Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Connolly Hospital Blanchardstown
Address of healthcare service:	Mill Road Abbotstown Dublin 15 D15X40D
Type of inspection:	Announced
Date(s) of inspection:	17 and 18 October 2024
Healthcare Service ID:	OSV-001018
Fieldwork ID:	NS_0100

About the healthcare service

Model of hospital and profile

Connolly Hospital Blanchardstown (Connolly Hospital) is a model 3* hospital. At the time of inspection, the hospital was transitioning from the Royal College of Surgeons of Ireland (RCSI) hospital group† to the HSE health region management structure,‡ with reporting lines in place to the integrated healthcare area of Dublin North County, within the HSE Dublin North East health region. Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- 24 hour emergency care
- intensive care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	364 inpatient beds 55 day case beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors§ reviewed information which included previous inspection findings (where available), information submitted by the

* A model 3 hospital, is a hospital that admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine, and critical care.
† The RCSI Hospital Group comprises seven hospitals. These are Beaumont Hospital, Mater Misericordiae University Hospital, Cappagh National Orthopaedic Hospital, Our Lady's Hospital – Navan, Connolly Hospital, Our Lady of Lourdes Hospital – Drogheda, Louth County Hospital, Cavan General Hospital, Monaghan Hospital and Rotunda Hospital.
‡ From Tuesday, 1 October 2024, the Health Service Executive (HSE) health regions management structure replaced the existing Community Healthcare Organisation and Hospital Group structures for this region. IHAs replace the existing structures and will be fully established by 3 March 2025. Latest health regions updates - HSE Staff
§ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare

provider, unsolicited information and other publically available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

Appendix 2 contains the compliance plan completed by the hospital to become compliant in any areas where the service was judged to be non or partially compliant.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
17 October 2024	09.00 – 16.54	Aedeen Burns	Lead
18 October 2024	09.00 – 15.00	Nora O' Mahony	Support
		Sara McAvoy	Support

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes[**] of the *National Standards for Safer Better Healthcare*. The emergency department was inspected under standards 5.5, 6.1, 1.6 and 3.1. The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited three clinical areas:

- Emergency department
- Maple Ward (32-bedded gastroenterology and general medical ward)
- Rowan Ward (28-bedded medicine for the older person)
- Walnut (8-bedded emergency admissions)

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

- Representatives of the hospital's executive management team:

[**] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[††] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient-safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
[‡‡] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[§§] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

  - General Manager
  - Director of Nursing (DON)
  - Clinical Director
- Head of Quality and Safety
- Human Resource Manager

A representative for:

- Infection Prevention and Control
- Drugs and Therapeutics
- Deteriorating Patient
- Transitions of care
- Non-Consultant Hospital Doctors (NCHDs).

Inspectors also spoke to hospital staff from various roles in the clinical areas visited during this inspection.

Acknowledgements

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

What people who use the service told inspectors and what inspectors observed

Inspectors visited the emergency department and three wards. The emergency department capacity comprised 14 cubicles, 32 ambulatory assessment bays (including 10 chairs and an ambulatory care area), five isolation spaces including two resuscitation rooms, three non-isolation resuscitation bays, six clinical decision unit bays and four other spaces that were used as required for assessment and treatment. One room was equipped as a sensory room*** to meet the needs of people who attend who are neuro-diverse and there was a dedicated mental health assessment room with appropriate safety features.

At 11am on the first day of inspection there were 41 patients registered in the department, the department appeared calm and uncluttered. There was one patient, who had just been admitted, accommodated in the emergency department awaiting an inpatient bed.

*** A sensory room is a place meant to provide relief from overwhelming sensory input. These designated areas are helpful to individuals with sensory processing disorders and can help to soothe them after dealing with triggering stimuli such as bright lights, loud noises, or crowded spaces.

The ward areas visited during this inspection comprised a mixture of single and multi-occupancy rooms. The multi-occupancy rooms varied in size to accommodate from two to seven patients. All rooms, except those on Walnut ward, had ensuite toilet and shower facilities.

There was one vacant bed on Rowan ward on the first day of inspection, all other beds on the wards visited were occupied.

Inspectors noted that staff engaged with patients in a manner that was both courteous and kind. Inspectors observed that staff were diligent in promoting and protecting patients' privacy and dignity within the clinical areas visited.

Inspectors spoke with a number of patients in all areas visited about their experience of the care they had received. In both the emergency department and on the wards, patients were complimentary about the care they received and the staff giving the care. They used phrases such as '*they are all very good here', 'staff can't do enough for you'* and *'staff are very attentive.'*

Information on the procedure for making complaints was displayed in all clinical areas visited. Patients, although they were unaware of the procedure for making complaints, described various ways in which they would get this information or make a complaint if needed. A number of patients said they would use *'the internet'*. Information on making a complaint in the hospital was readily available on the HSE and RCSI websites.

Capacity and Capability Dimension

Findings from national standards 5.2 and 5.5, 5.8 and 6.1 from the theme of leadership, governance and management are presented here as general governance arrangements for the hospital.

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

Connolly Hospital had established formal corporate and clinical governance structures in place. These clearly outlined roles, accountability, and responsibilities to ensure the quality and safety of the healthcare services provided. Inspectors reviewed organisational charts that illustrated the management reporting structures and the reporting mechanisms for governance and oversight committees. The governance structures described to inspectors during this inspection aligned with those depicted in the hospital's organisational charts. At the time of inspection the hospital was

transitioning to new reporting relationships within the new HSE structures of health regions. The new arrangements were also outlined and presented on organisational charts.

The General Manager (GM) was the senior accountable officer with overall responsibility for the governance of the hospital. At the time of inspection, the GM was transitioning from reporting to the Chief Executive Officer of the RCSI group to reporting to the Integrated Healthcare Area Manager, Dublin North County. The GM was supported by the Executive Management Team (EMT). This committee served as the senior executive decision-making body, tasked with ensuring proper governance and oversight of the quality and safety of the services provided by the hospital. The EMT had a current terms of reference and met in accordance with their terms of reference. The EMT had reported to the RCSI Hospital Group at monthly performance meeting up to the time of inspection. The EMT had presented monthly performance reports to the group, which measured performance against agreed key performance indicators (KPIs). As mentioned earlier, the hospital was transitioning to new reporting relationships within the new HSE structures of regional health areas.

The Clinical Director (CD) had governance over clinical practice in the hospital and sat on the EMT, as did the Director of Nursing (DON) who was responsible for nursing services at the hospital. Lead representatives of other health and social care professionals (HSCPs) were also represented on EMT.

