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:	Royal Victoria Eye and Ear Hospital
Address of healthcare service:	Adelaide Rd Dublin 2 D02 XK51
Type of inspection:	Announced
Date(s) of inspection:	21 and 22 August 2024
Healthcare Service ID:	OSV-0001088
Fieldwork ID:	NS_0091

About the healthcare service

The following information describes the services the hospital provided at the time of inspection.

1.0 Model of Hospital and Profile

The Royal Victoria Eye and Ear Hospital is a specialist eye and ear, publicly funded, voluntary hospital. It was a member of, and was managed by the Ireland East Hospital Group (IEHG)* on behalf of the Health Service Executive (HSE) through a service level agreement at the time of inspection. Services provided by the hospital included:

- in-patient eye and ear services
- elective surgery - eye and ear
- emergency care - eye and ear
- diagnostic services - eye and ear
- outpatient care - eye and ear

As a specialist eye and ear hospital, it is a tertiary referral service for complex diseases of the eye requiring medical and or surgical care including emergency service for acute retinal detachment and for conditions such as uveitis, ocular oncology, strabismus and corneal conditions.

The patient cohort included adults and children.

The following information outlines some additional data on the hospital.

Model of Hospital	Specialist hospital
Number of beds	Total of 49 beds as follows: 31 inpatient beds comprising 24 adult and 7 paediatric beds plus 18 day-case beds

* The Ireland East Hospital Group comprised eleven hospitals. These were St. Vincent's University Hospital, University Hospital Waterford, St Luke's General Hospital – Kilkenny, Tipperary University Hospital, Wexford General Hospital, St Columcille's Hospital – Loughlinstown, St Michael's Hospital – Dún Laoghaire, Kilcreene Regional Orthopaedic Hospital, National Maternity Hospital, National Rehabilitation Hospital and Royal Victoria Eye and Ear Hospital. The hospital group's academic partner was University College Dublin (UCD).
The HSE was re-organising its structure to create six new health regions in 2024. As part of this process, IEHG would become part of the health region HSE Dublin and South East.

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 of the Health Information and Quality Authority's (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, information submitted by the provider, 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
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

About the inspection report

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

1. Capacity and capability of the service

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

[†] *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 (2012)*

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-centred and safe. It also includes information about the environment where people receive care.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
21 and 22 August 2024	Day 1: 13.30 -17.50hrs Day 2: 09.00 -16.15 hrs	Patricia Hughes	Lead
		Bairbre Moynihan	Support
		Cathy Sexton	Support
		Eilish Browne	Support

Information about this inspection

HIQA conducted an announced inspection of the Royal Victoria Eye and Ear Hospital on 21 and 22 August 2024.

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

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

The inspection team visited two clinical areas:

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

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

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

- Operating theatre No. 2
- Inpatient ward- Harvey Lewis ward

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

- Representatives of the hospital management group (HMG)
  - Senior Accountable Officer and Clinical Director
  - Director of Nursing
  - Acting Business Manager
- Quality Manager
- Risk, Health and Safety Manager
- Lead representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager
- Assistant Director of Nursing (ADON) and Clinical Nurse Manager 3 (CNM3) in relation to transitions of care
- Representatives from each of the following hospital committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Irish National Early Warning System (INEWS) and Sepsis

During this inspection, inspectors visited Harvey Lewis inpatient ward and Operating Theatre number two which was situated within the main body of the operating theatre department.

There were 32 beds on Harvey Lewis ward, seven of which were used on alternate weeks for paediatric services. Inspectors noted that there were 14 adult patients admitted on the adult section of the ward with three further elective admissions planned for later that day. An isolation facility was in use at the time. This is discussed further under national standard 3.1.

The operating theatre department comprised a total of seven operating theatres. Three ophthalmology theatres and two ear, nose and throat (ENT) theatres along with a recovery room and an anaesthetic room were located on the first floor. There were two new cataract operating theatres located on the ground floor. Theatre number one was in use while theatre number two had yet to be commissioned for use.

HIQA issued a high risk letter to the service provider on 23 August 2024 highlighting weaknesses in governance, management and oversight of medication safety at the hospital and seeking details of actions taken or to be taken to address the shortcomings. HIQA also sought information on immediate actions following a specific incident which had occurred earlier in the year.

Acknowledgements

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

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

Inspectors visited both Harvey Lewis inpatient ward and operating theatre number 2 and observed staff interacting and engaging with patients in a respectful and empathetic manner. They supported and assisted patients with their individual needs and were observed to promote privacy, dignity and autonomy. Inspectors spoke with a number of patients to ascertain their experiences of receiving care at the hospital. Patients were complimentary stating, 'so far, everything is lovely' and that they had received 'very good care' and that the 'food is good'.

When asked what could be improved about the service, patients did not indicate any area for improvement. When asked if they knew how to go about making a complaint and if they had received any information on doing so, they said that they had not. This is discussed further under NS 1.8

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and under national standard 6.1 from the theme of workforce.

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

The hospital is a public, voluntary hospital with its own board known as council. The council is the governing body of the hospital as per the Dublin Eye and Ear Hospital Act 1897 with Royal Victoria Eye and Ear Hospital (RVEEH) as the corporate Body. Terms of reference (TOR) for meetings between the council and the hospital executive were requested by HIQA. These were not provided.

Organisational charts setting out the hospital's reporting structures were submitted to HIQA, as part of the pre-onsite documentation, data and information request. These charts contained details of the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability

relationship of hospital committees to the hospital's Council was outlined on the organisational chart.

Shortly after the inspection, inspectors found that that the organisational charts provided for the governance of the hospital at executive management level did not clearly reflect the roles held by some senior staff. Inspectors noted that the ambiguity was also evident in other documentation. Inspectors found that although there were separate references to a chief executive officer (CEO) and a clinical director in the organogram and also in various terms of reference for committees, the term CEO was not applicable to a specific position held in the hospital at the time of inspection. Inspectors were told by Ireland East Hospital Group after the inspection that the hospital was governed and managed by the 'senior accountable officer and clinical director' (SAO-CD). The SAO-CD reported to the hospital's council and by way of a service level agreement, to the HSE Ireland East Hospital Group (IEHG).

Clarity was sought from hospital management shortly after the inspection on the posts held by senior staff members listed on the organogram and on matters relating to medication safety via a 'high risk letter'. A revised organogram was submitted to HIQA. Inspectors noted that the Clinical Director post reported to the SAO as outlined in the revised organogram and both of these posts were held by the same post holder. There was no reference to a CEO.

In summary, inspectors found that although the service provider of the Royal Victoria Eye and Ear Hospital had some documented formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of the healthcare service, there remained a lack of clarity on documentation regarding the titles of CEO and SAO-CD. Following the inspection, assurances were provided on review of additional documentation received, that the SAO-CD was responsible for providing clinical oversight and leadership at the Royal Victoria Eye and Ear Hospital. The director of nursing (DON) was responsible for the organisation and management of nursing services at the hospital and reported operationally to the SAO-CD.

Hospital Management Group (HMG)

The Royal Victoria Eye and Ear Hospital's Hospital Management Group (HMG) was the main governance structure at the hospital. The terms of reference (TOR), dated October 2023, referred to the 'Chief Executive Officer' as being the chairperson of the HMG with specific assigned duties. The HMG were due to meet 'fortnightly or as otherwise requested'. Inspectors noted that the HMG were not meeting in line with their TOR. The most recent three meetings of the HMG were held every four to six weeks. The HMG had collective responsibility for ensuring that high-quality, safe healthcare was provided at the hospital. Membership of the HMG was appropriate and comprised the clinical director, director of nursing, chief operations officer, director of HR, director of education and research and the director of finance. Minutes of HMG meetings, submitted to HIQA,

showed that the meetings followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting. The HMG reported to the council and also to the HSE performance group of Ireland East Hospital Group.

Council Sub Committee - Quality and Patient Safety (QPS)

The terms of reference for this committee were requested and not provided. A member of the council chaired the committee. Comprehensive minutes of three meetings held in June and December 2023 and March 2024 were viewed and inspectors noted that the meetings were attended by a second council member, the SAO-CD, DON, chief pharmacist, quality manager, the risk, health and safety manager, senior medical scientist and IPC nurse. Minutes were action-oriented and a responsible person was listed for each action although these were not time-bound. Matters discussed included a patient's positive experience, the Quality Safety Executive Committee (QSEC) report, update on the culture of safety survey, review of the dashboard of key performance indicators (KPIs) relating to infection control, quality and patient safety, risk, health & safety, audits conducted, complaints and compliments, compliance with standards and corporate risk register items.

