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:	Ennis Hospital
Address of healthcare service:	Gort Road Lifford Ennis Co. Clare V95 HN29
Type of inspection:	Announced
Date(s) of inspection:	17 and 18 May 2023
Healthcare Service ID:	OSV-0001065
Fieldwork ID:	NS_0040

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

Ennis Hospital is a Model 2* hospital managed by the University Limerick Hospitals Group (ULHG)† on behalf of the Health Service Executive (HSE).

ULHG operate a hub-and-spoke model, across six hospital sites and five clinical directorates. Within this model, University Hospital Limerick (UHL) is the 'hub' with key services, such as critical care services centralised in UHL. The other Model 2 hospitals within the group provide a range of services and have defined reporting arrangements to ULHG's directorate structure. Hospital management at Ennis Hospital report on the hospital's performance and compliance with defined quality and safety indicators at ULHG level, through the medical, perioperative and diagnostic directorates.

Ennis Hospital provides the following care and services to medical and surgical patients from the catchment area of the Midwest region of Ireland:

- acute medical in-patient and day patient services
- day service surgery
- endoscopy services
- a medical assessment unit
- a local injury unit
- outpatient care and diagnostic services.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	50 inpatient beds

* A Model 2 hospital provides the majority of hospital activities including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services, including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.

† The University Limerick Hospitals Group comprises six hospitals - University Hospital Limerick, University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St. John's Hospital. The hospital group's academic partner is the University of Limerick.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This two-day announced inspection of Ennis Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, the inspectors[‡] reviewed information, which included previous inspection findings, information submitted by the provider, unsolicited information[§] and other publically available information.

During the inspection, inspectors:

- spoke with people who used the services in Ennis Hospital to ascertain their experiences of receiving care in the hospital
- 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 were receiving care in Ennis Hospital and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection.

About the inspection report

A summary of the findings and a description of how Ennis Hospital performed in relation to compliance with the 11 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 at a particular point in time — before, during and following the inspection.

‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's *National Standards for Safer Better Healthcare.*

§ 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.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe healthcare service is being sustainably provided in Ennis 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 the safe delivery of high-quality care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare services in Ennis Hospital receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care. A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
17 May 2023	13:30hrs to 18:00hrs	Danielle Bracken	Lead
		Denise Lawler	Support
18 May 2023	08:45hrs to 16:00hrs	Aoife O'Brien	Support

Information about this inspection

This announced inspection of Ennis Hospital focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on the following four key areas of known harm:

- infection prevention and control
- medication safety
- the deteriorating patient[**] (including sepsis)[††]
- transitions of care.[‡‡]

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

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

[‡‡] Transitions of Care 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

The inspection team visited the following clinical areas:

- the Medical Assessment Unit
- the Local Injury Unit
- Burren ward (general medical ward).

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

- representatives of the hospital's site operational team:
  - Operational Director of Nursing (DON)
  - Business Manager
  - Consultant Clinical Lead
- a representative for the non-consultant hospital doctors (NCHDs)
- patient flow representatives from Ennis Hospital
- complaints officer from Ennis Hospital
- Director of Quality and Patient Safety for ULHG
- Human Resource manager from ULHG
- a representative from each of the following ULHG committees:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Deteriorating Patient Steering Committee.

Acknowledgements

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

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

On the days of inspection, inspectors visited the Local Injury Unit (LIU), Medical Assessment Unit (MAU) and the Burren Ward.

The LIU, was located in a new purpose built area, built in 2022. It had a bright and spacious waiting room, a triage room and five treatment bays for patients presenting with minor injuries. The LIU and MAU were interconnected by an internal corridor. Signage to help patients get to the MAU was clearly visible during the inspection.

The MAU was located on the ground floor of the main hospital. Access to MAU was by appointment only. The MAU had a small waiting area, located at the main door of the unit that could accommodate three or four people at a time. However, given the distance of the waiting room from the nurse's station, in practice, the main public corridor in MAU, comprising eight chairs was used as the main waiting area for the unit. Inspectors observed that this corridor was busy on the first day of inspection. MAU had two single isolation rooms, an eight bed multi-occupancy room and a separate room comprising two cubicles, where patients attending the medical review clinic were seen. The review clinic was staffed by doctors in MAU, patients that had recently attended the MAU returned here for medical review, when appropriate.

The Burren Ward was a modern, spacious, general medical ward consisting of 25 single rooms with en-suite bathroom facilities. The ward also had a treatment room with two beds, which could accommodate an additional two patients in times of increased service demand. At the time of inspection, all 25 rooms were occupied and one extra patient was accommodated in the treatment room. The ward had adequate toilet and bathroom facilities for patient use.

People using the service who spoke with inspectors in MAU described staff as *'brilliant'* and *'attentive'*. Staff were also described as *'busy but always have time for you'* and *'staff are lovely but busy'*. In relation to care and treatment, people who used the service described the care as *'100%'*, and how tests were *'done very quickly'* and staff *'explained all my tests to me* [patient]*'*.

Patients who spoke with inspectors in all clinical areas visited were not aware of the formal complaints process. However, patients told inspectors that they felt they could approach staff if they had any concerns and or wanted to make a complaint. Inspectors observed information leaflets on how to make a complaint displayed in clinical areas visited.

Patients' experiences recounted on the day of inspection, were consistent with Ennis Hospital's overall findings from the 2022 National Inpatient Experience Survey,[§§] where 87% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, this was above the national average of 82%. Overall, there was consistency with what inspectors observed in the clinical areas visited, what patients told inspectors about their experiences of receiving care in Ennis Hospital during the inspection and the findings from the 2022 National Inpatient Experience Survey.

[§§] The National Inpatient Experience Survey (NIES) 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. The findings of the NIES are available at: https://yourexperience.ie/inpatient/national-results/.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the two themes of leadership, governance and management and workforce. Ennis Hospital was found to be substantially compliant with all four of the national standards assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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

Corporate and clinical governance arrangements were in place at Ennis Hospital. Management in Ennis Hospital who spoke with inspectors clearly outlined the defined roles, accountability and responsibilities that were in place at the hospital for assuring the quality and safety of healthcare services provided there.

In keeping with the hub-and-spoke configuration of ULHG, Ennis Hospital was governed and managed by the CEO of ULHG supported by ULHG's Executive Management Team (EMT). The CEO of ULHG reported to and was accountable to the HSE's National Director of Acute Operations. Governance of day-to-day operations in Ennis Hospital was provided by the hospital's operational Director of Nursing (DON) supported by the hospital's business manager. ULHG had appointed a clinical lead for all Model 2 hospitals in the hospital group who provided clinical governance and leadership and represented the Model 2 hospitals at meetings of ULHG's Executive Management Team (EMT). There was a local clinical lead in place at Ennis Hospital at the time of inspection.

Organisational charts provided to inspectors clearly outlined lines of accountability and responsibility at Ennis Hospital. These detailed the corporate and clinical reporting structures internally to the operational DON of Ennis Hospital and from Ennis Hospital to ULHG. They also outlined the reporting relationships to ULHG's chief director of nursing and midwifery. The business manager for Ennis Hospital reported upwards to the manager for scheduled care at ULHG level. These reporting arrangements were consistent with what inspectors found during inspection. Oversight of hospital performance and the quality and safety of services was through the clinical directorate structure. Operationally there were two main structures at Ennis Hospital, these were the Operational Site Steering Committee and the Medical Clinical Operational Governance Group (Medical COG Group).

Operational Site Steering Committee

This committee had oversight of operational issues that affected the effective functioning of Ennis Hospital. The committee met every three months. The committee received updates from and provided updates to department heads in Ennis Hospital on service

development, staffing and departmental issues. The committee focused mainly on operational issues, clinical issues were discussed at the Medical COG Group and clinical directorates had oversight of the quality and safety of services at Ennis Hospital. Inspectors found that the Operational Site Steering Committee was functioning effectively, in line with its terms of reference. The committee was action oriented, although inspectors noted that actions were not time-bound or formally tracked from meeting to meeting. Additionally, inspectors were told that the operational DON and medical consultants in Ennis Hospital met monthly. The operational DON and Ennis Hospital's business manager also met monthly. These meetings were described as informal and focused on day-to-day operational issues.