The hospital had a directorate structure of governance and had established five directorates: medical, perioperative, diagnostics, radiology and emergency. Each directorate had an associate clinical director (ACD), business manager and assistant director of nursing (ADON). The function of the Directorate Groups was to provide governance, management and operational oversight for the functions of the directorates and they reported to the EMT on a quarterly basis.

The Quality and Safety Executive (QSE) was the primary committee responsible for overseeing, coordinating, monitoring and advising on quality, risk and safety activities in the hospital. According to its terms of reference, the QSE aimed to integrate quality and patient safety into departmental activities and enhance the quality of services provided throughout the hospital. This committee had responsibility for the management and implementation of the hospital's risk register, it had up-to-date terms of reference and was meeting with the frequency outlined. Medication safety and infection prevention and control were standing agenda items discussed at this meeting. Evidence was seen that the QSE had oversight of the implementation of recommendations from reviews, oversight of complaints management and the management of the risk register. There was also evidence that relevant committees, as depicted in organisational charts and described to inspectors, reported to this committee.

The hospital had a Deteriorating Patient Committee that provided oversight for the implementation of national guidelines relating to early warning systems, including the Irish National Early Warning System (INEWS) version 2, the Irish Maternity Early Warning System (IMEWS), the Emergency Medicine Early Warning System (EMEWS) and Sepsis Management for Adults. This committee was chaired by a medical consultant and had appropriate senior representation from across the organisation. Meetings were well attended and at the frequency outlined in the terms of reference. There was evidence of time-bound actions arising from meetings, with named persons assigned to implement these actions which were monitored and progressed from meeting to meeting.

The hospital had a Drugs and Therapeutics Committee, the purpose of which was to ensure the safe and effective management of all medication processes within the hospital. Evidence was seen that this committee had appropriate multi-disciplinary membership and met in line with the frequency laid out in its terms of reference. Meeting agendas view by inspectors were appropriate to its function. Actions arising from meetings were time-bound, with specific individuals assigned responsibility for implementation. These actions were systematically monitored and tracked from one meeting to the next to ensure progress. The hospital also had a Medication Safety Committee which supported and promoted the safe use of medications in the hospital. Meetings followed a set agenda which included reviews of incidents, staff education, performance reports, and publications to share learning across the organisation. This committee met four times per year and evidence indicated that time-bound actions were identified during meetings, with specific individuals assigned to implement these actions, which were then monitored and tracked from one meeting to the next. Evidence was seen that the committee reported to the QSE and the Drugs and Therapeutics Committee at each meeting of those committees.

The hospital had an Infection Prevention and Control Committee (IPCC) to advise the EMT on all aspects of infection prevention and control in the hospital. This committee had appropriate senior and multidisciplinary representation and was chaired by the General Manager. The IPCC was meeting as per their terms of reference, although the terms of reference were overdue for renewal. Meetings followed a set agenda that addressed key areas of concern relevant to the committee. Evidence was seen that the IPCC reported to the EMT through the QSE as depicted on organisational charts and as described to inspectors during this inspection.

An Unscheduled Care Committee had been convened to provide oversight and management of the patient's journey through the emergency department and onwards through the hospital. This committee monitored performance related to the Emergency Medicine Programme and the National Service Plan 2024 key performance indicators, and monitored the hospital performance related to access, length of stay and discharge. They reported the hospital performance monthly to the EMT and also to performance meetings with the RCSI hospital group. This committee had

appropriate senior membership from across the organisation, and was chaired by the General Manager. They met in line with terms of reference. Minutes, actions, and innovations by this group showed executive influence, oversight and management of patient flow from emergency department through the hospital to discharge.

The hospital had acquired access to 80 off-site beds in a private facility. Patients in these beds remained under the clinical governance of Connolly Hospital. The hospital had established monthly governance meetings with the management team of the private facility and Connolly Hospital. Admission inclusion and exclusion criteria had been established.

Overall, it was evident that the hospital had established formal governance structures in place to ensure the provision of high-quality, safe, and reliable healthcare. There was documented evidence of formal reporting pathways from each governance committee to the QSE and the EMT, as appropriate, and onward to the RCSI hospital group. Governance committees had appropriate membership and were consistently attended by relevant members. Meetings followed structured agendas and, with minor exceptions, were happening with the frequency outlined in the terms of reference and were action orientated with time-bound actions allocated to individuals.

Judgment: Compliant

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

The hospital had management arrangements in place that were functioning well to meet the planned objectives of the hospital. The structures in place ensured that there was a focus on achieving quality and safety outcomes for the service users in the four areas of known harm; infection prevention and control, medication safety, deteriorating patient and transitions of care, which were the focus of this inspection.

There were management arrangements in place to manage patient flow through the hospital, including the emergency department and onwards back to the community. Hospital activity and performance was reviewed at daily patient flow meetings to progress actions to support patient flow. During the inspection, these were working well and demand and capacity were being managed so that there were no admitted patients in the emergency department awaiting beds for long periods. There were eight patients in the hospital for whom transfer of care out of the hospital was delayed. The majority these patients were reported to be awaiting specialist rehabilitation beds or home-care packages. While the hospital did have a policy for escalation when activity exceeded demand, the hospital was not in escalation on the days of inspection.

The hospital reported having managed 48,057 emergency department attendances in the year to date which represented a 7% increase on 2023. For the year to date, the hospital reported that patients had an average duration in the emergency department of 5.9 hours for non-admitted patients and 12.9 hours for admitted patients. On the day of inspection, the hospital was performing well and was compliant with the targets set by the HSE for emergency department patient experience times.[†††]

Transitions of care were actively managed by senior managers with the input of the patient flow team and multidisciplinary teams. To further support patient flow, a Patient Journey Ward Round was undertaken daily by senior management at the hospital to ensure the principles of right patient, right ward, right bed, and right consultant were monitored and employed, and that each patient was seen by a senior medical decision maker daily. In addition, the hospital had employed a number of admission avoidance strategies and discharge initiatives, and had sourced offsite beds to facilitate patient flow.

The pharmacy service was led by the Pharmacy Executive Manager. There was evidence that the aims and objectives of the Drugs and Therapeutics and Medication Safety committees were pursued through monitoring and management of risks, development and approval of medication related policies procedures and guidelines and staff education.

The hospital had an infection prevention and control service plan for 2024 which defined the priorities for infection prevention and control activities in the hospital and reflected national guidance.[‡‡‡] The implementation of this plan was the led by infection prevention and control team who reported to the IPCC. Evidence was seen that this team reported regularly to this committee and produced an annual report of its activities for the EMT. Evidence of performance of the activities laid out in the service plan for 2024 were observed on inspection such as training, audit, surveillance and outbreak management.

