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 known as (trading as) Clontarf Hospital
Address of healthcare service:	Blackheath Park Clontarf Co. Dublin D03 AY95
Type of inspection:	Announced
Date(s) of inspection:	09 and 10 August 2023
Healthcare Service ID:	OSV-0005678
Fieldwork ID:	NS_0051

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

The Incorporated Orthopaedic Hospital of Ireland known as (trading as) Clontarf Hospital is a Model 1* rehabilitation and community inpatient hospital. As a voluntary† (section 38) hospital, it is governed by a Board of Governors and on behalf of the Health Service Executive (HSE), it also has a reporting relationship to the HSE Community Health Organisation 9‡ (CHO9). Services provided by the hospital include:

- adult orthopaedic rehabilitation
- rehabilitation for older people
- specialist rehabilitation, for example, post stroke or other neurological conditions.
- diagnostic services (x-ray only)
- outpatient care.

The hospital comprises five wards: Swan, Kincora, Gracefield, Blackheath and Vernon.

Referrals to Clontarf Hospital were from consultant to consultant (older peoples' and specialist rehabilitation services) and from orthopaedic consultants to Clontarf Hospital's patient flow department, usually a week in advance. Referrals were primarily accepted from the Mater Misericordiae University Hospital (MMUH) and Beaumont Hospitals. Patients deemed suitable for admission included those who had completed their acute care and who had the cognitive ability to undertake rehabilitation and who required no more than the assistance of one person with their care needs or mobility. Patients in the hospital had access to a wide range of services which included a consultant-led medical team, pharmacy, physiotherapy, occupational therapy, medical social work, nutrition and dietetics, speech and language therapy and chaplaincy.

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*Model 1hospitals:are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care – as defined by the National Acute Medicine Programme's model of hospitals.
† Section 38 relates to agencies provided with funding under Section 38 of the Health Act 2004. It is limited to 23 non-acute agencies and 16 voluntary acute hospitals currently within the HSE Employment Control Framework.
† HSE Community Health Organisation 9 area consists of Dublin North, Dublin North Central and Dublin North West

The following information outlines some additional data on the hospital.

Model of Hospital	Rehabilitation and community inpatient hospital
Number of beds	160 beds of which 144 were operational at the time of inspection.

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.

[§] 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)

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

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.

Compliance classifications

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 August 2023 10 August 2023	09.00 – 17.00hrs 09.00 – 12.45hrs	Patricia Hughes	Lead
		Nora O'Mahony	Support
		Emma Cooke	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†† (including sepsis)‡‡ ▪ transitions of care.§§ The inspection team visited two clinical areas and spoke with a range of staff members on: ▪ Kincora Ward ▪ Vernon Ward

†† 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

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

- Representatives of the hospital's Executive Management Team (EMT)
  - Chief Executive Officer (CEO)
  - Director of Nursing (DON)
  - Chief Operation Officer
  - Quality Improvement Officer (QI officer)
  - Health and Social Care Professionals (HSCP) representative
  - Chief Financial Officer
  - Consultant 1
  - Consultant 2
- Lead representative for the non-consultant hospital doctors (NCHDs)
- Human Resource (HR) Manager
- Representative from each of the following hospital committees or areas of focus:
  - Infection Prevention and Control (IPC) committee
  - Drugs and Therapeutics committee (DTC)
  - The Deteriorating Patient
  - Delayed Discharge and Bed Management in relation to Transitions of Care.

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 like to thank people using the service who spoke with inspectors about their experience of the service.

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

Throughout the inspection, inspectors observed staff actively engaging with patients in a respectful and kind manner. Patients' call bells were observed to be promptly responded to. This observation was validated by patients who spoke with inspectors. When asked 'what has been good about your stay', patients were complimentary about staff, '*staff are just fantastic*', '*staff are brilliant*', '*staff come to you when you need but you can see they do be under pressure especially when patients have more dependant needs*' and '*when I call the bell, they always come, I am never waiting too long'.*

When asked '*what could be improved in the way your service or care is provided?'*, patients told inspectors that they would like to have more choice on the food menu, '*You almost know what you are going to be eating next week, it's the same thing*', '*more choice in the food options'*, '. Other patients said they would *'like more activities during the day'* and suggested '*the opportunity to get out into the garden - to see my grandchildren*'. This is discussed further under NS 1.6. Most patients spoken with said they did not know their expected date of discharge but said that they were being kept up to date with their plans of care.

Inspectors found that of the patients spoken with, none were aware of the complaints mechanism. All of them however, explained that if they had an issue, they would speak with the nurse on the ward.

Capacity and Capability Dimension

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

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 formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Inspectors heard how the hospital primarily works with hospitals within three hospital groups, Royal College of Surgeons, Ireland (RCSI), Ireland East Hospital Group (IEHG) and Dublin Midlands Hospital Group (DML). The hospital has its own website.

The CEO was the accountable officer for the hospital and reported to the Board of Governors. The hospital did not have a clinical director but had submitted a business case, supported by the Board, for funding for a 0.5 whole-time equivalent (WTE)*** post to Community Health Organisation area 9 (CHO 9). Inspectors were told that the post had been advertised but efforts to recruit were unsuccessful to date. The director of nursing (DON) was responsible for the organisation and management of nursing services including healthcare assistants at the hospital and reported to the CEO. The DON attended and provided reports to the Board. The DON also attended the performance meetings between Clontarf Hospital and senior managers from CHO9.

Organisational charts setting out the hospital's reporting structures for nursing, management and governance and oversight committees were submitted to HIQA. These detailed the direct reporting arrangements for hospital management, the relationship to the Board and to the Head of Older Persons Service - CHO9 and they aligned to what inspectors were told during inspection.

Board of Governors

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

The hospital was governed by a Board of Governors. The Board had a Code of Governance dated January 2023 which was due for review in January 2025. It set out the roles and responsibilities of Governors and the frequency of meetings. The Board were scheduled to meet eight times a year and had met five times, year to date by the time of this inspection. The CEO and the DON attended the Board meetings. The chief financial officer (CFO) attended the part of the Board meeting dealing with the financial report. The Board had the following subcommittees: audit, ethics, finance, quality, safety and risk management, and the governance, remuneration and nominations committee. Minutes of Board meetings, submitted to HIQA, showed that Board meetings followed a structured format and maintained a Monitoring of Actions document outlining the responsible persons and timelines which was reviewed and updated at each meeting. Items of note included the ongoing challenge in filling the clinical director post, reference to the monthly occupancy rate of 90-99% between February and May 2023 and a business case submitted to the HSE to open an additional 16 high dependency beds within the hospital's bed complement. Operational reports from the DON were also reviewed at Board meetings which included results of monthly nursing metrics.

Executive Management Team (EMT)

The Executive Management Team was the main governance structure at the hospital. The terms of reference for the committee had been approved, were in date and had a planned review date. Membership comprised the CEO (chairperson), the DON, consultant geriatrician, chief operations officer (COO), CFO, QI officer, and HSCP representative who shared collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. The EMT met monthly and reported to both the Quality, Safety and Risk Committee (a sub-committee of the Board) and directly to the Board. It had a set agenda based on the National Standards for Safer Better Healthcare. The EMT was also the committee responsible for the approval of policies, procedures and guidelines (PPGs). Minutes of EMT meetings, submitted to HIQA, showed that meetings followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting.

The following committees reported to the EMT, infection prevention and control, drugs and therapeutics, delayed discharges, healthcare records and information, falls prevention and management, nutrition and hydration, green committee, health and safety, radiation safety and education and training. The senior person in charge of human resources (HR), risk, health and safety, catering, procurement and general services also reported to the EMT.

