE, in line with public health guidelines at the time of inspection. Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms in the inpatient clinical areas visited.

There were processes in place to prioritise and ensure appropriate placement and management of patients with suspected or confirmed communicable disease, which was underpinned by a formalised prioritisation criteria. There were isolation facilities in both inpatient clinical areas visited. Notwithstanding this, the number of isolation rooms with adequate en-suite bathroom facilities was insufficient. An area of good practice identified by inspectors was the Connolly Hospital Isolation Priority Score (CHIPS) in use on both areas inspected.

During inspection, inspectors observed that both clinical areas inspected were remote however, one of the clinical areas inspected had just two staff on night duty and HIQA highlighted the need for a review of security measures in place 24/7 for both patients and

§§§§§§§§§ Department of Health, United Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

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

†††††††††† World Health Organisation (WHO) 5 moments of hand hygiene.

staff. This was discussed with the ADON at ward level and with the Executive Management Team (EMT) at the time of inspection.

Inspectors found that the physical environment did not fully support the delivery of high-quality, safe, reliable care, and protected the health and welfare of people receiving care given the lack of isolation facilities, security risks due to the remoteness of one of the clinical areas in conjunction with the available staffing in place out of hours and the necessary upgrade and general maintenance of sinks in one of the clinical areas inspected.

Judgment: Partially compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level. HIQA found that measures used by the hospital to evaluate the effectiveness of healthcare included: performance metrics, activity data, audit, quality nursing metrics, surveillance data, national inpatient experience data and self-assessments against the *National Standards for Safer Better Healthcare.*

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee had oversight of the monitoring of infection prevention and control (IPC) practices at the hospital. The hospital monitored and publically reported monthly IPC metrics for the following items:

- hospital-acquired staphylococcus aureus bloodstream infection- 2 cases or 0.02 per 10,000 BDU January to September 2022 (target <1 per 10,000 BDU)
- hospital acquired Clostridium Difficile – 11 cases or 1.31 per 10,000 BDU January to September 2022 (target <2 per 10,000 BDU)
- Carbapenemase-producing *Enterobacteriaceae* (CPE) surveillance testing - Compliance for Quarter 1 2022 100% (target 100%)
- healthcare workers compliance with hand hygiene protocols - Compliance 98% (target 90%)

Monthly environment, equipment and hand hygiene audits were undertaken by the hospital. Inspectors reviewed results for the clinical areas visited during the inspection with overall good compliance achieved.

Inspectors were informed that hand hygiene audits were conducted using the HPSC hand hygiene audit tool. Hand hygiene audit results ranged from 86.7% to 96.7% during 2021, with an average compliance level of 91%. Monthly environment and equipment audits in Quarter 4 2022, for the two clinical areas inspected had an overall compliance of 96.2% and 89.9% respectively.

Quality improvement plans (QIPS) were developed by the hospital when standards fell below acceptable levels. Documentation provided by the hospital assured HIQA that QIPS were being developed with associated time bound actions.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.[‡‡‡‡‡‡‡‡‡‡] The infection prevention and control team submitted an infection control report to the Infection Prevention and Control Committee annually.

During inspection HIQA inspectors observed copies of outbreak reports with time bound actions and recommendations. There were eight outbreaks of transmissible or multidrug resistant organisms during 2021, as reported in the IPC Annual Report 2021. This included one CPE and seven COVID-19 outbreaks. Inspectors were told that the hospital-wide COVID-19 outbreak in particular had a significant impact on multiple wards. At the time of inspection the hospital had three closed wards due to COVID-19 outbreaks. Outbreak reports were being completed in line with national guidelines.

HIQA was satisfied that the hospital were investigating outbreaks appropriately and sharing the learning with staff to reduce the incidence of recurrence.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. HIQA were told that antimicrobial stewardship rounds took place daily across the hospital with learning disseminated to the Executive Management Team, ADON and staff on the ground. Staff reported access to antimicrobial pharmacy at ward level.