Ireland East Hospital Group (IEHG)

Inspectors noted that the hospital management team met with the IEHG monthly. Inspectors viewed documentation relating to the three most recent meetings held in advance of the HIQA inspection, dated April, May and July 2024. The agenda contained standard items including review of actions from previous meetings, finance, workforce, quality and safety, access, scheduled and unscheduled care, performance year to date, capital projects, ICT and reports from the DON and from the SAO-CD. Minutes of the meetings show that they were well attended and action-oriented. The actions were not time-bound however and there was no responsible person documented. There was however, evidence of progression of actions from meeting to meeting.

Quality and Safety Executive Committee (QSEC)

The QSEC was the main committee assigned with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital as per one of its terms of reference 'to ensure the effectiveness of all committees and working groups with an accountability to the integrated risk, quality, health and safety committee'.

According to its TOR dated February 2023, the QSEC was chaired by the clinical director and met every three months. Membership also listed the 'chief executive officer' as a further member. Membership otherwise was multidisciplinary. The QSEC reported to and was accountable to the HMG and it also reported to the council's quality and safety sub-committee which was chaired by a council member.

Inspectors were told that the QSEC reviewed and considered reports, both verbal and written from the various committees that reported into it. These included quarterly reports from the Infection Prevention and Control committee (IPCC), Drugs and Therapeutics and Antimicrobial Surveillance committee (DTAMSC), the Deteriorating Patient Improvement Programme committee (DPIPC) and the Risk, Health and Safety Committee among others in line with the hospital's organogram. Inspectors reviewed the agendas and minutes of the three most recent meetings held in October 2023, February 2024 and May 2024. Inspectors noted that there was scant evidence of reports from the DTAMSC reflected in the minutes of the QSEC in the first two meetings held and it was noted that no report had been received from the DTAMSC in the most recent QSEC minutes. There was no reference to monitoring of medication safety incidents in the minutes of the QSEC provided. Inspectors spoke with staff representatives in relation to these shortfalls in governance which are discussed further under national standards 3.1 and 3.3.

The QSEC provided updates on the hospital's risk register, reported on patient-safety incidents, complaints management, feedback on patient experiences, and progress on implementation of patient safety and quality improvements to the hospital's HMG.

Inspectors also reviewed documentation relating to meetings held by the council's sub-committee on quality and safety in June and December 2023 and in March 2024 to which the QSEC also reported. The top rated risks on the corporate risk register were reviewed and a staff member reported back from the risk, health and safety group noting the number of reported incidents and the number of systems analysis incident reviews conducted or in progress.

Risk, Health and Safety Committee

The hospital had a Risk, Health and Safety department which was responsible for managing incidents and legal claims and liaising with various regulatory bodies. It was led by the risk and health and safety manager who also acted as secretary to the Risk, Health and Safety Committee. The committee was chaired by the SAO-CD and reported to the QSEC.

The terms of reference for this committee, version three were dated 2019, approved by the 'CEO' and were due for review in August 2025. They stated that the chairperson was the CEO/clinical director. Membership comprised the director of nursing, assistant director of nursing, chief operations officer, risk, health and safety manager, theatre manager, infection control nurse, patient services manager, catering manager, medical administration manager, head porter, facilities manager, quality & patient safety manager, manual handling trainer and two safety representatives. The committee was to meet quarterly and report to QSEC. Inspectors found that the committee had met in line with its TOR. The agenda topics included health & safety incident statistics, risk incident statistics, health & safety annual report for 2023 and health & safety plan 2024. Minutes of the meetings indicated that they were well attended, were comprehensive in nature

and indicated progression of items. The responsible person was noted although actions were not time bound.

Infection Prevention and Control Committee (IPCC)

The hospital's multidisciplinary Infection Prevention and Control Committee was responsible for the governance and oversight of infection prevention and control at the hospital. It was chaired by the 'medical director' and was scheduled to meet quarterly. The term 'CEO' was also listed as a member. Other members included the consultant microbiologist, registrar in microbiology, clinical nurse specialist (CNS) for IPC, pharmacist, the quality and safety manager, the health and safety manager, nursing administration, theatre manager and catering manager among others. Staff told inspectors that the pre-existing Decontamination Committee had been subsumed into the IPCC and decontamination matters were reflected in IPCC minutes.

Minutes of meetings of the IPCC for February, April and July 2024 submitted to HIQA, were reviewed by inspectors. Meetings were well attended, the minutes were structured and comprehensive in content and there was evidence of progression of actions and new actions were assigned to named responsible persons. There was evidence of some but not all actions from the IPCC being time-bound.

The IPCC was operationally accountable and submitted a report to QSEC quarterly. It produced an annual IPC programme and work plan. The programme set out the objectives of the IPC team for the year ahead including analysis of the activity in the preceding year, reviewing and keeping up to date with emerging evidence of infectious diseases, development, implementation and monitoring of policies, procedures and guidelines in line with national standards, provision of training for staff, audit of practice and facilities, investigation and leading on outbreak management, risk assessment and management, provision of advice and support. The work plan was action-orientated and contained named responsible persons per task.

The IPC team also produced an annual report which was presented to the IPC committee for ratification. Inspectors viewed the 2023 report which set out the governance of IPC at the hospital and reported on surveillance (hospital-based key performance indicators (KPIs), MRSA and CPE screening, antimicrobial consumption data, sepsis, common transmissible organisms, surgical site infection and COVID-19), audit and monitoring, facilities, decontamination and education and training.

Overall, inspectors found evidence of good governance and oversight of infection prevention and control practices including infection outbreak management.

Medication Safety

The hospital had a multidisciplinary Drugs and Therapeutics-Antimicrobial Surveillance Committee (DTAMSC) with assigned responsibility for the governance and oversight of medication safety practices at the hospital. The committee was chaired by a consultant

anaesthetist as nominated by the Medical Board and ratified by the HMG. Core membership included the pharmacist, consultant microbiologist, CNS-IPC, nursing management, quality and safety manager, the risk, health and safety manager and a trainee medical staff member. The TOR, dated 2024 stated that these were for review on a tri-annual basis and would be submitted to the medical board for approval. The terms of reference were confusing in a number of regards as follows: it was stated that two members of the management team (Name 1- described as the 'CEO / Clinical Director' and Name 2 - described as the 'CEO') were 'welcome to attend'.

Although the organogram provided to HIQA indicated that DTAMSC reported to QSEC, the TOR stated that 'the DTAMSC is considered an advisory sub-committee of the hospital's medical board (MB) to act on its behalf' and that 'the formal reporting structure of the committee and the governance framework of RVEEH, allows direct reporting lines from the DTAMSC to the MB, HMG and CEO, to allow advice from the committee to be enacted by hospital management'. The TOR also stated the following: 'the approved minutes of each meeting to be submitted to the Medical Board, Medical Director and the CEO' and 'the chair reports at Medical Board meetings and attends and communicates with the Quality and Safety Executive on risk issues as necessary (there is a significant overlap in committees' remit). The hospital CEO is the designated authority to make decisions (financial or policy) versus the advisory role of DTAMSC. DTAMSC advises, assists, and is accountable to the CEO'. The TOR indicated that 'an annual report was to be submitted from DTAMSC to the Medical Board'. Inspectors viewed a copy of the most recent annual report which was produced by the DTAMSC in 2022 for 2021.

The frequency of meetings was stated to be 'between two and four times a year (as dictated by agenda items)'. Inspectors heard during meetings with staff and noted from documentation that the committee was due to meet quarterly but had not yet met in the current year at the time of inspection. Inspectors were told that this was due to availability issues of a quorum. In particular, the absence of regular meetings by the DTAMSC meant that there was no consistent forum to consider either medication safety or antimicrobial stewardship and this was brought to the attention of hospital management in writing following the inspection. HIQA received assurances that this would be addressed.

In summary, inspectors found that the lack of regular meetings and ambiguity noted within various terms of reference particularly with regard to roles such as CEO, SAO, clinical director and medical director impacted negatively on matters related to medication safety which is discussed further under national standards 3.1 and 3.3.