[†††] Patient experience time (PET) measures the patient's total time in the emergency department, from registration time to emergency department departure time. Targets are set for the percentage of all attendees at emergency department who are discharged or admitted within six hours (target 70%), within nine hours (target 85%) and with 24 hours (target 97%) of registration, and the percentage of all attendees aged 75 years and over at emergency department who are discharged or admitted within six hours (Target 95%), within nine hours (target 99%) and within 24 hours (target 99%) of registration.

[‡‡‡] National Clinical Effectiveness Committee. National Clinical Guidelines No. 30. Infection Prevention and Control. 2023. Available on line from: https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-summary-report.

The deteriorating patient improvement programme in the hospital was led by the Clinical Director. All early warning systems[§§§] relevant to the hospital had been enacted as per National Clinical Guidelines.[****]

Staff reported that management were visible and available to staff and conducted quality and safety walk rounds.[††††] Evidence was seen of quality improvement plans (QIPs) implemented as a result of these quality and safety walk rounds. Staff, who spoke with inspectors during the inspection, described reporting relationships with clear lines of responsibility to enable a response to increases in activity or acuity.

Overall, it was evident that management arrangements effectively and efficiently achieved planned objectives to support and promote the delivery of high quality, safe and reliable healthcare services.

Judgment: Compliant

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

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital had risk management structures and processes in place to proactively identify, manage and minimise risk, and arrangements were in place to monitor the service's performance. There was evidence that the hospital promoted effective communication with people who used the service and used feedback to promote learning.

There were formal processes and structures to facilitate proactive identification, documentation, monitoring and analysis of patient-safety incidents. The hospital had established a Local Incident Management team (LIMT) which convened following serious patient-safety incidents to decide on the level of investigation required and the composition of the investigating team. This group reported to QSE.

[§§§] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient. The EWS focuses on categorization of patients' severity of illness, early detection of patient deterioration, use of a structured communication tool (ISBAR) promotion of an early medical review, prompted by specific trigger points use of a definitive escalation plan

[****] The National Early Warning Score (NEWS) National Clinical Guideline (NCG) 1 applies to adult (≥ 16 years) non-pregnant patients in acute settings. NCG 4 (IMEWS) applies to women with a confirmed clinical pregnancy and for up to 42 days in the postnatal period, irrespective of age or reason for presentation. NCG 18 EMEWS applies to adults patients (16 years and older) attending an ED in Ireland who meet the inclusion criteria from triage to discharge or decision to admit.

[††††] quality and safety walk rounds are a structured process whereby senior managers meet frontline staff on the clinical areas to have quality and safety conversations with a purpose to prevent, detect and mitigate patient and staff harm

The hospital had systems in place for the management of patient-safety incidents with processes in place to learn from incidents to improve the quality of care provided at the hospital. This is discussed further under standard 3.3.

Connolly Hospital measured and published a range of quality and safety key performance indicators (KPIs) in the dimensions of access and patient flow, infection prevention and control, medication management, patient care and treatment, patient and family experience, staffing and integration. Performance metrics for these KPIs were reported at both hospital and group level in a metrics performance report. Performance data up to August 2024 was made available publicly on the RCSI website, and on the HSE website.[‡‡‡‡] This data was presented and discussed from directorate to group level and was used to monitor and improve performance and to identify trends and opportunities for quality improvement initiatives. Evidence was seen that information from monitoring of KPIs was used to improve the quality, safety and reliability of services.

The hospital had an ongoing programme of audit for 2024, and had appointed an audit coordinator to support clinical audit activity within the hospital. The audit coordinator worked with the Quality and Safety Manager to ensure that recommendations arising from audits were implemented. Evidence of performance of audit, implementation of QIPs and re-audit for improvement of patient care and safety were seen. This will be discussed further under standard 2.8.

The hospital had an overarching quality and safety programme for 2024-2026, approved by the EMT, to actively assess, monitor, and improve the quality, safety and reliability of its services. Actions on goals from this strategy were evident in the clinical areas visited, for example, the maintenance of local risk registers and training for staff in their use and 98% of staff being trained in open disclosure by end 2024. Evidence was seen that the hospital proactively engaged with patients to learn from their feedback via a patient representative council and from complaints. Overall, it was clear that there were structured monitoring systems in place to identify and act upon opportunities for continuous improvement in the quality, safety, and reliability of services. There were processes in place to proactively identify, manage and reduce risk and feedback from patients was taken into account to inform these improvements.

Judgment: Compliant

[‡‡‡‡] RCSI Key Performance Indicator's available on line at Key Performance Indicators - RCSI Hospital Group - RCSI Hospital Group HSE hospital activity and performance data available on line at https://www.hse.ie/eng/services/publications/performancereports/

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

Workforce planning and management in the hospital was the remit of the Human Resource Manager. The HSE and Department of Health's 2024 Pay and Numbers Strategy announced in July 2024 impacted posts unfilled as of 31 Dec 2023. The hospital had not established new ceilings for whole time equivalents (WTE) in the areas where vacancies were present prior to December 2023. Vacancies which existed prior to the pay and numbers strategy were entered onto the risk register. These risks were escalated to group level.

Prior to the announcement of the pay and numbers strategy the hospital reported a deficit of 45.48 WTE across medical, nursing, HSCP, management and administration, general support and patient and client care grades. The deficit was currently resulting in deficits or curtailment in some services.

Prior to December 2023, the hospital had 87 allocated consultant posts, 15 of which were vacant. There were also a number of vacant NCHD posts. The hospital gave assurances that if a consultant was not listed on the relevant specialist register, the Clinical Director would provide the necessary supervision and support to ensure safe practice and facilitate the consultant's registration.

The emergency department had an allocation of 8.75 WTE consultants in emergency medicine. These posts were filled and all consultants were on the appropriate specialist register. The consultants were supported by 15 WTE registrars and 15 WTE senior house officers and all of these posts were filled. The hospital was recognised as a training site for core and advanced specialist training for doctors in emergency medicine.

There was a consultant in emergency medicine rostered and available in the emergency department from 8am to 10pm Monday to Friday, 8am to 6 pm on Saturdays, and for five hours on Sundays, the timing of which was determined by service demand. Outside of these hours a registrar in emergency medicine was on duty in the department and a consultant remained on call from home. There was also a general practitioner service onsite five days per week.

