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:	The Incorporated Orthopaedic Hospital of Ireland trading as Clontarf Hospital
Address of healthcare service:	Blackheath Park Clontarf Co. Dublin D03 AY95
Type of inspection:	Unannounced
Date(s) of inspection:	10 and 11 December 2024
Healthcare Service ID:	OSV-0005678
Fieldwork ID:	NS-0109

About the healthcare service

Model of hospital and profile

The Incorporated Orthopaedic Hospital of Ireland trading as Clontarf Hospital is a rehabilitation and community inpatient hospital. It is a voluntary (section 38) [*] hospital and is governed by a Board of Governors on behalf of the Health Service Executive (HSE). Until 1 October 2024 the hospital was under the governance of Community Health Organisation 9 (CHO 9). At the time of inspection the hospital was transitioning to the governance of the Integrated Healthcare Area Dublin North City and West.

Clontarf Hospital has 160 inpatient beds. Services provided by the hospital include:

- adult orthopaedic rehabilitation (43 beds)
- rehabilitation for older people (80 beds)
- specialist rehabilitation (16 beds)
- Rehabilitation and Function after Trauma (5 beds-pilot)

A further 16 beds allocated to older persons were funded as 'HSE Winter Action Plan for Urgent & Emergency Care Operational Plan 2024/2025'[†] beds. On the days of inspection 136 beds were occupied.

How we inspect

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

[*] Section 38 relates to agencies provided with funding under Section 38 of the Health Act 2004.
[†] HSE Winter Plans are developed to provide additional capacity and resources to meet the expected high levels of activity during the winter period.
[‡]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.

- 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 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 of this report.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
10 December 2024 11 December 2024	09.00 – 17.00hrs 09.00 – 13.50hrs	Sara McAvoy	Lead
		Nora O'Mahony	Support
		Eileen O'Toole	Support

Information about this inspection

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

- infection prevention and control
- medication safety
- the deteriorating patient
- transitions of care[§]

The inspection team visited two clinical areas:

- Swan (older persons rehabilitation)
- Blackheath (specialist rehabilitation, orthopaedic rehabilitation and Rehabilitation and Function After Trauma)

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

- Chief Executive Officer
- Director of Nursing
- Quality Officer
- Representatives for the non-consultant hospital doctors (NCHDs)
- Human Resource Manager
- A hospital representative from each of the following areas:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Transitions of Care
  - Deteriorating Patient

Inspectors also spoke to hospital staff from a variety of professions and disciplines in the clinical areas visited during this inspection.

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

[§] 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

Inspectors spoke with patients accommodated on both wards visited. Overall patients reported that they were satisfied with the care they received on the ward and were complimentary of the staff and the care. They said staff were *'responsive, helpful and kind'* and *'very friendly'*. Patients said the care was *'very good'* and one patient reported they were *'getting better every day'*. Inspectors observed staff engaging with patients in a kind, respectful and considerate manner. Staff were observed supporting and assisting patients with their individual needs.

Most of the patients who spoke with inspectors were aware of their plan of care. Inspectors observed information about the hospital complaints process displayed alongside feedback/suggestion boxes in the hospital corridors. Although not all patients that spoke with inspectors were aware of the complaints process they were confident that they could raise any issues with the nursing teams on the wards.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce, use of resources.

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

Inspectors found that Clontarf Hospital had integrated corporate and clinical governance arrangements in place to assure the delivery of high quality, safe and reliable healthcare.

Clontarf Hospital was governed by an independent Board of Governors. The chief executive officer (CEO) was the senior accountable officer with overall responsibility and accountability for the governance and quality of the healthcare services delivered in the hospital. The CEO reported to the board of governors and the hospital had a reporting relationship with CHO 9. At the time of this inspection the hospital was transitioning to reporting to Integrated Healthcare Area Dublin North City and West. The hospital did not have a clinical director, however inspectors were told that a 0.5 whole-time equivalent (WTE)** post had been advertised but that efforts to recruit were unsuccessful to date. The

** Whole-time equivalent - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker, 0.5 refers to an employee that works half full-time hours.

director of nursing (DON) was responsible for the management of nursing services in the hospital and reported to the CEO. Organisational charts provided to HIQA clearly outlined the direct reporting structures for Clontarf Hospital and these were consistent with the governance arrangements outlined by staff during this inspection.

The hospital was governed by a Board of Governors which had a remit to provide leadership and direction for assuring the delivery of quality and safe services at the hospital. Board subcommittees included audit, finance, quality, safety and risk management, and governance, remuneration and nominations. The CEO and DON attended Board meetings and provided reports which included nursing quality care metrics[††], activity data and infection prevention and control (IPC) issues. Board meetings were scheduled eight times per year and minutes of Board meetings reviewed by inspectors indicated that the Board was meeting at a frequency aligned to its terms of reference. The Board maintained an action plan log which was updated at each meeting and included action owners and timelines for completion of actions.

As previously mentioned, at the time of this inspection the hospital was transitioning to the governance of the Integrated Healthcare Area Dublin North City and West. The CEO and DON had attended quarterly Integrated Management Report meetings with the head of services for older persons and the general manager for older persons services for CHO 9. The meetings were chaired by the head of services for older persons and standing agenda items included risk management, serious reportable events, complaints and IPC updates. Minutes provided to inspectors showed that actions arising were time bound, had owners assigned to them and were being progressed from meeting to meeting.