The 2021 IPC Annual Report shared with HIQA reported antimicrobial stewardship activities including increased restrictions for certain antimicrobials, development and revision of the hospital antimicrobial guidelines, initiatives to optimise antimicrobial stewardship in COVID-19 in-patients, staff education sessions and updating of vancomycin prescribing guidelines. Findings of audits and associated learning points were distributed to all prescribers and directorates as applicable.

‡‡‡‡‡‡‡‡‡‡ Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example HIQA were provided with a quarterly audit of clinical pharmacy services documenting medicine reconciliation practices across the hospital.

Medication metrics and nursing quality metrics were collected monthly with evidence provided of quality improvements developed when standards fell below acceptable targets with actions assigned to an individual with time frames. Medication safety risks and incidents were tracked and trended by a medication safety pharmacist. Risks were also escalated to hospital group level where indicated.

There was evidence that initiatives were introduced to improve medication safety practices at the hospital. This included automated medication dispensing systems, a high risk medicine list with reduction strategies, APINCH§§§§§§§§§§ lists and SALAD********** lists. Risk reduction strategies in relation to medication safety are discussed further under NS 3.1.

Information from medication monitoring had been used to develop QIPs. For example, inspectors received documentation seeking to replace the current paper-based system for medication incident reporting with improved analysis and reporting facilities.

Inspectors reviewed documentary evidence of re-audit to ensure improvement in practice for example, an audit of the effectiveness of the insulin kardex†††††††††††† in April and May 2022 and recommended re-audit. However, it did not give a timeline for this re-audit.

Deteriorating patient monitoring

The hospital collated performance data through 'Test your care' metrics relating to the escalation and response of the acutely deteriorating patient. The hospital was locally auditing healthcare records for compliance against national guidance on INEWS. Inspectors received copies of audits of INEWS. The metrics included the measurement of baseline observations, increased escalation of care, monitoring the use of the ISBAR tool, documentation of care of the deteriorating patient and escalation of care using the sepsis form. Compliance with the metric showed that all seven parameters were recorded correctly at all times (100% compliance). Looking at escalation and response, frequency of monitoring was not increased appropriately in five of the sample of healthcare records reviewed. There was no evidence of informing the Nurse in Charge (NIC) for scores of three or more recorded in any chart. In total, 29% of INEWS scores of three or more were not escalated to medical staff as required. ISBAR was 67%

§§§§§§§§§§ APINCH list: acronym for high risk medicines including **a**nti-infective agents, anti-psychotics, **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy, **h**eparin and other anticoagulants

********** SALAD list: **S**ounds **A**like, **L**ooks **A**like **D**rugs

†††††††††††† A kardex is medical-patient information system which uses forms pre-printed on durable card stock

compliant. Timely medical review with a plan of care was documented in 88% of patients.

HIQA recommends that there is room for improvement for early warning systems monitoring data to be used to implement improvements in practice in areas such as: the use of ISBAR, increased frequency of observations and escalating care in cases of the deteriorating patient.

Transitions of care monitoring

The hospital tracked the average length of stay and the rate of delayed transfer or discharge. On the day of inspection the average length of stay for medical patients was 10 days (HSE target 7 days or less and for surgical patients was 4 days (HSE target 5.2 days or less). At the time of inspection, the hospital reported having nine patients whose transfer of care was delayed. Audits of clinical handover were in progress by department in the hospital and examples were viewed by inspectors. Audits highlighted the hospital practice of handover using CUBAN - Confidential, Undisturbed, Brief, Accurate and Named Nurse in providing the verbal handover and use of the ISBAR communication tool.

In summary, improvements could be put in place to ensure that information from monitoring activities was being used to improve practices in relation to the four areas of known harm. There is also room for improvement for early warning systems monitoring data to be used to implement improvements in practice in areas such as: the use of ISBAR, increased frequency of observations and escalating care in cases of the deteriorating patient. Notwithstanding these areas, the hospital had established processes in place to monitor and evaluate healthcare services provided at the hospital.