The safe staffing framework[§§§§] for nursing had been had been approved in the hospital, however there were four staff nurse, one Clinical Nurse Manager (CNM) 2, one CNM 1, one clinical facilitator, one patient liaison and two healthcare assistant vacancies in the emergency department. It was reported by staff that vacant shifts

[§§§§] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

were usually covered by staff working overtime or by the use of agency staff. The use of agency or hospital staff doing extra overtime to fill the rosters is not sustainable in the long term. The emergency department usually had 14 staff nurses on duty. On the day of inspection, the department was short one staff nurse who was not replaced. The CNM reported that activity levels at the time of inspection meant that this deficit was manageable.

Walnut ward had a deficit of seven WTE staff nurses. Rosters seen by inspectors showed that these deficits were filled by regular agency staff. The CNM reported that these agency staff were familiar with Connolly Hospital policies procedures and guidelines. There was no allocation of HSCPs to Walnut ward, however, inspectors were informed that HSCP's of all specialties would be assigned to attend Walnut Ward as and when required to facilitate clinical need. Maple and Rowan wards were staffed in line with the framework for safe nurse staffing and skill mix and had minimal vacancies and the CNMs reported no gaps in their rosters.

The pharmacy department reported a 20% vacancy rate based on their pre pay and numbers strategy position. This impacted the delivery of clinical pharmacy services on the wards. There were five inpatient wards with no clinical pharmacy service and there was no clinical pharmacy service to the emergency department. This is discussed further under standard 3.1.

The hospital reported an absenteeism rate in August of 4.34%. This compared well with the HSE target of 4% or less. Occupational health supports were available to staff, and an employee assistance program for counselling was available. Staff spoken to on inspection were aware of this service.

An induction programme was available to all new starters and a specific program was repeated for new intakes of NCHDs on rotation. Uptake of this induction was good. Inspectors were told that any doctors who did not attend induction were provided with all the presentations and policies procedures and guidelines from the induction package.

Compliance with mandatory training was tracked and compliance rates were reported to EMT. Training levels for nurses and doctors for INEWS and sepsis were high ranging from 88 to 98%. Basic life support training for the hospital staff overall was low at 58%, with consultants 21%, NCHDs 41% and nurses 67% compliant in August 2024. Evidence was seen of management oversight, however, levels of training did not meet the required level for this essential skill. Medication safety and transfusion safety were other areas where compliance rates for training could be improved for some disciplines.

Connolly Hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of

services provided relevant to the size and scope of the centre. However it was noted that:

- A clear picture of vacancies in the organisation, the impact they had, and a strategy to mitigate the risks had not been developed since the pay in numbers strategy was announced.
- Nursing vacancies in the emergency department and Walnut ward had the potential to impact on patient safety.
- There was no allocation of HSCPs to Walnut ward.
- Compliance with mandatory training in key areas such as basic life support and medication safety was poor.

Judgment: Partially Compliant

Quality and Safety Dimension

Inspection findings related to the quality and safety dimension are presented under national standards 1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3 from the themes of person-centred care and safe care respectively.

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

During the inspection, it was observed that staff in the emergency department consistently maintained the dignity, privacy, and autonomy of patients. Individuals awaiting triage or medical review were accommodated in single cubicles or designated waiting areas. Additionally, several treatment rooms were available for patients' examinations or for private discussions. On the day of the inspection, patients reported positive experiences with the care they received in the emergency department. Staff reported that patient's nearing the end of life were given priority for a hospital room. A family room was accessible for the relatives of critically ill patients, and a bereavement room ensured privacy and confidentiality for families in the event of a patient's death.

In the emergency department a room with special equipment and lighting had been designed which offered a suitable environment for neuro-diverse patients for whom the emergency department might cause sensory overload.

Patient liaison officers were available to patients in the emergency department to address concerns they had while in the emergency department.

Patients on the wards were accommodated in a mixture of single and multi-occupancy rooms all of which, except for the adapted treatment rooms and Walnut ward, had a toilet and shower ensuite. Measures including the use of privacy curtains and the use of meeting rooms on the wards were used to promote dignity and privacy in multi-occupancy areas. Staff reported that patients receiving end-of-life care were prioritised for single rooms.

Patients on Walnut ward did not have access to a shower on the ward and had to use the shower on the emergency department corridor.

There was evidence that patient information was stored to ensure confidentiality and initiatives to promote General Data Protection Regulation (GDPR) compliant management of patient documents were seen. However, Rowan ward had a board in a public area with the patients' name and status on view. This was addressed with management on the day of inspection, and inspectors were informed that a new board which would maintain the privacy of patients' information had been ordered.

Notwithstanding physical constraints, the hospital endeavoured to deliver care in a manner that promoted the dignity, privacy and autonomy of people using the service. However, some personal information was on public view on the day of inspection and patients on Walnut ward had to use a shower on a public corridor in the emergency department.

Judgment: Substantially Compliant

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

In all areas of the hospital visited, including corridors, staff of many disciplines were observed in kind considerate, respectful interactions with patients and visitors.

Connolly Hospital had a Patient Council which actively sought patient feedback and contributions to improve services at the hospital. Various patient information leaflets in English were available to patients on the wards including those on how to make a complaint or give feedback. While some patient information had links to information in other languages it was not evident that all information was available in languages other than English.

The hospital was a hospice friendly hospital and had an end-of-life care coordinator. Evidence was seen that special consideration was given to the people approaching end of life and to their families.

On the day of inspection patients commented on the kindness shown to them.

Overall it was clear that the hospital actively promoted a culture of kindness, consideration and respect through its design and delivery of the service. People using the service were communicated with in an open and sensitive manner and actively listened to. Patients were offered opportunities to raise any issues relevant to their care and were supported to explore and discuss these issues.

Judgment: Compliant

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

There was a clear and defined complaints management process in Connolly Hospital, which was supported by a policy that reflected the HSE Comments, Compliments and Complaints policy. Information on how to make a complaint was available on the hospital's website and on patients' information leaflets on the wards. A complaints officer was responsible for managing complaints and reported to the Head of Quality and Safety.

Written complaints were tracked and trended and reported onwards. Managers of clinical areas received a monthly report regarding specific feedback on complaints for their areas and shared learning during safety pauses, at handovers and at staff meetings. Newsletters issued by the quality and safety department were also used for sharing learning and these were seen on the wards.

A quality and safety performance metrics report, which included data on complaints, was produced monthly for the Quality and Patient Safety Executive and this data had also been reviewed at monthly performance meetings with the RCSI group. For the year to date, the hospital was achieving and exceeding the target of 75% of complaints investigated and response sent to the complainant within 30 working days.

Examples of quality improvement initiatives in response to complaints were seen by inspectors. For example a QIP was developed for the creation and monitoring of single point of contact emails for people contacting services within the hospital. This allowed each department to have a single point of contact email address which was monitored. Inspectors were told that this had improved communication for patients and community stakeholders with the hospital.