The Executive Management Team (EMT) had a remit to ensure the effective running of the hospital in order to optimise the quality of care provided and the experiences of patients. The EMT was chaired by the CEO and was accountable to the Board of Governors. Membership included a hospital medical consultant, the DON and the quality officer. The EMT met monthly, which aligned with its terms of reference. Meeting minutes reviewed by inspectors showed that meetings followed a structured format and actions had owners assigned to them. However, not all actions had associated timelines for completion.

The Quality and Safety Committee (Q&SC) was a subcommittee of the board, and its function was to assure the Board that there were appropriate and effective systems in place that managed all aspects of clinical quality, safety and risk, and to provide strategic oversight in the development and implementation of national patient safety programmes relevant to patient safety and quality of care. The committee was chaired by a board member and was meeting quarterly, which aligned with its terms of reference. The CEO, DON, risk officer and quality officer attended these meetings, however the committee terms of reference did not clearly outline the committee membership. Nursing quality care metrics, incident management, medication errors, complaints and IPC issues were standing

[††] Nursing and midwifery quality care-metrics (QCM) provide an indication of the quality of the fundamentals of nursing and midwifery care

agenda items and meeting minutes reviewed by inspectors showed that a rolling action log was reviewed at each meeting and included action owners.

The Infection Prevention and Control and Hospital Hygiene Committee had a remit to maintain an overview of infection control priorities and hospital hygiene, and to link this to clinical governance and risk management processes. The committee was chaired by the DON and had met four times in 2024, which aligned with its terms of reference. Membership included an IPC clinical nurse specialist (CNS), a consultant microbiologist, health and social care professional (HSCP) managers and representatives from general services and contract cleaning services. The committee reported quarterly to the EMT and to the Quality and Safety Committee. Inspectors were provided with meeting minutes which showed that outbreak management, hygiene audit results and healthcare associated infection surveillance were discussed. However not all actions from meetings had clear owners and time frames for completion.

The Drugs and Therapeutics Committee (DTC) had a remit to improve health and economic outcomes of patient-centred care through rational and cost-effective use of medicines. At the time of this inspection the committee was chaired by the Chief Pharmacist, who also performed the role of secretary. The terms of reference did not accurately reflect who chaired this committee. Committee membership included the chair of the medication safety committee, the DON, a consultant microbiologist and the risk manager. There was also representation from a non-consultant hospital doctor (NCHD) and Clinical Nurse Manager 2 (CNM2) staff groups. The terms of reference indicated that meetings should occur four times per year. The DTC had met twice year to date and planned to meet in December 2024. Minutes of DTC meetings reviewed by inspectors showed that although actions had owners allocated to them there were no timeframes for completion of actions. The terms of reference indicated that the DTC reported into the EMT on a quarterly basis, however minutes of EMT meetings reviewed did not reflect these reporting structures. Medication errors were discussed at EMT meetings as part of the safety and quality report.

The Medication Safety Committee was a sub-committee of the DTC and reported into the DTC. It was chaired by a senior pharmacist and its function was to monitor, review and audit medication incident reports and promote medication safety within the hospital. The terms of reference provided to HIQA had been due for review in March 2024 and indicated that the committee should meet monthly. The committee had met six times in 2024 year to date, and inspectors were told there was a meeting planned for December 2024. The Medication Safety Committee reports provided to the DTC reviewed by inspectors included incident analysis, audit results and risks. Actions arising were assigned to action owners but did not include timeframes for completion.

Patients transferred to Clontarf Hospital were admitted under the clinical governance of a named consultant according to the type of rehabilitation for which the patient had been

referred. The Delayed Transfers of Care[‡‡] and Complex Discharges[§§] Committee had a remit to investigate why delayed discharges occurred, to develop pathways of care, explore specialised care plans and set key performance indicators to prevent and reduce the number of delayed discharges occurring in the hospital. It was chaired by the DON and membership included the CEO, patient flow manager, HSCP representatives and consultant geriatricians. The committee was meeting monthly, which aligned with its terms of reference and meeting minutes reviewed by inspectors showed that meetings were structured and that actions had owners allocated to them. However the completion of actions was not tracked in meeting minutes and did not include timeframes for completion.

The hospital had a deteriorating patient policy and was using a modified version of the Irish National Early Warning Score (INEWS). The Unscheduled Transfer of Care Group had recently been established as a sub-group of the Quality and Safety Committee to monitor the unscheduled transfer of care out of the hospital to other healthcare facilities, including acute hospitals. The committee had been meeting monthly which aligned with its draft terms of reference. It was monitoring transition of care issues related to unscheduled transfers of patients such as out of hour's admissions and transfer documentation issues. Actions arising had owners allocated to them but did not include timeframes for completion.

Overall, it was evident from documents reviewed by inspectors and meetings with relevant staff that Clontarf Hospital had governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. However:

- the committees responsible for medication safety were not meeting in line with their terms of reference
- not all actions arising from committee meetings had timeframes for completion.

Judgment: Substantially compliant

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

Management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital. Patients were admitted to the hospital principally from the

[‡‡] Clontarf Hospital defined a delayed transfer of care as when a patient is ready to leave hospital but is still occupying a bed. It happens when a patient is waiting to go home or into care elsewhere, but the care or home supports are not in place for them.
[§§] Clontarf Hospital defined a complex discharge as a situation where more involved specialised care planning is required after the patient leaves the hospital.