The Deteriorating Patient Improvement Programme Committee (DPIPC)

The hospital had a deteriorating patient improvement programme committee in place. This had recently been established from a merger of the cardiopulmonary resuscitation (CPR) and sepsis committees. The TOR, version two, dated May 2024 and due for review in 2026 did not indicate to whom the committee reported however inspectors were told

by staff that the TOR were approved by the QSEC and that it reported to the QSEC and also to the hospital medical board. The TOR stated that the committee was to meet quarterly. It had met twice in 2024 by the time of inspection.

The TOR stated that the DPC 'aims to create and drive a deteriorating patient programme aligned with HSE guidelines and best practice, to enhance patient outcomes'. Staff confirmed that the committee had oversight of the implementation of the Irish National Early Warning Score (INEWS), the Paediatric Early Warning Score (PEWS), the Irish Maternity Early Warning Score (IMEWS) and the sepsis guidelines at the hospital. The committee was chaired by a consultant anaesthesiologist. Membership included the consultant microbiologist, assistant director of nursing, practice development co-ordinator, clinical nurse manager (CNM3) from operating theatre department, clinical skills facilitator, CPR instructor, CNM from the cataract unit, assistant director of nursing-sepsis lead for the Ireland East Hospital Group, chief pharmacist, haemovigilance officer, quality manager, risk manager and a range of medical and nursing staff. The minutes of the meetings were structured, action orientated, person-bound but not time bound.

Transitions of Care (TOCC)

The hospital had an Unscheduled Care Committee (USC). The TOR were undated. They were approved by the QSEC. Membership comprised the chairperson, the head of ophthalmology from the emergency department (ED), the head of ENT from ED, the ED manager (nursing), the quality and safety manager, the risk, health and safety manager, the patient services manager, the assistant director of nursing and the ED clerical officer (secretary). Other members were appointed by the chair and ratified by members. The committee reported to the QSEC. Its objectives included 'the Committee shall deal with the day-to-day activities of the Emergency Department (ED), develop and implement policies, procedures and guidelines that have been recommended and approved by the Quality and Safety Executive (QSE) and execute plans and programmes developed by the Hospital Management Group (HMG)'. The TOR indicated that the committee met monthly but inspectors found that it was not meeting in line with its TOR, instead meeting every three to four months. Inspectors viewed minutes of the meetings and found that meetings were well attended, the minutes were structured and a responsible person was identified for actions but actions were not time bound.

In summary, inspectors found that although the hospital service provider had some formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare,

- there was ambiguity as to who was the senior accountable person for the hospital, which was evident in documentation
- the DTAMSC had not been meeting in line with its terms of reference and in particular had not met in 2024 by the time of inspection, which was held in QTR 3

- there was ambiguity contained within the terms of reference of the DTAMSC as to its reporting line

HIQA issued a high risk letter to the hospital service provider outlining the weaknesses in governance after the inspection and received a response assuring HIQA that such matters were being addressed.

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.

Inspectors noted that the inpatient occupancy level of the hospital had decreased since before COVID-19 and now ranged between 50-80% with a concomitant increase in day-case activity by 21% at the time of the inspection. Between 35-45 patients were scheduled for surgery per day across the five theatres on the first floor and an additional 10 patients per day were scheduled for surgery in the cataract theatre. Fifty to sixty per cent of all patients were reported to have their surgery under general anaesthesia.

Infection, prevention and control

The hospital had an infection prevention and control team comprising;

- 0.2 whole-time equivalent (WTE)[††] consultant microbiologist. This was through a formal agreement with a local tertiary level maternity hospital.
- 0.5 WTE microbiology specialist registrar through a shared post with a local tertiary level maternity hospital
- a surveillance scientist, based at the microbiology laboratory in a local tertiary level maternity hospital also contributed to the surveillance service at RVEEH.
- 1.5 WTE clinical nurse specialists in IPC

The hospital had an overarching infection prevention and control programme[‡‡] as per national standards.[§§] The infection prevention and control team had developed an infection

[††] Whole-time equivalent (WTE). For example, to fulfil 1 WTE, a nurse currently works 37 hours per week. 0.5WTE would equate to 18.5 hours per week.
[‡‡] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out a 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.

prevention and control plan that set out objectives to be achieved in relation to infection prevention and control in 2024. These objectives focused on:

- education for staff on infection prevention and control
- co-ordination of activities in relation to emerging infectious diseases
- infection control audits of practice and facilities
- development and review of policies, procedures, protocols and guidelines (PPPG)
- monitoring and reporting on rates of infection, healthcare-associated infections (HCAI), notifiable diseases, antimicrobial resistance, antimicrobial consumption and alcohol gel usage
- investigating and leading on outbreak management
- identifying infection risks and advising on appropriate action to prevent or minimise these risks
- providing advice and support regarding infection prevention and control policy and related issues
- attending regular meetings and educational seminars relevant to infection prevention and control
- producing an annual work plan and annual report on activity and surveillance data

Inspectors found that staff were knowledgeable on how to recognise, respond to and manage an outbreak. Staff reported good support from the IPC team including access to and support from the consultant microbiologist. Educational talks were provided by the IPC team to new staff on induction and there was regular IPC updates on surveillance and other IPC matters issued via email. The outbreak committee was responsible for oversight and management of outbreaks at the hospital and for drafting a report of the outbreak highlighting any learning which was shared with staff by the IPCC and the director of nursing. Antimicrobial stewardship[***] was reported to be managed under the Drugs and Therapeutics Antimicrobial Stewardship Committee (DTAMSC) but was also a standard agenda item on the IPC agenda.

Medication safety

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

- 1 WTE chief pharmacist
- 1 WTE clinical pharmacist
- 2 WTE pharmacy technicians (both had taken up posts within the previous six months)

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

Inspectors found that medicine reconciliation by a pharmacist was undertaken on most inpatients within 24 hours of admission. There was an in-date medication management policy in place which included guidance on use of high risk and high alert medications and 'sound alike look alike drugs' (SALADS). The clinical pharmacist conducted monthly antimicrobial stewardship (AMS) audits. Medication information 'apps' were in use and upgraded monthly. Staff reported being provided with a medication safety talk at induction and receipt of a monthly 'Medication Safety Tip' from the chief pharmacist. Inspectors noted that reporting of medication safety incidents was comparatively low and were told that reporting levels had decreased in recent years following a change in the mode of reporting from submission of a manual form to data entry on a document management system. This is discussed further under national standard 3.3.

The Deteriorating Patient

The hospital's Deteriorating Patient Improvement Programme Committee (DPIPC) had oversight of the implementation of national early warning scores and sepsis guidelines at the hospital. Staff told inspectors that sepsis training on HSELanD was mandatory for staff and that in-house training on use of early warning scores and the communication tool known as ISBAR3[‡‡‡] was provided by the DON. The HSE Protocol 37[§§§] was used in the event of a patient requiring transfer to an acute hospital.

Transitions of care

HIQA found that the hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. Transitions of care incorporates internal transfers at shift and interdepartmental handover, external transfer of patients and patient discharge. Bed management and patient allocation was managed through the hospital's policies and procedures and was overseen by nursing administration and the out-of-hours on-site managers. The safe inter-departmental and external transfer of patients within and outside the hospital was supported by use of ISBAR3 and complimented with the use of formalised transfer and discharge documentation. Inspectors noted that the hospital had participated in a HSE National Healthcare Communication Programme to promote use of ISBAR3. Staff told inspectors that there was also an inbuilt overlap of one hour in the emergency department for staff to give and or receive clinical handover at the end of a shift.

A medical social worker on staff supported the admission and discharge of vulnerable patients. There was liaison with public health nurses and families or carers. For example

[‡‡‡] ISBAR3, Communication tool required staff to communicate with each other by the caller **I**dentifying themselves, their role and the patient, setting out the current **S**ituation (diagnosis, reason for admission, any impairments), providing relevant **B**ackground information (patient history, medications and level of function), **A**ssessment (observation, impairments and treatment) **R**ecommendation (handover plan, requests, risks and timeframes), **R**ead back and **R**isk.
[§§§] HSE Protocol 37 ensures provision of emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

in the event of sight impairment and the need for administration of eye drops, the PHN and or carer were involved in the handover of care. Where there were any foreseen difficulties with transitions of care, these were escalated to the nursing administration and or the medical team on call for the speciality.