Overall it was clear that complaints and concerns in the hospital were responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Judgment: Compliant

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

The wards visited on the days of the inspection were Maple, Rowan and Walnut wards. All areas were clean and well maintained and appeared safe and secure. These wards areas included a variety of room types, ranging from single rooms to multi-occupancy rooms with four, six, or in the case of Walnut, eight beds. All single rooms, with the exception of one adapted treatment room on each ward, were equipped with ensuite toilet and shower facilities. Patients on Walnut ward had to access a shower on a corridor that was part of the emergency department.

Clean utility rooms were accessed using swipe access and controlled drugs were stored appropriately. However, in one instance the doors of a press containing intravenous medications were broken. This was brought to the attention of management on the ward

The management of waste and the segregation of clean and soiled linen was appropriate. Chemicals used in the areas visited were securely stored. General areas were clean and there was appropriate storage of supplies and patient equipment.

The wards had allocated cleaning staff who were present on the ward during core hours. Outside of these times staff had access to cleaners via a bleep system. Staff reported good availability of and access to cleaning staff, and a timely and responsive maintenance service.

Environmental hygiene audits for inspected clinical areas were provided to inspectors. Compliance rates varied between clinical areas, with overall compliance ranging from 85% to 98%. Overall compliance rates for clinical areas inspected ranged from 85% to 98%, with evidence of actions taken on any issues identified.

Additionally, quality and safety walk rounds by members of the executive management team were utilised as opportunities to review and improve the environment. QIPs and resulting actions from these walk rounds were seen by inspectors.

Inspectors were informed that cleaning of equipment was the responsibility of the staff who used it, and a labelling system was seen in use to identify to staff that equipment was clean and ready for use. Extra cleaning of frequently used patient equipment was done on a daily and weekly basis by the healthcare assistants, overseen by the CNM of the wards. Mattresses were audited monthly and replaced if necessary. Regular flushing of outlets to minimise the risk of Legionella was

undertaken and a monitoring system was in place to monitor compliance with the flushing protocol.

Alcohol-based hand sanitiser dispensers, were readily available for use throughout the ward. Hand-hygiene signage reminding staff of the WHO 5 moments of hand hygiene were prominently displayed in the clinical areas. Inspectors noted that the majority of sinks in the wards visited adhered to national standards.*****

The hospital had 12% single rooms and a very small number of negative pressure rooms that were mostly in specialist areas. At the time of inspection there were a number of wards undergoing renovation, and management described a programme of works that were in various stages of development to further expand and improve conditions for patients on the campus. This included a new build of 100 single rooms which was at the design phase with the HSE.

A scheme of capital works, which was in progress, will be required for the hospital to come into full compliance with this standard. Overall it was evident that the areas visited on this inspection of Connolly Hospital provided a physical environment which was clean and well maintained to support the delivery of high quality, safe, reliable care and protect the health and welfare of service users.

Judgment: Substantially Compliant

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

It was evident that quality and safety of the care and its outcomes at the hospital were measured using national performance indicators and benchmarks. Where national performance indicators and benchmarks did not exist, local performance indicators and benchmarks were developed, adopted and adapted in line with best available evidence. Performance in the four areas of focus of the inspection was monitored and evaluated, using clinical and non-clinical audits, with evidence provided that improvements were implemented based on the findings.

Audits at the hospital were centrally coordinated by the audit coordinator and the hospital had a quality improvement strategy for 2024-2026. Clinical audits were overseen by the Clinical Audit Committee which reported to the QSE. The Clinical Audit Committee was chaired by a consultant in medicine for the elderly and had multi-disciplinary membership.

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

Metrics relating to the management of the deteriorating patient were collected through a variety of means including the patient monitoring and surveillance element of the nursing and midwifery quality care metrics.[†††††] A hospital wide audit of inpatient ward INEWS escalation and response compliance was undertaken just before this inspection. Inspectors were informed that QIPs relating to this audit were being developed. Audits were conducted to evaluate the hospital's response to patients presenting with suspected sepsis. Evidence was observed of the development of QIPs and actions arising from these audits, with regular re-audits. Improvements in sepsis care audit scores were noted from one audit cycle to the next. Results are discussed under standard 3.1.

Monitoring and evaluation of medication safety was performed via the medication safety and medication storage and custody element of the nursing and midwifery quality care metrics. These were repeated monthly in ward areas. Results of the care metrics seen for the medication safety and medication storage and custody were consistently high for the year to date (YTD) 2024. Staff reported that these results were communicated at ward level via safety huddles.[‡‡‡‡‡] Evidence was also provided of medication safety audit cycles completed for insulin management and Venous Thromboembolism (VTE) prescription and assessment. Evidence was seen of actions relating to a QIP following the insulin management audit. There was also evidence of re-audit which showed an improvement in compliance. Audit cycles relating to VTE prescription and assessment showed persistent non-compliance. Recommendations for improvement of this metric were outlined in the audit, but evidence of their implementation was not supplied to inspectors.

Infection prevention and control was monitored through nursing and midwifery quality care metrics with consistently high compliance rates seen by inspectors for IPCC-related metrics year to date 2024. The hospital monitored: environmental cleanliness, compliance with surveillance, screening and isolation, care bundles relating to invasive devices, antimicrobial stewardship and hand-hygiene practice. Evidence of quality improvements developed and implemented were provided to inspectors. Re-audits were undertaken to ensure improvements in practice.

Overall, the hospital was systematically monitoring and evaluating services. Examples of implementation of quality improvements and re-audits were provided, demonstrating continuous practice improvement. However, inspectors noted that evidence of action taken on all recommendations was not provided for all audits reviewed, for example VTE.

[†††††] Nursing and Midwifery, Quality Care-Metrics provide a standardised system to measure the fundamentals of care where care can be monitored and improved against evidenced based standards and professional consensus. National Guideline for Nursing and Midwifery Quality Care Metrics Data Measurement in Acute Care 2018.

[‡‡‡‡‡] Huddles are brief and routine meetings for sharing information about potential or existing safety and operational problems.

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

There was evidence that the hospital sought to systematically identify aspects of care delivery which were associated with possible increased risk of harm to people who use the service. There were structured arrangements in place to minimise these risks, and evaluation of the actions necessary to do so was reported through governance structures. The hospital had a risk management policy outlining risk identification, assessment and management processes that were appropriate to the complexity and size of the service. This policy clearly outlined the governance arrangements for the timely evaluation and review of risk assessments and the risk registers. Risks relating to the four areas of harm were identified, monitored managed and reviewed, and policies, procedures and guidelines were in place to guide practice in these areas. However some risks persisted, which are discussed below.