While there was consultant input at the EMT and key committees such as Infection Prevention and Control and Drugs and Therapeutics, consultants were not in attendance at the Board meeting or at the CHO performance meetings.

Performance meetings with HSE Community Health Organisation 9 (CHO 9)

There were no terms of reference supplied for these meetings. Inspectors noted that hospital management met with members of CHO 9 in November 2022, in February and May 23 and were due to meet again in August 2023. Prior to November 2022, the previous meeting was held in May 2022. There was a set agenda for this meeting which included a CEO update, and data from the following: finance, HR, quality and patient safety, risk and incident management, complaints and comments, performance management report, COVID-19 outbreaks, vaccination updates and assisted decision making. The minutes were comprehensive and action oriented. Inspectors noted the discussion relating to a business plan to recruit an antimicrobial pharmacist and the hospital were advised by CHO9 that funding for same would have to be approved in the first instance.

Quality and Safety Risk Management Committee (QSRM)

The Quality and Safety Risk Management Committee 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. It had terms of reference dated October 2022 which were scheduled for review in October 2024. The purpose of the committee was to assure the Board that there were effective and appropriate systems in place to manage all aspects of clinical quality, safety and risk. Membership was not outlined in the terms of reference but inspectors were told that it was chaired by a board member with clinical expertise and membership also included the CEO, DON, consultant, risk officer, a board member with corporate expertise and the QI officer. It was scheduled to meet quarterly or more often if required. Minutes of QSRM meetings, submitted to HIQA, showed that the meetings followed a structured format. The QSRM Committee also maintained an action plan setting out the actions, responsible person and timelines.

The committee reviewed the corporate risk register which was updated every six months or more often if required. At the time of inspection, the risks recorded on the corporate risk register included, 'non-compliance with HIQA IPC standards (antimicrobial stewardship)', 'harm to patients associated with a HCAI (healthcare associated infection) and the associated disruption of services resulting from infection outbreak' and the 'risk of a cyber-attack'. Each one had existing and additional controls listed. An action owner and review date was also detailed. The QSRM committee 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 quality improvements to the Board.

Infection Prevention and Control (IPC) committee

The hospital's multidisciplinary Infection Prevention and Control committee was responsible for the governance and oversight of infection prevention and control at the hospital. The terms of reference for the committee had been approved, were in date and had a planned review date. It was chaired by the DON and reported to both the EMT and

the Board. Membership of the IPC included the consultant microbiologist, clinical nurse manager (CNM) for IPC, a ward based CNM2, risk manager, health and safety representative, catering officer, maintenance staff, general services manager, health and social care professionals (HSCP), procurement officer, administration staff member and representatives from the external cleaning contractors. The IPC terms of reference listed the following objectives: infection prevention and control, provision of a clean hospital, an IPC strategy and an annual work plan, an antimicrobial stewardship (AMS) programme, outbreak management, compliance with HIQA National Standards for IPC in acute health services, liaising with and supporting the Drugs and Therapeutics Committee (DTC). It was scheduled to meet quarterly or more frequently if indicated. The minutes of meetings, submitted to HIQA, showed that the meetings were not held in line with the terms of reference having met only twice in 2022. Hospital management need to ensure that committees work in line with their agreed terms of reference. By the time of the inspection, the committee had met twice in 2023. Minutes of IPC meetings, submitted to HIQA, showed that the meetings followed a structured format, were action orientated and progress in implementing actions was recorded from meeting to meeting.

Drugs and Therapeutics Committee (DTC)

The hospital had a Drugs and Therapeutics committee with assigned responsibility for the governance and oversight of medication management at the hospital. The committee was operationally accountable and reported to the EMT on a quarterly basis. The terms of reference for the committee had been approved, were in date and had a planned review date. It stated that the committee was responsible for overall governance of medicine management to ensure it was patient-centred, judicious, appropriate, safe, effective and cost effective. Membership included the following; chief pharmacist, chair of the medication safety committee, DON or designate, clinical practice support nurse, CNM2-IPC, two ward based CNM2s, a ward-based staff nurse, consultant microbiologist from Clontarf Hospital, medical consultants, registrars, quality manager and the risk manager. The committee was scheduled to meet quarterly and had a set agenda which included policies, protocols, procedures and guidelines (PPPG's), medication safety management, projects – quality improvements, antimicrobial stewardship, clinical audit, medication education and risk management. The minutes of meetings, submitted to HIQA, showed that the committee only met twice in 2022 but had met twice in 2023 by the time of the inspection. Hospital management need to ensure that committees work in line with their agreed terms of reference. Inspectors were told and noted from minutes of the DTC meetings that the case for the recruitment of an antimicrobial pharmacist had been an agenda item since at least March 2022 and was escalated to CHO9 by March 2023. The situation remained unresolved by the time of the August 2023 inspection. Minutes followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting. The hospital also had a Medication Safety Committee (MSC) which reported to the DTC.

The deteriorating patient

The hospital had a policy relating to the deteriorating patient which was approved, in date and had a planned review date. The hospital were using version 2 of the Irish National Early Warning Score (INEWS). The use of INEWS was being applied to all non-pregnant persons aged 16 years and over except for those at 'end of life'. The policy referenced the procedure to be followed and responsibility when the INEWS score deviated from normal parameters including the use of ISBAR[†††]. The policy also referenced sepsis and the 'Sepsis 6'[‡‡‡] bundle noting that there was no on-site facility for testing blood gases (as this was a post-acute hospital). The hospital policy required vital observations (temperature, pulse and respiration rate) to be measured at a minimum of once every 24 hours and more often as the clinical situation indicated.

Transitions of Care

The hospital had a 'Complex and Delayed Discharge Committee'. Its terms of reference were overdue for review since May 2023. The committee was chaired by the DON, met monthly and reported to the EMT. The purpose of this committee was to identify why there were delayed discharges and to identify pathways of care through the development of policies, procedures, pathways of care and key performance indicators to prevent delayed discharges at Clontarf Hospital. It reviewed delayed discharges of 40 days or more, monthly audit findings of patients' estimated date of discharge (EDD), quarterly audit findings of monthly discharge trends and six-monthly audit findings of the discharge planning process. It also reviewed the key performance indicators (KPIs) for home care packages, Fair Deal[§§§], approval and length of delay in accessing home care packages and other community supports. Membership of the committee included the CEO, assistant director of nursing (ADON), two patient flow managers, the ward-based CNM2 from each of the five wards, the occupational therapy manager, physiotherapy manager, medical social work manager, two consultant geriatricians and one physician. Minutes followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting.

[†††] ISBAR is the acronym for the following prompts in communication: Identify, Situation, Background, Assessment and Recommendation ($ISBAR_3$). It outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

[‡‡‡] Sepsis 6 is a care bundle comprising six time-bound tasks, take three (blood cultures, lactate and urine output monitoring) and give three (fluids, antibiotics and oxygen), all to be instituted within one hour of recognition of the potential condition.

[§§§] Fair Deal Scheme is a financial support provided towards the cost of care in a nursing home through the Nursing Homes Support Scheme. It is managed by the Health Service Executive (HSE) and the person receiving the service is liable to pay a certain amount towards the cost of their care and the HSE pays the rest. Fair Deal covers approved private nursing homes, voluntary nursing homes and public nursing homes.

