Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	St Vincent's University Hospital
Address of healthcare service:	Elm Park Dublin 4 D04 T6F4
Type of inspection:	Announced
Date of inspection:	30 and 31 August 2022
Healthcare Service ID:	OSV-0001099
Fieldwork ID:	NS_0013

About the healthcare service

The following information describes the service the hospital provides.

St Vincent's University Hospital is a Model 4* voluntary public acute hospital, which is both a major academic teaching centre and a tertiary referral hospital. It is a member of and is managed by the Ireland East Hospital Group (IEHG)† on behalf of the Health Service Executive (HSE) through a service level agreement. St Vincent's University Hospital is part of the St Vincent's Healthcare Group (SVHG) which also includes St Vincent's Private Hospital and St Michael's Hospital.

St Vincent's University Hospital provides acute, chronic and emergency care across over 50 different medical and surgical specialties. The hospital is a major designated cancer centre and comprises a number of national centres including:

- the national centre for liver transplant
- the national centre for pancreas transplant
- cystic fibrosis
- pancreatic surgical services
- neuroendocrine tumours
- orthopaedic sarcoma services.

The hospital provides specialist critical care for adjacent hospitals in the region and supports the national mobile intensive care ambulance service in conjunction with Beaumont Hospital and the Mater Misericordiae Hospital, one week every month.

St Vincent's University Hospital operates as part of a network of hospitals within the Ireland East Hospital Group and has a hub-and-spoke model for adult emergency services, whereby the care of critically ill patients is centralised in St Vincent's University Hospital and supported by St Michael's Hospital in Dún Laoghaire and other hospitals in the Ireland East Hospital Group. St Michael's Hospital's emergency department has a major trauma bypass protocol in place, whereby patients with trauma injuries are taken to St Vincent's University Hospital.

The emergency department in St Vincent's University Hospital is the major trauma centre for the HSE South East Dublin region, providing emergency care in association with St Michael's Hospital and St Columcille's Hospital for a population of over 300,000. The emergency department is the primary referral centre for the region, so

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* A Model-4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit on site, a Medical Assessment Unit which is open on a continuous basis (24/7) and an emergency department.
† The Ireland East Hospital Group comprises eleven hospitals. These are the Mater Misericordiae University Hospital, St Vincent's University Hospital, Cappagh National Orthopaedic Hospital, the Royal Victoria Eye and Ear Hospital, the National Maternity Hospital, St Columcille's Hospital, Loughlinstown, St Michael's Hospital, Dún Laoghaire, the Midland Regional Hospital, Mullingar, St Luke's General Hospital, Kilkenny, Wexford General Hospital, Wexford and Our Lady's Hospital, Navan. The hospital group's academic partner is University College Dublin (UCD).

patients with specific conditions such as stroke and major trauma can be brought from other hospitals to the emergency department in St Vincent's University Hospital.

The average yearly attendance at St Vincent's University Hospital's emergency department is over 58,000 (based on 2019-2021 activity data), the total attendances to the department in 2021 was 60,748. The daily attendance to the emergency department for quarter one and quarter two of 2022 ranged from 4,802 to 5,634, which equated to 172 to 182 attendees per day. The admission rate (conversion rate) from the department for 2021 was 27%, which is comparable to other Model 4 hospitals. The conversion rate remained relatively stable, month on month for quarter one and two of 2022, ranging from 21% to 24%. Over that same time frame, the number of patients discharged or admitted to an impatient bed within six hours of registration varied from 49% to 56%.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	614

How we inspect

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

To prepare for this inspection, the inspectors[‡] reviewed information about this acute hospital. This included previous inspection findings, information submitted by St Vincent's University Hospital, unsolicited information[§] and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service

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

[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

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

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections, under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors at a point in time — before, during and following the on-site inspection.

1. Capacity and capability of the service:

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high quality and the safe delivery of care.

2. Quality and safety of the service:

This section describes the experiences, care and support people receive on a day-to-day basis. It is a check on whether the service is a good quality and a caring one that is both person centered and safe. It also includes information about the environment where people receive care.

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

Compliance classifications

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
30 August 2022	09:00hrs to 17:00hrs	Dolores Dempsey Ryan	Lead
		Denise Lawler	Support
31 August 2022	09:00hrs to 15:15hrs	Danielle Bracken	Support
		Emma Cooke	Support
		Lisa Corrigan	Support

Background to this inspection

This inspection focused on national standards drawn from five of the eight themes of the *National Standards for Safer Better Healthcare*. This inspection focused in particular, on four keys areas of known harm, these being:

- 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*

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

- Representatives of the hospital's executive management team:
  - Chief Executive Officer (interim)
  - Clinical directors from each clinical directorate — clinical director for medicine and emergency medicine directorate, perioperative directorate, hepato-pancreato-biliary (HPB) and liver service directorate, cancer directorate and diagnostic directorate
  - Director of Operations (interim)
  - Director of Quality and Patient Safety (interim)
  - Director of Nursing
  - Director and Deputy Directors of Human Resources
- Non-Consultant Hospital Doctors (NCHDs)
- Patient Safety and Clinical Risk Advisor
- Head of Bed Management
- Assistant Director of Nursing for Infection Prevention and Control
- Head of Pharmacy
- Medication Safety Pharmacist
- Group Clinical Director, St Vincent's University Healthcare Group
- A representative from each of the following committees:
  - infection prevention and control
  - drugs and therapeutics
  - the deteriorating patient programme
  - transitions of care.

In addition, the inspection team visited a number of clinical areas which included:

- Emergency department
- St Luke's 1 Ward (surgical ward)
- St Agnes' Ward (medical ward)
- St Lucy's Ward (medical ward).

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 experience of the service.

Primary Care. Geneva: World Health Organisation. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

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

Inspectors visited the emergency department, Acute Medical Assessment Unit and Acute Medical Unit on the first day of the inspection. The emergency department at St Vincent's University Hospital provides undifferentiated care for adults and children over the age of 14 years with acute and urgent illness or injuries.

Attendees to St Vincent's University Hospital's emergency department can present by ambulance, are referred directly by their general practitioner (GP) or self-refer. The emergency department has a total planned capacity of 52 comprising:

- three-bedded resuscitation area (open bays)
- two-bedded resuscitation area (isolation cases)
- 32 bays comprising:
  - 11 single occupancy cubicles in the COVID-19 area (excluding resuscitation)
  - 14 cubicles
  - one psych cubicle
  - four curtained areas in non COVID-19 area
  - three Rapid Assessment Treatment spaces
- 18 isolation cubicles for isolation streaming.

The department also had a 20 space ambulatory[§§] treatment zone.

The department's Clinic Decision Unit was not operational at the time of inspection. The unit was adapted in March 2020 to facilitate the establishment of a COVID-19 pathway in the emergency department and was, at time of inspection, operating in that way due to ongoing COVID-19 infection prevention and control guidelines.

On the first day of the inspection, the emergency department was extremely busy and the hospital had implemented the full capacity protocol.[***] The hospital's inpatient capacity for the month previous to HIQA's inspection (July 2022) was 113.5% and hospital management told inspectors that this was a normal occurrence.

At 11.00am on day one of inspection, there were 56 patients in the department. Seventeen of the 56 patients (30%) were aged 75 years or over. At that time, a total of 39 (70%) patients were admitted awaiting an inpatient bed. Seven of these patients had been

[§§] Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.
[***] Full capacity protocol is the final step in a hospital's escalation plans, where extra beds are placed in inpatient wards and corridors of hospitals as a measure to address emergency department overcrowding.

assigned an inpatient bed and the remaining 32 patients were awaiting an inpatient bed. Six patients were boarding in the emergency department in excess of 40 hours while waiting for an inpatient bed:

- three patients were waiting over 40 hours
- one patient was waiting 51 hours 18 minutes
- one patient was waiting 62 hours 21 minutes
- one patient was waiting for 83 hours 53 minutes.

Over half of the 56 (54%) patients in the emergency department were in the department for longer than nationally recognised safe and acceptable timelines. At the time:

- 20 of the 56 patients (36%) were in the department less than six hours from registration.
- Four of the 56 patients (7%) were in the department for six to nine hours from registration.
- 24 of the 56 patients (43%) were in the department for nine to 24 hours from registration.
- Eight of the 56 patients (14%) were in the department for over 24 hours from registration.

Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received. Overall, the majority of patients were happy with the care they received. The majority of patients described staff as '*really nice and helpful', 'excellent'*, '*lovely and kind*.' However, there was evidence on day one of inspection that admitted patients boarding in the department did not receive the same level of assistance with personal care that patients admitted to the clinical area might receive. Patients described assistance with personal care as '*poor'* and they felt there was '*not enough of staff'* to assist patients with personal care. The delay in providing personal care was brought to the attention of the clinical nurse manager on the day of inspection and the issues were addressed.

The finding was consistent with the hospital's overall findings from the 2021 National Inpatient Experience Survey,[†††] where 43% of patients considered their overall experience of the receiving care in the hospital as very good, which was below the national score of 54%. While the majority of patients who spoke to inspectors were accepting of the

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[†††] The National Care Experience Programme, is a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/

situation in the emergency department and did not want to make a complaint, others had raised their concerns about overcrowding and the delay in accessing an inpatient bed with staff in the department.

Overall, there was consistency with what inspectors observed in the emergency department, what patients told inspectors about their experiences of receiving care in the department and related findings from the 2021 National Inpatient Experience Survey.

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

During the inspection, inspectors visited three clinical areas, St Luke's 1 Ward, St Agnes' Ward and St Lucy's Ward.

St Luke's 1 Ward was a 24-bedded clinical area and was recently changed to a 25-bedded clinical area to accommodate patients who were moved due to the closure of another clinical area for refurbishment. On the day of inspection, St Luke's 1 clinical area comprised four multi-occupancy rooms — three rooms with five beds and one with six beds. There was one two-bedded room and two single rooms, one single room had en-suite bathroom facilities. The clinical area had one shower and six toilets and shared shower and toilet facilities with an adjacent clinical area. At the time of inspection, the clinical area was fully occupied. The clinical area accommodated male and female surgical and medical patients.

St Agnes' Ward was a 23-bedded clinical area consisting of four multi-occupancy rooms, each with five beds, one two-bedded room and one single room without en-suite bathroom facilities. This clinical area had two showers and four toilets. At the time of inspection, there were 23 patients on St Agnes' Ward. The clinical area accommodated male and female medical patients.

St Lucy's Ward was a 32-bedded clinical area consisting of six multi-occupancy rooms, each with four beds including en-suite bathroom and shower facilities. There was one three-bedded multi-occupancy room with en-suite bathroom facilities. There were five single rooms with en-suite bathroom facilities. At the time of inspection, there were 30 patients on St Lucy's Ward. The clinical area accommodated male and female medical patients.

Inspectors observed staff actively engaging and interacting with patients in a respectful and kind way. This was validated by patients on the ward who described staff as *'very nice and friendly'*, *'doing their best'*, and *'everything was a good experience'*.

Inspectors observed staff offering assistance to patients with their personal care needs while maintaining the patient's privacy and dignity, which is consistent with the human rights-based approach promoted by HIQA. Inspectors also observed many examples of staff assisting patients to the bathroom. However, patients who spoke with inspectors across the three clinical areas visited had mixed experiences in relation to the level of

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assistance provided by staff. Some patients were positive about being offered assistance but other patients had difficulty getting assistance, especially at night time. The experience recounted by patients on the day of inspection was consistent with the findings from the National Inpatient Experience Survey 2021, where the hospital scored 75% for offering patients assistance with meals, this was lower than the national score of 81%, and the hospital scored 79% with assistance to the bathroom or toilet, below the national score of 85%.

Inspectors did not observe patient information leaflets providing patients with information on how to make a complaint, such as the HSE's '*Your Service Your Say.*[‡‡‡] Patients told inspectors that they would speak to the nurse or nurse manager, or ask a family member to make a complaint on their behalf, if required.

Overall, there was consistency with what inspectors observed in the clinical areas visited, what the majority of patients told inspectors about their experiences of receiving care in those areas and the findings from St Vincent's University Hospital's Patient Satisfaction Survey 2021 and the National Inpatient Experience Survey 2021.

Capacity and Capability Dimension

Inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. The hospital was found to be partially compliant with standard 5.5 and with standard 6.1 in the emergency department.

In addition, inspection findings from the wider hospital and clinical areas visited related to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.4) from the two themes of leadership, governance and management and workforce. The hospital was found to be compliant with 5.2 and 6.4, substantially compliant with 5.8 and partially compliant with 5.5 in relation to the wider organisation. Key inspection findings leading to these judgments 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.

Inspectors found that the hospital had formalised corporate and clinical governance arrangements in place that defined the roles, accountability and responsibilities for assuring the quality and safety of healthcare services. The hospital was governed and managed by

[‡‡‡] 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

the Chief Executive Officer (interim) who had dual reporting responsibilities. The Chief Executive Officer (interim) reported to the Board of Directors of St Vincent's Healthcare Group and reported to the Chief Executive Officer of the Ireland East Hospital Group. Two organisational charts submitted to HIQA as part of the pre-on-site documentation, data and information request clearly set out the governance reporting and accountability structures at the hospital.

The Clinical Director of St Vincent's Healthcare Group provided overall clinical oversight and leadership at St Vincent's University Hospital. The Director of Nursing was responsible for the organisation and management of nursing services at the hospital. The Director of Nursing was a member of the hospital's executive management team and reported to the hospital's Chief Executive Officer, and had a close working relationship with the Ireland East Hospital Group's Chief Director of Nursing and Midwifery.

Executive management team

The executive management team was responsible for overseeing the executive functions of the hospital and provided assurance to the Chief Executive Officer (interim) on the hospital's performance and safety. The team chaired by the Chief Executive Officer (interim), met monthly and membership included the group clinical director, all five clinical directors and the directors of finance, nursing, quality and safety, human resources, operations, one of the clinical directors from the Ireland East Hospital Group, director of information communication and technology (ICT) and the chair of bed management committee. Minutes of meetings of the executive management team submitted to HIQA showed that meetings followed a structured agenda and were well attended. Collated performance data in relation to scheduled care, unscheduled care and emergency department activities were reviewed at meetings of the executive management team. The organisational risk register was also reviewed at meetings of the team, and the team approved hospital policies, procedures, guidelines and protocols.