The QSE was the primary committee responsible for the assessment, monitoring and management of risks that impacted the quality and safety of healthcare delivery at the hospital. Risks that could not be managed at hospital level were escalated to group level. Risks were recorded on the corporate risk register with evidence seen on inspection that controls were put in place.

Oversight and management of the deteriorating patient lay with the Deteriorating Patient Committee which escalated risks in this area through the governance structures discussed under standards 5.2. Risks relevant to the deteriorating patient were escalated to the corporate risk register. For example, the hospital had developed a Critical Care Outreach Team (CCOT) and plans were described to inspectors for the formation of a special care unit in response to risks relating to the deteriorating patient.

All early warning scores relevant to the service provided were in use in the hospital which were the INEWS, the EMEWS and the IMEWS. One ward was allocated as the ward where women requiring IMEWS would be admitted should the need arise. There were policies and procedures in place to support the use of these tools. Compliance with the use of these tools was monitored primarily through the patient monitoring and surveillance element of the nursing and midwifery quality care metrics and scores ranged from 62%-89% compliance in 2024 on the wards visited. Evidence was provided of QIPs and re-audit for wards which had low compliance. The hospital had also performed hospital wide audits focused on the compliance with the early warning system escalation and response protocol in 2023 and 2024. In 2023 overall compliance was 61.7%. In the 2024 audit, while

improvements were seen in some parameters such as documentation of a post review plan of care (83%) the overall average score had decreased to 42%. Inspectors were informed that QIPs were in development as a result.

The hospital's critical care outreach team had advanced nurse practitioners available as part of this team to respond to patients whose condition was deteriorating. However this team was only available during daytime hours Monday to Friday. This team was part of the hospital's mitigation response to a lack of beds for patients requiring an escalation in care such as special care, high dependency, or intensive care. Plans to open a special care unit are at an advanced stage and management also described plans for expansion of higher dependency beds in the medium term. Inspectors were informed that there were plans to extend the availability to the CCOT.

The hospital also had a dedicated bleep alert system to ensure rapid response to a deterioration in a patient's condition when an early warning system had been triggered by an early warning score of seven or over.

The hospital had a number of risks relevant to infection prevention and control which had been escalated to the corporate risk register such as, inadequate isolation facilities and the infrastructure of some wards such as Walnut. In the event that patients requiring isolation outnumbered isolation or single rooms available, the hospital used both AMIRC and local policy to guide practice. Patient flow and site managers could access advice from IPC nurses as to the allocation of patients in order to incur the least risk possible. When a patient was allocated to a bed not in line with advice of IPC, staff reported that a risk assessment and an incident form were completed. On the day of inspection inspectors noted a patient who was not in an appropriate isolation room, there was no record that the patient's placement had been risk assessed or an incident form completed. This was brought to the attention of management for immediate resolution. Not all staff spoken to on the day were familiar with the AMRIC or local guideline prioritisation of patients for single room isolation when there are not sufficient single rooms for all patients that require Isolation.

Evidence was provided that patients were screened for multi-drug resistant organisms (MDROs) on admission adhering to national guidelines, with additional screening to address local infection prevention and control concerns. The hospital's electronic patient information management system flagged individuals with a history of MDROs from previous admissions.

A multidisciplinary outbreak team was established to ensure outbreak management adhered to best practice standards and guidelines. Outbreak reports were prepared under the supervision of the IPC Committee. Learning from outbreaks was communicated to staff. Hospital staff had 24/7 access to microbiology expertise.

The hospital continually monitored compliance with hand hygiene. The HSE target for hand hygiene compliance is 90%, and overall compliance achieved for the hospital was 91% during Q2 2024. Local prevalence for healthcare associated infection in a point prevalence survey seen by inspectors conducted in Connolly Hospital in 2023 was 4.5%, which compared well to the national average of 6.1%.

Oversight and management of medication safety was the responsibility for the Drugs and Therapeutics Committee which escalated risks in this area through the governance structures discussed under standards 5.2. Risks relevant to medication safety had been escalated to the corporate risk register. The highest rated medication safety risk related to the lack of clinical pharmacy service provision to all areas due to a lack of pharmacists. Five in-patient wards and the emergency department had no pharmacist allocated. On wards without an allocated clinical pharmacist, staff described that a pharmacist would come to the ward if staff requested to undertake clinical medicines reviews or medicine reconciliation for patients with complex medication regimens. Pharmacists also provided education for patients on discharge who were prescribed complex medications. There was a reduced antimicrobial stewardship (AMS) pharmacy service due to staff shortages. AMS pharmacy services were targeted to surgical areas and wards in the main hospital building, with other wards on campus having access to the AMS approved digital applications or phone advice.

Staff had access to up-to-date information on medications via the hospital's approved electronic resources which they accessed on desktop computers. However printed, out-of-date information was seen on one ward in the clinical room where medicines were prepared. Not all clinical rooms visited by inspectors had computers for staff to access medicines information when preparing medicines. The electronic resources were available on mobile phones, however some staff reported that they did not have access to mobile phones while on duty.

Inspectors saw extensive use of the Identify, Situation, Background, Assessment, Recommendation (ISBAR)§§§§§ communication tool at transitions of care from the emergency department and onwards to manage transitions within the hospital. Patient Journey Ward Rounds using an adapted ISBAR format further facilitated safe transitions of care between teams through providing oversight by senior clinicians, at ADON and clinical director level, of the patient's journey through the hospital.

Safety huddles as well as clinical handovers followed the ISBAR format. Standardised documents had been devised to capture essential information at

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

transitions of care, such as the transfer of patients' offsite to beds under the governance of Connolly Hospital. Protocols were in place for the urgent and non-urgent transfer of these patient back to Connolly Hospital.

The delay in preparation of discharge letters for patients on discharge returning to the care of general practitioners (GPs) persisted since the last inspection. However, evidence was seen that this matter was being actively monitored and managed by the hospital and had improved since the last HIQA inspection. 52% of discharge summaries were completed within one week of patients' discharge in January 2024, which had increased to 65% in September 2024. Staff reported that patients who required immediate engagement with their GP were given a letter on discharge.

Walnut ward, at times, had both admitted and non-admitted patients allocated to it. The standard operating procedure (SOP) available to staff on the ward and seen by inspectors during the inspection did not fully support staff in the management of the deterioration of these patients. This was raised with hospital management, who outlined that the version of the SOP available to staff on the ward was not the most up-to-date SOP version. They indicated that the updated version would be circulated immediately. Not all patients were transferred off this ward in a timely fashion in accordance with the SOP.