Performance Meetings

Monthly performance meetings between the EMT of ULHG and the HSE took place where compliance with key performance indicators (KPIs) for quality and safety were reviewed. This included data from the Hospital Patient Safety Indicator Reports (HPSIR) for each hospital in ULHG. A HPSIR report was produced for Ennis Hospital each month. Every second month, the hospital group held performance meetings with each clinical directorate's management team where quality and safety priorities and issues were discussed and actions agreed to ensure the quality of healthcare services at Ennis Hospital.

Clinical Directorate Structure

Clinical services at Ennis Hospital were delivered under the leadership and governance of three clinical directorates — medicine, perioperative and diagnostics. These directorates were three of five clinical directorates established at ULHG level. Each clinical directorate comprised a management team consisting of a clinical director, general manager and directorate DON. The clinical directorates were responsible for the operational functioning and management of the quality and safety and identified risks for the healthcare services under their remit. The medicine directorate was the main directorate that Ennis Hospital interacted with, the business manager of the medicine directorate and clinical lead for the Model 2 hospitals attended meetings of the Medical COG Group in Ennis Hospital. The medicine, perioperative and diagnostics directorates also had defined reporting arrangement to ULHG's EMT and the clinical director for each clinical directorate also reported to the Chief Clinical Director of ULHG. Each directorate reported formally on the quality and safety of services under their remit, including Ennis Hospital, to ULHG's Quality and Safety Committee (QUALSEC).

Quality and Safety Committee

Ennis Hospital did not have a local Quality and Safety Committee, they were represented on ULHG's QUALSEC by the operational DON. Each clinical directorate reported on the quality and safety of the services under their remit to QUALSEC using a standardised report template every three months. Copies of directorate reports submitted to ULHG's

QUALSEC reviewed by inspectors showed that clinical directorates had effective oversight of the quality and safety of healthcare services under their remit. This included patient-safety incidents, complaints and quality improvements. These reports were comprehensive, informative and showed that the medicine, perioperative and diagnostics directorates had effective oversight of the quality and safety of the healthcare services in Ennis Hospital.

Medical Clinical Operational Governance (COG) Group

The Medical COG Group was responsible for ensuring services provided in Ennis Hospital were delivered in line with clinical need and that the care provided was safe. This group was not meeting monthly as outlined in its terms of reference, they met in December 2022, but had not met in 2023, in the months preceding HIQA's inspection. Membership included the clinical lead for Ennis Hospital, the clinical lead for the Model 2 hospitals and the general manager of the medicine directorate. Given the role and responsibility of this group, it is important that it continues to meet regularly as per the group's terms of reference. Minutes of meetings of this group reviewed by inspectors were comprehensive, with clearly documented, assigned actions, including issues for escalation to the medicine directorate. There was evidence of discussion of medical staffing, medical related risk on the hospital's risk register, site developments, and activity at the hospital's MAU, LIU and out-patients department. However, the hospital's compliance with defined quality indicators were not discussed.

Infection Prevention and Control Committee

Ennis Hospital did not have a local Infection Prevention and Control Committee (IPCC). The hospital was represented by the operational DON on ULHG's IPCC. This multidisciplinary committee, was responsible for the governance and oversight of infection prevention and control practices across the five clinical directorates and for each hospital within ULHG, which included oversight of the implementation of ULHG's infection prevention and control programme.[***] It was clear from documentation reviewed by inspectors and meetings with staff during inspection that the medical and perioperative directorates, and ULHG's infection prevention and control team provided an update of the infection prevention and control practices at Ennis Hospital at monthly meetings of the IPCC. ULHG's infection prevention and control team also produced an annual report in relation to infection prevention and control practices at Ennis Hospital to the IPCC.

Medication Safety Committee

Ennis Hospital had a Medication Safety Committee (MSC) who had oversight of the medication safety practices in the hospital. This included staffing shortfalls, medication

[***] 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.

reconciliation practices, medication patient-safety incidents and medication related risks recorded on the hospital's corporate risk register. The multidisciplinary MSC committee was chaired by the clinical lead for Ennis Hospital. Minutes of MSC meetings reviewed by inspectors showed these meetings were action oriented with a focus on learning. Committee meetings were well attended by staff members. Ennis Hospital's MSC reported to ULHG's Drugs and Therapeutics Committee (DTC). ULHG's DTC promoted medication safety practices across the five hospitals in ULHG and had developed a medication safety strategy to be implemented across the hospital group. Ennis Hospital was represented on ULHG's DTC by the hospital's pharmacist. Inspectors noted from minutes of meetings of ULHG's DTC that no medication safety update had been provided from Ennis Hospital for three consecutive meetings, but medication related patient-safety incidents were discussed. Oversight of antimicrobial stewardship practices was the responsibility of ULHG's DTC and ULHG's IPCC.

There was evidence that a quality improvement plan developed following HIQA's previous inspection of medication safety at Ennis Hospital, was being implemented and the progress of implementation was being reviewed approximately every six months. It was clear to inspectors, that the operational DON in Ennis Hospital had oversight of the implementation of the quality improvement plan.

Deteriorating Patient Committee

Ennis Hospital did not have a Deteriorating Patient Committee. The hospital was represented by a clinical skills facilitator on ULHG's Deteriorating Patient Steering Committee (DPSC). Oversight and integration of ULHG's deteriorating patient improvement programme, including sepsis management was provided by the DPSC. Although audit templates for Irish National Early Warning System (INEWS) (version 2),[†††]were discussed at these meetings, there was no evidence in the committee minutes reviewed by inspectors that audit findings and quality improvement plans were discussed for Ennis Hospital or other hospitals in ULHG. This is a missed opportunity for shared learning. The operational DON at Ennis Hospital had oversight of INEWS audit results for the hospital. Audit results will be discussed in more detail in national standards 5.8 and 2.8.

Unscheduled Care Committee

Ennis Hospital did not have an Unscheduled Care Committee, but the hospital's operational DON and a consultant physician were members of UL Hospitals and Mid-West Community Healthcare Organisation Integrated Unscheduled Care Operational Committee. Inspectors noted that recent minutes of meetings from this committee (April and May 2023) highlighted that representation from Ennis Hospital was one of the outstanding actions to be addressed. Notwithstanding this, there was evidence from minutes of

[†††] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.

committee meetings reviewed by inspectors that activity and issues impacting on healthcare services in Ennis Hospital were being discussed.

An internal escalation plan for ULHG set out clear expectations regarding the minimum daily number of transfers from UHL, to the Model 2 hospitals within ULHG during times of high activity in UHL. Patient transfers from and to UHL were underpinned by a protocol that detailed all of the requirements that had to be fulfilled to ensure the safe transfer of patients between hospitals in ULHG. The numbers of and factors contributing to delayed transfers of care (DTOC) at Ennis Hospital were discussed at the weekly Mid-West Delayed Transfers of Care meeting attended by clinical nurse manager's grade 2 (CNM 2's) with responsibility for bed management and patient flow in Ennis Hospital, the ULHG bed manager, discharge co-ordinators throughout ULHG and representatives from the community.

In summary, while it was clear that Ennis Hospital had corporate and clinical governance arrangements in place, there were some areas that required improvement. The Operational Site Steering Committee would benefit from tracking the progress of implementation of agreed actions from meeting to meeting to ensure the quality and safety of healthcare services. The Medical COG Group had not met in 2023. Given the role and responsibility of this group, it is important that it continues to meet regularly as per the group's terms of reference. Oversight of the quality and safety of services at Ennis Hospital could be strengthened through discussions of the hospital's compliance with defined quality indicators at meetings of the Medical COG Group.

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.

Inspectors found that Ennis Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare, appropriate for the size, scope and complexity of the service provided at the hospital.

Findings relating to the Medical Assessment Unit and Local Injury Unit

Inspectors were satisfied that there were defined lines of responsibility and accountability with devolved autonomy and decision-making for the management of the MAU and the LIU and nursing management in those units understood these arrangements.

Operationally, on the days of inspections the units were functioning well. There was evidence of strong clinical and nursing leadership in both units. The MAU and LIU were consultant led. Additionally, an emergency medicine consultant based in UHL attended the LIU once a week. Operational oversight of day-to-day workings of the units was the

responsibility of the onsite clinical nurse manager grade 2 (CNM 2), who reported to the ADON.

The MAU operated seven days a week from 8am to 8pm. Inspectors were informed that the pathway for referral to the MAU was through the patient's general practitioner (GP) and appointment slots were booked through the bed bureau service based in UHL.