Mater Misericordiae University Hospital (MMUH), Beaumont Hospital and the National Orthopaedic Hospital Cappagh but accepted referrals from all acute hospitals in the greater Dublin area

- Orthopaedic rehabilitation was provided using 32 beds in Vernon ward, eight beds in Kincora ward and three beds in Blackheath ward. Patients were referred from the acute hospitals and from Cappagh hospital and remained under the clinical governance of their referring consultant during their inpatient stay in Clontarf Hospital.
- Geriatric rehabilitation was provided using 32 beds in Gracefield ward, 32 beds in Swan ward and 16 beds in Kincora ward. Patients were referred for active rehabilitation from Beaumont Hospital, MMUH and from the Integrated Care Programme for Older People (ICPOP).*** A consultant geriatrician from Beaumont Hospital provided clinical governance for the patients in Gracefield ward. A consultant geriatrician from MMUH provided clinical governance for patients in Swan ward and for the cohort of patients in Kincora ward receiving geriatric rehabilitation.
- Specialist rehabilitation was provided using 16 beds in Blackheath ward to patients referred from Beaumont Hospital following for example, stroke or traumatic brain injury. These patients were under the clinical governance of a consultant from Beaumont Hospital.
- Five of the beds located on Blackheath ward were allocated specifically to patients requiring 'rehabilitation and function after trauma' (RAFT) as a pilot rehabilitation programme of care. Clinical governance for these patients was provided by a consultant in rehabilitation medicine from MMUH.
- A further 16 beds were funded and allocated to assist the 'HSE Winter Action Plan for their Urgent and Emergency Care Operational Plan' for older persons. Eight beds were allocated to patients referred from MMUH in Kincora ward and eight beds were allocated to patients referred from Beaumont Hospital in Blackheath ward.

There was one WTE approved consultant geriatrician employed by Clontarf Hospital, comprised of two 0.5 WTE consultants. As previously mentioned the 0.5 WTE post of clinical director was unfilled at the time of this inspection. A medical registrar and senior house officer (SHO) were assigned to each ward Monday-Friday during core working hours. Out-of-hours medical cover was provided by an SHO who remained on site. A medical registrar provided on-call support to the SHO at weekends from Saturday 8am

*** Integrated Care Programme for Older Persons (ICPOP): The aim of ICPOP is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care.

until Monday 8am, including bank holidays. There was no consultant physician providing formal on-call cover out of hours. There was no senior clinical decision-maker employed by Clontarf Hospital available to the SHO or medical registrar on call. Inspectors were told that management planned to have senior clinical decision-making cover in place out of hours by the end of Q1 2025. There were management arrangements in place to transfer patients who required an escalated level of care outside of normal working hours. Senior nursing support out of hours was provided by a clinical nurse manager 2 on site, and staff were aware of how to access this support.

The hospital had an IPC strategy and action plan for 2022-2024, with evidence of tracking of actions by assigned owners. There was one WTE IPC clinical nurse specialist (CNS) and a consultant microbiologist who had a commitment of six hours per week onsite to the hospital. The consultant microbiologist was available for advice during normal working hours. Out of hours, staff could access microbiology expertise from the acute hospitals, however this arrangement was informal. The IPC CNS and cleaning manager attended a daily operations huddle in order to address any IPC issues, and the IPC CNS produced a daily IPC report which included the details of any patients awaiting test results.

Inspectors were told that due to resourcing the clinical pharmacy service[†††] provided was targeted and prioritised to provide medication reconciliation[‡‡‡] on admission, stock management, cross checking of discharge prescriptions and answering clinical queries. Arrangements were in place to access medications out of hours and staff on the wards were aware of these.

The hospital had current admission, transfer and discharge policies, and patients referred to Clontarf Hospital were assessed in Beaumont Hospital and MMUH by the consultant geriatricians employed by Clontarf Hospital prior to being accepted for admission. Clontarf Hospital had processes in place for the management and transfer of a deteriorating patient. Contact details for required services were displayed clearly on the ward. Staff who spoke with inspectors were knowledgeable about the management of a deteriorating patient and the processes for escalation and transfer of care when required. Patients who required transfer to the acute setting were transferred back to the referring hospital where possible. Transfers taking place out of hours were managed by the SHO on duty and the nursing team, liaising with the on call medical registrar in the acute hospital receiving the patient.

Overall, the management arrangements were effective to support and promote the delivery of high quality, safe and reliable healthcare services relevant to the size and scope of the hospital. However:

[†††] Clinical pharmacy service - a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[‡‡‡] Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies.

- there was no designated lead clinician with oversight for the medical activity in the hospital.
- there was no consultant physician providing formal on-call cover out of hours.

Judgment: Partially compliant

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

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

The hospital collected data on a range of different measurements related to the quality and safety of healthcare services for example, patients who required readmission to the acute hospital, patient-safety incidents and complaints. Evidence was seen by inspectors that this data was reviewed and discussed at Quality and Safety Committee meetings, EMT meetings and at Integrated Management Report meetings with CHO 9. The average length of stay was monitored at the Delayed and Complex Discharge Committee meetings and EMT meetings.

The hospital had risk management structures and processes in place to identify, monitor, analyse and manage identified risks. The corporate risk register was reviewed twice yearly by the CEO with oversight by the Board. The hospital also maintained a hospital level risk register with oversight by the CEO and department risk registers which were overseen by heads of departments. The hospital and department risk registers were reviewed every six months. Risks related to the four key areas which were the focus of this inspection, such as infection prevention and control, are discussed under section 2.7 and 3.1.