Members of the hospital's executive management team attended performance meetings between the hospital and the Ireland East Hospital Group held every month, where items such as finance, workforce, quality and safety risk issues including serious reportable events, scheduled and unscheduled care, nursing and capital projects, and risks on the hospital's risk register were reviewed and discussed. Inspectors were satisfied that the performance meetings were well attended by representatives from the hospital and hospital group, and that actions were progressed from meeting to meeting.

At clinical governance level, the hospital had a directorate system in place. The hospital had recently increased the number of clinical directorates from three to five directorates. These clinical directorates were:

- medicine and emergency medicine
- perioperative

- cancer
- diagnostic
- liver and hepato-pancreato-biliary (HPB).

Each clinical directorate was led by a clinical director who reported and was accountable to the hospital's Chief Executive Officer (interim) and the hospital group's clinical director. Directorate staff may also include a directorate nurse manager and a business manager. Each clinical directorate had a quality and safety representative assigned to it to provide support to staff from a quality and safety perspective. Each clinical director provided an update on their directorate's activities and performance at meetings of the executive management team. Clinical directors also attended meetings of the Quality and Patient Safety Executive.

Quality and Patient Safety Executive

The Quality and Patient Safety Executive was responsible for providing assurance to the executive management team on known risks and incidents, including serious reportable events. The executive were operationally accountable to the executive management team.

The Quality and Patient Safety Executive was chaired by the Chief Executive Officer (interim) and membership included the hospital group's clinical director, members of the executive management team, directorate nurse managers and other heads of department in the hospital. The committee met monthly and meetings followed a structured agenda. A total of 13 sub-committees reported into the Quality and Patient Safety Executive, including the Infection Prevention and Control Committee and the Drugs and Therapeutics Committee. Minutes of meetings of the committee submitted to HIQA were comprehensive and showed that meetings were well attended, action-orientated and actions were progressed from meeting to meeting.

The hospital's Director of Quality and Patient Safety (interim) provided an update, which included information on complaints data, trends, quality improvement initiatives in response to emerging trends and learning notices at each meeting of the Quality and Patient Safety Executive. The hospital's quality and patient safety department also submitted a summary report to the Quality and Patient Safety Executive every month, ongoing updates to the executive management team on a monthly basis and St Vincent's Healthcare Group Board Quality and Risk Committee on a quarterly basis. This report provided information on the hospital's performance in relation to the:

- total number of clinical incidents reported and trends to emerge from analysis of reported clinical incidents
- clinical incidents related to infection prevention and control, medication safety, falls, hospital acquired pressure ulcers and challenging behaviour
- patient safety incident reviews

- serious reportable events
- national key performance indicators
- complaint data, trends and learning notices
- findings from the National Inpatient Experience Survey.

Information on clinical incidents related to the deteriorating patient and transitions of care was not detailed in the monthly summary report. This is something that could be included in future reports.

At operational level, HIQA was satisfied that the hospital had clear lines of accountability with devolved autonomy and decision-making for the four areas of known harm. The hospital had the following four committees in place, all were operationally accountable and reported to the Quality and Patient Safety Executive:

- Infection Prevention and Control Committee
- Drugs and Therapeutics Committee
- Deteriorating Patient Committee
- Bed Management Committee.

Infection Prevention and Control Committee

The hospital had a well established multidisciplinary Infection Prevention and Control Committee, who had assigned responsibility for the governance and oversight of the hospital's infection prevention and control programme. The committee was operationally accountable and reported to the Quality and Patient Safety Executive. The committee was chaired by the Chief Executive Officer (interim) and met every three months, in line with its terms of reference. Membership of the committee included members of the hospital's infection prevention and control team, representatives from the senior management team, an antimicrobial pharmacist, a representative from the quality and patient safety department and occupational health. A number of sub-committees reported and provided monthly updates to the Infection Prevention and Control Committee, including the antimicrobial stewardship committee and the water management committee.

The Infection Prevention and Control Committee approved the annual programme of activity for the hospital's infection prevention and control team and this was outlined in an annual infection prevention and control plan. The committee received updates on the progress of the implementation of the annual infection prevention and control plan, from the team every three months. The plan is discussed in more detail under national standard 5.5.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA, were comprehensive and showed that the committee had oversight of key infection prevention and control performance indicators (including antimicrobial stewardship), audit findings, infection prevention and control related patient safety incidents and related risks,

relevant infection prevention and control policies and staff education and training. Meetings were well attended and actions were progressed from meeting to meeting. Overall, HIQA was satisfied with the governance and oversight of infection prevention and control practices, and infection outbreaks at the hospital.

Drugs and Therapeutics Committee

The hospital had a well-established Drugs and Therapeutics Committee, who were assigned with responsibility for the governance and oversight of medication safety at the hospital. The committee was a sub-committee of the Medical Executive Committee[§§§] and reported on medication safety data to the Quality and Patient Safety Executive every month. The committee, chaired by a consultant geriatrician, met monthly in line with its terms of reference. Membership of the committee comprised the chief pharmacist, pharmacists representing clinical pharmacy services, medicines information, medication safety services, education and training, formulary management at chief 2 level, consultants, non-consultant hospital doctors, nursing representatives and a representative from the hospital's quality and safety department. The committee was responsible for developing the hospital's annual medication safety plan. The plan is discussed in more detail under national standard 5.5. Three sub-committees, including the antimicrobial advisory sub-committee, reported into the Drugs and Therapeutics Committee.

Minutes of meetings of the Drugs and Therapeutics Committee submitted to HIQA showed that the committee had oversight of medication safety incidents, nurse prescribing, antimicrobial stewardship, clinical audit, policies, patient information leaflets and the hospital formulary. Meetings were well attended, action orientated and actions were progressed from meeting to meeting. The medication safety coordinator also submitted a medication safety report to the Drugs and Therapeutics Committee and the Quality and Patient Safety Executive every month. This report provided information on the total number of medication safety incidents reported per month, incidents for review, incident trends and audit findings. Similarly, the medication safety annual report for 2021 provided information on the total number of medication incidents reported, incident trends, categories and incidents by location. The annual report is discussed in more detail under standard 3.3 below.

Deteriorating Patient Committee

The hospital had a Deteriorating Patient Committee who had assigned responsibility for overseeing the provision of services for the deteriorating patient within the hospital. This committee was operationally accountable and reported to the Quality and Patient Safety Executive every three months. The committee, chaired by a consultant in emergency medicine, met every three months, in line with its terms of reference. Membership of the committee included, the clinical director for the medical directorate, a consultant

[§§§] The Medical Executive Committee (MEC) acts as a representative of the medical staff. The committee proposes change and enacts policies, procedures, and other items in an effort to improve patient care and medical staff structure

microbiologist, a non-consultant hospital doctor, the director of nursing, assistant director of nursing for the Ireland East Hospital Group, resuscitation officer(s), Irish National Early Warning System (INEWS)[****] facilitator, critical care outreach coordinator[††††] and other heads of department. Minutes of meetings of the committee submitted to HIQA showed that the committee had oversight of audit activities related to INEWS, performance data including the National Office of Clinical Audit (NOCA)[‡‡‡‡] and mortality data, risks and clinical incidents related to the deteriorating patient, relevant policies, and staff education and training. Meetings were well attended, action orientated and actions were progressed from meeting to meeting.

Transitions of Care

The hospital had a multidisciplinary Bed Management Committee chaired by a consultant physician in geriatric medicine who was operationally accountable and reported to the executive management team every month. Membership of the committee included the director of operations with responsibility for scheduled and unscheduled care, director of nursing, lead clinical directors, head of bed management, discharge coordinator, chair of the medical executive, an emergency department representative and the clinical nurse manager grade three from critical care. Minutes of meetings submitted to HIQA showed the committee met monthly, in line with its terms of reference, meetings followed a structured agenda and the committee had oversight of the hospital's performance in relation to relevant key performance indicators and organisational activity. Meetings of the committee were well attended, action orientated and actions were progressed from meeting to meeting. Members of St Vincent's Healthcare Group also attended these meetings.

Overall, HIQA was satisfied that St Vincent's University Hospital had formalised corporate and clinical governance arrangements in place that defined the roles, accountability and responsibilities for assuring the quality and safety of healthcare services.

Judgment: Compliant

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

†††† Critical Care Outreach Coordinator is an ICU or CCU nurse who works within the multidisciplinary outreach team to identify patients at risk of deterioration on the ward, as well as patients with high early warning system scores. The outreach team provides advice and clinical support to the ward staff by liaising with the primary and anaesthetic teams as early as possible to respond and deliver the most appropriate management.

‡‡‡‡ National Office of Clinical Audit (NOCA) - manages a suite of national clinical audits. Each audit focuses on a unique area of healthcare, such as hip fracture, major trauma, hospital mortality, ICU care and joint replacements. Available online from: https://www.noca.ie/audits/irish-national-icu-audit.

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

Findings relating to the emergency department

The hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. There was evidence of strong clinical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the emergency department was the responsibility of the consultant lead in emergency medicine. Two governance structures — the Emergency Department Operations Working Group and the Medicine and Emergency Medicine Directorate — had oversight of operational processes in the hospital's emergency department including those that impact on patient flow and surge capacity in the department.

On arrival to the emergency department, all attendees were promptly assessed for signs and symptoms of COVID-19 and streamed to the appropriate care pathway, in line with national guidance. Self-presenting attendees checked in at reception and waited to be called for triage. Patients with no signs or symptoms of COVID-19 were directed to a specific waiting area comprising 18 chairs. Patients presenting with signs or symptoms of COVID-19 were directed to a separate waiting area. There was minimum physical distancing of one metre in both areas. Inspectors observed that staff working in the emergency department were wearing appropriate personal protective equipment (PPE) in line with current public health guidelines.

At 11.00am, there were 56 patients in the emergency department. Three patients were waiting in the non-COVID-19 waiting area awaiting triage, not all patients were observed wearing facial coverings. One patient was waiting in the COVID-19 waiting area awaiting triage, this patient was observed wearing facial covering.

The remaining 52 patients in the main emergency department area were assigned to the non-COVID-19 or COVID-19 pathway based on their infective status. All patients had been triaged and assigned to the relevant prioritisation category levels 1-5 in line with the Manchester Triage System.[§§§§] The majority (27) of patients were prioritised as orange category (priority level 2, review within 10 minutes, very urgent cases). Nineteen patients were prioritised as yellow category (priority level 3, review within 30 minutes, less urgent cases). The remaining six patients were prioritised as green category (priority level 4, review within 90 minutes, standard cases). Staff could view the status of all patients in the department — their prioritisation category levels and waiting times via the hospital's electronic operating system.

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

Continuous and effective flow of patients within and out of the hospital is essential for optimal service delivery in an emergency department. On the first day of the inspection, the hospital had 23 beds closed because a clinical area was being refurbished. However, despite this, inspectors were assured that hospital management had implemented contingencies to ensure that the hospital's full bed capacity of 614 beds was maintained. This was done through increasing inpatient capacity in other clinical areas and accessing beds in St Vincent's Private Hospital. There were no beds or clinical areas closed as a result of an infection outbreak on the days of HIQA's inspection.

Staff who spoke with inspectors recounted how the delay in discharging and transferring patients from the hospital impacted effective patient flow from the emergency department. Between January and July 2022, the hospital's number of bed days lost to delayed discharges increased month on month, ranging from 960 to 1,305. Over the same time frame, the monthly delayed discharges (including fair deal) at the hospital ranged from 28 to 44. On the days of inspection, the availability of inpatient beds was further impacted by the delay in accessing diagnostic services at the hospital, which was as a result of issues with resourcing – equipment and staffing.

Collectively, the mismatch between availability and demand for inpatient beds, evident on the days of inspection, impacted the flow of patients through the emergency department and contributed to the boarding of admitted patients in the department. This in turn negatively impacted on patient experience times. At 11.00am on day one of inspection, the waiting time from:

- registration to triage ranged from two minutes to one hour 10 minutes. The average waiting time was 17 minutes
- triage to medical review ranged from one minute to three hours 54 minutes. The average waiting time was one hour four minutes
- the decision to admit to actual admission in an inpatient bed ranged from 10 minutes to 10 hours, the average time was four hours 30 minutes. Notwithstanding this, on the morning of day one of HIQA's inspection, there were patients waiting longer than 10 hours in the emergency department – five patients were boarding in the emergency department in excess of 40 hours.

Hospital management had implemented or were implementing measures to improve and support effective patient flow in the emergency department and increase surge capacity across the hospital and hospital group. These included:

- establishing the Productive Patient Journey Taskforce which will incorporate the emergency department's operations working group. The purpose of this group is to establish a structure to implement new and enhanced processes to support continuous, effective patient flow in St Vincent's University Hospital, in conjunction with primary care, St Vincent's Healthcare Group (including St Michael's Hospital, St

Vincent's Private Hospital, St Columcille's Hospital, Ireland East Hospital Group and Community Health Organisation 6 (CHO 6)

- maximising and utilising step-down beds in the community in facilities under and outside the governance of St Vincent's University Hospital
- using the 'safety net initiative,' whereby inpatient beds in St Vincent's Private Hospital, are used to increase inpatient bed capacity
- the hospital carrying out a high level strategic assessment review of its current and future capacity needs both from a surgical and critical care perspective. This strategic assessment review will be submitted to the HSE in order to progress a preliminary business case for future capital investment to increase hospital capacity.

A number of pathways to support patient flow from the emergency department included:

- streaming patients to established care pathways, where appropriate. For, example, the stroke, sepsis, respiratory, deep vein thrombosis[*****] and syncope[†††††] pathways
- transfer patients to the hospital's Acute Medical Assessment Unit and Acute Medical Unit
- transfer patients to St Columcille's Hospital and St Michael's Hospital
- the Assistant Director of Nursing with responsibility for patient flow meets with the multidisciplinary team daily to discuss inpatient bed capacity and demand, and issues with delayed transfers of care. Information on inpatient capacity and demand, and patient flow is captured on an information management system, accessible to nursing and medical staff
- meetings with the community nursing homes and Public Health Nurse link person were held weekly to identify capacity and issues that may potentially impact on the timely transfer and discharge of patients. For example, issues with homecare services and social issues, such as homelessness that might negatively impact on the timely transfer of patients
- carrying out additional ward rounding by medical consultant staff Monday to Friday to identify patients for discharge and or issues impacting on discharge
- using the navigation hub meetings with clinical nurse managers to identify, plan and support patients for discharge and identify issues that may impact on their timely discharge
- proactively working with the Head of Social Care, Older Persons and CHO 6 to facilitate the safe and timely transfer and discharge of patients, and the integration of unscheduled care at hospital and regional levels

[*****] Deep vein thrombosis occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs.
[†††††] Syncope is a temporary loss of consciousness, often referred to as passing out, usually related to insufficient blood flow to the brain.