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 monitoring, analysis and response to information significant to the delivery of care. This was achieved through the undertaking of risk assessments and review of the hospital's corporate risk register. The Quality and Safety Executive were assigned with responsibility to review and manage risks that impact the quality and safety of healthcare services. Risks in relation to the four areas of known harm were recorded on the hospital's corporate risk register which was reviewed at relevant quality and safety meetings and LIMT meetings. The hospital's organisational risk register had controls and actions in place to mitigate the recorded

risks. Each clinical directorate had their own risk register and there was evidence that risks not managed at directorate level were escalated to the organisational risk register.

A sample of high-rated active risks recorded on the hospital's organisational risk register related to this monitoring programme included:

- risk of delayed diagnosis due to limited access to radiology diagnostic services (CT/MRI).
- risk posed to patients due to poor clinical handover or communication of information during transitions of care.
- risk of adverse patient outcomes due to non-compliance with the 9-hour patient experience time (PET) in the emergency department.
- risk of adverse patient outcomes related to non-compliance with KPIs for scheduled care.
- risk to the quality & safety of services provided to all patients at risk of clinical deterioration for any reason including sepsis.

There was evidence that risks which could not be managed at hospital level were escalated to the RCSI Hospital Group.

Infection prevention and control

The hospital had systems and processes in place to protect services user from the risk of harm related to infection prevention and control. The hospital had an effective infection prevention and control programme and an antimicrobial stewardship programme in place. An outbreak management team was in place to manage outbreaks. Completed outbreak reports were reviewed by inspectors.

The infection prevention and control team maintained a local risk register of potential infection risks. Lack of negative pressure isolation rooms in Connolly Hospital compliant with HBN 04-01[‡‡‡‡‡‡‡‡‡‡‡‡] was one of the high rated risks recorded on the local infection prevention and control risk register. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register.

Infection outbreak preparation and management

HIQA was satisfied that the hospital screened patients for multidrug resistant organisms at point of entry to the hospital. However, due to limited numbers of single isolation rooms at the hospital, all patients with an infective status were not isolated within 24 hours of admission or diagnosis as per national guidance. Potential risks were mitigated

[‡‡‡‡‡‡‡‡‡‡‡‡] Department of Health, United Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

by the cohorting of patients suspected or confirmed with infection in multi-occupancy rooms.

In 2021, the hospital had seven outbreaks of COVID-19 and one outbreak of CPE. At the time of inspection the hospital had three closed wards due to COVID-19 outbreaks. Outbreak reports were being completed in line with national guidelines and recommendations and time bound actions were in place.

Infection prevention and control education was provided to staff in the following: standards and transmission precautions, outbreak management, donning and doffing of PPE and hand hygiene. Training records reviewed by inspectors for wards visited during the inspection identified full compliance with all of the above aspects of training in one of the clinical areas and some notable gaps in the other clinical area. The gaps related to all areas with scores ranging from 60 to 80%. Oversight of training records was monitored at ward level.

On the day of inspection, the hospital provided overall hospital training records for IPC. Training rates for standard based precautions, transmission based precautions, donning and doffing of PPE and hand hygiene ranged from 98-99% except for doctors who scored 73%. HIQA inspectors were told that outbreak management training was integrated into mandatory IPC training. The hospital provided documentation reporting an overall compliance rate of 91% for mandatory sepsis training in October 2022.

The hospital had a suite of up-to-date Infection Prevention and Control (IPC) policies and guidelines which were accessible to staff and provided guidance on IPC issues such as outbreak management, isolation prioritisation, environmental cleaning, and transmission-based precautions.

A review of a sample of healthcare records over the course of inspection outlined that all healthcare records reviewed by inspectors had the patient's infection status recorded.

Medication safety

HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications represented by the acronym 'A PINCH'§§§§§§§§§§§. Inspectors observed the use of risk reduction strategies to support safe use of medicines in relation to anticoagulants, insulin and opioids. The hospital had a list of sound-alike look-alike medications (SALADs). Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care in hard copy and soft copy format. The hospital had developed a dedicated medication prescription and administration record to support medication safety.