The hospital had a quality and safety programme and action plan for 2024 which demonstrated tracking of actions, action owners and timelines. There was an annual audit plan which detailed oversight of audits which included medication safety and IPC audits. Audit findings were used to inform quality improvement plans. For example the hospital had developed a quality improvement initiative centred on improving continence which had resulted in positive patient outcomes and supported the recruitment of a CNS in Continence Promotion.

Clontarf Hospital had structures in place to report and monitor patient-safety incidents. Incidents were managed by the risk officer with oversight by the EMT. Recommendations arising from incident reviews were discussed at the Incident Management Team meetings

and implementation of recommendations was tracked by the Quality Improvement department. Learning from incidents informed quality improvement projects (QIPs) where appropriate for example, all toilet doors on wards were retrofitted to allow them to open both inwards and outwards following an incident where access was hindered by an inward-only opening door. Compliments and complaints were tracked and reported upwards to EMT and the Board, and shared at ward level by ward managers at safety pauses and huddles. An annual patient satisfaction survey was undertaken to inform improvement measures, and inspectors saw evidence of resultant focussed QIPs.

Overall the hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided relevant to the size and scope of the hospital.

Judgment: Compliant

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

Clontarf Hospital had effective workforce arrangements in place to support the delivery of high-quality, safe and reliable healthcare.

There were 96.2 WTE approved nursing posts, all of which were filled at the time of the inspection. Vacant nursing shifts arising due to short-term sick leave were covered by the hospitals own nursing staff. Care was supported by 66.6 WTE healthcare assistant (HCA) posts, and there was 0.45 WTE HCA vacancy at the time of the inspection. IPC support and advice was provided by one approved WTE IPC CNS and this post was filled at the time of the inspection.

Patients had access to a multidisciplinary team which included physiotherapists, speech and language therapists and occupational therapists onsite. There were 48.67 WTE approved health and social care professional posts and these were all filled at the time of inspection. There were also two WTE approved physiotherapy assistants and two WTE approved occupational therapy assistants in post.

As previously described, there was one WTE approved consultant gerontologist post in Clontarf Hospital and this was filled by two consultants each providing 0.5 WTE. A 0.5 WTE clinical director post had been advertised but efforts to recruit had been unsuccessful. There were seven WTE approved senior house officer posts and three WTE approved medical registrar posts, all of which were filled at the time of the inspection. Each ward had an SHO and medical registrar allocated to them daily and there was an SHO onsite outside of core working hours.

There were three approved and filled WTE pharmacist posts, and this team was supported by 0.5 WTE approved pharmacist technician, also filled. Inspectors were told that a business case had been submitted to CHO 9 for a 0.5 WTE antimicrobial pharmacist post, but had not been progressed at the time of the inspection. A consultant microbiologist had a commitment of six hours per week onsite to Clontarf Hospital (0.16 WTE) and was available for advice Monday to Friday during core hours.

Oversight of nursing training was provided by an assistant director of nursing, and electronic records of training facilitated managers to prompt staff when refresher training was due. Records of training provided to inspectors indicated that staff were up to date in their mandatory training and other training relevant to their individual scopes of practice. For example full compliance rates (100%) were reported in hand hygiene training, infection outbreak management and standard based and transmission based precautions for nursing, HCAs, NCHD, housekeeping and HSCP staff groups. Nursing compliance rates for INEWS training (88%), medication safety training (90%) and clinical handover training (88%) were also high. Basic Life Support training compliance rates were 94%, 84% and 100% for nursing, HCA and NCHD staff groups respectively. Inspectors were told that all doctors were provided with Advanced Cardiac Life Support training (100% compliance), and that NCHDs were afforded online HSE Early Warning Score training (75% compliance).

Overall Clontarf Hospital had arrangements in place which were planned and managed to support the delivery of high-quality, safe and reliable healthcare. However there was room for improvement found in NCHD compliance rates for INEWS training.

Judgment: Substantially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

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

Overall inspectors found that patients' dignity, privacy and autonomy were respected and promoted. Inspectors observed staff communicating with patients in a manner that respected their dignity and privacy, and staff were observed seeking consent when

providing care. Patients' personal information and healthcare records were stored securely on the wards visited.

On both wards privacy curtains and screens were available and utilised for patients receiving personal care, and patients were supported to dress in their own clothes. Most patients that inspectors spoke with were aware of their plan of care and knew their predicted length of stay.

Overall, staff and management in the unit made every effort to ensure that patients' dignity, privacy and autonomy were respected and promoted.

Judgment: Compliant

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

It was evident that a culture of kindness, consideration and respect was actively promoted in Clontarf Hospital. Kind interactions between staff and patients were observed by inspectors. Staff were observed providing individualised assistance with respect and consideration, for example in relation to offering support at mealtimes if needed and accommodating food preferences.

Inspectors observed that patients were communicated with in a respectful manner. There was a hairdressing and barber service available to patients, and one patient reported '*I get assistance with everything I need*" and another said *'all I have to do is ask'*.

Patient information leaflets and posters were accessible, including advice on the different services provided in the hospital. The hospital undertook an annual patient experience survey, the results of which had informed several QIPs, for example in relation to food choices. Overall, staff and management in the hospital promoted a culture of kindness, consideration and respect.

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.