- liaising with general practitioners (GPs) in the hospital's catchment area to ensure timely discharge of patients
- increase access to diagnostic services - hospital management had submitted a business case to the Ireland East Hospital Group for an additional computerised tomography (CT)[‡‡‡‡‡] scanner to help increase access to diagnostics in the hospital's emergency department.

On day one of inspection, there was evidence that the measures described above were being implemented.

The Acute Medical Assessment Unit and Acute Medical Unit together comprised 40 beds — five beds were located in the Acute Medical Assessment Unit (short stay unit for six to 12 hours) and 35 beds were located in the Acute Medical Unit (longer stay of 72 hours). The Acute Medical Assessment Unit and Acute Medical Unit operated 24/7 and during core working hours (9.00am-5.00pm), it was staffed by designated staff comprising four whole-time equivalent (WTE)[§§§§§] consultant physicians supported by five non-consultant doctors — two registrars, one to two senior house officers and one intern.

The medical team were supported by a multidisciplinary team comprising 3.5 WTE advanced nurse practitioners (ANPs), and health and social care professionals, including a physiotherapist and occupational therapist. The on-call medical physician was responsible for the unit outside core working hours (5.00pm-8.00am). The unit also had a designated nursing staff complement comprising 33.5 WTE (including management grade) and one WTE clinical skills facilitator. Nursing staff were supported by 14 WTE healthcare assistants. Performance data, including the number of patients admitted and discharges from the unit, average and median length of stay and readmission rate were collected and collated every month.

The Acute Medical Assessment Unit and Acute Medical Unit were not functioning as designed, as an alternate flow pathway for patients in order to take pressure from the emergency department, rather it was used as a pathway from the department. This indicated to HIQA that the normal means of facilitating patient flow were not as effective as they should be. This combined with reduced surge capacity and the total volume of attendees to the hospital's emergency department further contributed to the boarding of 70% of admitted patients in the emergency department.

In the first seven months of 2022 (January-July), 96% of patients admitted to the short stay Acute Medical Assessment Unit were from the hospital's emergency department. After six to 12 hours in the Acute Medical Assessment Unit, these patients were moved to the

[‡‡‡‡‡] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles of the body and uses computer processing to create different images of the bones, blood vessels and soft tissues in the body.
[§§§§§] Whole-time equivalent (WTE) - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

Acute Medical Unit, where after 72 hours if not discharged, they were admitted under the care of a specialist medical team and assigned an inpatient bed.

Overall, the hospital had defined management arrangements in place to manage and oversee delivery of care in the emergency department. However, circumstances such as high numbers of attendances to the department combined with issues of ineffective patient flow, limited surge capacity and reduced access to transitional, rehabilitation and step down beds in the community impacted on the continuous and effective flow of patients through the emergency department. Although, hospital management had implemented a range of measures to improve the flow of patents in the department and increase surge capacity, it was evident from findings on day one of inspection, that the measures implemented to date were not fully effective in managing the potential patient safety risks associated with lengthy stays in the department.

Judgment: Partially compliant

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

Findings relating to the wider hospital and other clinical areas visited

HIQA found that the hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas as follows:

Infection Prevention and Control

The hospital had an infection prevention and control team comprising:

- 3.15 whole-time equivalent (WTE) consultant microbiologists
- Four WTE non-consultant hospital doctors at specialist registrar and registrar grades
- Six WTE infection prevention and control clinical nurses specialists
- One WTE assistant director of nursing with responsibility for infection prevention and control
- Two WTE surveillance scientists
- One WTE surgical site surveillance coordinator
- Two WTE antimicrobial pharmacists
- 1.5 WTE administrative support.

Staff had 24/7 access to a consultant microbiologist. The hospital did not have an overarching infection prevention and control programme[******] as per national

[******] 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),

standards,[††††††] but had an infection prevention and control plan. The infection prevention and control team had responsibility for the implementation of the hospital's infection prevention and control annual plan and reported on progress in implementing the annual plan to the Infection Prevention and Control Committee every three months. The team also submitted an annual report to the Infection Prevention and Control Committee.

The infection prevention and control annual report for 2021, submitted to HIQA was comprehensive. It comprised a number of reports, including an alert organism surveillance report, performance against key infection prevention and control performance indicators and a hand hygiene audit report. HIQA noted that some of the reports had identified recommendations to improve infection prevention and control practices at the hospital, but time-bound action plans to support the implementation of all recommendations were not developed. This can be easily remedied after this inspection, as action plans provide a framework to implement recommendations from reports and ensure that identified changes are made to improve healthcare services.

The hospital had an Antimicrobial Advisory Committee assigned with responsibility for the development and coordination of the hospital's antimicrobial stewardship programme. This committee was accountable and reported to the Drugs and Therapeutics Committee and the Infection Prevention and Control Committee. The antimicrobial stewardship team comprised a consultant microbiologist supported by two clinical pharmacists. The antimicrobial stewardship team developed an annual plan that outlined its key objectives for the year and produced an annual report detailing the achievements in meeting the objectives in the plan, surveillance data, audit findings and education sessions provided to non-consultant hospital doctors.

Medication safety

The hospital had a clinical pharmacy service,[‡‡‡‡‡‡] which was led by the hospital's chief pharmacist. The hospital had approval for:

- 46 WTE pharmacists
- 22 WTE pharmacy technicians.

At the time of inspection, the hospital's pharmacy department had nine WTE vacancies — six clinical pharmacists and three pharmacy technicians, which represented a variance of 13% of the department's approved and actual pharmacist and pharmacy technician staff

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sets out clear strategic direction for the delivery of the objectives of the programme in short-, medium- and long-term, as appropriate to the needs of the service.

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

[‡‡‡‡‡‡] A clinical pharmacy service is a service provided by a qualified pharmacist, which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

complement. HIQA was satisfied that hospital management were actively working to recruit pharmacy staff.

The Drugs and Therapeutics Committee developed a medication annual plan, which comprised short-, medium- and long-term objectives to support medication safety practices at the hospital. The areas of focus identified in the short-term plan for 2022 included, analysis of medication incidents reports and quality improvement initiatives related to patient discharge and Parkinson's disease. The committee produced an annual medication safety report, which provided information on medication safety incidents, including the quality improvement initiatives implemented in response to clinical incidents, such as medication safety huddles.[§§§§§§] Medication safety incidents are discussed further under standard 3.3 below.

Deteriorating patient

The hospital did not have a deteriorating patient improvement programme, but had a Deteriorating Patient Committee with assigned responsibility for overseeing the care provided to the deteriorating patient. This included oversight of the implementation of national INEWS and sepsis guidelines at the hospital.

Transitions of Care

HIQA was satisfied that the hospital had management arrangements in place to monitor issues that impact effective, safe transitions of care. Transitions of care incorporates internal transfers, shift and interdepartmental handovers, external transfer of patients to other healthcare services and patient discharge. The hospital's Bed Management Committee had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital.

Nursing, medical and support staff workforce arrangements

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

The hospital's Director of Human Resources was operationally accountable for the human resource department and reported to the hospital's Chief Executive Officer (interim). The director also reported on performance to the Director of Human Resources in the Ireland East Hospital Group.

The hospital's total approved complement of nursing staff was 1232.76 WTE. At the time of inspection, 1169.2 WTE nursing positions were filled, which represented a variance of 63.56 WTE (5.2%) between the approved and actual nursing staff complement. Clinical nurse managers provided inspectors with documentary evidence in relation to staffing

[§§§§§§] A huddle is a short, stand-up meeting — 10 minutes or less — that is typically used at the start of each shift in a clinical setting.

levels in their clinical areas. On the days of inspection, there was evidence of nursing staffing deficits in the range of 15% to 24.5% in the three clinical inpatient areas visited. This was a concern for HIQA. Nurse staffing levels in the emergency department is discussed under national standard 6.1 in the emergency department section. The hospital used agency staff and existing nursing staff worked extra shifts to fill shortfalls in the nursing staff roster. While hospital management were actively working to recruit nursing staff to fill vacancies, reliance on agency staff and staff working extra shifts to fill shortfalls in the staff roster is not sustainable.

The hospital's total approved posts for healthcare assistants was 196.84 WTE. At the time of inspection, 179.35 WTE healthcare assistant positions were filled. Documentary evidence submitted to HIQA showed that there was a deficit of healthcare assistants in the range of 10% to 20% in two of the three clinical areas visited during the course of HIQA's inspection.

The hospital had a total approved complement of 530.82 WTE for medical staff (consultants and non-consultant hospital doctors). All consultant positions were filled on a permanent or locum basis, but the hospital did have a deficit of ten WTE non-consultant hospital doctors.

The hospital's reported total absenteeism rate for May 2022 was 3.5% excluding COVID-19 absenteeism, which when included increased the absenteeism rate to 5.27%. The hospital's rate of absenteeism was lower than Ireland East Hospital's Group overall rate of 4.7% and below the national rate of less than or equal to 4%. Supports in place to address absenteeism are discussed further under national standard 6.4.

Staff training and education

The Quality and Patient Safety Executive had oversight of the staff uptake of mandatory training. The Director of Human Resources also provided an update on the uptake of mandatory training at meetings of the executive management team.

Staff were required to complete online mandatory training in relation to fire training, hand hygiene and manual handling. Staff were also required to complete mandatory and essential training relevant to their scope of practice and role. Staff uptake of online mandatory training was recorded on the hospital's electronic training system and attendance at training was monitored by the hospital's Learning and Organisational Development Department. Attendance and uptake of mandatory and essential training in relation to the four areas of known harm was also recorded at local clinical area level. Further details on staff uptake of mandatory and essential training is provided under national standard 3.1.

Overall, the hospital had management arrangements in place to manage, support and oversee the delivery of safe and reliable healthcare in the wider hospital and clinical areas visited on the days of inspection. Notwithstanding this, there were staffing deficits in all clinical areas visited during HIQA's inspection and while HIQA acknowledges that hospital

management were actively working to address staff vacancies across all disciplines, the short-term measures of using agency and staff working extra shifts to fill shortfalls in the roster is not sustainable and is a patient safety risk.

Judgment: Partially compliant

Inspection findings relating to the Emergency Department

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

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

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. Staffing levels for medical staff in the emergency department were maintained at levels to support the provision of 24/7 emergency care.

The emergency department had 8.53 WTE consultants in emergency medicine. One of the consultants in emergency medicine was the assigned clinical lead for the department and was responsible for the day-to-day functioning of the department. The consultant was operationally accountable and reported to the hospital's Clinical Lead for the Medicine and Emergency Medicine Directorate. All nine consultants in emergency medicine were on the specialist register with the Irish Medical Council. One consultant had sessional commitments in other hospitals within the St Vincent's Healthcare Group.

A senior clinical decision-maker[*******] at consultant level was on site in the emergency department each day, with availability on a 24/7 basis. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed.

The hospital was an approved training site for non-consultant hospital doctors on the basic training and higher specialist training schemes in emergency medicine. Consultants in the emergency department were supported by 33 WTE non-consultant hospital doctors at registrar, senior house officer and intern grades, providing 24/7 medical cover in the department — 13 registrars and 15 senior house officers. Five WTE (15%) of the 33 non-consultant hospital doctor positions were unfilled at the time of inspection — four at

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

registrar grade and one at senior house officer grade. Just under half (45%) of the non-consultant hospital doctors were on a training scheme.

The emergency department's approved nursing staff (including management grades) complement was 77.52 WTE. On the first day of inspection, the department's actual nursing staff complement was 75.64 WTE. This represented a variance of 1.88 WTE, a difference of 2.4% between the approved and actual nursing staff complement. Hospital management were managing the difference in nurse staffing levels through an ongoing recruitment campaign, the use of agency nurses and existing staff working additional hours, which is not sustainable in the long-term.

On the first day of inspection, the department were running short on the number of nurses rostered on day and night shift. The department did not have its full rostered complement of 18 WTE staff nurses (including management grades) on day duty and 18 WTE staff nurses (including management grades) on night duty. Due to short-term absenteeism, the department was short two WTE (11%) staff nurses on day duty and four WTE (22%) staff nurses on night duty.

Inspectors reviewed nursing staff rosters from the preceding four-week period and these showed that short-term absenteeism did impact on the department's nurse staffing levels. During this period, the department was short in the range of four to eight (22%-44%) staff nurses during the day and three to nine (16-50%) staff nurses at night. While, the shortfall in nurse staffing levels over the four-week period was generally in the mid-20%, inspectors noted that on one occasion it was 44% and on another occasion it was 50%.

The nurse manager for the medicine and emergency medicine directorate had overall nursing responsibility for the emergency department. A clinical nurse manager grade 3 was rostered on duty Monday – Friday during core working hours (8am-6pm). A clinical nurse manager grade 2 was rostered on each shift (day and night). Nursing staff were supported by 15 WTE healthcare assistants — six were rostered on day duty and six on night duty. However, rosters from the preceding four-week period showed that, due to short-term absenteeism, the department was short in the range of one to three (17%-50%) on the rostered complement of healthcare assistants during some day and night shifts.

The hospital will be included in the phase 2 roll out of the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*, launched by the Minister of Health in June 2022.[†††††††] This framework supports emergency department nurse managers and hospital management to assess and plan their nursing and support staff workforce to meet the needs of their specific emergency care setting. The framework will

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

help determine if an uplift in nursing and support staff is required for the emergency department at St Vincent’s University Hospital.

Other members of the multidisciplinary team in the emergency department included:

- five advanced nurse practitioners
- an infection prevention and control nurse
- a clinical pharmacist
- three clinical skills facilitators
- a general practitioner (GP) liaison nurse
- other health and social care professionals — medical social worker, occupational therapist, psychiatric liaison nurse and physiotherapist.