§§§§§§§§§§§ 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.

There were limited clinical pharmacy services at the hospital and medicine reconciliation was not undertaken on all patients. However, it was evident that clinical pharmacists were accessible to staff and visited clinical areas daily. The consultant microbiologist visited a range of the clinical areas daily. Wards also had pharmacy technician services for medication stock control. Medication fridge temperatures were noted to be monitored with a daily log of temperature checks. Inspectors noted that one of the medication fridges was unlocked in an unlocked room and this was reported and discussed with the ADON on-site. Medication safety risks and incidents were tracked and trended. Risks were also escalated to the hospital group level where indicated. Incidents were reported directly onto the National Incident Management System (NIMS).

Deteriorating patient

The hospital had systems in place to manage patients whose early warning system triggered. This included the INEWS version 2 observation chart and an ISBAR communication tool which was placed in the patient's chart. Staff in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient and reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating.

Inspectors reviewed a sample of healthcare records and found that all of the INEWS charts were completed correctly, with all INEWS charts calculated correctly. The escalation protocol within charts where applicable had also been completed in line with the protocol.

Safe transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning, such as daily multidisciplinary team rounds and clinical handover using the ISBAR communication tool.

The hospital had a number of transfer and discharge templates to facilitate safe transitions of care as well as a patient discharge leaflet and a communication log to record communication with families of patients. The patient's infection status was recorded on the discharge and transfer templates. As discussed under NS 5.5, the hospital was not providing patient discharge letter for all patients at the point of discharge. A chart audit conducted by inspectors showed that where discharge summaries were provided, they contained biographical data, multi-drug resistant organisms (MDROs) status, and a clinical narrative summary. Legible signatures were documented on each discharge summary reviewed.

Policies, procedures and guidelines

The hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines which included policies on standard and transmission

based precautions, outbreak management, management of patients in isolation and equipment decontamination.

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of medication, high alert medicines and sound alike look alike drugs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care through hard copy and via the hospital's Intranet.

All policies, procedures, protocols and guidelines were accessible to staff via the hospital's Intranet.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. To support medication safety, the hospital should ensure that safe practices around the use of medication such as medicine reconciliation is in place for all patients.

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 effectively identify, report, manage and respond to patient safety incidents. Staff who spoke with inspectors were clear on the systems in place to identify and report patient safety incidents and on their roles and responsibilities supported by the HSE National Incident Management Framework. Patient safety incidents were reported in a timely manner through the National Incident Management System (NIMS) in line with national guidance. The Quality and Patient Safety Committee had governance and oversight of reported patient safety incidents at the hospital.

Clinical incidents were tracked and trended, these included serious reportable events (SREs), medication safety incidents, hospital-acquired pressure ulcers, violence and aggression, self-injurious behaviour, falls and infection prevention and control incident rates. Incidents were tracked according to numbers, location and severity. The hospital annual incident management report December 2021 provided to inspectors outlined that a total of 5,771 incidents were reported from January to December 2021. Levels of reporting compared with previous years was also recorded showing a strong culture of reporting with a 72% increase from 3,355 in 2020 to 5,771 in 2021. Across the two clinical areas inspected, 188 incidents were reported in 2022, with two of these recorded as SREs. The majority of incidents were categorised as slips, trips and falls. The hospital annual incident management report highlighted that rates had increased throughout 2021. In response to queries about the increased incident reporting rates, documentation

provided to inspectors in the annual incident management report December 2021 reported a number of quality improvement initiatives including:

- review and evaluation of a new medication incident reporting process by end of Q1 2022
- additional training on incident reporting to be advertised to all staff on a monthly basis
- audit undertaken of frail elderly unit and work stream plan implemented
- roll out a delirium dementia bundle and 'Get up, Get Active, Get moving' programme
- purchase and installation of Automatic Dispensing Cabinets

Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported — slips, trips and falls, pressure ulcers and medication errors.