Clontarf Hospital had systems in place to ensure that complaints and concerns were responded to promptly, openly and effectively. The management of complaints was guided by a local policy, adapted from the HSE policy 'Your Service Your Say', and was under the remit of the quality, safety and risk management department. Information about how to make a complaint was on display in the hospital corridors alongside suggestion boxes, however these were not available in the wards. Inspectors were told that patients were provided with patient information booklets on admission which included information about the complaints process, and this was validated by the patients inspectors spoke with. Independent advocacy services were displayed on Swan ward.

Complaints relating to the hospital were discussed at EMT meetings and reported to the Quality and Safety Committee. Inspectors reviewed the complaints register which tracked timeframes, and noted that 92% of the complaints received year to date were closed within the HSE target of 30 days. Complaints and compliments were also discussed at Integrated Management Report meetings.

Complaints management training was not formally tracked, but inspectors were told that the quality officer had provided education sessions with a focus on local resolution of complaints. Compliments were also tracked by the hospital and the number of compliments received far exceeded complaints.

Overall there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

Inspectors observed that overall the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care with a few exceptions which were highlighted on the day of inspection. There were 16 single rooms in total, all of which had en-suite toilet and shower facilities. These rooms were prioritised for patients who required transmission based precautions.

Patients on Blackheath ward were accommodated in five six-bedded rooms which all had an en-suite toilet, and two single rooms which had en-suite showers and toilets. There were three shower rooms on the main corridor for patients accommodated in the multi-occupancy rooms. Patients on Swan ward were accommodated in four six-bedded rooms which had en-suite toilet and one four-bedded room which had en-suite shower and toilet. There were four single rooms with an en-suite shower and toilet. There were three

shower rooms available for patients accommodated in the six-bedded rooms, which were located close to those rooms. Inspectors observed that not all wards had secure access. This will be discussed further in standard 3.3.

Inspectors noted that the tiling in the shower rooms in Blackheath ward was stained in places. Several corridors on the wards visited were cluttered with extra patient equipment, and the environment showed some signs of wear and tear including chipped paint, all of which impeded thorough cleaning. On both wards visited there was storage of inappropriate items in the clean utility which impeded effective cleaning and pose an IPC risk. This was brought to the attention of staff on the day and immediately remedied. Management told inspectors that refurbishment works to include painting were planned in Blackheath ward to commence in January 2025. Risks related to the four key areas of harm, such as infection prevention and control, which were the focus of this inspection are discussed under national standard 3.1.

Wall-mounted alcohol based hand sanitiser dispensers were located strategically throughout the unit and hand-hygiene signage was clearly displayed. There was personal protective equipment and hand-hygiene facilities available for staff. Inspectors noted that the majority of clinical hand-wash basins conformed to HBN 00-10 part C Sanitary Assemblies or equivalent standards.[§§§]

Environmental cleaning was undertaken by contract cleaners who were available daily up until 3pm. A janitor was available up to 6pm and any out-of-hours cleaning required was undertaken by nursing and HCA staff. Inspectors noted that there was supervision in place for daily cleaning schedules. Inspectors were informed that the cleaning of patient equipment was the responsibility of the staff member who used it. There were additional routine equipment cleaning schedules with oversight by the clinical nurse manager (CNM). Equipment was observed to be clean and the hospital had a labelling system in place to identify clean equipment. Terminal cleaning[****] was undertaken by a healthcare assistant and a contract cleaner. Bedside curtains were in use and were changed and dated in line with the hospital policy.

In summary, there was evidence that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care with some exceptions which were highlighted to management during the inspection and included the following:

- there was some wear and tear to the physical environment of the clinical areas inspected which impeded effective cleaning

[§§§] National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30. May 2023. Available online https://www.gov.ie/

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

- storage of inappropriate items in the clean utility of clinical areas inspected which impeded effective cleaning.

Judgment: Substantially compliant

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

Clontarf Hospital management were systematically monitoring, evaluating and responding to information in order to identify opportunities for improvement. There was an audit plan for 2024 for the hospital which demonstrated tracking of hospital audits including quality, safety and risk management audits, medical audits and nursing audits.

Environmental, equipment, hand hygiene and medication safety audits and nursing quality care metrics were carried out monthly. Quality improvement plans were developed in response to audit findings which included time-bound actions assigned to responsible persons. Environmental audits were undertaken by contract cleaners, and the action plans developed to address issues arising from these audits were closed out. Compliance levels for October and November 2024 in Blackheath ward were high at 85.1% and 90.5% respectively. In Swan ward compliance levels for November and December 2024 were also high at 90.5% and 91.7% respectively. The IPC CNS undertook separate monthly environmental audits which included patient equipment, sharps management and waste management. The most recent results of these audits for Blackheath and Swan wards showed high levels of compliance at 97.3% and 97.9% respectively. Audit results were shared with ward CNMs and at staff huddles and reported upwards to the IPC committee. Monthly equipment decontamination audits were undertaken by CNMs and audit results viewed by inspectors showed high levels of compliance. However these audits did not include overall compliance scores to facilitate tracking and trending of results.

Hand hygiene audits were undertaken monthly by CNMs at ward level with full compliance levels for hand hygiene (100%) for October and November 2024 reported in Blackheath ward. In Swan ward the compliance level for December 2024 was 100%. Medication safety audits were performed as part of monthly nursing quality care metrics and compliance was high with results for October and November 2024 in Swan ward at 98% and 99% respectively. Results on Blackheath ward for the same period were 100% for both months. The monthly nursing quality care metrics report indicated that action plans were enacted where compliance fell below 85%, and this was validated by staff on the ward. Inspectors reviewed quarterly IPC reports which included outbreak reports, surveillance reports, audit findings and legionella testing results. Inspectors saw

evidence of quality improvement measures taken and action plans developed to address issues highlighted by audit and monitoring.