Medical and nurse staffing was an identified risk recorded on both the medical directorate risk register and hospital’s corporate risk register. Hospital management had enacted controls and actions to mitigate this risk and these controls were reviewed and updated every month at meetings of the executive management team and Medicine and Emergency Medicine Directorate.

It was evident from staff training records reviewed by inspectors that nursing and medical staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The hospital had a system in place to monitor and report on staff attendance at mandatory and essential training. Essential training relevant to the four areas of harm was overseen by the clinical nurse manager and clinical skills facilitators assigned to the emergency department.

HIQA found that the percentage of staff attendance and uptake at mandatory and essential training could be improved. Training records for nursing staff showed that:

- 55% of nurses were compliant with hand hygiene practices – significantly below the HSE’s target of 90%
- 55% of nurses were up to date in basic life support training
- 55% of nurses were up to date with training on the national early warning system
- 55% of nurses were up to date with training on the national maternity warning system
- 96% of nurses were up to date with training on medication safety

- all nurses were up to date in training on national guidance in clinical handover and Introduction, Situation, Background, Assessment, Recommendation (ISBAR)[‡‡‡‡‡‡‡] communication tool
- 55% of nurses were up to date in training on the Manchester Triage System.

Training records for medical staff showed that:

- 31% of medical staff were up to date in basic life support training

Overall, HIQA found that as a result of short-term absenteeism, the emergency department had a shortfall of two WTE on the number of nurses rostered on the first day of inspection. Immediate risks to patients posed by this deficit were being prevented by the use of agency staff and existing staff working overtime to maintain the nursing roster, but this is not sustainable in the long term. However, a review of nursing rosters for the four-weeks previous to HIQA's inspection, showed that there were significant shortfalls in the number of nurses rostered and the actual number of nurses on duty during the day and at night. Generally, the shortfall in nursing staff was in the range of the mid 20% however, on one occasion it did reach 44% during the day and 50% at night. HIQA was concerned about the potential patient safety risk as a result of the nurse staffing shortfall. Hospital management need to plan, organise and manage their workforce to ensure the service is responsive to changes in workload or resources to ensure the delivery of high-quality, safe services. Furthermore, staff attendance at and uptake of mandatory and essential training is an area that needs to be improved. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should be readily fixable, and should represent a key focus for early improvement efforts following this inspection.

Judgment: Partially compliant

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[§§§§§§§] Staff working in the

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

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

hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed by inspectors to be kind and caring towards patients in the department.

On day one of the inspection, inspectors observed patients' privacy and dignity promoted and respected during clinical assessments and when providing care. Curtains were drawn around patients accommodated in multi-occupancy areas and the doors of single rooms were closed. Patients sitting on a chair awaiting admission were provided with a blanket at night and were provided with light meals and drinks throughout the day. On day two of the inspection, inspectors observed four patients accommodated on trolleys on corridors in the emergency department. The privacy and dignity of these patients could not be protected in the same way as those accommodated in cubicles and multi-occupancy areas. Maintaining confidentiality in such a location was also difficult.

These findings were consistent with the findings from the 2021 National Inpatient Experience Survey, where in relation to questions specifically related to the emergency department, the hospital's score was similar to the national average score. Specifically, with regard to:

- communication with doctors and nurses in the emergency department, the hospital scored 8.0 (national average - 8.0)
- privacy when being examined or treated in the emergency department, the hospital scored 8.2 (national average - 8.3)
- being treated with respect and dignity in the emergency department, the hospital scored 8.8 (national average - 8.8).

The hospital had implemented a number of person-centred initiatives to improve the experiences of older persons attending the emergency department and or to reduce or avoid the need for these patients to come to the emergency department. These included:

- Older Persons Assessment Hub (OPRAH) — there was a designated area in the emergency department where older persons were assessed by a multidisciplinary team and a plan of care developed, which integrated relevant services in the community. The service is led by the geriatric emergency medicine consultant in the emergency department and staffed from the existing complement of staff in the department. The service had two designated advanced nurse practitioners who were Older Person Assessment Liaisons (OPAL).
- Emergency Department in the Home (EDITH) — this service was developed to support frail and older persons living in the catchment area of the hospital who require additional support to be able to remain in their home or place of residence. The team comprised a non-consultant hospital doctor at registrar grade in emergency medicine or geriatric medicine and or an advanced nurse practitioner in geriatric medicine and an occupational therapist to support the provision of care in the person's home or place of residence. The service refers patients to a range of

different pathways according to their assessed needs, for example, primary care referral to the GP or Public Health Nurse, the Community Intervention Team,[********] hospital outreach pathways and community pathways. The service was operational during the week (Monday to Friday) 10.00am to 8.00pm and at the weekends (Saturday and Sunday) 8.00am to 6.00pm.

- Working with the Community Intervention Team to identify those patients where enhanced services or acute intervention may be needed for a defined short period of time, which may be provided at home, in a residential setting or in the community, as deemed appropriate and thereby facilitate early discharge.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital, and this is consistent with the human rights-based approach to care supported and promoted by HIQA. Notwithstanding the initiatives implemented for the older person, the practice of boarding admitted patients in the emergency department impacted on the effective functioning of the department as evident by the patient experience times, and did impact on any meaningful promotion of the patient's human rights and assistance with personal care. This challenge was recognised by hospital management on the days of inspection.

Judgment: Partially compliant

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

The hospital collected data on a range of different quality and safety indicators related to the emergency department, in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times. Collated performance data and compliance with relevant national key performance indicators was reviewed at meetings of relevant governance and oversight committees — Emergency Department Operations Working Group, Executive Management Team, Medicine and Emergency Medicine Directorate and performance meetings with the St. Vincent's Healthcare Group and Ireland East Hospital Group.

[********] A Community Intervention Team (CIT) is a specialist, health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services or acute intervention for a defined short period of time, which may be provided at home, in a residential setting or in the community as deemed appropriate, thereby avoiding acute hospital attendance or admission, or facilitating early discharge.

Performance data on the patient experience time collected on day one of inspection, showed that at 11.00am, the hospital was not compliant with any of the national key performance indicators for the emergency department set by the HSE. At that time:

- 34 (61%) attendees to the emergency department were in the department for more than six hours after registration. This was not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 31 (55%) attendees to the emergency department were in the department for more than nine hours after registration. This figure falls short of the national target of 85% of attendees being admitted to a hospital bed or discharged within nine hours of registration.
- Seven (13%) attendees to the emergency department were in the department for more than 24 hours after registration. The department was below the national target which aims for 97% of patients to be admitted to a hospital bed or discharged within 24 hours of registration.
- 17 (30%) attendees to the emergency department were aged 75 years and over. 65% (14) of these patients aged 75 years and over were admitted or discharged within nine hours of registration. This was not in line with the national target that 99% of patients aged 75 years and over be admitted to a hospital bed or discharged within nine hours of registration.
- Two (12%) attendees to the emergency department aged 75 years and over were not discharged or admitted within 24 hours of registration. The national target for this indicator was 99%, which the department fell short of.

Hospital management had developed a quality improvement plan to address findings of the National Inpatient Experience Survey related to communication and dignity, respect and privacy.

Similar to other emergency departments, the hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In June 2022, 11% of ambulances that attended the hospital's emergency department had a turnaround time interval less than 30 minutes, which further demonstrates how the issue of ineffective patient flow in the emergency department affects the timely offload and review of patients.

Risk management

Risks were managed at emergency department level with oversight of the process assigned to the clinical nurse manager grade three and the Assistant Director of Nursing for the emergency department. Risks that could not be managed at local and directorate level were escalated to and recorded on the hospital's organisational risk register. At the time of inspection, there were five risks recorded on the medical directorate's risk register, two of

the risks related to the emergency department — capacity and risk of transmission of COVID-19. Both risks were risk-rated high — the risk related to capacity was risk-rated red, with a score of 20 and the other risk related to the transmission of COVID-19 was also risk-rated red, with a score of 20. Actions and controls to manage and minimise the risks were set out in the hospital's organisational risk register and inspectors identified evidence of the actions and controls being applied to reduce the identified risk. Organisational and directorate risk registers were reviewed and updated at monthly meetings of the executive management team and Medicine and Emergency Medicine Directorate. Risks not managed at hospital level were escalated to the St Vincent's Healthcare Group Board.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were screened for signs and symptoms of COVID-19 and assigned to the appropriate pathway. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single cubicles. Staff confirmed that terminal cleaning[††††††††] was carried out following suspected or confirmed cases of COVID-19. The emergency department was generally clean and well maintained. There were no neutral or negative pressure isolation rooms in the department.

Medication safety

A clinical pharmacist was assigned to the emergency department. Medication reconciliation occurred on patient admission. All medication information, policies, procedures protocols and guidelines were available on an educational software application for mobile phones and computers at point of care. Medication safety huddles were provided by pharmacists to staff in the emergency department, when needed.

Deteriorating patient

The hospital was using the INEWS, version 2 observation chart to support the recognition and response to a deteriorating patient in the emergency department. Compliance with the use of, and completion of the INEWS observation chart was audited. There was evidence that action plans were developed to address audit findings and a repeat audit carried out to monitor the effectiveness of change in practice. The emergency medicine early warning system was not used in the emergency department and while there was a plan to implement the system, inspectors were told the date of implementation and roll out was dependent on staffing levels in the department. The ISBAR communication tool was used when requesting patient reviews. Compliance with ISBAR was audited. A multidisciplinary safety huddle was held in the emergency department each day at 8.30am to discuss the activity, staffing and the status of patients in the department. Medical and surgical clinical handover occurred from 3.00pm to 4.00pm and nursing handover occurred at shift

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

changeover (7.30am and 8.00pm). The practice of nursing handover was supported by an up-to-date formalised policy.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers. The hospital used an interdepartmental handover sheet when transferring patients within the hospital.

Management of patient safety incidents and serious reportable events

HIQA was satisfied that patient safety incidents and serious reportable events related to the emergency department were reported in line with the HSE's incident management framework. Patient safety incidents and serious reportable events related to the department were tracked and trended by the quality and patient safety department and feedback on emerging trends and themes was provided to the nurse manager grade three, Assistant Director of Nursing and the directorate nurse manager for the Medicine and Emergency Medicine Directorate. The hospital's Serious Incident Management Team had oversight of the management of serious reportable events and serious incidents that occurred in the emergency department.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally, in accordance with the hospital's complaints policy. Complaints relating to the emergency department were tracked and trended by the quality and patient safety department with oversight from the Quality and Patient Safety Executive. Feedback on emerging trends and themes was provided to the nurse manager grade three and Assistant Director of Nursing for the emergency department, and was shared with nursing staff thereafter.

While acknowledging the many measures that hospital management had implemented to seek to manage patient flow and surge capacity, and reduce the immediate and potential risk to patient safety, HIQA found that the measures implemented to date were not fully effective in managing the issues in the emergency department. On the day of inspection, the level of patients boarding in the department was symptomatic of ineffective patient flow and limited surge capacity. This impacted on the waiting times of those where a decision to admit had been made. Considering the increase in morbidity and mortality associated with prolonged waiting times in the emergency department, this was a concern for HIQA.

Judgment: Partially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). Collated performance data relating to finance, workforce, quality and patient safety risks, including serious reportable events, scheduled and unscheduled care activities, nursing and capital projects was reviewed at monthly performance meetings between the hospital and Ireland East Hospital Group and meetings of the executive management team. The chief clinical director for St Vincent's Healthcare Group attended meetings of the executive management team.

The hospital reported clinical incidents through the National Incident Management System (NIMS).[‡‡‡‡‡‡‡‡] There was evidence that the hospital's timely reporting of clinical incidents (percentage of incidents created within 30 days of date of notification) had improved from 63% to 75% in quarter four of 2021, in line with the HSE's national target of 70%.

Risk management

HIQA was assured that St Vincent's University Hospital had effective structures and processes in place to monitor and manage risk and escalate risk appropriately. The hospital's organisational risk register was reviewed at monthly meetings of executive management team and meetings of the Quality, Safety and Risk sub-committee of St Vincent's Healthcare Group Board. The hospital's Chief Executive Officer (interim) reported on the hospital's high-rated risks to the Ireland East Hospital Group every month.

The hospital submitted copies of their organisational risk register, clinical directorate risk registers and local risk registers related to the clinical areas visited during the course of the inspection to HIQA. All risk registers viewed by inspectors had controls and actions in place to mitigate identified risks. There was evidence that risks that could not be managed at directorate level, such as risks associated with infection prevention and control, insufficient staffing and inadequate inpatient bed capacity were escalated from the directorate risk registers to the organisational risk register. These risks are outlined further in national standard 3.1.

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

The hospital had one patient advice and support lead who acted as the main contact for patients, their families and carers.

Audit activity

St Vincent's Healthcare Group's Clinical Audit Committee had oversight of all clinical audit activity across the hospital group. The committee, chaired by a consultant clinical pathologist, met a minimum of six times a year and was operationally accountable and reported to St Vincent's Healthcare Group Board, in line with its terms of reference. Membership included the Chief Executive Officer (interim), head of clinical audit and the director of quality and safety. The head of clinical audit provided feedback from the Audit Committee to clinical directors. Minutes of meetings of the Clinical Audit Committee submitted to HIQA showed the meetings were well attended, action-orientated and actions were progressed from meeting to meeting.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of reporting, review and management of category one incidents and serious reportable events, which occurred in the hospital and were responsible for ensuring that all patient safety incidents were managed in line with the HSE's Incident Management Framework.

The SIMT was chaired by the hospital's Chief Executive Officer (interim) and membership included clinical directors, patient safety and risk advisor, members of the executive management team and relevant heads of departments, as applicable. The committee met monthly and more recently two weekly and was operationally accountable and reported to the executive management team, in line with its terms of reference. Minutes of meetings submitted to HIQA indicated that preliminary assessments and final review reports were reviewed and attendance at meetings of the SIMT was good. Serious reportable events were tracked and trended each month and reviewed at meetings of the Quality and Patient Safety Executive. In addition, there was governance oversight of serious reportable events by the executive management team and at the monthly performance meetings with the Ireland East Hospital Group.

Management of patient safety incidents

The hospital had systems and processes in place to identify and manage patient safety incidents. Patient safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System, in line with the HSE's Incident Management Framework. The Quality and Patient Safety Executive had governance and oversight of reported patient safety incidents. Patient safety incidents were also discussed at performance meetings with the Ireland East Hospital Group and at the executive management team meetings. Feedback on patient safety incidents was provided

to staff by clinical nurse managers at shift handover. Patient safety incidents related to the four areas of known harm are discussed further under national standard 3.3.