Evidence of tracking and trending of incidents was provided to inspectors with governance and oversight arrangement in place to review and manage incidents. At local level, incidents related to each service were reviewed by the Local Incident Management Team (LIMT) and reviewed at monthly performance meetings.

Evidence of how the service used information arising from patient safety incidents to promote improvements in safety and quality was provided to inspectors. For example, clinical staff outlined to inspectors the process involved in identifying, reporting and responding to a patient safety incident related to falls with learning shared at ward safety huddles. Documentation provided to HIQA also included a falls quality improvement plan for rollout throughout the hospital and staff also mentioned this during inspection.

The hospital's medication safety incidents were tracked and trended to identify areas for improvement and share learning. A total of 1,568 medication incidents were reported in Q2 2022, with a monthly average of 522.7 incidents. Medication patient-safety incidents were reviewed by the chief pharmacist who categorised the incidents in terms of severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)********** medication error categorisation. There were four Adverse Drug Reactions (ADRs).

Medication safety bulletins quarterly and medication safety minutes weekly were disseminated to all staff.

Overall, HIQA was assured that Connolly Hospital had systems in place to effectively identify, report, manage and respond to patient safety incidents from the information reviewed on inspection. The hospital were tracking and trending infection prevention and control patient-safety incidents, medication incidents and incidents related to transitions of care. There was evidence that the quality and safety executive had governance and

********** https://www.nccmerp.org/sites/default/files/index-color-2021-draft-change-10-2022.pdf

oversight the management of these incidents and that the LIMT and the EMT had oversight of serious incidents and reportable events. The significant increase in incident reporting with associated quality improvement initiatives should continually be reviewed at management level to ensure all risks are mitigated where possible to maximise patient safety.

Judgment: Substantially Compliant

Conclusion

HIQA carried out an announced inspection of Connolly Hospital on 6 and 7 December 2022 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection involved an overall assessment of compliance of the effectiveness of governance against national standards 5.2 and 5.5. Compliance with three other national standards were assessed in the emergency department: standard 6.1 from the dimension of Capacity and Capability and standards 1.6 and 3.1 from the dimension of Quality and Safety. Compliance with national standard 5.8 from the dimension of Capacity and Capability and seven national standards from the dimension of Quality and Safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) were assessed in the following ward areas, Cedarwood and Sycamore. The inspection placed a particular focus on measures the hospital had put in place to manage four areas of known potential patient safety risk — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, with the exception of four standards which were found to be partially compliant, HIQA found the hospital to be substantially compliant with seven standards and compliant with two standards. Opportunities for improvement were identified across a number of areas.

Capacity and Capability

Connolly Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. The governance arrangements defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. However, inspectors found that the Drugs and Therapeutics Committee and the Medication Safety Committee meetings were not operating in line with their terms of reference. The hospital needs to ensure that these committees function as required going forward to support and promote medication safety.

At the time of inspection, the emergency department was busy and staff were responding to a surge in the urgency of acute emergency care due to time critical patient presentations. Attendees to the department were waiting an average time of 31 minutes from registration to triage (the target is 15 minutes as recommended by the HSE's

emergency medicine programme). The hospital registration to triage time requires improvement as it was not meeting the HSE emergency medicine programme target and the hospital was not compliant with the HSE's key performance indicators related to patient experience times. The hospital had systems and processes in place to support continuous and effective patient flow through the emergency department. Inspectors noted however that the systems and processes were not always functioning in the way they should. On the days of inspection, the hospital's COVID-19 streaming practices were not functioning in line with local and national guidance and this was highlighted and being addressed and managed by the DON.

The hospital had management arrangements in place to support the delivery of medication safety however inspectors were told that deficits in the available pharmacy resources were impacting on the provision of a comprehensive clinical pharmacy service across all departments and ward areas. HIQA acknowledges hospital management's efforts to recruit medical, nursing and pharmacy staff. Nevertheless, at the time of inspection there were particularly high vacancy levels within nursing, clinical pharmacy services and the health and social care professions.

The hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare. However, the oversight and uptake of essential and mandatory training required improvement. Significant improvements are required to meet national targets for mandatory and essential training, especially in the area of infection prevention and control for doctors and, basic life support across all professions and staff grades. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

The hospital were monitoring performance against key performance indicators in the four areas of known harm and inspectors were assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital.

Quality and Safety

The hospital promoted a person-centred approach to care and the hospital staff promoted a culture of kindness, consideration and respect. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff. However, inspectors observed patient's personal information unattended on windowsills on ward corridors. The hospital needs to have systems in place to ensure the patient's personal information is protected at all times.

The hospital were aware of the need to support and protect more vulnerable patients and had developed a plan to act on findings from the National Inpatient Experience Surveys. For example, based on findings the hospital ensured there was a 'communication log' on wards to enable staff to liaise with patients' families and a newly designed 'patient discharge leaflet' to prepare patients and their family for discharge.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of isolation and en-suite facilities which has the potential to increase the risk of cross infection. Furthermore, security risks due to the remoteness of one of the clinical areas in conjunction with the available staffing in place out of hours and the necessary upgrade and general maintenance of sinks in one of the clinical areas inspected requires review. Despite the best efforts of staff the physical environment in which care was delivered did not always promote and protect confidentiality for the patients in the emergency department.

HIQA was satisfied that the hospital had systems in place to monitor and improve services. However, there is room for improvement for early warning systems monitoring data to be used to implement improvements in practice in areas such as: the use of ISBAR, increased frequency of observations and escalating care in cases of the deteriorating patient. The hospital needs to ensure that plans outlined to implement the emergency department early warning systems are progressed. Improvements are also needed in the emergency department PET and ambulance turnaround times to support optimal patient care.

HIQA was assured that Connolly Hospital had systems in place to effectively identify, report, manage and respond to patient safety incidents from the information reviewed on inspection. Nonetheless the significant increase in incident reporting requires ongoing management and review with dedicated quality improvement initiatives to ensure all risks are mitigated where possible to maximise patient safety. The hospital had processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, management at the hospital need to review mechanisms to ensure that responses to complaints are sent to complainants within 30 days in line with HSE guidance.

HIQA was satisfied that, in relation to the four areas of known harm, the hospital had systems in place to identify, prevent or minimise unnecessary or potential risk and harm associated with the provision of care and support to people receiving care at the hospital. Inspectors identified some opportunities for improvement in the systems in place to protect services user from the risk of harm especially in the four areas of focus of this inspection. The hospital should ensure that discharge summaries reach the primary care healthcare professional in a timely manner, to allow for safe and continued care and management following discharge. The hospital also needs to ensure compliance with attendance at all mandatory training. To support medication safety, the hospital should ensure that safe practices around the use of medication such as medicine reconciliation is

in place for all patients. Furthermore, the COVID-19 management pathway was not functioning effectively during this inspection and should be regularly reviewed and monitored to ensure it is functioning in line with national guidance.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management (see Appendix 2), as part of the monitoring activity, continue to monitor the progress in implementing the short, medium and long-term actions being employed to bring the hospital into full compliance with the national standards assessed during inspection. It is imperative that action occurs following this inspection to properly address HIQA's findings at the hospital, in the best interest of the patients that the hospital serves.

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

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Judgments relating to overall inspection findings	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
National Standard	**Judgment**

Theme 5: Leadership, Governance and Management	
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
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
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.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Compliance Plan

Compliance Plan Service Provider's Response

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted – **EMERGENCY DEPARTMENT**	Partially compliant Page 30

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

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

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

Location	Risks	Interim Action	Person Responsible	By when	Long term plans (If applicable)
Emergency Department	The Physical environment in which care was delivered did not always promote the and protect confidentiality for the patients in the emergency department	Patient flow pathways to be reviewed to ensure that no patient is waiting to be placed in the ED for long periods	GM/ COO/ DON/ CD Head of Patient Flow ADON in Patient Flow ED	Immediate	Full and continued implementation of the Hospital operational plan and winter plan
Emergency Department	Some conversations overheard in the ED relating to Patient Care	All areas to raise awareness re this risk and ensure	ADON in ED All HODs	Immediate 12/1/23	FOI and legal Advisor to participate on Executive

		patient confidentiality is protected at all times HODs to raise awareness of this at staff meetings Discussed each morning at ED safety Huddle			Walkarounds in 2023 to identify further opportunities for improvement