Overall, HIQA was satisfied that the hospital had formalised arrangements for assuring the delivery of high quality, safe and reliable healthcare.
Judgment: Compliant

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

Effective management arrangements were in place to support the delivery of safe and reliable healthcare at the hospital. The hospital had developed a strategic plan and established a project team chaired by the CEO with terms of reference dated March 2022. It had three sub-committees including a major trauma team, to drive the strategic plan. Inspectors were told about engagement with MMUH in defining the level of post-acute rehabilitation capacity and resources required for implementing the Dublin Major Trauma Centre. Work was continuing in collaboration with Beaumont Hospital to further develop more specialist rehabilitation, so that patient needs for post-acute rehabilitation could be met without delay once they were identified in Beaumont Hospital for rehabilitation. Clontarf Hospital was supported by the National Rehabilitation Hospital (NRH), who provided prosthetic expertise and support during the year. The hospital was also engaging with CHO 9 and the MMUH in preliminary discussions on implementing an integrated care team at the hospital which, under consultant geriatric lead, would reach out to older people in the community to manage care in their homes, as well as aim to prevent or minimise attendance at emergency departments in local acute hospitals.

Clontarf Hospital managed and operated 48 orthopaedic rehabilitation beds for patients transferred from the acute hospitals in Dublin and approved private hospitals. It provided a further 80 beds for rehabilitation for older persons and 16 beds for those requiring specialist rehabilitation. Inspectors were told that this number could vary depending upon the clinical need and or infection prevention and control measures in place at any given time. There were no convalescent, step-down, transitional care, respite or assessment beds.

- Orthopaedic rehabilitation for patients aged 18 years or more was provided in 32 of the 48 beds which were operational. Referrals were accepted from all acute hospitals plus the National Orthopaedic Hospital, Cappagh and the Mater Private Hospital. These beds were primarily on Vernon ward and half of Kincora ward.
- Rehabilitation for older persons aged 65 years or more was provided using 96 beds (48 for MMUH, 40 for Beaumont Hospital and 8 for Connolly Hospital). These were used for active older people's rehabilitation and for MMUH's Integrated Care

Programme for Older Persons (ICPOP).[****] These beds were primarily on Swan and Gracefield wards and half of Kincora ward. Inspectors were told that access to 'step-up' beds for 'emergency department avoidance' were available by arrangement via consultant agreement as part of ICPOP.

- Specialist rehabilitation for patients aged 18 years or more was provided in the 16 beds used by Beaumont Hospital. These were patients who had higher acuity rehabilitation needs for example, amputation, acquired brain injury or neuro-medical conditions. These beds were primarily on Blackheath ward.
- The hospital also provided general non-urgent plain X-rays as required by its inpatients and outpatients

Inspectors were told that 16 single rooms within the overall complement had been designated private rooms but that 12 of these were predominantly being used for infection prevention and control, high observation or other clinical reasons. All of them had en-suite facilities. None of the single rooms had anterooms[††††]. There were no neutral or negative pressure rooms at the hospital.

In terms of overall activity levels, Clontarf Hospital reported 1072 admissions and 1100 discharges in 2022. This equated to an average of 89 admissions per calendar month or four admissions per day (Monday – Friday). For the first seven months of 2023, the activity levels had increased by 39% with a total of 873 admissions and 774 discharges. This equated to an average of 124 admissions per calendar month or five to six admissions per day (Monday – Friday). At the same time, the average length of stay for 2023, year to date had reduced to 34 days (from 36.8 days in 2022) and the mean to 24 days (from 28 days in 2022) representing decreases of 6.5% and 14% respectively. The hospital reported a 92% occupancy rate for 2023 year to date and this increase was being monitored at EMT and Board meetings.

On the day of inspection there were 121 inpatients at Clontarf Hospital. Orthopaedic patients remained under the clinical governance of their referring orthopaedic surgeon who remained the attending consultant throughout the patient's admission in Clontarf Hospital. The referring orthopaedic consultant was responsible for ensuring that weekly specialist orthopaedic registrar rounds were completed and the referring orthopaedic team were available for consultation throughout each patient's admission.

A consultant geriatrician and a consultant physician from MMUH were responsible for the clinical governance of older persons on Swan ward and their cohort of patients on Kincora ward. A consultant geriatrician from Beaumont hospital was responsible for the clinical governance of older persons on Gracefield ward and finally a locum consultant from

[****] 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.

[††††] Anterooms are a sealed space with air filtration to remove harmful particles or pathogens from the air. They also give workers and providers a space to safely remove contaminated items before returning to a non-contaminated space.

Beaumont hospital was responsible for the clinical governance of patients receiving specialist rehabilitation.

The hospital had pathways of care in place for patients who required palliative care or who were homeless. The hospital also had management arrangements in place in relation to areas of known harm as follows:

Infection, prevention and control

The hospital had

- 0.16 WTE[‡‡‡‡] of a consultant microbiologist (equated to two sessions per week. The consultant also provided 24/7/365 phone support) and
- 1 WTE infection prevention and control nurse.

Inspectors note that relying on one person to provide 24/7/365 on-call support is not sustainable in the medium to long term even where out-of-hours activity is low to moderate. Hospital management should review its plans for this service in the medium term. Inspectors viewed the January-June 2022 and the July – December 2022 IPC reports which provided a comprehensive overview of IPC activity including data on outbreaks, quality improvements, audit results and training.

Inspectors heard how hospital management have been actively seeking funding and approval from CHO9 for over 3 years to recruit an antimicrobial pharmacist to support the establishment of an antimicrobial stewardship (AMS) programme. At the time of inspection, this was yet to be approved. Inspectors were told that CHO9 employed 1 WTE AMS pharmacist for the region. Inspectors were told there is support from the pharmacists/pharmacy department for practices to support antimicrobial stewardship however this is not the remit of any individual. Consultants reviewed antibiotic use for patients and the IPC nurse had provided additional education to nurses on AMS but there was no regular stewardship round or high level surveillance of AMS. The hospital had a guideline and a SMART[§§§§] care bundle in place and the medication chart was designed to support AMS. The hospital did not have access to surveillance scientists.

Clontarf Hospital procured their laboratory services from St. James' hospital with the exception of virology tests which were provided by the national virus reference laboratory (NVRL). During core hours, IPC results were phoned through to the consultant who acted on these, including involvement of the IPC team as required. During the out-of-hours, IPC results were phoned through to the consultant microbiologist who liaised with the on-call team as required. Inspectors were told by members of the IPC committee that they were satisfied that these arrangements were working well and that they were satisfied with the quality of the service in terms of turn-around-times of results.

‡‡‡‡ Wholetime Equivalent (WTE)
§§§§ SMART: Specific, measurable achievable relevant and time bound.

Inspectors were told that there have been five outbreaks of COVID-19 within the last year. Outbreak management as outlined to inspectors, was in line with national guidance. The hospital had conducted risk assessments of the potential impact of ongoing COVID-19 outbreaks and had decided to continue to test all patients on admission using a COVID-19 antigen test. Those who screened positive were then isolated and a PCR test was conducted with further follow up in line with national guidance.

Inspectors heard how daily surveillance of the infection rate at the hospital, symptoms of communicable infectious diseases, alert organism surveillance (MRSA, ESBL VRE) and hospital acquired infections were being monitored. The IPC nurse collated the data including location of patients with particular IPC requirements and these were shared at the daily hospital-wide operational huddle held at 9.45 am. During the inspection, 15 patients required isolation. Eleven of these were cared for in single rooms, three were cohorted in a multi-occupancy room with no other patient present. One patient with a transmissible infection was cared for in a multi-occupancy room and this had been risk assessed by the infection prevention and control team.

Inspectors were told that monthly water sampling for legionella was carried out at the hospital and following one positive result, the affected area (one room) was closed and recommended actions put in place. The area was due to be retested before consideration of re-opening once a clear result was obtained.