Standardised transfer letters were used to support safe and effective transfers. Inspectors heard that discharge planning began either at the pre-operative consultation or on admission. A discharge summary on the front of the chart for inpatient and day-case patients had to be completed before a patient could be discharged. Discharge letters contained as standard, the reason for admission, duration of admission, instructions for follow-up care, return appointment, name of the discharging doctor and contact details. Day-case patients received a hard copy of their discharge letter for their GP while discharge letters for in-patients were issued via post.

There were no regular formalised meetings with the Community Health Organisation[****] in respect of the possibility of delayed discharges and inspectors were told that delayed discharges were not an issue at the hospital in general, given the types of specialist care provided.

Where incidents relating to transitions of care occurred, they were reported to the risk, health and safety manager using the hospital's electronic document management system. These were reported to the QSEC and HMG and feedback was shared with the relevant stakeholders.

Overall, inspectors found that the hospital service provider had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services in the four areas of known harm.

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.

Inspectors heard how 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). The hospital collated performance data for unscheduled and scheduled care, including data on emergency department attendances, bed occupancy rate, average length of stay and scheduled

[****] Community Health Organisation – services offering healthcare outside of acute hospitals, such as primary care, social care, mental health and other health and well-being services.

admissions. The hospital also collected and collated data relating to patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at quarterly meetings of the QSEC which reported to the fortnightly HMG which in turn reported to council including the quarterly QPS sub-committee of council and to the monthly performance meetings between the hospital and hospital group.

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. Risks not manageable at ward or departmental level were escalated via the QSEC to the HMG for inclusion on the corporate risk register. The hospital's corporate risk register was reviewed at the fortnightly HMG and the quarterly QPS sub-committee of council. Items escalated to the hospital group were reviewed at their monthly meetings. Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to mitigate the risks on the hospital's corporate risk register.

Patient-safety incidents and serious reportable events related to the clinical areas visited by inspectors were reported to the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. The hospital's risk, health and safety manager tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the QPS sub-committee of the council. Incidents were rated by category and frequency. In 2023, the five most frequently recorded incidents included medical emergencies and or use of the HSE Protocol 37, slips, trips and falls by a patient, equipment or device issues, treatment incidents and records or documentation issues. In 2024, up to the end of quarter two, the five most frequently recorded incidents included perioperative procedures, equipment or device issues, slips, trips and falls by a patient, records or documentation issues and medical emergency and or use of HSE Protocol 37.

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital and were responsible for ensuring that all patient safety incidents were managed in line with the HSE's Incident Management Framework. The TOR for the team meetings were viewed by inspectors. The SIMT was chaired by the SAO-CD and the group reported to the HMG. Membership included the DON and the risk, health and safety manager. It was noted that external clinical or technical experts could be nominated to join the SIMT if required. The SIMT met on a quarterly basis 'or as required'. It committed to meeting within 72 hours of receipt of a notification of a serious reportable incident by the SAO. In addition, serious incidents and serious reportable events were discussed at the QPS sub-committee of the council and at performance meetings with the Ireland East Hospital Group. Feedback on patient-safety incidents was provided to clinical nurse managers by the risk, health and safety manager.

The hospital had arrangements in place to monitor the service's performance. Examples of audit and monitoring in respect of the four key areas of harm were provided to inspectors, however, not all audits findings were addressed with quality improvement

plans. Results were relayed to clinical nurse managers and were reviewed by the relevant governance meetings. The need to ensure action on non-compliances presents an area for improvement by the hospital.

Findings from the National Inpatient Experience Survey (NIES) were reviewed at the relevant governance meetings. The hospital had received its results from the 2024 survey at the time of inspection and these were subsequently published. These showed that participation in the survey at 56% was higher than the national response rate of 41% and that overall satisfaction was significantly higher for inpatient care at RVEEH with a score of 8.9 compared to the national score of 8.0. RVEEH had also improved its performance since the most recent NIES results in 2022.

The hospital's Quality Plan for 2024-25 stated that 'A review of the patient comment card submitted is completed by the quality manager on a monthly basis. The findings from this review are discussed at the monthly Quality and Safety Executive Team and an annual report is generated for discussion at the annual quality and safety executive team meeting. Improvements are made and communicated to staff'. Inspectors did not find evidence of this in minutes of the QSEC meetings reviewed or in meetings with staff or on inspection at ward level. For example, inspectors viewed three sets of minutes from the QSEC dated October 2023, February and May 2024. References to complaints management included: the duration of time taken to close off complaints which was discussed at the October 2023 meeting with a recommendation to address the delay. By May 2024, it was stated that very few complaints were being recorded on the hospital's document management system and a plan was documented to address this by mid July 2024. Inspectors also viewed three sets of minutes from the Hospital Management Group dated May, June and July 2024. The May and June minutes stated that there was no update under the heading 'Quality' and there was no reference to complaints in the Quality report of the July minutes. Inspectors noted that the volume of complaints and the numbers still open were reviewed at monthly performance meetings with the Ireland East Hospital Group (IEHG). Inspectors noted in the minutes of the two meetings that minutes were provided for, that complaints data for March was requested at the April meeting as only data for February was provided and it stated in the May 2024 minutes that there had been 60 complaints received year to date.

Complaints were also mentioned in the minutes of the quarterly meetings of the Quality and Safety sub-committee of council meeting insofar as they were included on a dashboard circulated at the committee in June 2023. There was no update or reference to complaints in the minutes dated December 2023 and March 2024.

Overall, inspectors found that the hospital service provider was identifying and acting on only some opportunities to continually improve the quality and safety of healthcare services at the hospital. Inspectors found that there were arrangements in place to monitor performance against key performance indicators including in the four areas of known harm and there was some evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvement

initiatives were implemented in response to some but not all audit findings, patient safety incidents or feedback from people using the service. This presents an opportunity for the hospital service provider to improve upon.

Judgment: Partially compliant

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

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 and reported to the SAO-CD. The hospital had an up-to-date workforce plan in place. Workforce was reviewed at HMG level and at performance meetings with the hospital group. The hospital had workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital's total approved complement of staff at the time of inspection was 385 whole-time equivalent (WTE). This figure was derived from the number of whole-time equivalent staff in post at the end of December 2023 which was the benchmark being used by the HSE for its 'Pay and Numbers Strategy'. The actual complement of staff in post at the time of inspection was 384.7 WTE resulting in a 0.3 WTE vacancy. However, inspectors heard that a further three consultant posts (two for the cataract unit and one for community) plus 5.5 WTE healthcare assistant and 4.4 WTE nursing posts had recently been approved and recruitment campaigns were being planned for these. The hospital's reported absenteeism rate was 4.34% and 3.78% for April and May 2024 respectively. The HSE target was 4% or less. The ward and theatre were fully staffed on the day of inspection. There were no vacancies and no sick leave. Inspectors were told that agency staff are not allocated to theatre and in the event of additional staff being required, staff are deployed from other areas of the hospital.

Hospital management confirmed that all consultants were on the relevant specialist division of the register with the Irish Medical Council. The SAO-CD held annual reviews with each of the consultant staff and records were held by the HR department. The Director of Nursing was responsible for oversight of induction and performance of nurses and healthcare assistant staff. Annual personal development plans were in use for nurses. The DON collaborated with the relevant colleges in the provision of training of nurses and healthcare assistants.

A consultant anaesthesiologist held a joint appointment between RVEEH and a local tertiary level children's hospital. There were no paediatric trained nurses in post at RVEEH at the

time of inspection. Inspectors noted that such a deficit has the potential to impact the quality and safety of care provided to paediatric patients. Inspectors were told that all nurses working with children were up-to-date in use of the Paediatric Early Warning Score (PEWS) and that the hospital had seconded a healthcare assistant to undertake the four-year dual Registered General and Registered Sick Children's Nurse qualification which would be complete by January 2025. Training records reviewed by inspectors demonstrated 99% compliance with mandatory training in PEWS by nurses however less than 1% medical staff were compliant with up-to-date mandatory training in PEWS. This represents an area requiring significant improvement.

A senior clinical decision-maker[††††] at consultant level was on-site in the hospital's emergency department each day. The consultant was operationally accountable and reported to the SAO-CD. The hospital was an approved training site for non-consultant doctors (NCHDs) for the specialty areas. Inspectors were told by staff that RVEEH was a good hospital to work in, that NCHDS received a one-day protected induction period, that on-call arrangements, teaching and learning opportunities, and access to senior support was good with a senior house officer, registrar and a consultant on-call 24/7 for each of the two specialty areas provided at the hospital. Staff reported good access to employee assistance programmes and the staff occupational health service.