Feedback from people using the service

Findings from National Inpatient Experience Surveys were reviewed at meetings of the Quality and Patient Safety Executive and updates were provided to the executive management team. The hospital was working to implement quality improvement initiatives, in response to the National Inpatient Experience Survey findings (2021). The quality improvement plans were focused on improving discharge summaries and providing discharge specific information to families.

Overall, the hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided. However, the hospital's rate of reported clinical incidents to the National Incident Management System within 30 days of date of notification is less than the national target of 70% and this is something that needs to be reviewed and addressed following HIQA's inspection.

Judgment: Substantially compliant

Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare

The hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare. Staff had access to and were aware of how to access occupational health services and the employee assistance programme through a dedicated page on the St Vincent's Healthcare Group Intranet. Inspectors observed a good working atmosphere between management and staff in the clinical areas visited. Staff recounted being '*well supported in their role*' and having a '*good working relationship*' with line managers and felt that they could raise concerns about the quality and safety of healthcare services. Clinical nurse managers also felt comfortable about escalating concerns to their assistant directors of nursing and felt supported to do so.

Non-consultant hospital doctors who spoke with inspectors felt supported and included as part of the multidisciplinary team, and as members of relevant governance committees, such as the Drugs and Therapeutics Committee and the Deteriorating Patient Committee. The lead non-consultant hospital doctor had responsibility for providing support to non-consultant hospital doctors. Supports provided included information and advice on mental health and medical staff had access to the Employee Assistance Programme. Additional support for non-consultant hospital doctors was also available through the Royal College of Physicians of Ireland. Non-consultant hospital doctors were satisfied with on-call rostering arrangements and felt well supported by consultant colleagues during core and outside

core working hours. Over 90% of non-consultant hospital doctors were on a training scheme and inspectors were told that mentoring and supervision was provided by consultants during core working and outside core working hours.

The hospital had an up-to-date staff planning policy which outlined the human resources directorate's responsibilities for coordinating staff planning and the hospital manager's responsibilities for reviewing and approving resources necessary to meet the needs of patients. The human resources directorate also had responsibilities for the assessment of organisational learning and development needs.

Overall, HIQA was assured that the hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare.

Judgment: Compliant

Quality and Safety Dimension

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

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

Staff promoted a person-centred approach to care and were observed by inspectors as being respectful, kind and caring towards people using the service. Inspectors observed staff offering assistance to patients with their individual needs and protecting their privacy. For example, inspectors observed that privacy curtains were drawn in multi-occupancy rooms when patients were being assessed, receiving personal care or being assisted into bed or when assisting with dressing.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. The clinical areas had single rooms – one clinical area visited had two isolation rooms, one of these rooms had en-suite bathroom facilities. A second clinical area visited had one single room with no en-suite-bathroom facilities. The third clinical area had five single rooms, all with en-suite bathroom facilities and the multi-occupancy rooms in this clinical area also had en-suite bathroom facilities. The lack of en-suite bathroom facilities meant patients with an infection risk or mobility issues had to use commodes in multi-occupancy rooms, which had the potential to impact on their privacy and dignity.

The findings from the 2021 National Inpatient Experience Survey show that the hospital scored 83% in relation to maintaining patient's privacy and dignity on the ward which was slightly below the national score (87%). Patient's personal information in the clinical areas visited during the inspection was observed to be protected and stored appropriately.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care supported and promoted by HIQA. However, the limited number of en-suite bathroom facilities within the hospital impacted on the ability to promote and protect a patient's privacy and dignity, especially those accommodated together in multi-occupancy rooms for infection prevention and control reasons.

Judgment: Substantially compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. For example, inspectors observed staff telephoning a patient's family to provide them with an update on the patient's condition. Staff were also observed responding in a timely and calm way to a patient who was confused and tried to leave the clinical area a number of times.

Inspectors also found evidence of a person-centred approach to care, especially for vulnerable patients receiving care in the clinical areas visited. For example, inspectors observed how staff responded promptly to a falls alarm for patients at risk of falling. One of the clinical areas visited had five low beds[§§§§§§§§] to reduce the severity of the injuries related to falls of vulnerable patients associated with getting in and out of high beds. In another clinical area visited, there was an 'end--of-life suite' where family members visiting a seriously ill relative or a relative at end of life could stay overnight.

Overall, HIQA was satisfied that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care in the three clinical areas visited in the hospital. Relevant findings related to the emergency department are discussed under national standards 1.6 in the emergency department section of this report.

Judgment: Compliant

§§§§§§§§ Low beds can help to prevent harm from falls - particularly for patients with delirium who are at risk of falling out of bed, but who cannot be given bedrails as they might try to climb over them.

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

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*', and had local complaints management guidelines for staff. The director of quality and safety was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints.

The Quality and Patient Safety Executive had oversight of the effectiveness of the hospital's complaints management process. Collated data and information on the hospital's compliance with national guidance and standards on complaint management was submitted to the Quality and Patient Safety Executive and to the Ireland East Hospital Group's complaint managers and patient liaison forum every month. The Quality, Safety and Risk sub-committee of St Vincent's Healthcare Group Board also had oversight of complaints.

The complaints officer reported to the director of quality and patient safety (interim) and was supported by three quality coordinators. The complaints team comprised one WTE patient advice and support lead but, at the time of inspection, the position was not filled on a full-time basis (0.8 WTE was filled with a deficit of 0.2 WTE). The hospital had approval for two WTE patient advice and support administrators, 0.8 WTE of these positions were filled and 1.2 WTE was unfilled. However, despite the unfilled positions, there was evidence that the hospital responded promptly to complaints as per the HSE's '*Your Service Your Say*' policy.

Documentation submitted to HIQA showed that in 2021, 89% of formal complaints were resolved within 30 working days, which was above the HSE's national target of 75% for closing complaints and higher than other hospitals within the Ireland East Hospital Group (84% for voluntary hospitals and 67% for statutory hospitals). In 2022, for the year to date, the hospital had achieved 79% compliance in resolution of formal complaints within 30 working days.

In 2021, the hospital received 2,093 complaints — 142 complaints were formally resolved and 1,951 were resolved at local clinical area level. Complaints (verbal and written) were tracked and trended by the complaints lead to identify emerging themes, categories and the departments involved. Themes identified in 2021, included communication, patients' property and visiting restrictions. The hospital had introduced quality improvement initiatives as a result of some complaints received. For example, during the COVID-19 pandemic, the hospital introduced the '*With Best Wishes*' initiative in response to visiting restrictions, where families and friends could send special messages and photographs to

inpatients. Following the introduction of this initiative, the hospital experienced a reduction of 42% in complaints related to communication.

Staff in the clinical areas visited were knowledgeable about the complaints management process. Staff who spoke to inspectors were aware of how verbal complaints were managed and were provided with feedback on complaints at shift handover. When a formal complaint was made to the quality and safety department, this information was shared with staff on the ward.

Inspectors observed that there was no information about access to advocacy services for patients displayed in the clinical areas visited.

Overall, HIQA was assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

On the day of inspection, inspectors visited three clinical areas and observed that overall, the hospital's physical environment was generally clean with few exceptions. There was evidence of general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning. Hospital management were progressing with plans to refurbish ward areas and one ward was closed due to refurbishment on the days of inspection.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available, with hand hygiene signage clearly displayed throughout the clinical areas. Inspectors noted that hand hygiene sinks throughout the hospital conformed to national requirements.[*********] However, there were non-clinical hand hygiene sinks in some of the dirty utility rooms in some of the clinical areas visited.

The bed pan washer in one clinical area visited was out of service for four months and staff were using a bedpan washer in another clinical area. No risk assessment had been completed regarding this workaround. Inspectors were concerned that the practice presented an infection prevention and control risk and requested that hospital management complete an immediate risk assessment to identify and control any potential risks to patient safety. A risk assessment was completed and inspectors were satisfied that relevant controls, which included a business case for funding for replacement equipment, were put

[*********] 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

in place to potentially mitigate the risk to patients. This needs to be progressed to ensure the measures identified were implemented.

The hospital had implemented processes to ensure appropriate placement of patients with suspected or confirmed communicable disease ─ the infection prevention and control nurse liaised with bed management on the placement of patients daily. Notwithstanding this, the hospital did have a shortfall in isolation rooms and the ageing infrastructure was an infection prevention and control risk recorded on the hospital's organisational risk register.

Infection prevention and control signage in relation to transmission-based precautions was observed in the clinical areas visited. Where precautions were in place, patient charts were stored outside patient's rooms. PPE was available outside isolation rooms and clinical areas where patients with confirmed or suspected infections were accommodated. Staff were also observed wearing appropriate PPE in line with public health guidelines at the time of inspection. Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Doors to isolation rooms were observed opened in all three clinical areas visited and this was brought to the attention of the clinical nurse managers. More stringent attention is required to ensure that the doors to isolation rooms are closed at all times.

Cleaning supervisors and clinical nurse managers had oversight of the cleaning and cleaning schedules in the clinical areas visited, and clinical nurse managers were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe. Environmental cleaning was carried out by an external contract cleaning company who met with the infection prevention and control team weekly. Cleaning staff were available during core working hours and outside of core working hours. Discharge and terminal cleaning was being carried out by designated cleaning staff.

Cleaning of equipment was assigned to healthcare assistants. In all clinical areas visited, inspectors found that while most of the equipment viewed was cleaned, there was some evidence of equipment not being cleaned. Opportunities for improvement in relation to the cleaning of some patient equipment were noted and brought to the attention of clinical nurse managers on the days of inspection.

Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

In summary, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. This included:

- a lack of en-suite bathroom facilities, which increased the risk of cross-infection
- issues with cleaning of equipment

- a bed pan washer that was out of service for four months
- doors of isolation rooms that were left open.

HIQA acknowledges that hospital management were progressing with the refurbishment of ward areas to reduce the risk of infection outbreaks and to support effective cleaning. However, notwithstanding this, the issues identified on the days of inspection did present a potential risk to patient safety.

Judgment: Partially compliant

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

The hospital monitored and reviewed information from multiple sources that included; patient safety incident reviews, complaints, risk assessments, audit findings, infection surveillance reports and patient experience surveys.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in the hospital. The clinical areas visited on the days of inspection had achieved a high level of compliance (over 90%) with environmental audits and the average environmental hygiene audit score across the hospital for quarter one and two of 2022 was 92%, which was above the national HSE target of 90%.

The overall patient equipment audit score across the hospital for quarter one and two of 2022 was 87%. The patient care equipment audit findings for August (2022) for the three clinical areas visited ranged from 76% to 89%. Audit findings were shared with clinical staff and action plans were implemented to address areas of non-compliance. The infection prevention control team, clinical nurse managers and the assistant directors of nursing were responsible for and had oversight of the implementation of action plans arising from audit findings.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infections.[†††††††††] The infection prevention and control team submitted a healthcare-associated infection surveillance report to the Infection Prevention and Control Committee every three months and these

[†††††††††] 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

reports were also shared with consultants and staff in the clinical area. In line with the HSE's national reporting requirements, the hospital reported on rates of:

- *Clostridioides difficile*
- Carbapenemase-Producing Enterobacterales (CPE)
- Hospital-acquired *Staphylococcus aureus* blood stream infections
- Hospital-acquired COVID-19
- staff cases of COVID-19 and outbreaks of COVID-19.

The hospital's patient safety indicator report for quarter one and two of 2022, indicated that:

- the hospital reported between four and 12 new cases of hospital-acquired CPE detected per month
- new cases of hospital-acquired *Clostridioides difficile* continued to rise above the national target rate of target of <2/10,000 bed days
- cases of hospital-acquired *Staphylococcus aureus* blood stream infection continued to rise above the national target rate of <0.8/10,000 bed days
- the hospital's rates for *Methicillin-Resistant Staphylococcus aureus* (MRSA), CPE, *Clostridioides difficile* and COVID-19 were higher in quarter one and two in 2022, when compared to rates for the same periods in 2021.

There was evidence that quality improvement initiatives, such as the upgrading and refurbishment of clinical areas to help effective cleaning, increasing screening for multi-drug resistant organisms and staff education were implemented to address high infection rates.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices at the hospital. These included participating in the HSE's national antimicrobial point prevalence study, audit of antimicrobial stewardship practices and reporting on compliance with ten antimicrobial stewardship-related key performance indicators every three months. The findings of the October 2021 point prevalence survey showed the hospital's use of antimicrobial therapy decreased in 2021 (38.8%) when compared to 2020 (43.2%). This is commendable. The hospital's performance with relevant antimicrobial stewardship key performance indicators were reviewed at meetings of both the Infection Prevention and Control Committee and the Drugs and Therapeutics Committee. Documentation provided to inspectors showed that in quarter two of 2022, five of the key performance indicators for antimicrobial stewardship were below the set target, this is an area that could be improved. Inspectors noted that there was no time-bound action plan identified to address the non-compliance.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were carried out in:

- venous thromboembolism (VTE) prophylaxis[‡‡‡‡‡‡‡‡‡]
- daptomycin dosing and levels
- prescribing of intravenous ferric carboxymaltose
- medication incidents reported every month
- the use of reversal agents in procedural sedation and opioid free anaesthesia audits.

Relevant medication related key performance indicators, clinical audit findings and medication safety incidents were reviewed at monthly meetings of the Drugs and Therapeutics Committee. There was evidence that quality improvement initiatives were introduced to improve medication practices at the hospital. This included the introduction of medication safety huddles on one clinical area visited and in the emergency department. Risk-reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Nursing quality care metrics[§§§§§§§§§] was an agenda item discussed at monthly meetings of the Quality and Patient Safety Executive and data on the metrics was collected every two months. All three clinical areas visited achieved a high score (100%) for medication safety practices in the nursing quality metrics.

Deteriorating patient monitoring

The hospital collated performance data in relation to INEWS audits and the findings were presented at meetings of the Deteriorating Patient Committee, the Quality and Patient Safety Executive and to the St Vincent's Healthcare Group's Clinical Audit Committee.