The IPC committee had their own risk register which was reviewed at the quarterly IPC committee meetings and at the time of inspection, included both the ongoing concern of potential COVID-19 outbreaks and the physical infrastructure issues including the absence of a hand hygiene sink in a utility room on Vernon ward.

Inspectors were told that IPC learning was shared at the IPC committee, the CNM meetings and the weekly journal clubs. IPC was also covered at induction and orientation of new staff.

Medication safety

The hospital had a clinical pharmacy service,[*****] which was led by the hospital's chief pharmacist. Pharmacy staffing at the hospital comprised:

- 3 WTE pharmacists including the chief pharmacist
- 0.5 WTE pharmacy technician.

Inspectors viewed a report from the medication safety committee to the DTC where it was stated that the committee had met ten times in 2022. The medication safety committee had been monitoring key metrics including the number of medication incident

[*****] 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.

reports and noted that the level of reporting these was lower than expected in 2021 but had improved by 2022. Focused efforts were made to explore and reduce barriers to nurse reporting of medication incidents. The medication safety committee also commenced the reporting of medication incidents identified on transitions of care. It found that 43% of reported medication incidents originated off-site and were identified and rectified on admission to Clontarf Hospital, 5% originated off-site and continued to manifest on site and the remaining 52% of medication incidents originated on-site. Inspectors were told about actions taken to help reduce this which included feedback to the referring hospital, ensuring that notes were received from the referring hospital in a timely manner and that medicine reconciliation was completed on admission and any deviations acted upon.

Medication safety and medication storage were monitored on a monthly basis using the nursing quality metrics and apart from pain assessment which required attention in some areas, all other targets were being consistently met. Inspectors also viewed evidence of additional medication-safety related activities such as audit and medication reconciliation undertaken by pharmacists and other staff. The hospital had approved use of an online medicines compendium and this was made available to all staff with a hospital email address. Inspectors noted that work was in progress to restrict access to areas where medications were stored in locked cabinets and presses.

Deteriorating patient

The hospital had processes in place to guide and inform staff on how to manage and care for a patient whose health status was deteriorating. In the event of a patient becoming acutely unwell and requiring transfer to an acute hospital, the medical and nursing teams arranged the patient's transfer by ambulance to the accepting hospital. The hospital had a repatriation agreement in place with each referring hospital however patients from Cappagh hospital were transferred to the emergency department in the MMUH.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. HIQA was satisfied that Clontarf Hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. It was evident that transitions of care was an area of focus at clinical handover, daily safety huddles, on admission, transfer and discharge.

The hospital had a detailed policy in place dealing with 'admissions and pathways of care'. It included pre-admission referral, assessment and preparation for admission. This included attention to infection prevention and control issues, medicine reconciliation and or medicine requirements and individualised care planning. Access to the hospital's services was via consultant to consultant referral with the patient's consent usually a week in advance using the approved referral form via email. The accepting consultant and

patient flow manager reviewed the referrals to assess the clinical need and suitability of the service for the patient prior to a decision to admit. A decision to admit included consultation with the patient and their carers as appropriate. The patient flow manager then liaised with the referring hospital about the acceptance of the patient and the referring hospital were responsible for the safe and appropriate transfer arrangements of the patient, their records, medications and belongings. Admissions were scheduled to take place Monday to Friday. Although the policy indicated that all patients would be assigned an estimated date of discharge (EDD) on or shortly after admission, and that this would be reviewed weekly, inspectors found that the patients they spoke with were unaware of such dates being planned. The hospital also had a documented 'Discharge Procedure' in place. The hospital's Complex[†††††] and Delayed Discharge[‡‡‡‡‡] Committee and patient flow co-ordinator had oversight of the scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital.

Nursing, medical and support staff workforce arrangements

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place. The Human Resources manager was operationally accountable and reported to the CEO. Inspectors were told that the hospital had an approved complement of 279 WTE and that 274 WTE positions were filled at the time of inspection.

Overall, inspectors found that the hospital had effective management arrangements in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm outlined above. The hospital should however continue to progress its efforts in seeking either the support or the recruitment of an antimicrobial pharmacist to support the hospital in the provision of an AMS programme and also review its provision of 24/7/ 365 access to a consultant microbiologist. There is also scope for improving the involvement of the patient in setting and working towards their personal predicted discharge dates insofar as is possible.

Judgment: Substantially compliant

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

[†††††] Complex discharge was defined by Clontarf Hospital as "relating to patients who will be discharged to either their home, a carer's home, intermediate care, a nursing home or a residential care facility and who have complex ongoing health and social care needs which require detailed assessment, planning and delivery by the multi-professional team and multi-agency working, and whose length of stay is more difficult to predict".
[‡‡‡‡‡] Delayed discharge was defined by Clontarf Hospital as "when the patient is medically fit for discharge and the discharge is delayed".

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Minutes of meetings reflected that performance data was reviewed at the internal EMT, QSRM and the Board meetings and externally at meetings with HSE CHO9 management.

The hospital produced an annual report which included input from each department and an overview of the quality nursing metrics for 2022, all of which met the HSE targets with the exception of healthcare associated infection prevention and control (average score of 89% - target 90%) and pain assessment and management (average score of 88.75% - target 90%). The QSRM had oversight of the 'Quality and Safety Programme Action Plan for 2023' whose implementation was the responsibility of the EMT. The action plan comprised four objectives:

- be well led, governance, leadership and management
- improve safety
- improve experience
- develop an effective and empowered workforce

and listed actions towards meeting each objective with assigned owners and target dates.

Monitoring the hospital's performance

The hospital collected data on a range of clinical measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents, clinical audit, service user feedback, infection prevention and control surveillance, and workforce related data. It was evident that collated performance data was reviewed at EMT, Board and CHO9 level meetings.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. Risks that could not be managed at department level were escalated to the EMT and recorded on the hospital's corporate risk register. Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to mitigate the risks, as recorded on the hospital's corporate risk register. The hospital's corporate risk register was reviewed at the quarterly QSRM meetings. These were reported at Board level and escalated to CHO9 as indicated.

Audit activity

The EMT and QSRM Committee had overall oversight of clinical audit activity. Inspectors viewed the Clontarf Hospital 2023 audit plan which was a comprehensive listing of all audits conducted at the hospital, their frequency and their current status. It was evident that some were completed, many were ongoing (monthly frequency) and several were scheduled to take place by year end. Audit activity was overseen by the relevant

department, for example, medication safety audits were overseen by the Drugs and Therapeutics Committee and nursing audits were overseen by the DON. Inspectors noted that while there was a range of audits being undertaken in IPC, medication safety and recognition of the deteriorating patient, there was scope to increase the level of audit activity relating to transitions of care. Audit plans were in place for relevant departments and outlined in quality and safety reports submitted to HIQA. Findings and the learning from audit activity were shared with staff in the clinical areas through the use of information boards, at weekly journal clubs and at clinical handover.

Management of serious reportable events

There were effective systems and processes in place at the hospital to proactively identify and manage patient-safety incidents. The hospital's QSRM Committee had oversight of the management of serious reportable events and serious incidents which occurred in the hospital. Incidents reported were initially reviewed by the risk officer and an Incident Management Team (IMT) comprising the risk officer, QI officer, DON and senior clinician, met monthly to review these and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. Patient-safety incidents were logged on the National Incident Management System (NIMS)*. In addition, serious incidents and serious reportable events were also discussed at EMT, QSRM, Board and CHO9 meetings. The hospital's QI officer tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the IMT. Minutes of the IMT meetings were comprehensive, followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting. Feedback on patient-safety incidents was provided to clinical nurse managers by the quality and safety manager.