The hospital conducted an annual culture of safety survey among staff. Seventy four staff participated in the 2023 survey. Its findings were reviewed by the QPS sub-committee of the council. A quality improvement plan had been developed with three goals to be achieved by year end in 2024 including improvement in the participation rate of the survey, improvement in reporting near misses and improvement in compliance with ISBAR audits.

Uptake of mandatory and essential staff training

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. It was evident from staff training records reviewed by inspectors that nursing staff in the inspected areas undertook multidisciplinary team training appropriate to their scope of practice every two years however HIQA found that attendance and uptake at mandatory and essential training hospital-wide by medical staff required improvement especially on hand hygiene, medication safety and PEWS training.

Training records for nursing and medical staff showed that:

- 98% of nurses, 100% of healthcare assistants and 81% of medical staff were up to date with hand hygiene training – HSE's target is at least 90%.

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

- 98% of nurses, 87.5% of healthcare assistants and 77.5% of medical staff were up to date in basic life support training.
- 99% of nurses, 100% of healthcare assistants and 71.43% of medical staff were up to date with training on the Irish National Early Warning System (INEWS).
- 96% of nurses were up to date with training on the Irish Maternity Early Warning System (IMEWS). No data was provided on this for healthcare assistants or medical staff.
- 99% of nurses, and 0.8% of medical staff were up to date with training on the Paediatric Early Warning System (PEWS).
- 88.2% of nurses and 2.08% of medical staff were up to date with medication safety training.
- 42% of nurses, 40% of healthcare assistants and 50% of medical staff were up to date with complaints management training.

Inspectors noted that the TOR for the DTAMSC included the statement that the DTAMSC would 'disseminate important medication safety information and/or update clinical staff on medication management updates…'. There was no reference in either of the DTAMSC agendas (dated November 2022, June 2023 and December 2023) to oversight of medication safety training. The minutes of the DTAMSC November 2022 meeting however, outlined the concern of the committee in relation to the low uptake particularly among medical staff of both the HSELanD and the RVEEH medication safety e-learning packages and it was noted that the DTAMSC had written to both the Medical Board and medical administration about this (276 users, 84 (30.4%) completed – mainly nursing and pharmacy compliant). There was no update at the next meeting in June 2023 and by December 2023 it was noted on the draft minutes that there was 141 completions to date and a further action was noted to 'send e-mail reminders to complete Medication Management Training'. This was also noted on the December 2023 minutes of the Quality and Safety subcommittee of council and again in the minutes of the February 2024 meeting of the Quality and Patient Safety Executive Committee. Inspectors also noted that the consultant microbiologist had written to the medical board highlighting the need for improvement in compliance with attendance at mandatory training in sepsis (nurses 90%, medical staff 28.75% and consultants 2%).

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare however uptake of mandatory and essential training for nursing and medical staff requires improvement overall.

Judgment: Substantially compliant

Quality and Safety Dimension

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

Inspectors observed the hospital's mission statement and human rights charter on display. Staff were aware of the need to respect and promote dignity, privacy and autonomy of patients and were observed to do so.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care, for example, by the use of privacy curtains and use of a range of single rooms. Patient's personal information in the clinical areas visited, during the inspection, was observed to be prioritised for protection and was stored appropriately in line with relevant standards.

The hospital had recorded the risk of compromising confidentiality within the theatre department due to limitations on available space for pre-operative check-in of patients. The controls put in place included conducting the pre-operative check outside of the door of theatre if there was a patient already waiting inside to go to theatre and the use of a privacy screen between patients where required.

Inspectors noted the use of patient information leaflets throughout the inspected areas but there was no information on display in languages other than in English.

Overall, there was evidence that the hospital service provider and the staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. Inspectors found that staff demonstrated this requirement which is consistent with the human rights-based approach to care promoted by HIQA. Compliance with this standard could be further improved by

- addressing the infrastructural deficits within the operating theatre department to afford confidentiality in transition of care
- expanding access to information to patients who do not speak English

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. This was validated by patients who spoke with inspectors. Patients told inspectors that staff were 'courteous', 'attentive', 'polite' and 'very nice'. Inspectors were told that response to their call bell at night was 'immediate'.

HIQA noted evidence of a person-centred approach to care, especially for vulnerable patients receiving care. Inspectors noted the presence and activity of a sign language interpreter who had been facilitated to attend a patient attending for surgery who had no hearing. As outlined under national standard 5.8, inspectors noted that the National Inpatient Experience Survey 2024 findings showed that the overall rating of experience at Royal Victoria Eye and Ear Hospital was higher than the national average and the overall rating of experience at the hospital had increased since the 2022 survey. Findings from the inspection based on what patients told inspectors also demonstrated high levels of satisfaction with care.

Overall, inspectors found that the hospital service provider and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The hospital service provider had a quality and patient safety plan in place for 2024-2025 which included complaints management. It stated that 'all staff are trained to deal with complaints from service users at the point of contact. If unresolved, complaints must be escalated to the Quality Department through the [hospitals document management system]. The Quality Department reviewed the complaint and assigned it to the relevant department head for response. The hospital's goal is to close all complaints within 30 working days. Closing of complaints will be followed up with relevant departments'.

The quality manager was the designated complaints officer assigned with responsibility for managing complaints and for reporting to QSEC. The QSEC, chaired by the SAO-CD was responsible for the oversight of the effectiveness of the hospital's complaints management process. The hospital had a policy and procedure in place for the management of comments, compliments and complaints which outlined the complaints management process. The hospital also had a comment card system in place at the hospital. Patients could use this to provide anonymous feedback. Collection boxes were located in the hospital.

Inspectors were told by staff that all complaints were acknowledged in line with the hospital policy. The percentage of complaints resolved within 30 days had increased in 2024 to 85% meeting the HSE key performance indicator (KPI) of resolving at least 75% of complaints within the recommended 30 days. It had been 72% in 2022 and had dropped to 40% in 2023. Inspectors were told that complainants had not always received the recommended updates at 20-working day intervals in line with the policy and that this had led to additional complaints about the delay in the processing of complaints. Inspectors heard that a significant proportion of complaints had related to communication around billing issues which had been resolved earlier in the year. This had resulted in a 50% reduction in complaints since then. Inspectors were told that complaints were not specifically trended.

While inspectors did not find posters on display in the inspected clinical areas informing patients on how to make a complaint should they wish to or on any information of advocacy services, inspectors were told and noted that there was detailed information on this on the hospital website with information on use of both the local complaints management mechanism as well as the HSE's 'Your Service, Your Say'. The hospital website also had information on the Patient Advocacy Service including the National Advocacy Service (NAS) for People with Disabilities.

Inspectors heard how informal or stage one complaints were discussed at ward level. Inspectors were provided with two quality improvement plans that had been implemented in response to complaints in recent months however there was limited evidence that feedback from formal complaints was shared with staff.

In summary, inspectors noted that the hospital service provider had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service however inspectors noted that tracking, trending and sharing of learning from complaints was not yet taking place.

Judgment: Substantially compliant

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

On the day of inspection, inspectors visited Harvey Lewis Ward, a 32-bedded inpatient ward and operating theatre number two.

The ward comprised two bays with two beds each, one bay with four beds, one bay with seven beds, and a separate eight-bedded children's ward. In addition, there were nine single rooms, two of which had en-suite facilities. There was one negative pressure room on the ward which was not in use but staff demonstrated its use to inspectors in the event that it should be required. A further single room, used for isolation, was located on a level accessible only by stairs.

Inspectors noted that there was adequate access to toilet, wash-hand basin and shower facilities on the ward. Wall-mounted alcohol based hand sanitiser dispensers were strategically located with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) clearly displayed throughout the clinical areas. Inspectors noted a clinical hand hygiene sink in the sluice room which did not conform to national requirements[‡‡‡‡].

Physical distancing of one metre was observed between beds in multi-occupancy rooms. Staff were observed wearing appropriate personal protective equipment in line with current public health guidelines. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical area visited. There was a walaniting room used for patients admitted to the ward, however, it was also being used for storage. There were two treatment rooms on the ward, one for ophthalmology and one for ENT. There was a medication storage and preparation room which was in an area annexed off the ENT treatment room. There were three sluice rooms on the ward where cleaning agents and cleaning equipment were stored. There was a small 'nurses office' available.