Since January 2023, Ennis Hospital have accepted non-urgent 999 and 112 ambulance calls, with diverted patients reviewed in the MAU. There were defined criteria in place for referral of medical patients to Ennis Hospital under this protocol. Since then, 68 patients had been directly transferred and seen in the hospital's MAU, of these, 46 (68%) were admitted to an inpatient bed in the main hospital. Had this arrangement not been in place, these patients would have most likely attended for care in UHL.

At 11am on the first day of inspection, there were:

- 12 patients present in the MAU, with a total of 24 patients reviewed in the unit that day
- 8.3% of patients seen in MAU were admitted to an inpatient bed at Ennis Hospital
- 91% were admitted or discharged within six hours of registration, which was above the target set by the HSE of 75%.

In relation to activity in the MAU for the month of April 2023, the month preceding the inspection, data reviewed by inspectors showed the following:

- on average the MAU saw 21 patients a day that month
- the average daily admission rate from MAU was 14.2% and 17.4% year to date in 2023
- on average, those attending MAU were admitted or discharged in under three hours, well below the HSE target of six hours.

The LIU operated seven days a week from 8am to 8pm. There were defined inclusion and exclusion criteria for the LIU. The LIU had been newly refurbished and reopened in 2022 and had a recorded attendance of 12,411 from April 2022 to March 2023. Data reviewed by inspectors for the month preceding HIQA's inspection, showed that 1,071 patients had attended LIU. A total of 42 patients attended the LIU on the first day of inspection with 2.4% of those attending requiring inpatient admission to UHL. The average daily admission rate from LIU to an inpatient bed in UHL, year to date in 2023, was less than 1%. The average patient experience time in LIU was 1 hour 35 minutes, well within Ennis Hospital's target of patients admitted or discharged within two hours. Inspectors were told that access to diagnostics was good, with the X-ray department available daily until 8pm, this helped the LIU achieve quick turnaround times for patients.

Findings relating to the wider hospital and other clinical areas

In line with the hub-and-spoke arrangement of ULHG, some resources were centralised in UHL with an offsite allocation to the Model 2 hospitals in the hospital group. The quality and patient safety department was centralised at UHL with a designated risk advisor visiting Ennis Hospital regularly. Ennis Hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas and these are discussed in more detail below.

Infection prevention and control

There was no dedicated infection prevention and control team or nurse for Ennis Hospital. The risk of healthcare-associated infection due to a lack of infection prevention and control cover onsite was a moderate risk recorded on the hospital's corporate risk register. Inspectors were satisfied that the control measures in place were appropriate and sufficient to mitigate against this risk. Staff at Ennis Hospital were supported by the infection prevention and control team from UHL with a designated infection prevention and control nurse manager visiting the hospital once a week. An ADON for infection prevention and control within ULHG also regularly visited Ennis Hospital and any infection prevention and control issues specific to Ennis Hospital were raised at the weekly ULHG infection prevention and control team meeting. Outside of scheduled visits, staff at Ennis Hospital could access the infection prevention and control team in UHL. UHL's infection prevention and control team had oversight of the infection prevention and control requirements of all patients in Ennis Hospital. Staff in clinical areas that spoke with inspectors felt supported by UHL's infection prevention and control team. ULHG's IPCC had oversight of the infection prevention and control practices in Ennis Hospital.

Staff at Ennis Hospital were supported by an antimicrobial stewardship (AMS) pharmacist, based at UHL that visited Ennis Hospital approximately every two weeks. When the unfilled AMS pharmacist position is filled in UHL, site visits to Ennis Hospital will be weekly. Staff in Ennis Hospital had access to microbiology consultants 24/7.

Medication safety

Ennis Hospital were approved and funded for 1.0 whole-time equivalent (WTE)[‡‡‡] pharmacist and 1.5 WTE pharmacy technicians with all of these posts filled. When the pharmacist was on planned leave, pharmacist cover was provided by an agency pharmacist. If agency cover was not available, access to the hospital pharmacy was as per out of hours arrangements, staff could contact the pharmacy in UHL for advice. A comprehensive clinical pharmacy service[§§§] was not available in Ennis Hospital, and this was a high risk recorded on the hospital's corporate risk register. NCHD-led medication reconciliation was carried out on all patients.

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

Ennis Hospital did not have a medication safety officer (MSO). This was a moderate risk recorded on the hospital's corporate risk register. Inspectors were satisfied that control measures were sufficient to mitigate the risk. Inspectors were told of a plan for the two MSO's based in UHL to support medication safety practices in Model 2 hospitals within ULHG, the details on how this would work were yet to be determined at time of inspection. One MSO had taken up a position at UHL with a second due to commence employment shortly after HIQA's inspection.

Deteriorating patient

Inspectors met with the clinical skills facilitator and the clinical lead for Ennis Hospital who was Ennis Hospital's nominated lead for the deteriorating patient. The relevant early warning system — INEWS version 2 and the accompanying Identify, Situation, Background, Assessment and Recommendation (ISBAR)**** communication tool were used in Ennis Hospital. The clinical skills facilitator attended ULHG's Deteriorating Patient Steering Committee meetings and carried out audits of compliance with INEWS guidance in Ennis Hospital. The use of INEWS was not underpinned by a local formalised, ratified policy or procedure. However, ULHG were working on a draft guideline for the management of deteriorating patients within ULHG.

Transitions of care

Inspectors were satisfied that Ennis Hospital had effective arrangements in place to monitor issues that impact effective, safe transitions of care, including effective patient flow arrangements. The hospital had 2.0 WTE CNM 2's dedicated to bed management and patient flow, their role included complex discharge and they provided weekend cover. The CNM 2's told inspectors that as part of their role they linked and collaborated daily with others involved in patient flow activity within Ennis Hospital, ULHG and the Midwest Community Healthcare Organisation. The CNM 2's told inspectors that they attended a weekly teleconference regarding delayed discharges within the Mid-West region and liaised frequently with public health nurses and GP's in the region. There was no medical social worker onsite in Ennis Hospital, but the CNM 2's for bed management and patient flow liaised with a medical social worker within the community, with nursing homes and the community intervention team regarding patient needs.

In summary, inspectors found that the MAU and LIU in Ennis Hospital were functioning well and as intended. Ennis Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare with some areas for improvement identified. Moderate risks on Ennis Hospital's corporate risk register included those associated with a lack of infection prevention and control and MSO cover onsite. Ennis

**** ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a structured way to transfer critical information between health professionals with the goal of improved communication and patient-safety.

Hospital should continue to monitor these risks to ensure that their impact on the quality and safety of services provided at the hospital is low.

Judgment: Substantially compliant

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

Ennis Hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on a range of KPIs, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital.

Monitoring service's performance

Ennis Hospital provided assurances in relation to service performance to three of the five clinical directorates governing clinical services across ULHG. The directorates in turn provided assurances to ULHG's QUALSEC through quality and safety reports submitted quarterly. At Ennis Hospital level, 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 was collected and collated. Inspectors reviewed the hospital's HPSIR report and noted that there were no outliers†††† in relation to performance in 2022.

Ennis Hospital collated performance data for unscheduled and scheduled care, including data on MAU and LIU attendances and patient experience times (PETs), bed occupancy rate, average length of stay (ALOS), and DTOC. This will be discussed in more detail in national standard 2.8.

Risk management

Inspectors found Ennis Hospital had effective risk management structures and processes in place to proactively identify, manage and minimise risks in line with the HSE's integrated risk management policy. Risks were identified, managed and monitored locally at clinical area level, hospital level and clinical directorate level. HIQA was satisfied that risks recorded on the local and hospital corporate risk registers, had control measures in place to minimise actual and potential risks to patient safety and that controls applied to mitigate the risk were regularly reviewed and updated. However, inspectors noted that while actions were assigned, they were not always time-bound. Risks that could not be fully managed at hospital level were escalated to the relevant clinical directorate. ULHG's QUALSEC had oversight of risks recorded on Ennis Hospital's corporate risk register in

†††† An outlier is a single data point that goes far outside the average value.

relation to infection prevention and control, medication safety, the acutely deteriorating patient and safe transitions of care. The management of actual and potential risks to patient safety are discussed further in national standard 3.1.