Feedback from people using the service

The hospital carried out an annual patient satisfaction survey. Findings from this were reviewed at EMT, QSRM and Board meetings. The CEO was responsible for ensuring the approval and implementation of the time-bound associated quality improvement plan.

In summary, Clontarf Hospital was monitoring performance against key performance indicators in the four areas of known harm and there was 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 audit findings, patient safety incidents and feedback from people using the service. There is scope to consider increasing the level of audit activity relating to transitions of care. Overall, inspectors were assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at 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.

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare however, the hospital and CHO9 management need to ensure

- the adequacy of the antimicrobial stewardship programme by ensuring the hospital has access to support from a antimicrobial pharmacist
- a clinical director has oversight of all medical activity within the hospital
- sustainable out-of-hours telephone support from a consultant microbiologist

Inspectors were told that medical staffing at the hospital was as follows:

- Consultant staff – 1.52 WTE approved posts and two WTE in post (+0.48 WTE or 31%) all of whom were on the specialist register of the Irish Medical Council (IMC)
- Registrars – five WTE approved and in post (three from Clontaft hospital and two from Beaumont Hospital)
- Senior House Officers (SHOs) – seven WTE approved posts and seven WTE in post

Inspectors heard how consultant staff at Clontarf Hospital had shared contracts between either MMUH and Clontarf or Clontarf and Beaumont hospitals and were supported by non-consultant hospital doctors (NCHDs) at registrar grade and SHO grades who were employed by Clontarf Hospital. There was an SHO and a registrar assigned to each ward Monday to Friday.

There was also Senior House Officer (SHO) cover on-site during all of the out-of-hours period and there was a registrar on-call from home from 8.00 am on Saturday to 8.00 am on Monday and also on bank holidays.

There was a senior clinical decision-maker§§§§§ at consultant level on-site in the hospital Monday to Friday during core hours. During the out-of-hours period, the on-call senior house officer was available on-site for medical review of patients. The SHO then liaised with the Registrar on-call in MMUH or Beaumont hospital – Monday to Friday and transfer arrangements were made as indicated.

At weekends, the SHO could liaise in the first instance with the on-call-from home Clontarf Hospital registrar. Hospital management and staff reported that these arrangements were currently satisfactory but recognised the need to keep the level of out-of-hours medical cover under review. Hospital management should review this on a regular basis to ensure the level of out-of-hours medical cover is sufficient to meet the

§§§§§ 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.

needs of patients particularly in light of the recently reported increase in activity since January 2023.

Consultants contracted by Clontarf Hospital were operationally accountable and reported to the CEO at Clontarf Hospital and also to their respective clinical directors at the MMUH and Beaumont hospital.

Two MMUH consultants were responsible for oversight of the clinical care of older persons on Swan ward and the cohort of patients on Kincora ward and had contractual commitments to Clontarf Hospital as follows:

- 0.64 WTE consultant geriatrician – remaining contracted hours at MMUH
- 0.16 WTE consultant physician (ICPOP) – remaining contracted hours at MMUH emergency department and the community Sláintecare post

One Beaumont hospital consultant was responsible for oversight of the clinical care of older persons on Gracefield ward and the Beaumont cohort of patients on Kincora ward and had contractual commitments to Clontarf Hospital as follows:

- 0.32 WTE consultant geriatrician (remaining contracted hours at Beaumont hospital)
- A further consultant from Beaumont hospital was responsible for oversight of the clinical care of patients receiving specialist neuro-rehabilitation services on Blackheath ward.

Orthopaedic patients on Vernon ward remained under their referring consultant orthopaedic surgeon at either MMUH, Beaumont, St. James's, St Vincent's or Tallaght hospitals. They were reviewed weekly or more often as required by their respective visiting specialist orthopaedic registrars. A medical registrar allocated to the ward Monday to Friday liaised with the orthopaedic teams supported by 24-hour SHO cover for the ward. The visiting specialist orthopaedic registrars reported to their respective Head of Orthopaedics in the referring hospitals.

The hospital had an approved complement of 89 WTEs nursing staff, with 84.36 WTEs (94.8%) nursing positions filled on day of inspection. The variance between the approved and actual nurse staff complement was 4.64 WTEs (5.2%). Hospital management told inspectors that they were actively recruiting to fill nursing vacancies. The breakdown of the nursing workforce was as follows:

- Clinical Nurse Manager CNM2 – 5.0 WTE approved and 5.0 WTE in post
- Clinical Nurse Manager CNM1 – 4.96 WTE approved and 4.96 WTE in post
- Staff nurses – 67.74 WTE approved and 63.1 WTE in post (4.64 WTE or 6.8% vacancy rate)

- Nursing administration – 11.3 WTE approved and 11.3 WTE in post

Inspectors were told that the hospital had undertaken a full workforce review relating to nurses and healthcare assistants in 2022 and were engaging with the HSE and the Department of Health to ensure safe staffing levels.

Breakdown of staffing on the two inspected wards was as follows:
Kincora Ward

Clinical Nurse Manager CNM2 – 1.02 WTE approved and 1.02 WTE in post

- Staff nurses – 15.04 WTE approved and 15.04 WTE in post
- Healthcare Assistants – 12.0 WTE approved and 11.5 WTE in post (0.5 WTE or 4% vacancy rate)

Vernon Ward

- Clinical Nurse Manager CNM2 – 1.0 WTE approved and 1.0 WTE in post
- Clinical Nurse Manager CNM1 – 0.96 WTE approved and 0.96 WTE in post
- Staff nurses – 14.16 WTE approved and 13.66 WTE in post (0.5 WTE or 3.5% vacancy rate)
- Healthcare Assistants – 12.85 WTE approved and 12.25 WTE in post (0.6 WTE or 4.6% vacancy rate)

Nursing staff were supported by four healthcare assistants on day duty and two on night duty on each of the wards inspected. Inspectors were told that vacancies in the roster were generally filled by Clontarf Hospital staff working an extra shift through bank nursing rather than through the use of agency nurses.

Staff in the hospital had access to 1 WTE infection prevention and control nurse who visited each ward daily. Staff also had access to a 0.16 WTE consultant microbiologist (who provided 24/7/365 telephone support), 3 WTE pharmacists (including the chief pharmacist) and a 0.5 WTE pharmacy technicians. There was no designated medication safety pharmacist, no antimicrobial pharmacist and no overall clinical director on the staff. There was 0.64 WTE QI officer, 1 WTE risk manager (on leave at time of inspection. 0.5 WTE backfill provided) and 1 WTE health and safety officer on the staff. Inspectors note that the absenteeism rate was reported to be 3.74% in July 2023 and 4.71% year to date (HSE target 4% or less). Inspectors were told by staff that Clontarf Hospital was a good hospital to work in.

Uptake of key and essential staff training
It was evident from staff training records reviewed by inspectors that clinical staff undertook multidisciplinary team training appropriate to their scope of practice every two years. Inspectors found that staff attendance and uptake at key and essential training

overall was good but note that further improvement is required to ensure that nurses and doctors have attended up to date training in infection outbreak management, recognising and managing the deteriorating patient including basic life support and in the use of ISBAR.

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. Hospital management should however, seek to improve their compliance level with some elements of key and essential training as outlined above. Inspectors note the responsiveness of the hospital to enhance out-of-hours medical cover and note that hospital management should keep this under continuous review especially in light of increased activity. The hospital and CHO9 management should seek to ensure the adequacy of the antimicrobial stewardship programme by ensuring the hospital has access to an antimicrobial pharmacist, that a clinical director has oversight of all medical activity within the hospital and that there is a sustainable out-of-hours telephone support service from a consultant microbiologist in the medium to long-term.