Inspectors observed a list of duties for the health care assistants on display on the ward and found that the cleaning checklists were in order and up to date. Overall the physical environment of the ward was clean with few exceptions. There was evidence of general wear and tear observed as well as some cracks in tiles and loose tiles in the shower room area and around wash-handbasins.

Cleaning of equipment was assigned to healthcare assistants. In the clinical areas visited, the equipment was observed to be clean. A tagging system was in used to identity cleaned equipment. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed.

‡‡‡‡ 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

The medicine fridge in the ophthalmic treatment room had a notice beside it stating that temperature checks were to be recorded daily however inspectors found that these were being recorded once every one to two weeks during the seven weeks preceding the inspection. On enquiry, inspectors found that the hospital also used a centralised temperature monitoring system which was displayed at local level and issued an audible alarm in the event of a problem arising with a particular drug fridge.

Environmental and terminal cleaning was carried out by the hospital cleaning staff. The clinical areas visited had dedicated cleaning staff. The cleaning supervisors had oversight of the cleaning and cleaning schedules in the clinical areas visited. Clinical nurse managers reported satisfaction with the level of cleaning staff in place to keep the clinical areas clean and safe.

The infection prevention and control nurse liaised with bed management daily to ensure appropriate placement of patients at ward level and also ensure correct practices during theatre lists where patients with multi-drug resistant organisms (MDROs) were scheduled for surgery. This included the co-ordination of effective communication, removal of all but the required furniture, equipment and consumables, correct placement on theatre lists and restriction of entry to the theatre with the use of signage.

During the inspection of the operating theatre department, the eye theatre was in use for cataract surgery. Inspectors noted a check-in area and a shared 'scrub' room for the two ENT theatres. The recovery room comprised four adult and two paediatric spaces. The hand hygiene sink in the recovery room did not conform to national requirements. Inspectors noted the presence of nitrous oxide cylinders as well as a bag of Christmas decorations within the electrical panel room of the department. This was brought to the attention of the nurse manager who arranged for their immediate removal and suitable relocation. Curtains were changed in line with the hospital policy. Inspectors noted a breach in the integrity of the wall between ENT and Eye theatres which was awaiting repair following removal of a pre-existing negative pressure unit.

Inspectors were told of ongoing work to secure effective and suitable air handling units for the building as the average temperature in the location was said to range between 22 to 25 degrees centigrade and the recommended air change rate of 20 changes per hour was not being met. This air handling deficit was noted on the corporate risk register and was risk-rated red as was a further risk relating to episodes of water leakage from air conditioning units in two theatres. Controls were identified and in place. These included controlled access via closed doors and use of door bells and restriction on the number of people in theatre to the required personnel as there was open access and egress to and from theatres via a public corridor, use of scavenging and three monthly monitoring and surveillance of bacterial counts. Inspectors were told that the issue and its associated funding request had been escalated to the HSE hospital group. Inspectors found that equipment was being stored on the corridors as storage space was insufficient within the theatre department. This was also recorded on the risk register.

In summary, inspectors were not fully assured that healthcare was being provided in a physical environment which supported the delivery of high quality, safe, reliable care and which protected the health and welfare of service users. In particular, inspectors noted:

- deficits in the physical environment in both areas inspected
- examples of inappropriate storage
- a hand hygiene sink in each clinical area did not conform to the required specifications
- the ventilation and air handling had been an ongoing issue for the hospital. It was recorded on the corporate risk register and had been escalated to the hospital group.

Judgment: Partially compliant

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

Inspectors found that there were systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided. These included audit findings, risk assessments, complaints, compliments, patient experience surveys and patient-safety incident reviews in the four key areas of known harm.

Infection prevention and control monitoring

The Infection Prevention and Control Committee (IPCC) were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Infection prevention and control audit summary reports submitted to HIQA showed that the clinical areas visited on the day of inspection had achieved an overall level of compliance (87%) year to date with environmental, patient equipment and infection prevention and control practices in 2024. There was evidence of progressive improvement in results overall although there remains room for improvement to meet the HSE target of 90% compliance. Audit findings were shared with clinical staff and action plans were developed to address areas requiring improvement however, these were not always time bound. Clinical areas visited were not all compliant with the HSE's target of 90% for hand hygiene practices. For example, Harvey Lewis ward scored 86% while operating theatre department scored 73% in the ENT theatre and 100% in the eye theatre.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection.§§§§ The infection prevention and control team submitted a healthcare-associated infection surveillance report to the Infection Prevention and Control Committee every three months. These reports were shared with consultants and staff in clinical areas.

In line with HSE's national reporting requirements, the hospital reported on rates of:

- *clostridioides difficile*
- *carbapenemase-producing enterobacterales* (CPE)
- hospital acquired *staphylococcus aureus* blood stream infections
- COVID-19

The hospital's rate of *clostridioides difficile* was within the national target of 2 cases per 10,000 bed days used in 2023. Data from the hospital IPC quarterly reports indicated that by end of quarter two in 2024, the hospital had:

- 0 new cases of hospital acquired *clostridium difficile*
- 0 cases of hospital acquired CPE
- 0 cases of RVEEH acquired *staphylococcus* blood stream infection
- 0 cases of RVEEH acquired COVID-19

Staff told inspectors that IPC information from the hospital's patient information system was used to audit both the incidence of multi-drug resistant organisms (MDROs) and to check compliance with screening. The IPC team received a monthly report from the laboratory which was also used to validate this information.

The IPC team conducted audits against the Sepsis 6***** standards and developed a quality improvement plan to address the deficits identified. Quarterly newsletters were issued to all staff with IPC updates.

Antimicrobial stewardship (AMS) monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included monthly AMS audits and participation in the national antimicrobial point prevalence study in 2023 conducted on behalf of the HSE and the Health Protection and Surveillance Centre. RVEEH showed a 4.7% prevalence of healthcare associated infection rate, less than the national average of 7.4% in the study and a higher rate of antimicrobial use at 45.8% compared to the national average of 40%. Inspectors were told that antimicrobial stewardship came under the governance of the quarterly Drugs

***** Sepsis 6 is the name given to a bundle of six actions to be taken in the event that a patient presents with suspected sepsis which has been shown to reduce mortality and morbidity. It comprise 'take three and give three', 1) take blood cultures, 2) take lactate and full blood count and 3) take urine output measurements and 1) give oxygen, 2) give IV fluids and 3) give anti-microbials.

and Therapeutics and Antimicrobial Stewardship Committee (DTAMSC) however, this committee had not met in 2024 at the time of inspection. HIQA issued a high-risk letter to the hospital provider on this matter following the inspection. The hospital service provider responded to HIQA with assurances that this was being addressed.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example monthly audits were carried out in the inpatient areas on medication safety (audit of the medication prescription record) and on medication storage and custody. Inspectors viewed the three most recent audits prior to the inspection and noted that there were a number of non-compliances found in the June and July audits but there was full compliance in all areas by the August 2024 audit. Audit findings in relation to the storage of controlled drugs was 100% in the three most recent biannual audits. There was no evidence of quality improvement plans to address the deficits identified in audits where required. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

National guidelines recommend that clinical handover practice be monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organisation to assure senior managers that any necessary continuous quality improvements are put in place. Inspectors found that the hospital collated performance data relating to the escalation and response of the acutely deteriorating patient by auditing healthcare records for compliance against national guidance on early warning scores. The hospital participated in the National Cardiac Arrest Audit and monitored both its use of Protocol 37 and use of internal calls to its cardiac arrest team. Audit findings were reviewed by the relevant governance groups, however, there were no quality improvement plans in place to address non-compliances.

Transitions of care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's hospital patient safety indicators. The hospital reported on the number of new attendances to ED and the number of admissions and inpatient discharges every month. The hospital was auditing its use of ISBAR3 each quarter and quality improvement plans were in place for non-compliances. Inspectors noted that the July 2024 audit showed 100% compliance.

Overall, the hospital services provider was systematically monitoring and evaluating healthcare services provided at the hospital. The development and communication of time-bound, quality improvement plans in association with audit findings of partial or non-compliance however, were not always completed.

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 identify, evaluate and manage immediate and potential risks to people using the service in the four key areas of harm with a few exceptions.