Admissions, transfer activity, bed occupancy and average length of stay was being tracked and discussed at EMT and Integrated Management Report meetings with CHO 9. Management were tracking the incidence of patients requiring transfer to the emergency department or return to an acute hospital and the average length of stay prior to such a transfer. This data was reported to the recently-established Unscheduled Transfer of Care Committee where trends were discussed.

The hospital was monitoring and tracking incidents and near-misses including medication errors, transfer incidents and common causes of harm. Year to date the hospital had reported 502 incidents and 79 near misses. The hospital was also tracking complaints and compliments, and had received 302 compliments and 12 complaints year to date. The effectiveness of the INEWS as a tool to identify deteriorating patients was audited as part of monthly nursing quality care metrics using the patient monitoring and surveillance audit tool. Compliance was 100% for October and November 2024 in both Swan ward and Blackheath ward.

The hospital undertook their annual patient satisfaction survey in July 2024 and had achieved a response rate of 84%. There were increased levels of satisfaction reported regarding the food quality compared to the previous year's survey results. Areas for improvement were identified in the area of discharge planning. Inspectors were provided with evidence that management were working to address this through a future pilot project whereby predicted discharge dates would be displayed over patients' beds.

Overall, the hospital was systematically monitoring and evaluating the service and utilising information gathered to inform quality improvement efforts.

Judgment: Compliant

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

The hospital had systems in place to proactively identify and manage risks. Risks were documented on the corporate, hospital or departmental risk registers as appropriate and existing controls were listed along with any other actions required to mitigate risks. Meeting minutes confirmed that risks were an agenda item at EMT meetings, at Integrated Management Report meetings with CHO 9 and at Quality and Safety Committee meetings. Risks that could not be managed at local level were escalated to the Board and to the head of services for older persons for CHO 9. Examples of this escalation were noted in meeting minutes reviewed by inspectors.

Staff on the wards visited told inspectors that the out-of-date ward-based risk assessments stored on the ward were no longer reviewed, and had been replaced by formal risk assessments undertaken at hospital level by an assistant director of nursing (ADON) and the risk manager. Senior management confirmed that the risk assessment process for the Department of Nursing had changed to nursing administration level to permit tracking and monitoring. Ward managers did not maintain local risk registers or undertake local risk assessments. This could impact on the ability of managers to proactively identify, assess and manage risks at local level. This was highlighted to senior management during the inspection.

The hospital had 16 single rooms with en-suite shower and toilet which could be utilised for patients requiring isolation. On the day of the inspection there were six inpatients for whom a single room was required for isolation purposes and all six patients were accommodated in single rooms. Patients were screened on admission for *Methicillin-Resistant Staphylococcus aureus* (MRSA), *Carbapenemase-Producing Enterobacterales* (CPE) and Covid-19 and this information was consistently documented in the healthcare records viewed by inspectors.

The hospital had three outbreaks of COVID-19 during Q3 2024, and evidence of outbreak management in line with national guidance and the completion of an outbreak report was provided to inspectors. On one ward visited, the doors to two isolation rooms had been left open which increased the risk of infection transmission to adjacent areas. On both wards visited inspectors noted a lack of appropriate signage at the entrance to an isolation room to alert healthcare workers of the need to apply standard and transmission based precautions. These observations were brought to the attention of ward staff who immediately acted to remedy these issues during the inspection.

The hospital had a medication safety strategy which highlighted key action areas, and medication safety in Clontarf Hospital was supported by a medication management policy. There was a list of high-risk medications, in the A-PINCH[††††] format, available on the ward. There were forcing functions in place for example, high-risk medications were not stored as stock items in order to reduce the risk of a high-risk medication error. Two-person checks were required for high-risk medications such as insulin and other injectable medicines. High alert stickers were observed on high-risk medications. Staff could access paper-based medicines information at the point of medicines preparation. Inspectors were told that staff could access some digital medicines information and policies electronically, however not all staff that inspectors spoke with in the wards visited were aware of this resource. On both wards visited the medicines were stored in a secure manner within the clean utility, however the door to the clean utility room did not have secure access controls. Management informed inspectors that there was a plan in place to install secure

[††††] A-PINCH is an acronym used to identify high risk medicines and includes anti-infective agents, potassium, insulin, narcotics and sedatives, chemotherapy and heparin and other anti-coagulants.

access control to clean and dirty utilities but no timeframes were available. This risk was added to the nursing department risk register following this inspection.

Inspectors were told that the clinical pharmacy service to the wards in Clontarf Hospital was limited by resourcing. Clinical pharmacy services were therefore targeted and prioritised. Medication reconciliation was undertaken on admission by a pharmacist. Cross checking of prescribed medicines was undertaken prior to discharge by a pharmacist, and this was confirmed by staff members. Pharmacists were available to answer queries and reviewed prescriptions in advance of admission.

There was no formal antimicrobial stewardship (AMS) programme in place due to the lack of a resourced antimicrobial pharmacist, and this risk had been escalated to the hospital risk register. The hospital had arrangements in place to manage this risk, for example if a patient was admitted on intravenous antibiotics then the referring hospital could provide advice and support as needed. There was restricted use of certain antibiotics and the IPC CNS provided education on antimicrobial stewardship for all new nursing staff. Inspectors were told a business case for 0.5 WTE AMS pharmacist had been developed and submitted to CHO 9 but had not been progressed.