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 respectively. Key inspection findings leading to these judgments are described in the following sections.

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. Patient's personal information in the clinical areas visited, during the inspection was observed to be protected and stored appropriately.

Staff were observed to promote independence, for example a staff member was heard explaining the set-up of the gym and offering a patient assistance if they would like to go there for their rehabilitation. Other staff were also observed to offer assistance to patients with mobility. In relation to comments from patients regarding use of the garden, hospital management explained that the garden is available to all patients and their visitors and that the gardens are also used by the physiotherapists and occupational therapists when working with patients, weather permitting.

Inspectors noted that the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. Inspectors were told that if a patient was at the 'end of their life' they would be facilitated in a single room where possible. Kincora ward had a communal room with a TV. Several patients were observed to be using this space.

Inspectors heard how the hospital had conducted a Patient Experience Survey of all inpatients (n=114) in the five wards in Clontarf Hospital in August 2022. The survey was based on the Health Service Executive's 'National Patient Experience Survey' 2017 and had been amended to meet Clontarf Hospital's requirements. It consisted of 15 questions covering the following areas: hospital and ward, hospital food, care and treatment, pain, leaving hospital, overall satisfaction. The methodology provided quantitative and qualitative data for analysis with the caveat that the survey's main limitation was identified in terms of 'timing' as patients responding are in-patients - who were dependent on care which could potentially bias their responses. The response rate was 83% up from 67% in 2021. Results overall showed an improvement of 7.5% from 2021. Some wards scored less or more in areas compared to 2021. The results were shared with ward managers with a request for quality improvement plans to address areas for improved within a given time frame. The survey had been repeated in July 2023 and analysis was underway at the time of inspection.

Overall, there was evidence that hospital management and staff were aware of the need and were actively seeking and 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.

Judgment: 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, '*staff very helpful', 'cannot do enough for you'* and '*staff are brilliant*'. Staff were heard to speak slowly and clearly and offer words of encouragement when assisting patients with their care needs including mobility. Nursing staff were heard to seek permission to both draw privacy curtains and also to remove a dressing to view a patient's wound. Inspectors also found evidence of a person-centred approach to care for example, two patients were having their hair styled by their nurse or carer. The staff and patients were engaged in kind and cheerful conversation with each other throughout. Staff also explained use of the 'red tray initiative' which indicated to staff at a glance who required assistance at meal time.

Inspectors noted the use and availability of patient information leaflets for example, advice on protecting and managing pressure areas of the body and use of anti-clotting medication (direct oral anticoagulants – DOAC). Inspectors were told that a further leaflet regarding bone health and fragility was under development at the time of inspection.

Overall, HIQA were assured that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. The hospital could also however based on this feedback, review the range of food options available to patients and the opportunities to facilitate outdoors activity for patients where deemed suitable.

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.

HIQA found that there were systems and processes in place at the hospital to respond to complaints and concerns received from patients and their families. There was evidence of effective systems and oversight of complaints at the hospital. The management of complaints was overseen by both the EMT and the QSRM committee. The risk manager was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. Written complaints were tracked and trended to identify the emerging themes, categories and departments involved. A quarterly report was provided to the

QSRM Committee. The management of complaints was guided by the hospital's complaints policy which was accessible by staff on the computer at ward level. The hospital also provided information on the HSE's complaints mechanism 'Your Service Your Say'.******

Complaints relating to the hospital were discussed at EMT meetings. Inspectors were told that four complaints had been received year-to-date and that most complaints related to communication and visiting especially in times of restricted access associated with COVID-19 or other outbreaks of infection. An example of a quality improvement plan following a complaint was provided to inspectors.

The QSRM report to the EMT dated February 2023 outlined a total of 16 complaints in 2022 which was down from 20 complaints made in 2021. All but two complaints from 2021-2022 had been closed out at that stage. The number of compliments had increased from 46 in 2021 to 85 in 2022.

Inspectors were told that the hospital did not monitor its compliance with the HSE target of investigating and closing out 75% of complaints within a 30-day target as standard practice.

The hospital had conducted an annual patient satisfaction survey in the days prior to the inspection and results were awaited. Inspectors were told that a quality improvement plan would be devised in relation to any areas in need of attention.

When patients were asked about their satisfaction with the service, inspectors were told how they would like more choice in the available food *'it's mostly chicken' and 'I would like a bit of variety'.* Patients also explained that they would like more opportunities to go out to the surrounding garden to facilitate family visits. This was shared with hospital management during the inspection.

Inspectors noted that there was both a section on the hospital's website and in the Patient Information Booklet on how to make a complaint but there was no information or booklets on display at ward level. Inspectors were told that patients can ask staff for help, and that a patient advocate could be sourced via the medical social worker and that translation services were also available as required. Inspectors spoke with patients on both Kincora and Vernon wards however none of them were aware of the process they could follow if they wanted to make a complaint. All of them said that they would ask to speak with a nurse if they had a complaint. This was brought to the attention of the CNM2 and hospital management.

****** Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

Inspectors found that there was a culture of complaints resolution among staff in the clinical areas visited. Staff spoken with were aware of how to support a patient in raising a concern or making a complaint, and of the hospital policy. Staff stated that complaints were addressed at ward level and if a complaint could not be resolved locally, they would escalate the complaint to management.

Feedback on complaints was generally provided to staff in the clinical area associated with the complaint.

In summary, while the hospital had most of the systems in place to effectively manage and monitor complaints, there is scope for further improvement in ensuring that the hospital monitors its effectiveness in managing complaints against national targets and that information on access to patient advocacy and on how to make a complaint is made accessible to all patients throughout their episode of care.

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 two clinical areas, Vernon and Kincora wards. Vernon ward was a 32-bed ward used for orthopaedic rehabilitation. There were 23 inpatients present at the time of inspection. The ward comprised four six-bedded rooms, each with their own toilet and wash hand basin, one four-bedded room with en-suite facilities and four single rooms with en-suite facilities. There was access to three shower rooms and toilets on the ward. One patient was in a single room as they were known to be a close contact of a person with a transmission-based infection.

Kincora ward was a 32-bed ward where 27 of the beds were operational and where there were 22 inpatients present at the time of inspection. Fifteen beds on this ward were used for orthopaedic rehabilitation and 12 beds were used for patients availing of the integrated care programme for older persons (ICPOP). The ward comprised one five-bedded ward, three six-bedded wards and one four-bedded ward, each with toilet and hand wash sinks and four single rooms with en-suite facilities. There was a total of seven showers on this ward including the en-suite rooms. There were no patients requiring isolation facilities on this ward at the time of inspection.

Inspectors observed that overall the hospital's physical environment was well maintained and clean with a few exceptions. There was evidence of general wear and tear of paint work and some wood finishes were chipped. This did not facilitate effective cleaning.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5

moments of hand hygiene) clearly displayed throughout the clinical areas. Inspectors noted that hand hygiene sinks throughout the unit conformed to national requirements.[††††††] Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Inspectors noted that wards were generally spacious and maintained in a tidy manner. Storage rooms were clean and clutter-free.

Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited. Staff were observed to be complying with the 'bare below the elbow' initiative, used to facilitate effective handwashing and infection prevention and control.

Environmental cleaning was primarily carried out by external cleaning contractors with a small amount of cleaning carried out by hospital staff mainly in non-clinical areas. Each ward inspected had a designated cleaner during core hours. Out-of-hours cleaning was undertaken by contract cleaning staff. Healthcare assistants undertook any required cleaning overnight. Inspectors were told that each six-bedded ward on Kincora ward had a deep clean once a week. Terminal cleaning[‡‡‡‡‡‡] was carried out by the contract cleaning staff. Disposable bedside curtains were in use and were included in the deep-clean schedule and were changed in line with the hospital policy. A hospital policy was in place outlining the enhanced cleaning and decontamination required during outbreaks. Cleaning supervisors and clinical nurse managers with input from the DON and the IPC CNM2 had oversight of the quality of cleaning and of the cleaning schedules in the clinical areas visited. Inspectors were told that managers were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe.