At ward level, inspectors heard that the clinical nurse manager (CNM2) was responsible for the ward risk register which was reviewed every three months. Items were added to this risk register in consultation with the hospitals' risk, health and safety manager. Inspectors heard from staff that the two highest rated risks on the ward related to the risk of transmissible infections and the lack of paediatric trained nurses. This latter risk was noted on the corporate risk register and inspectors were told by hospital management that this was being addressed through ongoing recruitment for paediatric nurses and by supporting a health care assistant to undertake the dual training in general nursing and in paediatric nursing. It was expected that the nurse would be available to work as a paediatric nurse from January 2025. Nursing staff were trained in PEWS. There was monthly health and safety risk assessments being undertaken at ward level and the lack of adequate storage facilities featured as an ongoing issue.

Staff told inspectors found that if a matter was not manageable at ward or department level, it could be escalated to the quarterly QSEC and from there to the fortnightly HMG for consideration for inclusion on the corporate risk register.

Inspectors viewed the overall corporate risk register and saw that 32 items were listed under one of seven headings as follows: governance, standards of clinical care and patient safety, hygiene, infection control and decontamination, human resources and staffing, infrastructural, fire and environmental. Each item was risk rated and had documented existing control measures and additional actions required to manage and reduce risks. The task owner was identified and there was a documented proposed completion date recorded for each item. The top rated risks across all categories included data governance across the IT systems in use, growing waiting lists for new patient appointments in both specialties, delay in 'review patients' obtaining OPD appointments, and ventilation issues in the operating theatre suites. The risks associated with service demand outstripping capacity and ventilation and air handling had been escalated to the hospital group. An application for funding had been submitted to the HSE in relation to ventilation and air handling and a response was awaited at the time of inspection. Risks specific to the four areas of known harm are discussed below. The corporate risk register was on the agenda for the HMG although inspectors noted that there was 'no update' on this item in the HMG minutes for May, June and July 2024.

Infection Prevention and Control

Inspectors found that risks related to infection prevention and control of healthcare associated infections (HCAI) were identified, monitored, managed and reviewed by the IPC team with oversight at QSEC level. The Infection Prevention and Control Committee maintained its own IPC risk register and reported on it to the QSEC. IPC related risks were also noted on the corporate risk register. The fact that there was 0.2 WTE consultant microbiologist available to the service was recorded on the corporate risk register where it was noted that there was a plan in place to recruit a second consultant microbiologist on a part-time basis. The need to upgrade sinks was listed and it was noted that 67% of all sinks were HBN compliant.

Patients were screened for multi-drug resistant organisms (MDROs) when booking into the hospital and again preoperatively, using a verbal assessment. Where a patient reported a history of being positive for any MDRO, they were followed up by the IPC clinical nurse specialist and underwent screening by swabs. MDRO positive patients were flagged on the hospital's patient administration system to facilitate communication relating to the necessary precautions, optimum bed placement and theatre listing. Inspectors were told that there had been no infection outbreak among patients at the hospital in the previous five years.

At ward level, inspectors noted that while signage was in place on the door of a single room being used to accommodate a patient with a transmissible infection, the door was open. This was brought to the attention of staff who closed the door. Inspectors found a sharps box where the temporary enclosure was open and another which was more than two thirds full. The tourniquets in the integrated sharps tray were not 'single-use' tourniquets. These observations were brought to the attention of the nurse in-charge of the clinical areas.

Medication Safety

Inspectors were told that reporting levels of medication safety incidents had reduced since a change in the mode of reporting was implemented. HIQA communicated this concern in a high risk letter to the hospital after the inspection and received assurances that the system of reporting was being addressed to streamline the process of reporting and so reflect the actual level of incidents.

Inspectors found that risk of harm and potential for errors from medications were identified, monitored and reviewed by the pharmacist and that there was a medication safety risk register dated Q3 2024 in place at the hospital. It contained twelve risks which had been risk rated as red, amber or green based on level of risk, with red being at the highest level. The highest rated risks related to documentation of medication history and risk of under-reporting of medication related incidents. Existing control measures were documented as well as additional control measures and contingency measures for some of the risks listed. A responsible person was noted for each risk. The risk register,

however, did not contain timelines for resolution. There was no record of follow-up on medication safety in the QSEC minutes reviewed by inspectors.

A clinical pharmacy service was available to the inspected clinical areas. Inspectors were told that pharmacy-led medicine reconciliation was conducted within 24 hours of admission. Inspectors observed a 'high risk medicine list' and a 'sounds alike, looks alike (SALADS) list' in the clinical area. Staff told inspectors that a 'Medication Safety Tip of the Month' was received from pharmacy each month. The hospital also had a formulary.

Deteriorating Patient

The hospital was using the HSE early warning score systems for the relevant cohorts of patients to support recognition, response and management of a deteriorating patient. Inspectors noted that the Sepsis 6 bundle, ISBAR3 and the HSE Protocol 37 were in use at the hospital. Policies, procedures, protocols and guidelines were in place to support the use of these risk management strategies. Mandatory training programmes were in place for staff on their use.

Transitions of Care

There were no incidents of delayed transfers of care recorded in HSE HPSIR data year to date. Staff told management that discharge was planned either from the preoperative stage or on admission. Where it was anticipated that assistance was needed in the case of a vulnerable patient, the multidisciplinary team including the medical social worker were involved. Inspectors noted that there was good compliance with the use and continued monitoring of ISBAR3.

In summary, inspectors found that the service provider had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service of the four key areas of harm with a few exceptions in the areas of compliance with standard and transmission based precautions and medication safety.

Judgment: Substantially Compliant

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

The hospital reported clinical incidents to the National Incident Management System (NIMS). Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of common patient-safety incidents for example, medication errors. Incidents were reported directly onto the hospital's electronic document management system and were reviewed by the risk, health and safety officer who categorised and risk rated the incidents and reported them to NIMS. Feedback to staff in clinical areas was provided informally by the risk, health and safety manager,

clinical nurse managers, clinical pharmacists and the infection prevention and control team.

The QSEC, HMG and the QPS sub–committee of council were responsible for oversight of the management of incidents. The Serious Incident Management Team, HMG and the QPS sub–committee of council also had oversight of serious incidents and reportable events. These were also reviewed in performance meetings with the Ireland East Hospital Group.

Inspectors noted that 166 incidents were reported to NIMS in 2023. That included 46 health and safety related incidents. Inspectors found that an average of 12 clinical incidents per month had been reported to NIMS from January to July 2024 according to published HSE HPSIR data. The hospital tracked and trended patient-safety incidents and an incident summary report was submitted to the quarterly QSEC and the quarterly QPS sub-committee of council. Inspectors found infection prevention and control and deteriorating patient safety incidents were being tracked and trended. Transitions of care was not a specific category when incidents were tracked and trended.

Patient-safety medication incidents were categorised by the person reporting the incidents in terms of type of medication and type of incident. Incidents were reviewed by the chief pharmacist. The hospital recorded 23 medication patient-safety incidents in 2023. The most common type of medication incidents related to prescribing and administration errors. The most frequently occurring medication incidents were associated with the use of antibiotics, topical ophthalmic preparations, and respiratory, cytotoxic and cardiovascular medications. By the end of quarter two in 2024, the hospital had recorded 11 medication patient-safety incidents. The most common type of medication incidents related to administration followed by prescribing. The most frequently occurring medication incidents were associated with the use of cytotoxic drugs and topical ophthalmic preparations.

Inspectors were told that the level of reporting of medication safety issues had decreased over a number of years. Inspectors noted that this concern had been recorded in minutes of the DTAMSC in 2023. Inspectors noted that the HSE KPI rate of medication incidents to be reported to NIMS was 3.0 per 1,000 bed days in 2024 (KPI Number A113 - Rate of medication incidents as reported to NIMS per 1,000 beds). Inspectors note that reports of 11 medication safety incidents to NIMS within the first six months of the year is below the expected range of reporting based on the number of inpatient beds at the hospital. The proportion of serious reportable events (medication related) relative to the total amount of reported medication incidents also indicated that the level of reporting was lower than it ought to be, where there is a positive patient safety culture.

Inspectors heard from staff, and viewed documentation relating to the management of a sample of serious reportable events. Open disclosure was carried out, actions were taken to mitigate the risks, and the patients were monitored and followed up. Anonymised preliminary assessment reviews were undertaken in line with hospital policy prior to the

SIMT meeting and immediate actions taken to avoid recurrence. Incidents were reported to NIMS within the recommended 30-day timeframe. The SIMT requested that systems analysis reviews be conducted. Inspectors viewed the terms of reference for one review which were in line with the *'HSE Incident Management Framework 2020'*. Inspectors also viewed an anonymised systems analysis review which included an apology to the patient, identification of a key causal factor and contributory factors, recommendations and an update on implementation of recommendations, all of which with the exception of one had been implemented and the remaining one continued to be under review at the time of inspection.