As previously described a consultant microbiologist had a commitment of six hours per week onsite to Clontarf Hospital (0.16 WTE) and was available for advice Monday to Friday during core hours. Outside of these times there was no formal microbiology access, but inspectors were told that staff in Clontarf Hospital could contact the referring hospital for an individual patient or the on-call microbiology team in an acute hospital. However there was no formal arrangement for microbiologist advice out of hours.

The hospital was using a modified INEWS version 2 and had a clear escalation process in place for the deteriorating patient. Both medical and nursing staff who spoke with inspectors were knowledgeable on the escalation processes in place for the deteriorating patient. The escalation of a deteriorating patient was supported by the use of the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool and patients' early warning scores were discussed at handover. A patient's sudden deterioration or medical emergency was managed through emergency ambulance calls and liaison with the acute hospital. Contact details for required services were observed clearly displayed on the ward. Staff spoken with were able to describe the procedures in place.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services. Management reported that referrals were reviewed in advance of admission to ensure all admissions aligned with the admission policy. Predicted discharge dates were determined and reviewed at the weekly multidisciplinary team meetings. To address a risk that had been identified associated with documentation during transitions of care, patients transferred from MMUH and Beaumont Hospital had their healthcare records transferred with them to Clontarf Hospital where it remained for a period of one week. Staff reported that this helped to reduce

safety incidents associated with transitions of care. Inspectors observed evidence that discharge summaries were completed for patients transferring out of the hospital. Clinical handover was undertaken using the ISBAR format, and inspectors saw evidence of this in use.

Printed copies of policies, procedures, protocols and guidelines (PPPGs) provided to inspectors on the ward were out of date in several cases. Inspectors were informed that staff experienced challenges accessing current medicines information and PPPGs due to inadequate computer access. This could pose a risk to patients if up-to-date policies and procedures are not readily available to staff providing care.

Overall, the service provider protected service users from the risk of harm associated with the design and delivery of healthcare services. However, opportunities for improvement were identified based on the following inspection findings:

- lack of appropriate signage at the entrance to an isolation room to alert healthcare workers of the need to apply standard and transmission based precautions
- Not all staff were aware of available electronic medicines information resources
- the doors to the clean utility room in clinical areas inspected in which controlled medicines were stored were not access controlled
- not all patients received a full clinical pharmacy service
- there was no formal antimicrobial stewardship programme in place
- formalised access to specialist microbiology advice, outside of core working hours was not available
- printed copies of policies, procedures, protocols and guidelines (PPPGs) provided to inspectors on the ward were out of date in several cases.

Judgment: Partially compliant

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

Clontarf Hospital had systems in place to identify, manage, respond to and report on patient safety incidents in line with national legislation, standards, policies and guideline.

Staff who spoke with the inspectors could describe the reporting pathways for patient safety incidents in Clontarf Hospital. All patient-safety incidents were uploaded onto the National Incident Management System (NIMS) and inspectors were told that the hospital

was compliant with the HSE target timeframe[‡‡‡‡] for uploading incidents. Reports and meeting minutes showed evidence that incidents were tracked and trended by the risk manager and quality officer. Inspectors reviewed the incident management analysis reports for Clontarf Hospital for 2024 which provided detailed analysis of incident categories and sub hazard types, including data on medication errors and pressure ulcer stages. Staff told inspectors that learning from incidents was shared at staff meetings, and this was validated by staff on the wards visited. There was evidence that there was oversight of incident management at both hospital management and CHO 9 level.

Inspectors were told that the Incident Management Team (IMT) reviewed and managed all serious incidents and serious reportable events. Implementation of recommendations arising from reviews was overseen by the quality improvement department. The IMT had commissioned one concise review in 2024 following a Category 2 incident.[§§§§] Inspectors reviewed a concise review commissioned in 2023 following a serious incident which included an action plan with one remaining outstanding action for completion. A concise report reviewed by inspectors demonstrated a missed opportunity for proactive risk assessment around secure access to wards as an element of shared learning. This was acted upon by management following the inspection and added to the hospital risk register, specifying existing controls and timeframes for completion of outstanding actions.

Overall, the hospital effectively identified, managed and responded to patient-safety incidents.

Judgment: Compliant

Conclusion

An unannounced inspection of Clontarf Hospital was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. Overall, the inspectors found good levels of compliance with the national standards assessed.

Capacity and Capability

Clontarf Hospital had governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare which were appropriate for the size, scope and complexity of the centre, with some opportunities for improvement found in the oversight of medication safety. The management arrangements in place did not fully support and

[‡‡‡‡] HSE target that 70% of reported incidents are entered onto NIMS within 30 days of notification of the incident.
[§§§§]Category 2 incident - clinical and non-clinical incidents rated as moderate as per the HSE's Risk Impact Table https://www.hse.ie

promote the delivery of high quality, safe and reliable healthcare services. There were opportunities to formalise clinical governance and out of hour's consultant cover. There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Workforce arrangements in the unit were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare

Quality and Safety

Staff and management in the hospital made every effort to ensure that patients' dignity, privacy and autonomy were respected and promoted. Management and staff promoted a culture of kindness, consideration and respect. The hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. The physical environment mostly supported the delivery of high-quality, safe, reliable care. The hospital did not fully protect service users from the risk of harm associated with the design and delivery of healthcare services, and opportunities for improvement were identified as outlined in this report. The hospital effectively identified, managed and responded to patient-safety incidents relevant to the size and scope of the service.