Cleaning of equipment was assigned to healthcare assistants. In the clinical areas visited, the equipment was observed to be clean and there was a system in place to identity equipment that had been cleaned using a green 'I am Clean' tagging system. Inspectors however, noted some items of equipment in that area which appeared visibly clean but which did not have the green tag on them.

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

The hospital had implemented processes to ensure appropriate placement of patients and the infection prevention and control nurse liaised with bed management on the placement of patients daily. Single rooms including designated private rooms were prioritised for patients requiring isolation.

[††††††] 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

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

In summary, HIQA was assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. Hospital management should however, ensure that whatever system is in use to identify clean and decontaminated equipment, it is standardised and used consistently across all equipment.

Judgment: Compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, the Board and to the CHO9 team on the quality and safety of the services provided. HIQA found that the hospital monitored and reviewed information from multiple sources including patient-safety incident reviews, complaints, risk assessments and patient experience surveys.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in 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 a high level of compliance (over 90%) with environmental and patient equipment infection prevention and control practices in May, June and July 2023. Audit findings were shared with clinical staff and action plans were documented to address areas requiring improvement. Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene and with 'bare below the elbow' practice.

Hospital management also monitored performance indicators in relation to the prevention and control of healthcare-associated infection.[§§§§§§] The Infection Prevention and Control Committee reviewed the healthcare-associated infection surveillance report

[§§§§§§] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf

every 3 months and their reports were shared with the EMT, QSRM, consultants and staff in clinical areas.

The hospital collated data on rates of:

- clostridium difficile
- carbapenemase-producing enterobacterales (CPE)
- hospital acquired staphylococcus aureus blood stream infections
- hospital acquired COVID-19
- all infections including COVID-19 and outbreaks among staff.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Audits were carried out by nursing, pharmacy and other staff for example the nursing care metrics included:

- pain assessment and management
- medication safety
- medication storage and custody

Medication Safety audits were overseen by the DTC. There was evidence that initiatives were introduced to improve medication safety practices at the hospital. This included conducting focus groups with nurses to explore and amend barriers to incident reporting relating to medication safety.

Deteriorating patient monitoring

The hospital was using the INEWS for monitoring patients and it collated performance data through nursing care metrics relating to patient monitoring and surveillance, achieving 96% overall in 2022. These audits were overseen by the DON.

Transitions of care monitoring

The hospital reported on the number of inpatient admissions and discharges, rate of transfers, average and mean lengths of stay and occupancy levels on a monthly basis. Patient flow and hospital activity were discussed at daily huddles and also shared at EMT, QSRM, Board and at CHO 9 mtgs. An example of assessing patients on transitions of care was outlined where inspectors were told that staff at Clontarf Hospital noted continence management challenges in up to 40% of patients being transferred in from two hospitals however 60% of that cohort had regained full continence by the time they were ready for home or transfer to residential care.

Inspectors were told of the approach undertaken in relation to medicines reconciliation by a pharmacist at transitions of care including the pre-admission prescription check, on admission to ward, and again on discharge.

Inspectors also heard evidence of communication back to the referring hospital where higher rates of pressure ulcers were noted on patients being transferred in. Senior nursing staff from Clontarf Hospital met with senior nursing staff in the referring hospital and subsequent audits showed a decrease in the rate of pressure ulcers on admission. Finally, the identification and reporting back of medication incidents which originated prior to transfer of the patient to Clontarf Hospital are indicators of compliance with this standard.

These are all evidence of good practice and are to be commended. Overall, HIQA was satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital.

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 identify and manage risks. Inspectors were told that the hospital was updating its policy in line with the recently published HSE Enterprise Risk Management policy. The QSRM committee was responsible for oversight of risk identification and management at the hospital and comprised members of the EMT. It reported upwards to the Board. The EMT also liaised with CHO9 management on risk issues. Risk registers were maintained at departmental head level, a hospital risk register at CEO level and a corporate risk register was maintained at Board level.

Inspectors viewed the corporate risk register and noted that it listed the following risks, all of which were red-rated and each with a list of controls in place:

- non-compliance with HIQA infection prevention and control standards- no antimicrobial pharmacist
- risk of hospital acquired infection to patients with disruption of services and risk of outbreaks
- risk of cyber attack

Staff at ward level explained that any risks noted are reported to the ADON who liaises with the risk manager. An example was provided to inspectors on how this operated at Clontarf Hospital. At departmental level, risks rated above five were escalated by the department manager to the CEO, the EMT and QSRM committee. The hospital's risk register was reviewed at quarterly risk management committee meetings and at CHO9

meetings and was updated twice a year (and more often if indicated) by the risk manager, the CEO and the risk officer.

Infection prevention and control

Staff confirmed that patients were screened for multi-drug resistant organisms (CPE and MRSA) on admission to the unit as per national guidance. Patients with a confirmed infection were isolated within 24 hours of admission or diagnosis as per national guidance. Clontarf Hospital was following the then current COVID-19 guidelines however they were continuing to carry out antigen testing all patients on admission as they had risk assessed their patients in line with national guidance and had concluded that as many of them were older, they were at higher risk.

The hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines which included for example, policies on standard and transmission based precautions, outbreak management and equipment decontamination to guide and support staff.

There was good evidence of training in IPC related matters among staff and evidence of active participation in IPC conferences and study days including a poster presentation at the IPC Ireland Conference in 2023 'Are you Bare below the Elbow?'.

Inspectors were informed that the external cleaning contractors had provided English language classes for their staff when Clontarf Hospital highlighted that there were language challenges.

Inspectors noted the presence of clearly labelled and stocked SEPSIS boxes in each of the two inspected wards containing the necessary equipment and storage to ensure timely and thorough assessment of sepsis. These are good examples of identifying, anticipating and managing risk at local level.

Medication safety

The hospital used risk reduction strategies including a high alert APINCH[*******] list dated July 22. This included a SALADs[†††††††] list. Inspectors heard about and viewed the adult IV antimicrobial guidelines dated 2020. Inspectors heard about and viewed examples of learning notices for example, 'Ordering Methotrexate' dated June 22, 'Watch the Decimals' dated Aug 22 and 'Treatment for Covid-19 infection with Paxlovid'. Medicine reconciliation was undertaken on all patients on admission and on average 73% of patients on discharge. Each ward had a HYPO box, stocked to assist in the timely

[*******] APINCH is an acronym for medications including anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

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

treatment and recording of care of patients with hypoglycaemia. Issues escalated to DTC included communication relating to prescriptions on transitions of care, self-administration of drugs and low level of reporting drug administration errors. A medication safety awareness day had been held in September 2022 to address these issues.

Deteriorating patient

The hospital had documented processes in place for staff to follow in the event of a patient becoming unwell and staff spoken with were able to describe the procedures in place. Inspectors noted that there was on-site SHO on duty 24/7/365 at Clontarf Hospital. There was also consultants and registrars on duty Monday to Friday and registrars on-call from home covering weekends and bank holidays. Inspectors were told that patients were risk-assessed daily by the registrar on duty Monday to Friday and that a plan was devised for those at potential risk of becoming unwell during the out of hours period which included transfer to an acute hospital where indicated. Additionally, a handover meeting was held each Friday to highlight any such patients and their proposed plans of care should there be any changes over the weekend. The hospital had a 'Code Red' system in place to alert a team of senior staff who came to the aid of the patient and staff in cases of deterioration or collapse.