In summary, inspectors found that the hospital service provider 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. There is room for improvement in the monitoring of incidents relating to transitions of care and also in ensuring that all medication incidents are reported to NIMS in line with national guidance.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of the Royal Victoria Eye and Ear Hospital on 21 and 22 August 2024 to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

Under the dimensions of capacity and capability, inspectors found that the hospital service provider was compliant in national standard 5.5, substantially compliant in national standard 6.1 and partially compliant in national standards 5.2 and 5.8.

The Royal Victoria Eye and Ear Hospital had some formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare, however, inspectors found that improvement was required in a number of areas. There was a lack of clarity leading to ambiguity in relation to who was the responsible person for the hospital particularly on documentation provided. Further weaknesses in governance impacted oversight of medication safety at the hospital. HIQA issued a high risk letter to the hospital in relation to the governance and oversight of medication safety and were provided with assurances by the hospital.

Inspectors found that the hospital had effective management arrangements and were monitoring performance against key performance indicators including in the four areas of known harm. There was some evidence that information from this process was being used to improve the quality and safety of healthcare services however the hospital would benefit from ensuring that quality improvement plans are in place for all audit findings of partial or non-compliances.

HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff to support the provision of high-quality, safe healthcare however in light of the paediatric population who avail of services at the hospital, the hospital needs to keep a focus on improving the ratio of paediatric nurses on its staff. Uptake of mandatory and essential training for nursing and medical staff requires improvement overall.

Quality and Safety

Under the dimensions of quality and safety, inspectors found that the hospital service provider was compliant in national standard 1.7 substantially compliant in national standards 1.6, 1.8, 2.8, 3.1 and 3.3, and partially compliant in national standard 2.7.

HIQA found that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. Inspectors found that there is a need for improvement in the physical infrastructure of the theatre for infection prevention and control reasons and to help improve privacy and enhance confidentiality for patients especially during transitions of care. People who spoke with inspectors were positive about their experience of receiving care in the hospital and were very complimentary of staff. Hospital staff demonstrated awareness of the need to support and protect more vulnerable patients and inspectors noted evidence of good practice with the use of sign language when communicating with patients who had hearing impairment.

Inspectors found that the hospital was not yet tracking and trending its complaints however management of complaints overall had improved in 2024 with most complaints being resolved within 30 days.

The physical environment inspected, while clean, was in need of infrastructural upgrading as the challenges in ventilation and air handling had been an ongoing issue for the hospital. This had been recorded on the corporate risk register and had been escalated to the hospital group. Modification was reported to be a challenge given the age of the building. Hand hygiene sinks which conform to national requirements, provision of adequate storage and maintenance of existing tilework were also needed. This is necessary to support the delivery of high-quality, safe, reliable care and protect the health and welfare of people receiving care, especially vulnerable patients. The hospital is likely

to require the support of the external HSE structure to progress some of these required improvements.

The fact that the Drugs and Therapeutics Antimicrobial Surveillance Committee was not functioning or meeting in line with its terms of reference was impacting negatively on medication safety for example, the proportion of serious reportable events (medication related) indicated that the level of reporting (medication errors) was lower that it ought to be where there is a safe culture of reporting. HIQA issued a high risk letter to the hospital. The SAO-CD provided assurances that all matters raised were being addressed.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor progress in relation to governance, completion of mandatory training, effective complaints management 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

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 standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

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

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

Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	**Substantially Compliant**
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	**Compliant**
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	**Substantially Compliant**
Theme 2: Effective Care and Support	
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**
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.	**Substantially compliant**
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	**Substantially Compliant**

Compliance Plan

Service Provider's Response

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

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.

Governance: The RVEEH is governed and managed by the Senior Accountable Officer-Clinical Director (SAO-CD). The SAO-CD reports to the Council of the hospital and the Dublin South East Region via the annual Service Level Agreement.

The lack of clarity regarding governance, that has been reflected in the shared documentation, particularly around roles and responsibilities, is now reflected in the attached organogram, which shows all roles within senior management at the hospital. Inaccuracies in hospital documentation, that has been shared with HIQA, will be corrected. Tommy Bracken is the acting Business Manager at the hospital. Between January and August 2024 the HMG met on 10 occasions (6 short of what is required in the HMG Terms of Reference). Going forward the meetings will be scheduled in accordance with the HMG ToRs.

DTAMSC and ToR: The DTAMSC meeting took place on September 4, 2024, where the Terms of Reference (TOR) with the revised reporting structure (direct line report into QPS Sub-Committee of Council and Medical Board) were agreed and will be submitted to the QPS for approval. The DTAMSC had not met in 2024 (terms of reference requires between 2-4 times per annum) and this will be rectified going forward.

Time Bound Actions: The HIQA report calls out that actions from the performance meetings between the RVEEH- Dublin South East region are frequently not time bound. This has been raised with Dublin South East and will be reflected in future meetings.

The minutes template for all RVEEH committees will be amended to include a section for time-bound actions.

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

Action plans: All action plans discussed and raised in the respective committees will have time-bound completion status.

Timescale: Q2 2025

National Standard	Judgment
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.	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. • A monitoring framework will be implemented to ensure all audit findings are reviewed by the respective committees/ departments to include Quality Improvement Plans (QIPs). These will be assigned to a dedicated staff member with task based, time-bound actions to be addressed (SMART methodology). A status report would be presented to the Quality and Patient Safety Executive (QPS). (b) where applicable, long-term plans requiring investment to come into compliance with the national standard • Quarterly reviews of the framework will be reviewed in the QPS and Sub-Committee of Council. • Information sessions on findings and recommendations arising from incident reviews to be held for all relevant staff following completion of incident reviews.	
Timescale: Q2 2025	

National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Outline how you are going to improve compliance with this national standard. This should clearly outline:	

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

- Deficits in the physical environment have been addressed.
- A breach in the integrity of the wall between ENT and Eye theatres which was awaiting repair following removal of a pre-existing negative pressure unit has been repaired.
- On the day of the inspection, it was found that there was inappropriate storage of items in the theatre department – the following interim measures are in place to mitigate the risks relating to inappropriate storage:
- Education provided to staff on appropriate storage of theatre equipment.
- Where adequate storage is not available, additional storage has been provided in Day-Care Unit.
- Hand hygiene sinks in clinical area did not conform to the required specifications: the following interim actions and measures have been implemented to mitigate risks relating to non-compliance of two hand hygiene sinks:
  - Sink replacement programme in place, currently 80% of hygiene sinks have been replaced; non-compliant sinks will be replaced by year end
  - 90% of staff have completed hand hygiene training
  - Hand sanitiser dispensers have been installed throughout the hospital

(b) Longterm planning requiring investment to come into compliance with national standard:

- Hand hygiene sinks in PACU are due to be replaced with two HBN 00-10 sink units in 2025

Operating Theatres

The lack of conventional ventilation in the first-floor operating theatres continues to be recorded on the corporate risk register.

To mitigate risks arising from structural and engineering deficits in OTs, the following controls are implemented by the IPCT:

- Portable HEPA filter machines are installed on corridor outside ENT theatres and Eye theatres.
- Air conditioning units installed in all theatres, these are serviced on a monthly basis; access to theatres are controlled by use of doorbells, closing all external doors and restricting number of people in theatre at any given time.
- Environmental air sampling, done quarterly in all 5 first floor OTs
- Results are reviewed by the IPCT, and where counts are outside the agreed parameters additional cleaning and re-testing is done. See Appendix 9
- Surveillance allows the IPCT to ensure that additional Infection Control measures are instigated when patients with known transmissible infections are in OT. This includes use of additional PPE and placing patient last on theatre list.
- Surveillance of all post-op infections allows the IPCT to identify patterns of infection that may be attributable to structural deficits.
- Regular environmental audits
- Liaising with head of department to ensure local policies and procedures for Infection Control in Theatre department are adhered to

• The issue has been escalated to the Medical Board, Hospital Management Group (HMG), and at Hospital Council meetings. • Plans for a new theatre complex and upgrading of existing theatres have been submitted to HSE estates.
Timescale: Q4 2025