The hospital audited the use and completion of the INEWS adult patient observation chart and found that the accuracy in calculating the INEWS score increased from 74% in March 2022 to 86.6% in June 2022. However, there was a 4.6% decrease in compliance with increasing the frequency of observations in response to the changes in the patient's condition. A second audit to assess compliance with the INEWS escalation protocol showed that there was poor documentation of the escalation process. HIQA was satisfied that time-bound action plans were developed to implement recommendations to improve the escalation and responses when a patient's INEWS score triggered.

Inspectors reviewed 20 INEWS charts and found that the charts were completed correctly in all 20 records. However, inspectors noted that while there was evidence of compliance

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‡‡‡‡‡‡‡‡‡ Venous thromboembolism (VTE) prophylaxis consists of pharmacologic and non-pharmacologic measures to diminish the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE).

§§§§§§§§§ Quality care metrics provide a measuring system that is specific to the measurement of nursing and midwifery care processes in individual care areas.

with the INEWS escalation protocol, not all charts reviewed were fully compliant with the hospital's policy in relation to the documentation of the escalation and plan of care. There was limited use of the ISBAR communication tool to support communication between healthcare staff and the medical team in relation to patients whose condition had deteriorated. These findings were brought to the attention of the clinical nurse managers on the days of inspection.

Transitions of care monitoring

The hospital's bed management department monitored performance data in relation to the average length of stay for medical and surgical patients, bed occupancy rates, admissions, transfers, delayed discharges, waiting list and emergency department patient experience times. On the day of inspection, the average length of stay for medical patients was 10.5 days, which is above the HSE's target of less than or equal to seven days. The average length of stay for surgical patients was 6.6 - 7.0 days, which is above the HSE's target (less than or equal to 5.2 days).

The hospital monitored compliance in using the patient handover form introduced in January 2022, to support staff and care teams to communicate essential patient information when patients were transferring from one area to another area within the hospital. There was evidence from audit and re-audit findings that the rate of compliance with the use of the form had increased from 55% in April 2022 to 83% in August 2022. This is commendable.

Inspectors observed performance data displayed on performance boards in the clinical areas visited. Staff in the clinical areas visited told inspectors that audit findings including INEWS audits results were shared with staff at clinical handover.

Overall, HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to the hospital's executive management team, the St Vincent's Healthcare Group Board and the Ireland East Hospital Group on the quality and safety of the services provided at the hospital. However, the hospital needs to continue to effectively monitor INEWS audit findings, equipment audit findings, patient flow and antimicrobial stewardship performance indicators to continually improve the quality and safety of the service. Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with standards and guidance, it identifies areas for improvement and provides hospital management, and people who use the service with assurances on the quality and safety of the care and services provided.

Judgment: Substantially compliant

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

The hospital had systems and processes in place to proactively identify, evaluate and manage immediate and potential risks to people using the service. Risks in relation to the four areas of known harm were recorded on the hospital's organisational risk register, which was reviewed at monthly meetings of the hospital's executive management team, St Vincent's Healthcare Group Board and the Ireland East Hospital Group. The hospital's organisational risk register had controls and actions in place to mitigate the recorded risks. High-rated active risks recorded on the hospital's organisational risk register related to this monitoring programme included:

- Infection prevention and control: risk due to a lack of single rooms and en-suite bathroom facilities, ageing infrastructure, limited inpatient bed capacity, limited screening for multi-resistant drug organisms and infection prevention and control resources.
- Workforce: insufficient staffing resources to manage increasing organisational workloads.
- Communication: risk associated with delayed receipt of discharge letters and outpatient clinical letters by general practitioners (GPs).

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

Infection prevention and control

The infection prevention and control team maintained a local infection prevention and control risk register which was reviewed every six months by the chair of the Infection Prevention and Control Committee. Risks that could not be managed locally were escalated to the executive management team and recorded on the organisational risk register.

Infection outbreak preparation and management

HIQA was satisfied that the hospital screened patients for multidrug resistant organisms. This included screening patients who were transferred from other hospitals or institutions, patients with a history of multidrug resistant organisms and all inpatients who were in the hospital for more than 30 days. Patients who were suspected or symptomatic for COVID-19 were screened at point of entry to the hospital. Patients were screened on admission for CPE. Between January and August 2022, 72% of patients admitted to the hospital was screened for CPE, which represented a 10% increase in compliance with national guidelines[**********] when compared to CPE screening levels of 67% in 2021. However, HIQA

[**********] Health Service Executive. *Requirements for Screening for Carbapenemase Producing Enterobacterales (CPE)*. 2019. Available online from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-

noted that not all patients with an infective status were isolated within 24 hours of admission or diagnosis as per national guidance. This practice needs to be addressed.

In 2021, the hospital had 13 infection outbreaks which included ten COVID-19 and three CPE outbreaks. In 2022 (January to August), there were a total of 43 COVID-19 outbreaks and five CPE outbreaks with three opened at the time of inspection. A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks. The infectious diseases outbreaks summary report of 2021 submitted to HIQA was comprehensive and outlined control measures, potential contributing factors and recommendations to reduce recurrence of a similar outbreak. HIQA was also provided with a copy of a CPE outbreak summary report for 2022, action plans were developed to ensure the implementation of recommendations from outbreak reports. For example, the following measures were implemented in 2022 to reduce the incidence of CPE outbreaks at the hospital:

- screening of all patients on admission for CPE and weekly screening in outbreak areas
- weekly environmental screening of water outlets and regular dosing of drains in the affected areas and daily placement of appropriate chemicals in sink outlets
- ongoing infection prevention and control education for staff on outbreak wards.

At directorate level, the directorate's nurse manager, assistant directors of nursing and clinical nurse managers at clinical area level, had responsibility for and oversight of the implementation of recommendations from infection outbreak reports. Staff on the wards visited confirmed that infection prevention and control link nurses provided refresher training to staff. The consultant microbiologist also visited the clinical areas weekly and more often, when required.

Medication safety

HIQA was satisfied that the hospital had implemented risk-reduction strategies for high-risk medicines. The hospital had a list of high-risk medications. Inspectors observed the use of risk-reduction strategies to support safe use of medicines in relation to anticoagulants, insulin and opioids in the clinical areas visited. The hospital had also developed a medication prescription and administration record, which included a section to support safe prescribing, monitoring and administration of antimicrobials requiring therapeutic drug monitoring and a specific section to enhance safe prescribing of anticoagulants and had a separate insulin medication record.

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programmes/hcai/resources/cpe/requirements-for-screening-for-carbapenemase-producing-enterobacterales-cpe-april-2019.pdf

The hospital had developed a list of sound-alike look-alike medications (SALADs)[††††††††††] and inspectors observed SALAD alert stickers on sound-alike look-alike medications. Inspectors observed medication safety information displayed on noticeboards in treatment rooms. Staff had access to up-to-date medicines information at point of prescribing, preparing and administration. Medication safety alerts related to oral anticoagulants and memos related to drug shortages were emailed to clinical nurse managers for sharing with staff. Clinical areas had a clinical pharmacist service, and medication reconciliation was completed for patients on admission.

Deteriorating patient

The hospital had implemented the INEWS version 2 observation chart and staff in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient and reported that there was no difficulty accessing the medical team to review a deteriorating patient. In addition, the hospital had an outreach critical care team who reviewed patients with a high early warning score in any clinical area. The critical care outreach team also visited wards (Monday - Friday during core working hours) to review patients up to 48 hours following discharge from the hospital's Intensive Care Unit and the relevant non-consultant hospital doctor at registrar grade (medical or surgical) reviewed patients at the weekend.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. The hospital had a discharge coordinator to facilitate effective discharge planning across all clinical directorates. Structures in place to support effective transitions of care included:

- daily multidisciplinary team meeting to review inpatient bed capacity and demand
- fit for home initiative, which included setting a planned date for discharge on admission, patient referral to a multidisciplinary team and referral to community support services, if required
- using a universal referral form to support the referral of patients to a rehabilitation unit, stepdown beds or convalescence beds, when delays are encountered with discharging patients home.

A multidisciplinary team clinical handover was held daily at 8.15am where on-call consultants and medical staff shared information in relation to patients admitted during out of hours to specific teams that required review.

[††††††††††] SALADS are 'Sound-alike look-alike drugs'. The existence of similar drug and medication names is one of the most common causes of medication error and is of concern worldwide. With tens of thousands of drugs currently on the market, the potential for error due to confusing drug names is significant.

To support patient flow, access to beds and effective discharge planning, the hospital had set up a Productive Patient Journey Taskforce to implement new and enhanced processes to support continuous, effective patient flow in St Vincent's University Hospital, in conjunction with primary care, St Michael's Hospital, St Vincent's Private Hospital, St Columcille's Hospital, Ireland East Hospital Group and Community Health Organisation 6 (CHO 6).

Information on patient flow was available on the hospital's electronic system. The hospital experienced challenges with the mismatch between inpatient bed capacity and demand, this included demand for patient beds transferred back to St Vincent's University Hospital from other hospitals following treatment. The hospital had recently secured funding from the HSE to scope out a capacity review that would inform future capital development projects.

Policies, procedures and guidelines

The hospital had a suite of up-to-date policies, procedures and guidelines in relation to all four key areas of harm monitored on this inspection. All policies, procedures, protocols and guidelines were accessible to staff via a computerised document management system.

Uptake of mandatory and essential training

The hospital's Learning and Organisational Development department tracked staff uptake of online mandatory training using an electronic training system. On the days of inspection, there was evidence that clinical nurse managers had oversight of the uptake of training for their clinical area.

The hospital had mandatory training programmes for infection prevention and control, medication safety and INEWS. Formal and informal training relevant to infection prevention and control was set out in the annual plan for 2022 and included training on hand hygiene and transmission-based precautions.

Staff uptake of mandatory training in hand hygiene in the last 24 months was:

- 75% for nursing staff - below the HSE target of 90%. Inspectors noted that there was evidence that staff in the three clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices from March to June 2022.
- 71% for healthcare assistants - below the HSE target of 90%.
- 25% for medical staff - below the HSE target of 90%.

Staff uptake of mandatory training in standard and transmission-based precautions in the three clinical areas visited was:

- 100% for both nursing staff and healthcare assistants.

- records for uptake of mandatory training in standard precautions and transmission-based precautions for medical staff were not submitted to HIQA.

Staff uptake of mandatory training in donning and doffing of personal protective clothing in the three clinical areas visited was:

- 100% for both nursing staff and healthcare assistants.
- records for uptake of mandatory training in donning and doffing of personal protective clothing for medical staff were not submitted to HIQA.

Training relevant to medication safety was included in induction training for medical staff which included training on safe prescribing. Nursing staff were also provided with medication safety training as part of their induction training. The uptake of mandatory training in medication safety in the last two years was:

- 87% of nursing staff
- records for uptake of mandatory training in medication safety for medical staff were not submitted to HIQA.

The uptake of mandatory training in INEWS V2 in the last two years was:

- 53% of nursing staff – below HSE target of 85%
- 66% of nurses completed IMEWS training
- records for uptake of mandatory training in INEWS for medical staff were not submitted to HIQA
- 82% of nurses had completed training on clinical handover
- 55% of nurses were up to date in training on the Manchester Triage System.

Non-consultant hospital doctors who spoke with inspectors reported that they have a national employment record where they update their mandatory and essential training.

Other training was also provided for staff, such as

- 73.6% of nursing staff had completed falls and harmful falls prevention and management learning training
- 67.14% of nurses had completed fundamentals of delirium training
- 43% of nursing staff and 29% of healthcare assistants had completed end-of-life care and final journey workshop training.

Staff uptake of the flu vaccine in 2021, was reported as 89.2% for medical staff and 58% for nursing staff and healthcare assistants, which was below the HSE target of 75%. Increased uptake of flu vaccine among nursing staff and healthcare assistants needs to be promoted by hospital management.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk and harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. Efforts were made by hospital management to provide mandatory training over the period of the COVID-19 pandemic. Notwithstanding this, staff attendance at and uptake of mandatory and essential training is an area that could be improved. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Judgment: Substantially compliant

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

The hospital had 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. The Quality and Patient Safety Executive had governance and oversight of reported patient safety incidents. Patient safety incidents were also discussed at performance meetings with the Ireland East Hospital Group and at the executive management team meetings.

Clinical incidents were tracked and trended, this included serious reportable events, medication safety incidents, hospital-acquired pressure ulcers, challenging behaviour, falls and infection prevention and control incident rates. The top ten clinical incidents reported in 2021 included incidents related to staffing, patient flow and communication (clinical handover).

Staff who spoke with HIQA were knowledgeable about how to report a patient safety incident and were aware of the most common patient safety incidents reported — falls and pressure ulcers. Inspectors were informed that clinical incidents were reviewed by the assistant directors of nursing and clinical nurse managers for each clinical area and reviewed at meetings of each clinical directorate.

Information relating to patient safety incidents was shared with staff at shift handover. Staff also had access to the quality and safety electronic dashboard system to view patient safety incident trends.

Infection prevention and control incidents

The infection prevention and control team reviewed all infection prevention and control related patient safety incidents and made recommendations for corrective action or preventative measures. Infection prevention and control related patient safety incidents were reported monthly to the Quality and Patient Safety Executive. The hospital was

tracking and trending infection prevention and control patient safety incidents and had introduced measures to improve patient safety in this area.

Medication safety incidents

The medication safety coordinator and the chair of the Drugs and Therapeutics Committee reviewed medication safety incidents and escalated high-risk medication safety incidents to the Medical Executive and to the Quality and Patient Safety Executive. Medication safety incidents were categorised according to National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). There were 593 medication safety incidents reported in the hospital in 2021, a decrease of 11% when compared to 2020. The Drugs and Therapeutics Committee produced a monthly and an annual medication incident report. The annual report for 2021 detailed the medication safety incidents by preventable and non-preventable incident trends, by category and by location. The report also outlined the actions taken in response to the incident findings.

The deteriorating patient and incidents

Clinical incidents related to the deteriorating patient were discussed at the Deteriorating Patient Committee meetings. In quarter one of 2022, 20 patient safety incidents related to the lack of compliance with the escalation protocol for INEWS and interdepartmental clinical handover were reported. There was evidence that the hospital had implemented quality improvement initiatives to improve practice.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient safety incidents, in particular, in relation to the four key areas of harm. The hospital was tracking and trending infection prevention and control patient safety incidents and had introduced practice to improve patient safety.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of St Vincent's University Hospital to assess compliance with 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.