On the days of inspection the emergency department was functioning well with patients accommodated in allocated spaces and seen by medical staff in a timely manner. On day one of inspection the wait times for various points in the patients emergency department experience were as follows:

- registration to triage: Range 5 minutes to14 minutes: Average 14 minutes
- triage to medical assessment : Range 0 minutes to 90 minutes: Average 45 minutes
- medical assessment to decision to admit to discharge: Range 0 minutes to 4 hours Average: 2 hours
- decision to admit to time inpatient bed: Range 0 minutes to 2.5 hours Average 2.5 hours.

These wait times were a significant improvement on the wait times during the last inspection by HIQA. Management attributed this improvement to a hospital wide focus on and engagement with the patient journey through the hospital, with an early focus on discharge, and good integration with community services. Decision makers at consultant level being onsite in the emergency department for extended rostered hours was also noted as a factor contributing to improvements. The hospital utilised admission avoidance pathways and clinical pathways to improve the patient journey, and had an ambulatory care area and GP onsite to whom patients could be referred from triage.

The hospital had fully implemented the EMEWS in the emergency department to mitigate the risk of deterioration of undifferentiated patients. A nurse was allocated to the waiting room to monitor and escalate patients' early warning scores as per the EMEWS policy. Evidence was seen that the filling of this role for the waiting room was prioritised and monitored my nurse management in the department. Staff reported that they found great value in the filling of this role.

Overall the hospital had established risk management processes with controls designed to mitigate potential harm. Inspectors observed evidence of significant progress in implementing additional measures to further reduce identified risks throughout this inspection particularly the full adoption of EMEWS and improved flow of patients through the emergency department and onwards through the hospital to discharge. However, a number of risks persisted;

- There was an identified risk in the lack of availability of higher dependency beds and the CCO team were only available during daytime hours Monday to Friday.
- Not all relevant staff spoken to on the day were familiar with the AMRIC and local guideline for prioritisation of patients requiring isolation.
- A clinical pharmacy service was not available for five inpatient wards or in the emergency department, and the antimicrobial pharmacy service was limited.
- Not all staff had access to up-to-date medicine information at the point of medicines preparation or administration and some printed material seen on inspection was out of date.
- Compliance with hospital policy on VTE assessment and prescription was poor.
- 35% of patients audited did not have discharge summaries issued to their general practitioners in a timely fashion.
- The most up-to-date SOP for the management of admitted and non-admitted patients on one ward had not been circulated and staff were not aware of it.

Judgment: Partially Compliant

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

A patient safety incident management system was in place in the hospital to identify, manage, respond to and report patient safety incidents. This system aligned with national legislation, standards, policy and guidelines. It was supported by a clear policy framework that included roles and responsibilities of individuals and committees. There was a clear process for reporting, investigating and monitoring

patient safety incidents and training on this process was provided. It was evident that information arising from patient-safety incidents was used to inform the EMT and the hospital staff on ways to promote improvements in safety and quality.

The QSE was the committee with overall oversight of patient-safety incidents in the hospital and incidents had been reported at monthly performance meetings with the RCSI group. Governance committees, including the Drugs and Therapeutics Committee, the Infection Prevention and Control (IPC) Committee, and the Deteriorating Patient Committee, provided oversight of patient-safety incidents related to the four key areas of harm focused on during this inspection. The Local Incident Management Team (LIMT), provided oversight and coordination for the management of serious patient-safety incidents to the QSE.

Patient-safety incidents were reported directly to the National Incident Management System electronically at the time of the incident and managed in line with the HSE's Incident Management Framework 2020. All incidents were categorised using a recognised format of hazard type and severity of outcome. Medication related patient-safety incidents were further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Incidents were tracked and trended and feedback reports were given at local, directorate and executive level. A database of recommendations from patient-safety incident reviews was maintained by the quality and safety department. Evidence was seen that progress with implementation of these recommendations was monitored by the Quality and Safety Manager. Responsibility for the implementation of the recommendation remained with the member of the EMT who owned the recommendation

Staff at all levels who were spoken to during the inspection were aware of their role and responsibilities relating to patient-safety incidents. The hospital reported greater than three medication safety incidents per 1000 bed days used, which indicated a culture of reporting.

The hospital audited compliance with national KPIs for incident management. In 2024, 95% of reported incidents were entered onto NIMS within 30 days of notification of the incident, which exceeded the national target of 90%. The hospital also exceeded the national target of 70%, for completion of concise reviews within 125 day. The hospital met the KPI of less than 1% of all reported incidents rated as extreme and major.

Learning from patient-safety incidents was shared with staff during directorate and ward meetings and via quality and safety newsletters which were circulated to wards and seen in clinical areas during the inspection. Staff reported that learning from incidents was shared via forums such as grand rounds, multidisciplinary meetings

and daily ward huddles. Evidence of actions taken to improve safety related to specific patient-safety incidents was provided to inspectors during this inspection.

The hospital had defined system for managing patient safety incidents, aligned with national standards and guidelines. This system included clear policies, defined roles, and a structured process for reporting and investigating incidents. Training was provided, and information from incidents was used to inform the Executive Management Team and staff to drive safety and quality improvements.

Judgment: Compliant

Conclusion

An announced inspection was performed in Connolly Hospital Blanchardstown on the 17 and 18 October 2024. The hospital was found to be compliant in six standards (5.2, 5.5, 5.8, 1.7, 1.8, 3.3), substantially compliant in three standards (1.6, 2.7, 2.8) and partially compliant in two standards (6.1 and 3.1).

Capacity and Capability

The hospital demonstrated governance structures which supported high-quality, safe, and reliable healthcare. Formal reporting pathways from each governance committee to the Executive Management Team, and onward to the RCSI hospital group, were well documented. Governance committees had appropriate membership and consistent attendance, with meetings following structured agendas and generally occurring as per the terms of reference. Action-oriented, time-bound tasks were assigned to individuals.

Management arrangements effectively achieved planned objectives, supporting the delivery of high-quality, safe, and reliable healthcare services. Structured monitoring systems were in place to identify and act on opportunities for continuous improvement in service quality, safety, and reliability. Proactive processes were established to identify, manage and reduce risk, incorporating patient feedback to inform improvements.

However, a strategy to address vacancies had not been developed since the pay and numbers strategy was announced. Nursing vacancies on Walnut ward and the emergency department posed potential risks to patient safety. A shortage of staff in pharmacy curtailed the provision of the clinical pharmacy service and antimicrobial stewardship. Additionally, mandatory training compliance levels were below acceptable levels for some areas.