Audit activity

Ennis Hospital did not have a local audit committee. The operational DON had oversight of clinical audits carried out at Ennis Hospital and had oversight of the implementation of quality improvement plans developed in response to audit findings. The operational DON told inspectors that they attended meetings of ULHG's Audit Committee. Audits in relation to infection prevention and control and medication safety were not discussed at ULHG's clinical audit committee, instead, they were discussed at meetings of ULHG's IPCC and DTC. It was not clear from reports of ULHG's audit committee to ULHG's QUALSEC reviewed by inspectors if discussions in relation to audit findings at individual hospital level took place. Inspectors were told that work was underway at ULHG to register all audits in order to have a more accurate overview of all audit activity occurring at clinical directorate and individual hospital levels. Audits will be discussed further in national standard 2.8.

Management of serious reportable events and patient-safety incidents

The operational DON at Ennis Hospital had oversight of serious reportable events and patient-safety incidents that occurred in Ennis Hospital. Oversight of serious reportable events and serious patient-safety incidents occurring in Ennis Hospital was also provided by the Serious Incident Management Team (SIMT) of each clinical directorate. Directorate SIMT meetings were convened every two weeks. Additional meetings were convened as necessary when category one[‡‡‡‡] incidents occurred. There was evidence that category one patient-safety incidents, which had resulted in harm and other incidents of note were discussed and managed at clinical directorate level and escalated to the ULHG's SIMT where appropriate. Serious reportable events and patient-safety incidents related to the clinical areas visited during inspection were reported to the National Incident Management System (NIMS),[§§§§] in line with the HSE's Incident Management Framework.

Evidence from meeting minutes from ULHG's DTC and QUALSEC, confirmed that serious reportable events and patient-safety incidents that occurred in Ennis Hospital were discussed. One of the purposes of Ennis Hospital's Medical COG according to its terms of reference was management of quality and safe patient care through the implementation of patient safety structures and processes. There was no evidence in minutes of these committees reviewed by inspectors that serious reportable events or patient-safety incidents were discussed at the Medical COG. However, a review of minutes confirmed

[‡‡‡‡] Category one incidents are clinical and non-clinical incidents rated as major or extreme as per the HSE's risk impact table.
[§§§§] 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).

that medication safety related incidents were discussed at Ennis Hospital's MSC and ULHG's IPCC had oversight of all infection prevention and control patient-safety incidents that occurred across ULHG. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3.

Feedback from people using the service

Inspectors found there was effective oversight of feedback from patients to inform improvements in healthcare services at Ennis Hospital. In response to the findings from the National Inpatient Experience Survey 2022, the hospital had three high level quality improvement plans in place. These included:

- improving communication at time of discharge
- introducing a day of discharge checklist in the nursing care documentation
- improving patients' knowledge about medication side effects using the 'know, check, ask'***** campaign and 'my medicines list'.

Ennis Hospital held their first Patient Experience Committee meeting in March 2023, this committee was responsible for enhancing patients' experience when using services in Ennis Hospital by proactively identifying areas in need of improvement and developing quality improvement plans to address these. Additionally, ULHG had a patient council in place, council meetings rotated between hospitals in ULHG, this meeting was held at Ennis Hospital in March 2023. Inspectors noted that at these meetings council members were asked for their input into issues and new initiatives in order to inform and drive improvements for patients. There were two designated complaints officers at Ennis Hospital who had oversight of the management of complaints, this will be discussed in more detail in national standard 1.8.

In summary, Ennis Hospital had effective and systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. However, local, clinical directorate and ULHG oversight of quality improvements arising from audit activity at Ennis Hospital should be an area of focused improvement after this inspection.

Judgment: Substantially compliant

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

***** The Know, Check, Ask campaign, encourages patients, to Know their medicines and keep a list, Check that they are using the right medicine in the right way and Ask a health professional if unsure.

HIQA found that hospital management had effective arrangements in place to plan organise and manage their staffing levels to support the provision of high-quality, safe healthcare. Ennis Hospital did not have an onsite Human Resources (HR) department, staff recruitment was coordinated through ULHG. Line managers at Ennis Hospital were supported by ULHG to effectively manage HR issues when required. In keeping with the clinical directorate structure, each directorate had a HR business manager and there was a designated link person in place to liaise with Ennis Hospital in relation to their specific workforce requirements in different specialties. Staffing was a standing item on the agenda of clinical directorate performance meetings reviewed by inspectors, items discussed included staffing requirements, vacancies and absenteeism.

Ennis Hospital had adequate workforce management arrangements in place to support the day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care, and where there was a need for additional resources, this had been identified and escalated to ULHG's EMT as required.

In May 2023 Ennis Hospital had a total of 270 WTE staff across all professions and disciplines, when compared to December 2022, this represented an uplift of 13 staff (5.1%). The hospital had an approved complement of 126.15 WTE nurses (this included management grades). At the time of inspection, the actual number of nurses in post was 114.39 WTE, this represented a shortfall of 11.76 WTE (9%) nurses. Rosters for the Burren Ward reviewed by inspectors for a four week period between 17 April and 14 May 2023 showed that in total over the four weeks there was six unfilled shifts, which were mostly due to short-term sick leave. Unfilled shifts were usually filled by redeployed nursing staff or agency staff. Staff told inspectors that the nursing workforce was supplemented by intern†††††† nurses and on occasion with additional healthcare assistants when shortfalls in nursing staff could not be filled. These arrangements may not be sustainable going forward.

Hospital management had applied to ULHG and the HSE for an increase in nursing staff to align with the requirements as determined by the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland*.‡‡‡‡‡ Inspectors were told that ULHG were recruiting to fill approved nursing posts.

At the time of inspection, all medical positions were filled at Ennis Hospital. The hospital had an approved complement of 4.5 WTE medical consultants, three emergency care physicians and 1.0 WTE resident anaesthesiologist. A consultant in emergency medicine from UHL visited the LIU in Ennis Hospital once a week. The consultant staff were

††††† An intern nurse is a nurse that is still training and works under the supervision of a registered nurse.

‡‡‡‡‡ *The Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland* 2018, provides recommendations in relation to the number and type of nurses and healthcare assistants required within a ward based setting https://www.gov.ie/en/publication/2d1198-framework-for-safe-nurse-staffing-and-skill-mix-in-general-and-speci/

supported by a total of 17 NCHDs – 6 WTE at registrar grade and 11 WTE at senior house officer (SHO) grade. All NCHD positions, except one SHO position were filled at the time of inspection. Inspectors were informed by management that all consultants employed at the hospital were on the relevant specialist division of the register of the Irish Medical Council. Inspectors reviewed the hospital's corporate risk register and noted that unfilled positions that presented a risk to the effective functioning of Ennis Hospital were being actively managed.

At the time of inspection, the absenteeism rate, year to date 2023 at Ennis Hospital was 8%, of this, less than 1% was related to COVID-19 absence. The absence rate was above the HSE's target of 4% or less but the absenteeism rate had reduced when compared to the 2022 rate of 9.9%. Staff education on the managing attendance policy and HR skills for managers had taken place. Notwithstanding this, lowering the absenteeism rate should be an area of continued focus after this inspection.

Staff training

All new staff at Ennis Hospital attended a corporate induction programme organised by the Learning and Development Unit at UHL, which took place several times a year. There were also specific induction programmes for new NCHDs and nursing staff. Staff who spoke with inspectors confirmed that they had attended induction when they commenced employment in Ennis Hospital.

There was evidence that education and training were discussed at relevant ULHG committee meetings such as the IPCC, DTC and DPSC, this included the types of training provided but there was no oversight of the attendance at and uptake of essential and mandatory training by these committees.

Staff were required to complete mandatory training in infection prevention and control, medication safety and the deteriorating patient. Training records were compiled in an electronic platform by the clinical skills facilitator and overseen by the CNM 2 in each clinical area visited during inspection. Medical staff attendance at and uptake of training was recorded in the National Employment Record (NER).[§§§§§]

Training records reviewed by inspectors demonstrated that although there was evidence of high uptake of training in some of the clinical areas visited, staff attendance and uptake of mandatory and essential training in relation to standard and transmission-based precautions, infection outbreak management, medication safety training, INEWs, sepsis management and Basic Life Support (BLS) training could be improved.

In summary, overall, inspectors found that hospital management had effective arrangements in place to plan, organise and manage their staffing levels to support the

[§§§§§] The 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.

provision of high-quality, safe healthcare. The shortfall in nursing staff should continue to be addressed. Hospital management should also 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.