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

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

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

Capacity and Capability Dimension	
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	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	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	Substantially compliant

quality, safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for: The Incorporated Orthopaedic Hospital of Ireland, Clontarf , OSV-0005678

Inspection ID: NS_0109

Date of inspection: 10 and 11 December 2024

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

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

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

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

Item 1: No designated lead clinician with oversight for medical activity in the hospital

- Existing consultants take a lead on recruitment of medical staff, medical staff rostering and medical staff training in conjunction with the Human Resources Department – Ongoing since 2015
- Joint Consultant appointments with the Mater Hospital and Beaumont Hospital, with lead consultants for particular wards/pathways – Ongoing since 2015
- National recruitment campaign to appoint a Clinical Director was completed in 2023 without a successful candidate – Complete 2023
- As an interim measure, the hospital has engaged a Senior Consultant in Geriatric Medicine to provide clinical director services on an interim basis to address priority areas pending a permanent appointment subject to available funding – Complete April 2025 and ongoing
- Clontarf Hospital will recommence a second formal recruitment campaign to appoint a Clinical Director once approval for funding has been received from IHA Dublin North City and West – Target date Q1 2026

Item 2 – No consultant physician providing formal on-call cover out of hours

- NCHDs providing 24/7 out of hours cover - Ongoing

- Policy in place for the transfer of the deteriorating patient to the acute hospital under the care of the on-call physician/surgeon - Ongoing
- Ongoing engagement with existing consultants and acute hospital partners to review all options to provide formal on-call cover out of hours with the support of the Interim Clinical Director – Target Date August 2025
- A business case for funding will be sent to the HSE for additional resources required for implementation - Target Date August 2025

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

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

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

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

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Item 1: Lack of appropriate signage at the entrance to an isolation room to alert healthcare workers of the need to apply standard and transmission based precautions

- Signage put on the isolation room on day of inspection – Complete 10.12.24
- Each ward Clinical Nurse Manager/Nurse in Charge to check signage on each shift to ensure correct signage is in place - Complete December 2024 and ongoing
- Infection, Prevention and Control Clinical Nurse Specialist continues to highlight the importance of the proper usage of signage on isolation rooms at both formal and informal staff training – Ongoing

Item 2: Full access to medicines information online was not available in Clontarf Hospital

- Access to medication information is available at ward level in the form of a copy of the British National Formulary on each drug administration trolley.
- Medicines Information Resources are available to staff on all computers at ward level.
- Pharmacy staff available for consultation during core working hours.

- Drugs and Therapeutics Committee leading a project to centralise and improve ease of access for staff to all medication management and PPPGs – Completion Date September 2025

Item 3: The doors to the clean utility room in clinical areas inspected in which controlled medicines were stored were not access controlled

- Access was further restricted to the clean utility rooms by the installation of security access panels - Complete April 2025
- This was in addition to the existing medication safe storage and custody measures in place for controlled medicines.

Item 4: **The clinical pharmacy service to the wards in Clontarf Hospital was limited by resourcing.**

- The Clinical Pharmacy Service is targeted at the internationally recognised areas of high risk such as transitions of care e.g. admission and discharge, to maximise patient safety and quality of care.
- Review of the Clinical Pharmacy Service in Clontarf Hospital – Completion Date December 2025

Item 5:There was no antimicrobial stewardship programme in place due to the lack of a resourced antimicrobial pharmacist

- Current elements of the Antimicrobial Stewardship Programme in place in Clontarf Hospital include:
    - There is restricted use of certain antimicrobials, which are only stocked in the pharmacy.
    - Prescribing guidelines, clinical pathways and prescriber aids in use to prevent inappropriate use of antimicrobials.
    - Antimicrobial stewardship is discussed as an agenda item at the Drugs and Therapeutics Committee meetings.
    - Doctors have access to the Mater Hospital and Beaumont Hospital prescribing guidelines.
- Business case for 0.5 WTE Antimicrobial Pharmacist role was developed, submitted and discussed with the HSE IHA Management Team, however no funding has been received for this post – Complete and ongoing.
- In the interim, an Antimicrobial Stewardship Programme for Clontarf Hospital is under development with input from the Consultant Microbiologist, Consultant Geriatrician, Chief Pharmacist 2 and the Infection, Prevention and Control Clinical Nurse Specialist under the governance of the Drugs and Therapeutics Committee – Completion Date December 2025.
- Audit of IV antibiotic usage per bed days in Clontarf Hospital was completed in Q1 in conjunction with the Consultant Microbiologist – Complete April 2025.

Item 6: Formalised access to specialist microbiology expertise outside of core working hours was not available

- Policy in place for the transfer of the deteriorating patient to the acute hospital under the care of the on-call physician/surgeon - Ongoing
- Standard Operating Procedure for Microbiology Out-of-Hours Communication with St. James Hosptial Laboratory – Complete November 2024
- Review of the microbiology service requirements out-of-hours for Clontarf Hospital to inform next steps – Target Date December 2025
- Continue engagement with the HSE and the HSE Chief Clinical Officer regarding microbiology resources for post-acute hospitals - Ongoing

Item 7: Printed copies of policies, procedures, protocols and guidelines (PPPGs) provided to inspectors on the ward were out of date in several cases

- Review and update PPPG folders at ward level – Completion date July 2025