Quality and Safety

The hospital fostered a culture of kindness, consideration, and respect. Communication with patients was open and considered their preferences and needs. Patients were encouraged to raise issues relevant to their care and were supported in discussing these concerns. The hospital endeavoured to deliver care that promoted the dignity, privacy, and autonomy of patients. Complaints and concerns were addressed promptly, openly, and effectively, with clear communication and support provided throughout the process.

The hospital's physical environment was clean and well maintained, supporting high-quality, safe, and reliable care. Systems were in place to systematically monitor and evaluate services, demonstrating continuous improvement through quality initiatives and re-audits. Risk management processes were established, with significant progress observed in reducing identified risks, particularly through the adoption of EMEWS and improved patient flow. Learning from patient safety events was shared, ensuring staff were informed and could apply lessons learned.

Infrastructural issues necessitated ongoing capital works to achieve full compliance with standards. Not all audit recommendations had documented follow-up actions, which is essential for enhancing healthcare services. There were risks due to the lack of higher dependency beds and limited availability of CCOT. Clinical pharmacy services were not available on all wards. There were delays in issuing discharge summaries to general practitioners.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant (Appendix 2). It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe, and reliable healthcare services.	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.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant

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

Appendix 2

Compliance Plan for Connolly Hospital Blanchardstown OSV-001018

Inspection ID: NS_0100

Date of inspection: 17 and 18 October 2024

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

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

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.
(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

Pg. in Report	**Location**	**Risks Identified during inspection**	**Actions required to improve compliance**	**Person Responsible**	**Timeframe**
14	Hospital Wide	*A clear picture of vacancies in the organisation, the impact they had, and a strategy to mitigate the risks had not been developed since the pay in numbers strategy was announced.*	HR Workforce Plan for the Dublin North East Region to be developed by the Regional HR Team, to mitigate the risk associated with Pay in Numbers Strategy.	HR General Manager HSE DNE	HR Workforce plan to be developed by end Q1 2025

14	Emergency Dept. / Walnut Ward	*Nursing vacancies in the emergency department and Walnut ward had the potential to impact on patient safety.*	• Nursing vacancies in the ED and Walnut ward to be reviewed and workforce plan developed. • HR to progress recruitment to backfill vacant positions / agency conversions in line with the provisions set out in the Pay in Numbers strategy by end Q1 2025 for the Emergency Department and Walnut ward.	Director of Nursing HR General Manager HSE DNE	Q1 2025
16	Walnut Ward	*There was no allocation of HSCPs to Walnut ward.*	Director of Clinical Services to review the demand for HSCP allocation on Walnut ward and develop a plan based on the clinical need identified.	Director of Clinical Services	Q1 2025
16	Hospital Wide	*Compliance with mandatory training in key areas such as basic life support and medication safety was poor.*	Executive oversight of mandatory training is the responsibility of each Executive Manager for staff under their remit. HR to provide monthly mandatory training compliance reports for oversight at the EMT on a monthly basis, pending improvement in compliance rates across areas of mandatory training including: 1. Basic Life Support (BLS) 2. Transfusion Safety 3. Medication Safety	Clinical Director & Director of Nursing	Q2 2025

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

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

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.
(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

Pg. in Report	Location	Risks Identified during inspection	Actions required to improve compliance	Person Responsible	Timeframe
26	Hospital Wide	*There was an identified risk in the lack of availability of higher dependency beds*	• Location assigned to accommodate Special Care Unit. DON to develop training plan required to ensure nursing staff allocated to this area have the requisite skills to care for patients requiring a higher level of care. • Source of funding to be identified for the development of a dedicated High Dependency Unit. • Business case to be submitted for staffing uplift required to staff this area.	General Manager / Director of Nursing	Q2 2025
26	Hospital Wide	*There was an identified risk in the CCO team were only available during daytime hours Monday to Friday.*	Business plan to be developed and progressed by DON to expand Critical Care Outreach Team to provide a 24/7 service Monday to Sunday.	Director of Nursing	Q1 2025
26	Hospital Wide	*Not all relevant staff spoken to on the day were familiar with the AMRIC and local guideline for prioritisation of patients requiring isolation.*	AMRIC and local guideline for prioritisation of patients requiring isolation to be shared with all nursing staff by DON via Nursing Executive and CNM forums and promoted through local safety huddles.	Director of Nursing	Jan-25
23	Hospital Wide	*Hospital wide audits of the early warning system escalation and response protocol saw overall average score decreased to 42%*	QIPs to be developed with oversight by the Deteriorating Patient Committee to address areas of low compliance in the EWS audit.	Director of Nursing	Q1 2025

26	Hospital Wide	*A clinical pharmacy service was not available for five inpatient wards or in the emergency department, and the antimicrobial pharmacy service was limited.*	• Chief Pharmacist to review Pharmacy workforce allocation of available staffing based on clinical need and risks identified and progress business case to support services. • HR General Manager to progress recruitment to backfill vacant positions in line with the provisions set out in the Pay in Numbers strategy	Chief Pharmacist HR General Manager HSE DNE	Q2 2025
26	Hospital Wide	*Not all staff had access to up-to-date medicine information at the point of medicines preparation or administration and some printed material seen on inspection was out of date.*	• MEG-E Guidelines to be used as the sole reference for medications information. DON to promote use of this through Nursing Exec and local safety huddles. • Review to be undertaken by DON and I.T. Manager regarding need to improve I.T. accessibility in Clinic Rooms	DON DON / IT Manager	Jan-25
26	Hospital Wide	*Compliance with hospital policy on VTE assessment and prescription was poor.*	• Associate Clinical Directors are responsible for ensuring that VTE Risk Assessments are completed and raise awareness with NCHDs at all forums. • VTE assessment to be promoted as a theme for the upcoming audit challenge for NCHDs in order to drive improvement in the documentation of the VTE risk assessment	Clinical Director/ Associate Clinical Director(s)	Q1 2025
27	Hospital Wide	*35% of patients audited did not have discharge summaries issued to their general practitioners in a timely fashion.*	• Associate Clinical Directors are responsible for ensuring that Discharge Summaries are completed and raise awareness with NCHDs at all forums. • Introduction of single sign on by Q2 2025 to enhance I.T. accessibility for NCHDs in an effort to increase completion of discharge summaries.	Clinical Director/ Associate Clinical Director(s)	Q2 2025
27	Walnut Ward	*The most up-to-date SOP for the management of admitted and non-admitted patients on one ward had not been circulated and staff were not aware of it.*	The updated SOP was finalised and circulated to staff in October 2024. The SOP has been added to the hospital shared drive for staff to access as required.	ED ADON	Complete