Judgment: Substantially 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. Ennis Hospital was found to be compliant with two national standards (1.6, 1.7), substantially compliant with four national standards (1.8, 2.8, 3.1, 3.3) and partially compliant with one national standard (2.7) assessed. Key inspection findings informing judgments on compliance with national standards are described in the following sections.

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

For the most part, it was clear to inspectors that staff in all clinical areas visited during inspection promoted the privacy, dignity, confidentiality and autonomy of patients receiving care.

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. For example, staff were observed responding promptly to call bells and reacting directly to patients with communication difficulties, to allow them to express their needs. Falling star signs****** were used outside patients' rooms without compromising dignity or privacy to identify patients at risk of falls.

There was evidence that patients' autonomy and independence was promoted, for example, patients were informed about their daily care schedule in advance and mobilisation was encouraged. There were a number of seating areas within the ward, including an enclosed, secure outdoor space. Staff who spoke with inspectors told them that they aimed to involve patients and families in the plan of care. This was confirmed by patients who told inspectors they received good information about their plan of care and

****** Falling star signs help those providing care to easily and subtly identify patients at risk of falling without compromising their privacy or dignity. The signs are normally placed above the bed space or outside the patient's room.

that they knew what was happening with their treatment and when to expect discharge. Inspectors observed ward staff providing updates to families on the telephone.

The physical environment in the clinical area visited promoted the privacy, dignity and confidentiality of patients receiving care. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care. One patient described the procedure of having a bed bath, when needed, as *'very dignified'.* Patients were accommodated in single rooms with en-suite bathroom facilities. In the case of the two-bedded treatment room, consideration was given to the selection of patients placed there and these patients were relocated as soon as a single room became available. There was a room available to patients to meet family or have private conversations. HIQA's findings were consistent with the overall findings from the 2022 National Inpatient Experience Survey, where with regard to privacy in the clinical area, Ennis Hospital scored 9.0 (national average – 8.6).

Inspectors observed patient's personal information in the clinical areas visited during the inspection to be protected and stored appropriately. Healthcare records were located in an office area that was only accessible via swipe access.

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

Judgment: Compliant

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

Inspectors observed staff in the clinical areas visited during inspection actively listening and effectively communicating with patients in an open and sensitive manner, in line with their needs and preferences. Patients who spoke with inspectors said that staff were approachable and *'very responsive'.* Consideration had been given to the design of the ward environment to promote patient wellbeing. There were televisions in every room and internal garden spaces. Inspectors observed that the ward was calm and quiet with one patient describing it as *'restful'*.

Inspectors observed staff in Burren Ward actively engaged with patients in a respectful and kind manner, taking time to talk and listen to patients and responding promptly to patients' needs. These observations were validated by patients who described staff as *'very approachable'* and said that they *'explained things well'.* Patients recounted how their needs were met quickly, telling inspectors that *'nursing staff were excellent'* and were *'as quick as they can be'.*

HIQA found evidence of a person-centred approach to care, especially for vulnerable patients receiving care. For example, inspectors observed the use of 'what matters to you?' boards as part of personalised care. Inspectors were told that family members were asked to contribute to the boards, if patients were not able to communicate directly. Vulnerable patients were observed to be located in rooms closest to the nurses' station and doors were left open to enhance engagement with staff when medically appropriate and risk assessed. Patient information leaflets about the Alzheimer's society and in relation to end of life were displayed in the inpatient clinical area visited. These findings were consistent with the overall findings from the 2022 National Inpatient Experience Survey, where with regard to staff treating patients with respect and dignity, the hospital scored 9.2 (national average – 8.9).

There was evidence of a good culture of kindness, consideration and respect in the way that staff engaged with and responded to feedback from people who use the services. Not all staff who spoke with inspectors were aware of the findings from the National Inpatient Experience Survey 2022, but inspectors were told that a number of improvements were planned to improve the experiences of patients using the healthcare services at Ennis Hospital. These included:

- staff introducing themselves to patients and wearing name badges
- providing communication training for staff to support them when interacting with patients and families
- adjusting meal times by 30 minutes to avoid overlap with visiting times or ward rounds.

Overall, HIQA were satisfied that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. This was aligned with the human rights-based approach to care promoted by HIQA.

Judgment: Compliant

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

Inspectors found Ennis Hospital had systems and processes in place to manage formal and informal complaints and to learn from and oversee the implementation of recommendations arising from review of complaints. The hospital had two designated Complaints Officers assigned with responsibility for managing complaints.

Ennis Hospital had implemented the HSE's complaints management policy 'Your Service Your Say',[††††††] and used the National Complaints Management System (CMS) to record, track and trend formal complaints using the HSE classification system. The operational DON who was one of the complaints officers, had oversight of complaints made in relation to Ennis Hospital. Additionally, ULHG's Director of Quality and Patient Safety had oversight of the effectiveness of the hospital's complaints management process. Complaints were reported and reviewed at ULHG's QUALSEC.

Hospital management supported and encouraged point of contact complaint resolution, with complaints managed at local clinical area level by the CNM. Staff in the clinical areas visited were knowledgeable about the complaints management process. Inspectors observed posters and leaflets on how to make a complaint displayed in all the clinical areas visited. Suggestion boxes for patient feedback were available inside and beside the entrance to the Burren Ward.

The hospital reported on the number and type of formal complaints received annually. The hospital received 21 formal complaints in 2020, 25 complaints in 2021 and 36 complaints in 2022. In 2021, the hospital resolved 12% of complaints within 30 working days. In 2022, this increased to 33% of complaints resolved within 30 working days, but the rate was significantly below the national HSE target of 75%. The hospital attributed delays in complaints responses to staffing resource issues, there had been a number of changes in the designated complaints officer which resulted in a backlog of complaints. At the time of inspection, the backlog from 2022 had been addressed with the exception of two complex complaints, which were due to be closed that month. Inspectors were told that Ennis Hospital had received three complaints in 2023 up to the time of inspection and these were within the HSE target of 30 days for complaints resolution.

Inspectors were told that staff were given feedback on complaints received and learning took place, one example of this was re-education around the communication process at time of discharge. Inspectors were told that there were quality improvement initiatives in place to improve communication at discharge, this included 'my medicines list' which was given to patients at time of discharge, so that patients could more easily understand what medicines they were prescribed and why. The hospital was also rolling out communication training to support staff to effectively manage complaints locally.

[††††††] 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.

Patients who spoke with inspectors, although not aware of the formal complaints process knew that they could raise a concern with staff members if required. When asked if there was anything that could be improved about their experience, patients commented that they were not dissatisfied with anything. Inspectors observed a patient information board, with information on how to access independent patient advocacy support displayed. There was no local Patient Advocacy Liaison Service (PALS)‡‡‡‡‡‡ in place at Ennis Hospital. Staff and patients at the hospital had access to the PALS service at ULHG level.

At the time of inspection, Ennis Hospital were not auditing the complaints process, ULHG had developed an audit template for this purpose and had plans to commence auditing the complaints management process.

In summary, overall, HIQA was satisfied that Ennis Hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. However, some areas required sustained improvement. The hospital with the support of and oversight by ULHG, should continue to ensure that complaints are resolved promptly, in line with HSE targets. Planned audit of the complaints management process throughout ULHG should help to provide assurances that processes are working as intended and that the HSE targets are being achieved at Ennis Hospital.

Judgment: Substantially compliant

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

The Burren Ward and LIU were modern buildings and in general, inspectors observed that the environment in these clinical areas was clean and well maintained. The MAU was located in an older part of the hospital and although inspectors observed that this area was clean on the day of inspection, the outdated infrastructure presented a challenge in relation to effective cleaning and maintenance.

The hospital had implemented processes to ensure appropriate placement of patients — the infection prevention and control team liaised with CNMs and bed management on the placement of patients daily. The hospital had effective arrangements for patients requiring transmission-based precautions. Burren Ward had 25 single rooms all with en-suite bathroom facilities, additionally two of these rooms were negative pressure rooms§§§§§§ with anterooms. LIU had five single occupancy treatment bays separated by glass

‡‡‡‡‡‡ The Patient Advocacy and Liaison Service (PALS) team acts as a point of contact between patients, their families or carers and the hospital to assist in addressing concerns about any aspect of care or service in the hospital.
§§§§§§ Negative pressure rooms, also called isolation rooms, are a type of hospital room that keeps patients with infectious illnesses away from other patients.

partitions with privacy curtains on each bay. This layout facilitated effective isolation of patients. There were two toilets and a shower available for patient use in LIU. There were two single rooms in MAU which could be used to isolate patients requiring transmission-based precautions. An eight bedded multi-occupancy room was located near the nurses' station. Two of these beds could be sectioned off for isolation purposes if required. In total there were three toilets and a shower available in MAU for patient use.