Capacity and Capability

St Vincent's University Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare with effective oversight by the Board of Directors of St Vincent's Healthcare Group and the Ireland East Hospital Group. The hospital had defined management arrangements in place

to manage and oversee delivery of care in the emergency department and at wider hospital level.

On the days of the inspection, there was evidence of strong clinical and nursing leadership in the emergency department. However, circumstances such as high numbers of attendances to the department combined with limited surge capacity and reduced access to transitional, rehabilitation and step-down beds in the community impacted on the continuous and effective flow of patients through the emergency department and the boarding of admitted patients. Hospital management had implemented a range of measures to improve the flow of patents in the department and increase surge capacity, but it was evident from findings on day one of inspection, that the measures implemented to date were not fully effective in managing the potential patient safety risks associated with lengthy stays in the emergency department. Other patient pathways, such as the Acute Medical Assessment Unit and Acute Medical Unit were not functioning as designed, as an alternative flow pathway for patients in order to take pressure from the emergency department.

HIQA was assured that the hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided. There was good audit activity in the hospital. However, there was evidence that time-bound action plans were not always developed to support the implementation of all recommendations. Action plans can provide a framework to implement recommendations from reports and ensure that identified changes are made to improve healthcare services.

The hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare. Staff who spoke with inspectors were positive about how they were supported by their clinical nurse managers and by senior hospital managers. However, there were staff deficits across all the clinical areas visited and this impacted on the delivery of high-quality, safe care especially in the emergency department. The use of agency nursing staff and existing staff doing overtime to fill the rosters is not sustainable. HIQA acknowledges that senior management were actively working to recruit staff.

Quality and Safety

The hospital promoted a person-centred approach to care. Hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital, and this is consistent with the human rights-based approach to care supported and promoted by HIQA. However, the practice of boarding admitted patients in the emergency department impacted on any meaningful promotion of the patient's human rights and assistance with personal care. In the wider hospital, patient's privacy and dignity was generally well promoted in the clinical areas visited.

People who spoke with inspectors were largely positive about their experience of receiving care in the emergency department and wider hospital and were complimentary of staff. The hospital had developed a plan to act on findings from the National Inpatient Experience Survey.

HIQA found that the hospital's physical environment did not fully support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of en-suite bathroom facilities, which increased the risk of cross-infection. HIQA acknowledges that hospital management were progressing with upgrading and refurbishing of some wards to support effective cleaning and reduce the risk of transmission of infections. However, the ageing infrastructure did present challenges to the delivery of care.

The hospital had systems in place to identify, monitor and manage identified potential risk and patient safety incidents associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital also had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service and patient safety incidents. However, the hospital was not meeting the HSE target of recording incidents in the national incident management system within 30 days of occurrence.

Efforts were made by hospital management to provide mandatory training over the period of the COVID-19 pandemic. Notwithstanding this, staff attendance at and uptake of mandatory and essential training is an area that could be improved. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

In summary, HIQA found variation in compliance with the nationals standards assessed during the course of the inspection. There was a good level of compliance with national standards in the inpatient clinical areas visited on the days of inspection. However, this was not the case in the emergency department, where insufficient patient flow and limited surge capacity contributed to the boarding of inpatients in the department. Deficits in staffing levels, especially nurse staffing levels was a consistent finding across all clinical areas visited and it was evident, as outlined in this report that the deficit impacted on the delivery of high-quality, safe care and posed a significant patient safety risk.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with mandatory training and improvements of the physical environment at the hospital.

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

Compliance classifications

Following a review of the evidence gathered during the inspection a judgment of compliance has been made under each standard monitored on how the service performed. The monitoring of judgments is included in the inspection report and where a non-compliance with the standards is identified, a compliance plan is issued by HIQA. It is the healthcare service provider's responsibility to ensure that it implements the actions in the compliance plan within the set time frames.

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

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
National Standard	**Judgment**
Theme 6: Workforce	
Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare.	Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient safety incidents.	Substantially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for St Vincent's University Hospital

Compliance Plan for St Vincent's University Hospital OSV-0001099

Inspection ID: NS_0013

Dates of inspection: 30 and 31 August 2022

Introduction This document sets out a compliance plan for service providers to outline intended action(s) following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare*. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.
This compliance plan only relates to:

- national standards that were deemed **partially or non-compliant** by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

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

Instructions for use

The service provider must complete this plan by:

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

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

- Specific to the standard.
- Measurable so that it can monitor progress.
- Achievable.
- Realistic.
- Time bound.

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Service Provider's responsibilities

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

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate action(s) to address the areas of risk previously identified by HIQA inspectors, may result in continued monitoring including further inspection activity. It may also result in further escalation in the HSE to the relevant accountable person, in line with HIQA policy.

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

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

In addition to detailing longer term solutions, HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed

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- information on short and medium-term mitigation measures to manage risks and improve the level of compliance with national standards should be included on the compliance plan
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are as follows:

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

Stage-3 In

Compliance Plan

Compliance Plan Service Provider's Response

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

St Vincent's University Hospital is committed to ensuring the delivery of high quality, safe and reliable healthcare services across the whole organisation.

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards.

- The National Safe Staffing Framework has been implemented in 7 ward areas in St Vincent's University Hospital **(current)** with an additional 13 ward areas scheduled to be completed **(Q4 2022)**
- Mandatory training and essential training will continue to be prioritised for all nursing and healthcare assistants, appropriate to their scope of practice **(ongoing)**
- Mandatory training compliance will be monitored through the Hospital Executive Management Team with reports of staff compliance provided to Line Managers and Heads of Department on a monthly basis **(ongoing)**
- One hundred and seventy six nurses have been recruited for all clinical areas in the hospital **(Quarter 4 2022**).
- Mandatory Training Compliance rates are available for all employees and managers on the on line HR Self Service System (MyView) for Hand Hygiene, Patient and Manual Handing and Fire Training **(current)**
- Life Support training (ACLS, BLS and Heartsaver) are being added to the self-service portal so employees and managers can review compliance (**January 2023)**
- Blood Transfusion Training to be added to the HR Self Service System (MyView) so employees and managers can review compliance **(December 2022)**
- Additional external Physiotherapy support secured to increase the places for Patient Handling training. **(November 2022)**
- Continuous communication by HR (Learning and Organisational Development) with Heads of Department and provision of the overall hospital compliance figures for Mandatory Training, Hand Hygiene (every 12 months) Fire Training (every 2 years) and Manual and Patient Handling (every 3 years) **(ongoing)**
- Development of action plans to increase BLS and ACLS compliance **(February 2023)**
- Establishment of Mandatory Training Governance Committee in 2021 to have oversight and provide strategic direction regarding all aspects of Mandatory Training **(ongoing)**

b) ***Details of medium to long term plans requiring investment to come into compliance with the standard***

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- The National Safe Staffing Framework will be implemented in the 4 remaining ward areas following the introduction of the Trendcare IT system to the hospital **(subject to the national rollout of Trendcare, planned Quarter 2 2023)**
- Awaiting approval of capital funding to increase Telemetry capacity (**business case submitted to IEHG October 2022)**
- Continued focus of Hospital Management on mandatory training – compliance reports to be reviewed at monthly Executive Management Team meetings **(ongoing)**
- Investment in HR and Learning systems, (Moodle) and HseLand for reporting purposes **(Business case under development for submission end Q1 2023)**

Compliance plan – ED specific

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards as relevant to the Emergency Department

PATIENT FLOW AND PATHWAYS

- Every effort is made to encourage the use of existing patient flow pathways and development of new pathways to support patient flow (**ongoing**) – this is managed through daily operations team meetings led by the Director of Operations where each pathway is reviewed and actions taken as appropriate.
- In the Emergency Department current patient pathways include but are not limited to :EDITH (Emergency Department in the Home); OPRAH (Older Persons Assessment Hub); OPAL (Older Persons Assessment Liaisons) and working with Community teams in CHO6 (**ongoing**)
- Promotion of pre-hospital alternative pathways to signpost older adults to most appropriate care pathway: OAsIS (**O**lder **A**dult**s** **I**ntegrated **S**ervices) **(operational from Q1 2023)**
- Approval to fully resource and establish an Early Supported Stroke Discharge Team on a permanent basis **(October 2022)**
- Productive Patient Journey Taskforce established to implement new and enhanced processes to support continuous, effective patient flow in SVUH in collaboration with CH East and other hospitals within the IEHG **(September 2022)**
- Availability of beds in St Vincent's Private Hospital funded through Winter Plan 2022/2023 to assist in optimising bed capacity (**ongoing with IEHG support & Winter Plan 2022/2023**)
- Daily review of patients in ED with diagnostic requirements with early communication to pathology, radiology & cardiology to ensure prioritisation **(ongoing**)
- Additional ANP cover to AMU/AMAU to further enhance patient care and patient flow through the Ward **(November 2022)**
- Bed Management and Modelling Strategy commenced – aim is to return to ward speciality based care (**November 2022**)
- Enhance the SVPH Public/Private pathways for schedule & unscheduled care (**ongoing supported by IEHG & Winter Plan 2022/2023)**
- Medical Clinical Handover Hub & Escalation meetings (**daily**)
- Pathways currently in place for admission to AMAU-DVT, Syncope, Stroke **(ongoing)**
- Regular review and update of risk register completed by Medical Directorate **(ongoing)**
- Winter plan 2022/23 to support reduction in ambulance delays **(current)**

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- Given national constraint with regard to access to rehabilitation services -SVUH ensuring referral process in place with National Rehabilitation Hospital for transfer out of SVUH to minimise any delays - Twice Weekly rounds **(ongoing)**
- SVUH working within Directorate Model to refine processes relating to inter hospital transfers - to support a balance of access between scheduled and urgent care **(ongoing)**
- SVUH review of the repatriation policy at a Senior Management level to support compliance when other organisations unable to provide a bed for repatriation in a timely manner **(ongoing)**
- SVUH engaged with IEHG & CHO6 to address CHO 6 Capacity for Rehab, Long term Care/ Home Care Support **(ongoing)**
- SVUH currently mid project with IEHG revising systems and services available to support early discharge in the region in place relating for homeless services **(ongoing)**
- SVUH co-ordinating with CHO6 to maximise access to long term care & rehabilitation placements for patient fit for discharge from SVUH **(ongoing)**
- Building systems of referral and assessment with disability services through Medical Social Work service in SVUH and engaging with families to support to maximise available disability support **(ongoing)**
- Participation in IEHG/CH East Winter Planning Action Team **(ongoing)**

INFRASTRUCTURE

- Revised infrastructural arrangements approved to streamline patient flow in ED: Reception to move with ticketing system to modular build (**commencing Q4 2022**)
- Improvement of temperature control at automatic doors repaired to ensure optimum temperature control in treatment zones **(ongoing)**
- Review of infrastructure to improve/support patient care and dignity. Space available for both streams will be reviewed in light of physical distancing requirements & subsequent ED capacity **(ongoing)**
- Way-finder (dementia friendly) painting in progress for Zone 2 (Oprah) **(November 2022)**

NURSING, SUPPORT STAFF & MEDICAL WORKFORCE ARRANGEMENTS

- The Nursing Department in St Vincent's University Hospital has a designated Assistant Director of Nursing for workforce planning **(in place)**
- Proactive recruitment of Nurses and Healthcare Assistants will continue into 2023 based on the turnover rates of previous years including overseas and graduate recruitment campaigns **(ongoing)**
- St Vincent's University Hospital will commence the implementation of the Safe Staffing Framework in the Emergency Department **(end of Quarter 4 2022)**
- In line with the framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland, SVUH ED has allocated a headcount of 94 nursing staff for general ED and 5 WTE for admitted patients which gives a total of 98 WTE, an increase on the existing allocation. An additional 35 nurses (mixture of new graduates & adaptees) will take up positions in the Emergency Department to support reaching safe staffing levels (**end of Quarter 4 2022)**
- Post Grad for Emergency Medicine is encouraged for all new joiners, Department facilitates 8 staff for course at any given time **(10 staff currently progressing)**
- Regular Simulation training in the ED is provided to upskill new and present staff **(weekly)**

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- Additional Clinical Facilitator posts have been approved for ED **(recruitment ongoing)**
- EMCOG (Emergency Medicine Clinical Oversight Group) – monthly meeting, chaired by ED, Director of Operation in attendance **(ongoing)**
- Hand Hygiene training updates arranged and monitoring to improve compliance in ED **(ongoing)**
- Mandatory Training compliance captured as an on-going risk on Medical Directorate Risk Register to support ongoing monitoring as a priority at Directorate level **(ongoing)**
- Recruitment of NCHD's to support the ED to facilitate medical decision making (ongoing)
- Additional ED Consultants approved at the Consultant Application Advisory Committee (CAAC) (**recruitment ongoing)**
- New roster shifts in place to support peak attendance times **(current).**
- Agency staff recruited when roster gaps identified **(ongoing)**
- Mandatory training participation actively encouraged. All staff have access to mandatory training on MyView system. Additional Clinical Facilitator once recruited will oversee and monitor compliance rates **(recruitment ongoing)**

b) details of medium to long-term plans requiring investment to come into compliance with the standard

PATIENT FLOW & PATHWAYS

- Rapid Improvement Event (RIE) Pathway directly out of ED to SCH :Discussion ongoing to develop direct transfer ward to ward pathways - maximum of 3 patients daily accommodated via this pathway **(ongoing)**
- ASU- Expand Acute Surgical Unit capacity (**Business case in progress for submission)**
- Neck of Femur pathway– component of trauma unit designation- build upon current pathway **(ongoing)**
- Cardiology/Chest Pain-patients admitted to CAU (Cardiac Assessment Unit) adjacent to Cardiology ward – part of Acute Medicine programme **(ongoing)**
- Slaintecare submission for ACE team (Accessing Emergency Care) which would provide Prehospital Triage if approved for patients of all ages **(Submitted October 2022)**
- Business case submitted to IEHG to support additional ANPs to facilitate 7 day service and improve safe discharges in AMU/AMAU (**Submitted to IEHG October 2022)**
- Advance Nurse Practitioner (ANP) Virtual clinics in place to support safe discharge and follow up (**ongoing**)
- Two ANP recruited to further support ANP team in Emergency Department , which will further improve patient experience and KPI's **(recruitment completed: Planned start date Q1 2023)**

INFRASTRUCTURE

- Approval at Estates Strategy Meeting to relocate ED pharmacy room, which will improve infrastructure in addition to patient safety **(approval date September 2022, awaiting start date)**
- Review of modular build **(reconfiguration commenced)**

NURSING & SUPPORT STAFF WORKFORCE ARRANGEMENTS

Stage-3 Inspection Report

- National and international recruitment for nurses and Healthcare Assistants will continue with a recruitment campaign for nurses scheduled in the Philippines (**mid-November 2022**).
- Mandatory training and essential training will continue to be prioritised for all nursing and healthcare assistants, appropriate to their scope of practice, monitored by Nursing Practice Development (NPD) **(ongoing)**
- St Vincent's University Hospital will work proactively with IEHG and UCD to increase the number of undergraduate nursing students undertaking their clinical placements in the hospital **(ongoing)**

Stage-3 Inspection Report

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

Compliance plan – ED specific

St Vincent's University Hospital is committed to ensuring the delivery of high quality, safe and reliable healthcare services across the whole organisation.