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 **- WIDER HOSPITAL**	Partially compliant Page 44

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

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

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

Location	Risks	Interim Action	Person Responsible	By when	Long term plans
Hospital Wide	The physical environment did not fully support the delivery of high-quality, safe, reliable care, and protected the health and	Patient Flow to maintain 2 hourly risk assessment data to	Head of Patient Flow	Immediate	COO to Ensure that all new capital developments

	welfare of people receiving care given the lack of isolation facilities	support decision making during times of surge Patient Flow Management Team to adhere to national guidance in relation to the segregation, placement and infection prevention and control requirements for confirmed COVID-19, MDRO, C –Diff and other infectious transmissible diseases. Daily patient placement review to be undertaken by CNMs/ ADOONs and Patient Flow Management Team Continued implementation of Connolly Hospital Isolation Priority Scoring System (CHIPS) to ensure	CNMs/ ADONs/ IPCT Head of Patient Flow/ CNMs/ ADONs/ IPCT CNMs/ ADONs/ IPCT		include adequate single rooms Major capital submissions planned for April 2023 involving 10 negative pressure rooms	

		appropriate use of existing single rooms and isolation rooms Oversight of compliance with national guidance including learning from Patient Safety Incidents will continue to be undertaken at Healthcare Associated Infection Committee meetings and outbreak meetings.	Head of Patient Flow/ CNMs/ ADONs/ IPCT		
Cedarwood	Security risks due to the remoteness of one of the clinical areas in conjunction with the available staffing in place out of hours Storage to be reviewed and waste Management	• Security at night enhanced given the proximity of the unit to the main hospital • Ongoing monitoring of staffing to be maintained to ensure adequate numbers • Issues with storage addressed	General Services Manager ADON ADON	4/1/23: Security visiting Cedarwood 2 hourly day and night. No security breaches reported	

	Staffing to be monitored to ensure safe staffing levels	• Staff training records to be reviewed by ADON • Local Risk Register to be Maintained	ADON ADON		
Sycamore	Upgrade and general maintenance of sinks in one of the clinical areas inspected.	• Splashbacks replaced and attention to hygiene/ repair to ensure compliance with HBN regulations	ADON	•4/1/23 Splashbacks and grouting repair of sinks completed	

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 – **EMERGENCY DEPARTMENT**	Partially compliant Page 32

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

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

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

Location	Risks	Interim Action	Person Responsible	By when	Long term plans (If applicable)
Emergency Department Standard 3.1 and 5.5	3.1 The COVID-19 management pathway should be regularly reviewed and monitored to ensure it is functioning in line with national guidance. 5.5 The COVID-19 management pathway should be regularly reviewed and monitored to ensure it is functioning in line with national guidance.	Patient Flow to maintain 2 hourly risk assessment data to support decision making during times of surge Covid swabs obtained earlier and test results prioritised and communicated at the earliest opportunity to Head of Patient Flow.	ADON in ED CNMs/ IPCT/ Head of Patient Flow (Complete)	Immediate 9/1/23 National Guidelines reviewed at HCAI Local risk assessment repeated and process reviewed by the HCAI including Consultant in Microbiology: Based on current incidence of COVID in the hospital and in the community. Sieving by HCA discontinued, risk assessment re patient status to be completed at triage only going forward.	