Inspectors observed and staff told inspectors that the physical environment in MAU made it challenging to maintain the patients' privacy and confidentiality. On entering MAU, there was a small separate waiting room with space for two or three patients, however it was out of sight of the nurses' station. Therefore, in general, patients waited along the main public corridor, where there was a total of eight seats. This could pose a potential difficulty for people with mobility issues and impact on the promotion of patient privacy as it was easy to overhear private conversations. Physical distancing in the multi-occupancy room was challenging and private conversations could be easily overheard here too. Notwithstanding this, it was clear that staff made every effort to uphold patients' dignity and privacy. Physical distancing of one metre was observed to be maintained between beds in the multi-occupancy room in Burren Ward.

In relation to the cleanliness and level of maintenance of the clinical environment, inspectors observed the LIU and the Burren Ward were well maintained to a high degree of cleanliness. There was an electronic system in place to submit maintenance requests, CNMs who spoke with inspectors were satisfied that responses from maintenance were timely. There was a green tagging system in place to identify equipment that had been cleaned. Inspectors observed equipment to be clean in all the clinical areas visited during inspection.

Clinical areas visited had dedicated cleaning staff. Inspectors were told by staff in clinical areas that they were satisfied with the cleaning schedule. During core working hours cleaners were always present and there was oversight of cleaning by the cleaning supervisor. Patients who spoke with inspectors in Burren Ward described the environment as "*clean*" and "*tidy*". In the 2022 National Inpatient Experience Survey, Ennis Hospital scored 9.5 in relation to the cleanliness of the hospital room or ward, higher than the national average of 9.0. The hospital the scored 9.1 in relation to the cleanliness of toilets and bathrooms which was also higher than the national average of 8.6.

Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited. Staff were observed to be wearing appropriate personal protective equipment (PPE) in line with public health guidelines in place at the time of inspection. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available in clinical areas. Inspectors observed posters in

relation to correct hand washing technique displayed and noted that hand hygiene sinks conformed to national requirements.[*******]

Inspectors observed that waste, including hazardous waste and linen was segregated and stored appropriately, all sharps containers had the temporary closure mechanism in place. Storage issues at ward level which had been an issue in the past had been resolved. Inspectors noted that emergency equipment and supplies were in place along with daily and weekly checklists which were completed.

Inspectors noted that a legionella risk assessment had not been carried out in Ennis Hospital since 2018, however, water sampling was carried out in March 2023. Hospital management provided a commitment to HIQA that a legionella risk assessment would be carried out as a matter of priority in 2023.

All clinical areas were secure, requiring swipe access for entry. There were alarms in place in the Burren Ward, allocated to patients at risk of absconding, these would alarm if a patient attempted to leave the ward. Additionally, patients at risk of absconding were placed in rooms close to the nurses' stations for close monitoring.

In summary, the physical environment in Burren Ward and LIU was well designed and the infrastructure was modern. The MAU was located in an older part of the hospital and had infrastructure issues such as wear and tear on flooring, walls and woodwork. Notwithstanding the efforts of staff, which inspectors acknowledge, these issues presented a risk in terms of infection prevention and control and compromised privacy and confidentiality. A legionella risk assessment, which should be regularly reviewed and updated,[†††††††] had not been carried out since 2018 and was planned for 2023.

Judgment: Partially compliant

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

Inspectors found Ennis Hospital had effective 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 ULHG on the quality and safety of the services provided at the hospital. Sources of

[*******] 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.

[†††††††] *European Society of Clinical Microbiology and Infectious Disease (ESGLI) Guidance for managing legionella in hospital water systems during the Covid-19 pandemic* 2020. https://www.escmid.org/fileadmin/src/media/PDFs/3Research_Projects/ESGLI/ESGLI_Guidance_for_managing_Legionella_in_hospital_water_systems_during_COVID__19_20200603_v_03_00.pdf

information to inform improvement included findings from audit activities, performance with defined quality and safety performance metrics, patient-safety incident reviews, complaints, risk assessments and patient experience surveys. Inspectors observed that results from audits and performance with metrics were displayed on notice boards in the clinical areas visited.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee at ULHG were actively monitoring and evaluating infection prevention and control practices in Ennis Hospital. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention and control guidelines and protocols. Inspectors reviewed Ennis Hospital's annual report for 2022 which summarised performance in relation to infection prevention and control audits and rates of healthcare-associated infection. Staff who spoke with inspectors confirmed that audit findings were shared with clinical staff and time-bound action plans were developed to address areas requiring improvement.

Monthly environmental hygiene audit results reviewed by inspectors showed that in April of 2023, the LIU (89% compliance) and Burren ward (74% compliance) performed better when compared to the MAU (40% compliance), which had consistently scored below the required standard in the preceding months before HIQA's inspection. Some of these issues related to the outdated infrastructure which was a challenge from both a cleaning and a maintenance perspective. Inspectors reviewed quality improvement plans developed for the Burren Ward and MAU to address the findings of these audits. Although the plans were detailed and time-bound, most of the actions were categorised as ongoing and while the immediate actions were clear, for example, contacting the maintenance department, it was not clear what issues were fully resolved. The tracking and oversight of the implementation of corrective actions is important to ensure that the required environmental hygiene standard is achieved and maintained.

Monthly equipment hygiene audits reviewed by inspectors showed that Ennis Hospital performed well in this area, with the following scores achieved in April 2023, LIU (100%), Burren Ward (93%), MAU (92%). The clinical areas visited during inspection all scored higher than the HSE's target of 90% for hand hygiene practices in recent hygiene audits reviewed by inspectors.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.[‡‡‡‡‡‡‡] In line

[‡‡‡‡‡‡‡] 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.

with the HSE national reporting requirements, the hospital was submitting data as part of the HPSIR report. In 2022, Ennis Hospital reported that:

- the rates of new cases of *Clostridium difficile* infection exceeded the HSE's target of less than 2 cases per 10,000 bed days for a four month consecutive period from July to October 2022
- there were no new cases of hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) blood stream infections
- there were no new cases of Carbapenemase-producing *Enterobacterales* (CPE).

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices at Ennis Hospital. The hospital did not have an AMS committee or AMS programme, but ULHG's IPPC and DTC had oversight of hospital AMS activity. Ennis Hospital participated in the national antimicrobial point prevalence study§§§§§§§ and reported to ULHG's IPCC and DTC on compliance with antimicrobial stewardship KPIs every three months. The 2022 results of the point prevalence study shows that AMS practices in Ennis Hospital had improved in relation to documenting stop and review dates of antimicrobials — 62% in 2022, an improvement from 58% in 2021 (target 95%) and compliance with choice of antimicrobial was 87% in 2022, an improvement from 42% in 2021 (target 90%).

Medication safety monitoring

There was some evidence of monitoring and evaluation of medication safety practices at Ennis Hospital, for example audits were carried out in relation to compliance with insulin policies and procedures, antibiotic prescribing and the use of Ferinject.******** Findings from these audits indicated good compliance with antibiotic prescribing at Ennis Hospital. Areas identified for improvement included; labelling and storage of insulin pens, improved documentation on the medication record and optimising Ferinject dosing. While inspectors note that quality improvement plans were in place to address audit findings, identified actions were not time-bound or assigned to a named individual with responsibility to ensure they were implemented. Notwithstanding this, there was evidence that initiatives were introduced to improve medication safety practices at Ennis Hospital. These included a regularly updated medication safety folder on computers, 'my medicines list' leaflets provided to patients at discharge to support their education and the implementation of a new ULHG medication record in February 2023, which incorporated guidance for those prescribing and administering medication. A separate ULHG medication record for safe prescribing and administration of subcutaneous insulin

§§§§§§§ The national antimicrobial point prevalence study collects information on prescribing practices of antibiotics and other information relevant to treatment and management of infectious disease of hospitalised patients.