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards.

NURSING, MEDICAL & SUPPORT STAFF WORKFORCE ARRANGEMENTS FOR ED

- The Nursing Department in St Vincent's University Hospital has a designated Assistant Director of Nursing for workforce planning **(in place)**
- Proactive recruitment of Nurses and Healthcare Assistants will continue into 2023 based on the turnover rates of previous years including overseas and graduate recruitment campaigns **(ongoing)**
- St Vincent University Hospital will commence the implementation of the Safe Staffing Framework in the Emergency Department **(end of Quarter 4 2022).** In line with the framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland, SVUH ED have allocated a headcount of 94 nursing staff for general ED and 5 WTE for admitted patients which gives a total of 98 WTE, an increase on the existing allocation. An additional 35 nurses (mixture of new graduates & adaptees) will take up positions in the Emergency Department to support reaching safe staffing levels (**end of Quarter 4 2022)**
- Post Grad for Emergency Medicine is encouraged for all new joiners, Department facilitates 8 staff for course at any given time **(10 staff currently progressing)**
- Regular Simulation training in the ED is provided to upskill new and present staff **(weekly)**
- Additional Clinical Facilitator posts have been approved for ED **(recruitment ongoing)**
- EMCOG (Emergency Medicine Clinical Oversight Group) – monthly meeting, chaired by ED, Director of Operation in attendance **(ongoing)**
- Hand Hygiene training updates arranged and monitoring to improve compliance in ED **(ongoing)**
- Mandatory Training compliance captured as an on-going risk on Medical Directorate Risk Register to support ongoing monitoring as a priority at Directorate level **(ongoing)**
- Recruitment of NCHD's to support the ED to facilitate medical decision making (ongoing)
- Additional ED Consultants approved at the Consultant Application Advisory Committee (CAAC) (**recruitment ongoing)**
- New roster shifts in place to support peak attendance times **(current)**
- Agency staff recruited when roster gaps identified **(ongoing)**
- Mandatory training participation actively encouraged. All staff have access to mandatory training on MyView system. Additional Clinical Facilitator upon recruitment will oversee and monitor compliance rates **(recruitment ongoing)**
- Regular teaching and simulation provided to all NCHDs in ED. SHO and registrar teaching sessions specific to each group provided **(weekly)**

Stage-3 Inspection Report

MEDICAL

- Recruitment of NCHD's to support the ED to facilitate medical decision making (**ongoing**)
- Additional ED Consultants approved at CAAC (**recruitment ongoing**)
- New roster shifts in place to support peak attendance times **(current)**
- Agency staff recruited when roster gaps identified **(ongoing)**
- Mandatory training participation encouraged by Clinical Director & the ED Consultant Group. All staff have access to mandatory training on MyView system. Compliance rates provided by Learning & Development **(ongoing)**
- Regular teaching and simulation provided to all NCHDs in ED. SHO and registrar teaching sessions specific to each group provided **(weekly)**

b) details of medium to long-term plans requiring investment to come into compliance with the standard

NURSING, MEDICAL & SUPPORT STAFF WORKFORCE ARRANGEMENTS FOR ED

- Recruitment on-going for all disciplines **(current)**
- St Vincent's University Hospital will commence the implementation of the Safe Staffing Framework in the Emergency Department (prior to the end of **Quarter 4 2022)**
- An additional 35 nurses will take up positions in the Emergency Department (**end of Quarter 4 2022**)
- Additional Clinical Facilitators are been employed to support the newly recruited staff and to facilitate the 4 Continuous Professional Development (CPD) Emergency Department programmes in 2023. Ongoing recruitment of Clinical Facilitator roles **(recruitment progressing)**
- National and international recruitment for the Emergency Department will continue with priority given for the recruitment of suitably qualified staff during the campaign scheduled to the Philippines **(mid-November 2022)**
- The provision of CPD ED specific programmes will be prioritised by the Nurse Education Centre with two additional CPD Emergency Department programmes will be provided in 2023 bringing the total provided to 4 for 2023 **(in progress)**
- Proactive recruitment of Nurses and Healthcare Assistants for the Emergency Department will continue based on the turnover rates of previous years **(national & international recruitment ongoing)**

Stage-2 Inspection Report

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

Compliance plan – ED specific

St Vincent's University Hospital is committed to ensuring the delivery of high quality, safe and reliable healthcare services across the whole organisation.

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards.

PATIENT FLOW & PRIVACY

- Improvement in patient flow and progression through ED in a more timely manner as required would support service users' dignity, privacy and autonomy. To that end a number of patient flow initiatives are in progress with additional pathways under investigation **(ongoing)**
- Patients attending with psychiatric presentations are assessed in a designated cubicle or a single room to promote privacy **(current)**
- Admitted patients from ED are prioritised for transfer as soon as bed is allocated on wards **(current)**
- Enhanced care is provided as required as per Enhanced Care pathway **(ongoing)**
- Ticket system to be implemented at reception will enhance patient confidentiality (**commencing Q4 2022**)
- Regular review of patient compliments, complaints & incidents and feedback to staff **(ongoing)**
- Availability of beds in St Vincent's Private Hospital funded through Winter Plan 2022/2023 to assist in optimising bed capacity (**ongoing with IEHG support & Winter Plan 2022/2023**)
- Daily review of patients in ED with diagnostic requirements with early communication to pathology, radiology & cardiology to ensure prioritisation (**ongoing**)
- Additional ANP cover to AMU/AMAU to further enhance care and flow to the Ward **(November 2022)**
- Bed Management & Modelling Strategy commencing-aim is to return to ward speciality based care (**November 2022**).
- SVPH Public/Private pathways (**ongoing supported by IEHG)**
- Medical Clinical Handover Hub (**daily**)
- Pathways currently in place for admission to AMAU-DVT, Syncope, Stroke **(ongoing)**
- National Constraint with regard to access to rehabilitation services - -SVUH ensuring referral process in place with NRH Bed for transfer out of SVUH to minimise any delays- Twice Weekly rounds **(ongoing)**
- SVUH working within Directorate Model to refine processes relating to inter hospital transfer - to support a balance of access between scheduled and urgent care **(ongoing)**
- SVUH review of the Repatriation Protocol at an Senior Management level to support compliance when other organisations unable to provide a bed for repatriation in a timely manner **(ongoing)**

Stage 3 Inspection Report

- SVUH engaged with IEHG & CHO6 to address CHO 6 Capacity for Rehabilitation, Long Term Care **(ongoing)**
- SVUH currently mid project with IEHG revising systems and services available to support early discharge in the region in place relating for homeless services **(ongoing)**
- SVUH co-ordinating with CHO 6 to maximise access to long term care & rehabilitation placements for patient fit for discharge from SVUH **(ongoing)**
- Building systems of referral and assessment with disability services through MSW service in SVUH and engaging with families to support to maximise available disability support **(ongoing)**
- Participation in IEHG/CH East Winter Planning Action Team **(ongoing)**

INFRASTRUCTURE

- Review of infrastructure to improve/support patient care and dignity. Space available for both streams will be reviewed in light of physical distancing requirements & subsequent ED capacity **(ongoing)**
- New arrangements approved to streamline flow: Reception to move with ticketing system to the modular build (**commencing Q4 2022**)
- Improvement of temperature control at automatic doors repaired to ensure optimum temperature control in treatment zones **(ongoing)**
- Way-finder (dementia friendly) painting scheduled for Zone 2 (Oprah) **(November 2022)**

b) Details of medium to long-term plans requiring investment to come into compliance with the standard

PATIENT FLOW & PATHWAYS

- Rapid Improvement Pathway (RIE) directly out of ED to SCH- Revision of pathway to increase capacity and make it more LEAN in process with maximum of 3 patient daily accommodated via this pathway **(ongoing)**
- ASU- Expand Acute Surgical Unit capacity (**Business case in progress for submission)**
- Neck of Femur pathway– component of trauma unit designation- build upon current pathway **(ongoing)**
- Cardiology/Chest Pain-patients admitted to CAU (Cardiac Assessment Unit) adjacent to Cardiology ward **(ongoing)**
- Slaintecare submission for ACE team (Accessing Emergency Care) which would provide Prehospital Triage if approved for patients of all ages **(Submitted October 2022).**
- Business case submitted to IEHG to support additional ANP's to facilitate 7 day service and improve safe discharges in AMU/AMAU **(Submitted to IEHG October 2022).**
- Advance Nurse Practitioner (ANP) Virtual clinics in place to support safe discharge and follow up (**ongoing**)
- Two ANP recruited to further support ANP team in Emergency Department , which will further improve patient experience and KPI's **(recruitment completed, planned start date Q1 2023)**

INFRASTRUCTURE

Stage-3 Inspection Report

- Approval at Estates Strategy Meeting to relocate ED pharmacy room, which will improve infrastructure in addition to patient safety **(approval date September 2022, awaiting start date)**
- Review of Emergency Department modular build annex **(reconfiguration commenced)**

Stage-3 Inspection Report

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

Compliance plan – ED specific

St Vincent's University Hospital is committed to ensuring the delivery of high quality, safe and reliable healthcare services across the whole organisation.

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards.

PATIENT FLOW & SURGE CAPACITY

- Escalation policy being reviewed and for full implementation once signed off by EMT **(November 2022)**
- Wards identified to provide surge capacity (**ongoing)**
- Bone and Joint (2 Cubicles) adjacent to ED is used in times of escalation for admitted patients deemed Fit to Sit **(ongoing)**
- National Ambulance Service (NAS) Winter plan for 2022/23 to be implemented which will provide a Liaison Ambulance Officer on site to de-escalate **(scheduled to start November 2022)**
- Risk register for Medical Directorate/ED reviewed regularly and any new risk identified and preventative measure put in place **(ongoing)**
- Dedicated Surgical Pathway out of ED (**4 patients daily**)
- Navigational hubs and MDT involvement to progress early discharge **(ongoing)**
- Daily Operations & escalation management meeting daily to manage Capacity vs Demand both Scheduled and Unscheduled, chaired by Director of Operations **(ongoing)**
- Medical Clinical Handover Hub **(daily)**
- GP Liaison Committee in place **(ongoing)**

b) Details of medium & long-term plans requiring investment to come into compliance with the standard

- Awareness of requirement to roll out specific INEWS in ED. Plan to implement by late 2023 subject to additional Clinical facilitators commencing **(end 2023)**
- Additional capacity in form of new building required to keep pace with population modelling plans and increased anticipated footfall to ED **(Incorporated into campus development plans)**
- Bereavement room and family room requirements to be included in any new infrastructure build **(Will be incorporated into campus development plans)**

Stage 3 Inspection Report

- National Constraint with regard to access to rehabilitation services - -SVUH ensuring referral process in place with NRH Bed for transfer out of SVUH to minimise any delays- Twice Weekly rounds (**ongoing**).
- SVUH working within Directorate Model to refine processes relating to inter hospital transfer - to support a balance of access between scheduled and urgent care **(ongoing)**
- SVUH review of the repatriation protocol at a Senior Management level to support compliance when other organisations unable to provide a bed for repatriation in a timely manner **(ongoing)**
- SVUH engaged with IEHG & CHO6 to address CHO 6 Capacity for Rehab, LTC, HCP Care **(ongoing)**
- SVUH currently mid project with IEHG revising systems and services available to support early discharge in the region in place relating for homeless services **(ongoing)**
- SVUH co-ordinating with CHO 6 to maximise access to long term care & rehabilitation placements for patient fit for discharge from SVUH **(ongoing)**
- Building systems of referral and assessment with disability services through MSW service in SVUH and engaging with families to support to maximise available disability support **(ongoing)**

Stage-3 Inspection Report

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

Infection Prevention & Control / Organisational:

St Vincent's University Hospital is committed to ensuring the delivery of high quality, safe and reliable healthcare services across the whole organisation.

a) Details of interim actions and measures to mitigate risks associated with partial compliance with standards.

- Planned refurbishment of selected ward areas **(ongoing)**
- Programme to replace non-compliant hand hygiene sinks in dirty utility rooms **(ongoing)**
- Replacement of broken bedpan washer **(completed November 2022)**
- Closing of doors to isolation rooms – daily review by IPC team and daily risk assessment by nursing team; ward–based transmission-based precautions education **(ongoing)**
- Cleaning of equipment - ward–based education and audit of practices with feedback to ward manager (ongoing); review of healthcare assistant staffing **(ongoing)**
- Refurbishment of additional ward areas **(ongoing)**

b) Details of medium to long-term plans requiring investment to come into compliance with the standard

- Upgrading of patient bathrooms in Herbert Wing **(Phase 1 commenced September 2022, estimated to continue to 18-24 months)**
- Hospital is in the process of carrying out a high level strategic assessment review (SAR) of its current and future capacity needs both from a surgical and critical care perspective. This SAR was submitted to the HSE in order to progress a preliminary business case for future capital investment to increase hospital capacity **(October 2022)**

Stage 3 Inspection Report

Service Provider Use	
Service Provider	St Vincent's University Hospital
CEO/ General Manager/ Master Signature	Michele Tait
Date	**11th November 2022**

HIQA Official Use	
Date Reviewed	
Authorised Person(s)	
Signature	

Stage-3 Inspection Report