Risk Management	The hospital must ensure that identified risks are being appropriately managed, evaluated and updated in line with risk management processes in order provide adequate oversight of risks.	Quarterly update of Risk Register to be recorded at QSE Meeting	Head of Q & S Executive Management Team	End Q1 2023	
Emergency Department	The hospital needs to ensure that plans outlined to implement the emergency department early warning systems are progressed.	Onsite training for emergency department early warning systems commenced in February 2023	ADON in ED NPQD		
Emergency Department	Improvements are needed in the emergency department PET and ambulance turnaround times to support optimal patient care.	PET times reviewed daily at 9am huddle PET analysed monthly via Unscheduled Care Report Daily ED activity spreadsheet sent to all key stakeholders Focus on walnut ward to transfer suitable medically referred patients Ambulance turnaround data given monthly by NAS,	ADON in ED Associate Clinical Director in ED ADON in Patient Flow, ED ADOPN in ED ADON in Patient Flow, ED ADON in Patient Flow, ED		3 additional Consultant posts appointed to the ED in July for rapid assessment of trauma and improve PET time: ANP Plans to increase

		discrepancies recorded (awaiting resolution) Triage system re configured to allow capturing of ambulance release times Local audit ongoing – pre planned spot checks, escalated to NAS control as needed, log book kept Audit and daily real-time review & management of Triggers & actions in SOP for 24/7 management to improve 9 hour compliance (admitted & non-admitted)	ADON in Patient Flow, ED ADON in Patient Flow, ED ADON in Patient Flow, ED		availability of ECG Technician to 24/7 Plans to increase Phlebotomy cover based on results from pilot study showing an 8 minute reduction in triage time.
Hospital Wide	Staff uptake of mandatory and essential training could also be improved.	Overall Connolly Hospital compliance with mandatory training is high as acknowledged by the inspectors on page 25 of the draft report. Mandatory training is monitored by local Heads of Department and executive oversight is monitored at the monthly mandatory	All HODs / HR		Learning Management System to be introduced by HR to improve capture of NCHD

		training meeting chaired by the COO. Full mandatory training compliance record maintained by HR available upon request. Targeted improvement in attendance at BLS training by nurses in ED	ADON in ED/ Clinical Facilitator in ED		attendance at mandatory training.

National Standard	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services – **EMERGENCY DEPARTMENT and WIDER HOSPITAL**	Partially compliant Page 16 - 26
Outline how you are going to improve compliance with this standard. This should clearly outline:	

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

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

Location	Risks	Interim Action	Person Responsible	By when	Long term plans
Hospital Wide	At the time of inspection there were particularly high vacancy levels within nursing, clinical pharmacy services and the health and social care professions.	Ongoing recruitment for all vacancies including overseas recruitment drives.	HR Operations Manager	Immediate and ongoing	Recruitment open days to be repeated based on success of the nursing recruitment open day onsite in Connolly Hospital in December 2022 RCSI HG HR Manager plans to establish forum for the retention of nurses and midwives
Hospital Wide	Staff attendance at and uptake of mandatory and essential training is an area that could be improved.	Overall Connolly Hospital compliance with mandatory training is high as acknowledged by the inspectors on page 25 of the draft report. Mandatory training is monitored by local Heads of Department and executive oversight is monitored at the monthly	All HODs	Immediate and ongoing	Learning Management System to be introduced by HR to improve capture of NCHD attendance at mandatory training.

		mandatory training meeting chaired by the COO. Full mandatory training compliance record maintained by HR available upon request.			
Emergency Department	The hospital wait time for triage requires particular attention and efforts should be made to improve this. Contingency arrangements should also be reviewed to ensure that triage continues in a timely manner during time critical events.	Triage times reviewed in real time in ED at safety huddles and action taken in response to improve triage times Triage times reviewed monthly via Unscheduled Care Meeting	ADON in ED		Pilot study that took place showed 8 minute decrease in triage times when an ECG technician on duty Business case to be submitted by ADON in ED for new post – HCA ECG technician
Hospital Wide	It is important that patient discharge summaries are provided for each patient at the point of discharge.	Weekly monitoring of completion of discharge summary within 7 days. Audit findings to be shared with Clinical Director and individual consultants for action	Business Managers/Clinical Director/ All NCHDs and Consultants		