******** Ferinject is an intravenous iron preparation, a medicine that is given in the treatment of iron deficiency conditions.

was also in place. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

Ennis Hospital collated performance data through Test Your Care metrics[††††††††] relating to the escalation and response of the acutely deteriorating patient. Audit of the INEWS escalation and response protocol was carried out in quarter one and quarter two of 2023. Compliance in this area had improved from 25% in quarter one of 2023 to 42% in quarter two of 2023. Two healthcare records reviewed by inspectors showed that triggered early warning scores had not been escalated in line with protocol, this was brought to the attention of the CNM for remedial action. A quality improvement plan with time-bound assigned actions to address findings was in place, which included targeted training for and re-audit of practice. Re-audit was due to take place in June 2023. This is an area that could benefit from continual close monitoring until the required compliance levels are consistently achieved.

Transitions of care monitoring

Compliance with defined KPIs in relation to transitions of care was monitored at Ennis Hospital. The number of attendances to the LIU and MAU, ALOS of medical and surgical inpatients and DTOC were reported monthly as per HSE reporting requirements. This performance data was discussed at meetings of the UL Hospitals, Mid-West Community Health Organisation Integrated Unscheduled Care Committee, the Mid-West Delayed Transfers of Care Committee, Directorate Performance and Ennis Hospital's Site Operational meeting. The hospital's ALOS for medical inpatients, was 2.1 days year to date 2023, this was the lowest ALOS of all model 2 hospitals and significantly lower than the national target of 7.0 days. At the time of inspection Ennis Hospital had three DTOC. This indicates that there was good patient flow in Ennis Hospital.

At the time of inspection, clinical handover and or the use of the ISBAR communication tool were not audited in Ennis Hospital.

In summary, inspectors found Ennis Hospital had effective systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services. Close monitoring of the escalation and response protocol for patients experiencing clinical deterioration through INEWS audits is required until the required level of compliance is consistently achieved. A programme of audit is required to assess if progress is being made in relation to all aspects of transitions of care including clinical handover and the use of the ISBAR communication tool.

[††††††††] Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

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.

Inspectors found there were effective systems and processes in place at Ennis Hospital to identify, evaluate and manage immediate and potential risks to people using the healthcare services at the hospital. It was evident from minutes of meetings reviewed by inspectors that the Medical COG Group and Operational Site Steering Committee had oversight of the management of identified risks to patient safety. Additionally, at ULHG level, QUALSEC had oversight of the management of risks escalated to ULHG.

It was clear to inspectors that staff working in clinical areas took responsibility for managing risk in their clinical areas, in line with the HSE's integrated risk management policy. Local risk registers were maintained and risks were discussed with senior management at Ennis Hospital every three months. Inspectors were told by staff in clinical areas that both the hospital and ULHG risk registers were available to staff to view electronically. At the time of inspection there was only one high-rated risk (clinical pharmacy services) on Ennis Hospital's corporate risk register that related to the four areas of known harm. High-rated risks that could not be managed at Ennis Hospital level were escalated to the relevant clinical directorate where they were documented on the directorate's risk register and escalated upwards to ULHG's EMT if required. Risk registers reviewed by inspectors had control measures and time-bound actions assigned to the relevant executive or clinical manager or clinical directorate. A designated risk advisor from UHL's quality and patient safety department attended Ennis Hospital regularly to assist staff to manage identified risks.

Infection prevention and control

Although risk was not a standing agenda item for meetings of ULHG's IPCC, there was sufficient evidence that infection related risk was discussed as part of each clinical directorate's and individual hospital's updates to the committee.

On admission to Ennis Hospital, patients were routinely screened for CPE and MRSA in line with defined criteria and for respiratory illnesses such as COVID-19 and influenza if symptomatic. The hospital was following national guidance in relation to screening for CPE. All patients with a history of CPE were screened on admission and patients who were known contacts of a CPE case were screened weekly for a duration of one month. Representatives from the infection prevention and control team and minutes of meetings of ULHG's IPPC reviewed by inspectors documented that there was good compliance with admission and weekly screening for CPE at Ennis Hospital. There were a total of 50 inpatient single rooms in Ennis Hospital. This number of single rooms ensured that all

patients requiring isolation could be isolated within 24 hours as per national guidance. Staff uptake of flu vaccination for nurses in Ennis Hospital was 56%, well below the HSE's target of 75%, this is an area that would benefit from improvement.

Inspectors noted from a review of ULHG's IPCC minutes that infection outbreaks and patient-safety incidents were not a standing agenda item for meetings of the committee. However, they were a standard item on the reporting template used by each clinical directorate and individual hospital when updating the committee on infection prevention and control practices. It was evident that comprehensive surveillance reports relating to infection outbreaks were discussed at meetings of ULHG's IPCC every three months. There was also evidence that quality improvement plans were implemented to improve infection prevention and control practices.

Inspectors reviewed a COVID-19 outbreak report and outbreak meeting minutes from April 2023 and were satisfied that the COVID-19 outbreak in Ennis Hospital was investigated appropriately and that all of the appropriate measures to control the outbreak were put in place promptly in line with national guidance and the process was underpinned by a formalised up-to-date policy.

Medication safety

As noted in national standard 5.5 the hospital did not have a comprehensive pharmacy-led clinical pharmacy service, this was a high-rated risk recorded on the hospital's corporate risk register, with appropriate controls implemented to mitigate the potential risks to patient safety. NCHD-led medication reconciliation was carried on all patients, but it was not clear if medication reconciliation practices were underpinned by a formalised policy. There was a medication management policy in place, however, it did not detail medication reconciliation practices. Medication stock control was carried out by the pharmacy technician daily.

Inspectors observed the use of risk reduction strategies to support safe medication practices, including segregated storage of pre-diluted potassium. The hospital had a list of high-risk medications aligned with the APINCH[‡‡‡‡‡‡‡‡] classification and the application of high alert and sound-alike look-alike medications (SALADs) labels on some medications.

Staff who spoke with inspectors in clinical areas were aware of the medication safety resource folder on the hospital's intranet, which contained information on medication safety audits, medication safety committee meeting minutes and other learning material. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of prescribing and administration.

Deteriorating patient

[‡‡‡‡‡‡‡‡] An acronym representing medicines known to be associated with high potential for medication-related harm: Antimicrobials, Potassium and other electrolytes, Insulin, Narcotics (opioids) and other sedatives, chemotherapeutic agents, heparin and other anticoagulants.

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose condition deteriorates. An adapted version of the Manchester Triage System§§§§§§§ was used to triage patients attending for care in LIU. INEWS version 2, was used in all clinical areas visited during inspection and all staff who spoke to inspectors were aware of the system and the escalation protocol when the INEWS triggered. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition had or was deteriorating. The ISBAR communication tool was used to support communication between staff in relation to a patient's care. Evidence of this was observed in the clinical areas visited during inspection.

Transitions of care

The hospital had systems and processes in place to reduce the risk of harm associated with patient transfer in and between healthcare services and to support safe and effective discharge planning. MAU used a detailed admission form which formed part of the healthcare record when the patient was admitted. For patients discharged, this form contained detailed discharge information and patient's follow up requirements. If deemed necessary, follow up included a return visit to the review clinic within MAU.

ULHG had an acute services inter hospital transfer of patient protocol in place, where the Model 2 hospitals within ULHG could transfer patients requiring a higher level of care or additional specialist care to and from UHL. When patients were transferred from UHL to Ennis Hospital a transfer form was used and a telephone handover was provided by nursing staff to ensure the exchange of appropriate clinical information.

At ward level, daily safety huddles took place where any issues that may impact on patient safety and a patient's care plan were discussed. Inspectors were told by staff that planning for discharge started as soon as the patient was admitted. Nursing documentation reviewed by inspectors contained a very comprehensive discharge planning section, which included requirements for complex discharge. A detailed discharge checklist to ensure safe discharge and inter hospital transfer, where applicable, was also included in the documentation. Staff who spoke with inspectors told them that discharge prescriptions and discharge summaries were completed on the day of discharge and the patient was given a copy of these when discharged, with a copy also being sent to their GP. ISBAR was not used as the format to provided clinical handover in Ennis Hospital.

Policies, Procedures, Protocols and Guidelines (PPPGs)

Ennis Hospital had a number of policies, procedures, protocols and guidelines in place in relation to infection prevention and control, deteriorating patients and transitions of care. The pharmacy service had a range of policies and guidelines to support medication safety. All policies, procedures, protocols and guidelines were available electronically for staff

§§§§§§§ The Manchester Triage System enables nurses to assign a clinical priority to patients, based on signs and symptoms.

through a shared folder on the hospital intranet on computers in clinical areas. Inspectors noted that some of these policies and guidelines had been adopted directly from UHL and had not been adapted or ratified for local use at Ennis Hospital, this should be an area of focused improvement following inspection.

In summary, policies and guidelines for Ennis Hospital in relation to medication safety adopted from UHL should be ratified or adapted for use in the hospital. Local implementation of INEWS requires strengthening to ensure that escalation and response to patients experiencing clinical deterioration is timely and in line with national guidance.

Judgment: Substantially compliant

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

Ennis Hospital had effective patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. As discussed in national standard 5.8, within ULHG, there were Serious Incident Management Teams (SIMT) at directorate and at ULHG levels, who had oversight for ensuring that patient-safety incidents were effectively managed.

ULHG national performance meetings with the HSE tracked the number of patient-safety incidents, including the percentage of patient-safety incident reviews completed within 125 days of notification and extreme and major incidents as a percentage of all reported incidents. ULHG performed well in relation to timely reporting of incidents on to the NIMS and exceeded the HSE target of 70%********* in 2022. ULHG also measured performance in relation to quality assuring incident reports and ensuring that they were assigned to an appropriate manager, their own target of 100% compliance was achieved in 2022 for these indicators. ULHG's Director of Quality and Patient Safety had oversight of implementation of recommendations from patient-safety incident reviews for all hospitals in ULHG. Inspectors were told that all recommendations were recorded electronically and tracked to completion. Staff in clinical areas visited had access to incident data and could see what incidents were closed and open with corrective measures in place.

A patient-safety incident overview report specific to Ennis Hospital was produced on a yearly basis. This report tracked and trended patient-safety incidents for different clinical areas within the hospital. Inspectors noted that the rate of incident reporting from Ennis

********* The HSE's target for entry of incidents on to NIMS is that 70% of reported incidents should be entered within 30 days of notification.

Hospital for 2022 was low when compared to other Model 2 hospitals, this may indicate a culture of underreporting.

Staff who spoke with HIQA were knowledgeable about the incident reporting process in place within Ennis Hospital. Staff described the process to inspectors, including the sharing of incident data. Learning from incidents was discussed at ward meetings every three months.

In 2022 there were a total of 375 clinical patient-safety incidents reported, the majority of these (205) resulted in no injury. The most frequently reported patient-safety incidents in Ennis Hospital in 2022 were slips, trips and falls of which there were 139 reported incidents. The patient population within clinical areas visited during inspection was mostly comprised of older persons, some of which had cognitive difficulties. At the time of inspection, eight out of 26 patients (31%) in Burren Ward were known to be at risk of falls. Ennis Hospital had implemented a number of falls related quality initiatives , these included:

- the MAU admission form contained a falls risk assessment and mobility and falls prevention care plan
- nursing documentation for inpatients contained a falls risk assessment and falls prevention section
- 'falling star' signage was used outside the rooms of those patients at risk of falling to alert staff to the additional needs these patient may have
- patients at risk of falls had falls alarms in place and some had crash mats at the bedside if appropriate.

In relation to medication related patient-safety incidents, inspectors noted that the incident reporting rate was low, with only 23 medication related patient-safety incidents reported in total in 2022. ULHG was aware of low rates of medication incident reporting throughout the hospital group. It was anticipated that the recruitment of two medication safety officers would help improve staff reporting of patient-safety incidents. Ennis Hospital's MSC had oversight of medication related patient-safety incidents.

Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not tracked or trended at Ennis Hospital. However, there was evidence that issues identified through other means were discussed and there was evidence of some quality improvement plans to address these issues.

In summary, hospital management at Ennis Hospital should work towards increasing the rate of reporting of patient-safety incidents, in particular, those relating to medication. A standardised approach to discussing incidents across all relevant governance committees could be beneficial in order to maximise opportunities for shared learning.

Judgment: Substantially compliant

Conclusion

HIQA carried out a two-day announced inspection of Ennis Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was judged to be:

- Compliant with two national standards (1.6, 1.7)
- Substantially compliant with eight national standards (5.2; 5.5; 5.8; 6.1; 1.8; 2.8; 3.1; 3.3)
- Partially compliant with one national standard (2.7)

Capacity and Capability

Ennis Hospital had effective, formalised corporate and clinical governance arrangements in place. However, there were some areas that required improvement. The Operational Site Steering Committee could benefit from tracking progress in implementing agreed actions to improve the quality of healthcare services from meeting to meeting. The Medical COG Group had not met in 2023. Given the role and responsibility of this group, it is important that it continues to meet regularly as per the group's terms of reference. Inspectors noted that there was good collaboration between Ennis Hospital and ULHG and oversight by ULHG especially in relation to the four know areas of harm.

On the day of inspection, the hospital's MAU and LIU were functioning well and as intended and were compliant with HSE targets related to patient experience times. Ennis Hospital had effective management arrangements in place to support and promote safe, high-quality healthcare in the areas of infection prevention and control, medication safety, deteriorating patient and safe transitions of care. There was evidence of good patient flow through the hospital with effective operational oversight by the hospital's management team.

Ennis Hospital had effective and systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. Inspectors found that hospital management had effective arrangements in place to plan, organise and manage their staffing levels to support the provision of high-quality, safe healthcare. However, attendance at and uptake of mandatory and essential training requires improvement.

Quality and Safety

Staff in Ennis Hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people receiving care in the hospital. Hospital

management and staff were aware of the need to respect and promote 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.

Inspectors were satisfied that Ennis Hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. However, some areas required sustained improvement. The hospital with the support of and oversight by ULHG, should continue to ensure that complaints are resolved promptly, in compliance with HSE targets.

People who spoke with inspectors were positive about their experience of receiving care in MAU and the wider hospital and were very complimentary of staff. 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.

The high number of single rooms at Ennis Hospital facilitated effective isolation of patients requiring transmission based precautions to reduce the spread of infection. The hospital's physical environment in some areas did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. The physical environment of the MAU required refurbishment, hospital management agreed with this finding on the day of inspection.

Inspectors found that Ennis Hospital had effective systems in place to monitor and improve healthcare services provided in the hospital. Hospital management were responsive in promoting the continual improvement of healthcare services provided in Ennis Hospital. Close monitoring of the timely escalation and response protocol for acute deterioration through INEWS audits is required until the required level of compliance with the protocol is consistently achieved. A programme of audit is required to assess if progress is being made in relation to all aspects of transitions of care including clinical handover.

Inspectors were satisfied that, in relation to the four areas of known harm, the hospital had effective 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. Ennis Hospital had appropriate oversight of the patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Staff in clinical areas had access to incident data and there was evidence of learning and quality improvements in response to incidents.

Overall, inspectors found a good level of compliance in Ennis Hospital with the 11 national standards assessed during this inspection. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the implementation of actions employed to bring Ennis Hospital into full compliance with the *National Standards for Safer Better Healthcare*.

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 at Ennis 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	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high 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

Quality and Safety Dimension	
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Compliance Plan for Ennis Hospital

OSV-0001065

Inspection ID: NS_0040

Date of inspection: 17 and 18 May 2023

Compliance Plan

Compliance Plan Service Provider's Response

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

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

Interim actions:

1. **Wear and Tear of the Medical Assessment Unit(MAU)**
   The painting of the MAU and the corridors has been completed as part of the maintenance programme.
2. **Review of waiting areas**
   -A review of the appointment system for return patients to the MAU has been completed, to ensure that only those patients who require immediate review are scheduled with fixed appointment times to reduce the number of patient waiting for access to the MAU.
   -A review of the sub waiting areas for the MAU has been completed. A new area has been identified that will cease the requirement for patients to wait on the corridor for access to the MAU.
3. **Completion of the Legionella Risk Assessment**
   The Risk Assessment for the Ennis site was completed in September 2023.

Plans requiring investment:

1. **Protection barriers**

Protection barriers are to be installed on the walls on the corridors adjacent to the MAU to protect paintwork and timber frames.
Date for completion: End of Q4 2023.

2. **Replace flooring in the Medical Assessment Unit**
   The flooring in the MAU is to be replaced by February end 2024.