Transitions of care

Inspectors viewed the hospital policies for 'Admissions and Pathways of Care' and the hospital's 'Discharge Procedures'. These had been approved by the CEO and were in date. Staff told inspectors that most risks identified by staff were associated with transitions of care and that these included medication prescriptions and issues with the availability of documentation on inter-hospital transfer. Inspectors were told that raising these issues had mostly been resolved since communication between Clontarf Hospital and two of the large referring hospitals. This resulted in the patient's chart being sent from the acute hospital to Clontarf Hospital for one week to enhance the quality of information shared on transitions of care.

Policies, procedures and guidelines

The hospital had a suite of policies, procedures and guidelines in place in relation to the four areas of known harm and overall these were in date and had been ratified at EMT level. These were accessible on a shared hard drive and inspectors saw that staff could access them.

In summary, HIQA found that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Judgment: Compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. There was evidence that both hospital and CHO 9 management had oversight of the management of incidents.

Incidents were reported locally on a form sent to the QSRM department where they were reviewed and entered onto the National Incident Management System (NIMS). Incidents were also escalated to the serious incident management team (SIMT) if required and an incident management team comprising the risk officer, DON and senior clinician was convened in response to incidents requiring closer review.

The risk officer tracked and trended patient-safety incidents and an incident summary report was submitted for review at the monthly EMT and the quarterly QSRM committee meetings and the quarterly CHO9 meetings. Reports and meeting minutes reviewed by inspectors showed that patient-safety incidents were reviewed and that actions arising from previous meetings were followed up. The quality, safety and risk management report to the EMT dated February 2023 showed that a total of 644 incidents had been reported by the hospital which was an increase on the 502 incidents reported in 2021. Inspectors were told that changes to the reporting mechanism had resulted in an improved incident reporting culture at the hospital.

The majority of reported incidents related to slips, trips and falls, followed by biological hazard-COVID-19 related incidents and then medication incidents. Reports reviewed provided a breakdown of these incidents in terms of degree of severity. Of the 209 reported slips, trips and falls which excluded reports of near misses, 162 were categorised as negligible in terms of severity, 17 were categorised as minor, four as moderate and none were categorised as extreme or major. Overall the rate of slips, trips and falls was 5.21 per 1000 occupied bed days in 2022 which was a decrease from 5.36 in 2021, both of which were within the HSE target of 6.63 per 1000 occupied bed days.

The number of reported medication incidents was up from 23 in 2021 to 186 in 2022. This included medication incidents arising in the referring hospital which had originated off-site (n=88) and were subsequently corrected and information shared with the relevant hospital team. Inspectors were told that the reporting had originally been lower than expected and that it had improved since the development of a new reporting form and additional focus on the need to report and that this was being monitored. All of the 98 on-site medication incidents were categorised as 'negligible' in terms of degree of severity (NIMS data).

Inspectors noted that of the five incident reviews that had been closed in 2022, two were undergoing ongoing review through different fora, for example, the complaints process, the coronial or medico-legal process. A sixth incident (from 2022) remained open and a final report was awaited at the time of inspection. A further 93 incidents were reported relating to transitions of care for example, no prescription or wrong prescription, no transfer documentation received, admission after the 5.00pm time frame and no notification of an existing pressure ulcer.

Inspectors were told that action plans following incidents are monitored by both the QSRM committee and the EMT. Action plans included recommendations, responsible person, completion dates and current status. Examples of changes in practice arising from incident reviews included: the introduction of a veno-thrombo embolism (VTE) risk assessment, audit of use anti-coagulants, identification and risk assessment of patients at risk of repeat falls and sharing that information with the family, intentional rounding and the 'red tray' initiative. Inspectors heard how an increase in the number of patients being referred from another healthcare facility were presenting with pressure ulcers. This was brought to the attention of the referring facility, meetings were held by senior nursing staff and the rate subsequently decreased.

The hospitals' incident management policy was accessible via a shared drive at ward level. Incident report forms were paper based. Inspectors found that staff in the clinical areas inspected were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported. Feedback on patient-safety incidents was provided to CNMs via a quarterly report. Inspectors heard who that learning was shared with staff at shift handover meetings, at the two to three-monthly ward meetings, the weekly journal club and at the twice daily safety pause meetings. Inspectors were told that support via the Employment Assistance Programme (EAP) is routinely offered to staff as part of the incident management process.

Inspectors observed a monthly training schedule for tissue viability and audit results on hand hygiene, bare below the elbow, fall statistics (number of inpatient falls per 1000 occupied bed days) and pressure sores displayed on the 'Safe Care Quality Board' on Kincora ward.

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

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Clontarf Hospital on 09 and 10 August 2023 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.

Overall, HIQA found the hospital to be:

- compliant in eight national standards
- substantially compliant in three national standards

Capacity and Capability

HIQA found that Clontarf Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare and had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services.

HIQA found that the hospital had effective management arrangements in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm outlined above. The hospital should however, continue to progress its efforts in seeking either the support or the recruitment of an antimicrobial pharmacist to support the hospital in the provision of an AMS programme and also review its provision of 24/7/ 365 access to a consultant microbiologist. There is also scope for improving the involvement of the patient in setting and working towards their personal predicted discharge dates insofar as is possible.

HIQA was assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital although there is scope to consider increasing the level of audit activity relating to transitions of care.

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. Hospital management should however, seek to improve their compliance level with some elements of key and essential training. Inspectors noted the responsiveness of the hospital to enhance out-of-hours medical cover in light of increased activity. The hospital and CHO9 management should seek to ensure the adequacy of the antimicrobial stewardship programme by ensuring the hospital has access to an antimicrobial pharmacist, that a clinical director has oversight of all medical activity within the hospital and that there is a sustainable out-of-hours telephone support service from a consultant microbiologist in the medium to long-term.

Quality and Safety

The hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their experience of receiving care in the hospital and were very complimentary of staff.

The hospital were aware of the need to support and protect patients and had developed their own annual patient satisfaction survey plan and associated quality improvement plans. The hospital could reflect on feedback from some patients with regard to the range of food options and the opportunity to facilitate more outdoor activity for patients where deemed suitable.

HIQA found that while the hospital had systems in place to effectively manage and monitor complaints, there is scope for further improvement in ensuring that the hospital monitors its effectiveness in managing complaints against national targets and that information on access to patient advocacy and on how to make a complaint is made accessible to all patients throughout their episode of care.

HIQA was assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients. Hospital management should however, ensure that whatever system is in use to identify clean and decontaminated equipment, it is standardised and used consistently across all equipment.

HIQA was satisfied that the hospital had systems in place to monitor and improve services. Clinical areas visited were compliant with the HSE's target of 90% for hand hygiene and with 'bare below the elbow' practice. Medicine reconciliation was undertaken on all patients on admission and on average 73% of patients on discharge. Nursing and other metrics were reviewed at Board level and overall the hospital was performing well in these.

HIQA was satisfied that, in relation to the four areas of known harm, the hospital had systems in place to identify, prevent or minimise unnecessary or potential risk and harm associated with the provision of care and support to people receiving care at the hospital.

HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm. The hospital were tracking and trending infection prevention and control patient-safety incidents, medication incidents and incidents related to transitions of care. Deteriorating patient incidents were not a specific category that were tracked and trended however,

there was evidence that the EMT and QSRM committee had oversight of the management of serious incidents and reportable events.

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	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	**Compliant**
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	**Substantially compliant**
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	**Compliant**
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	**Substantially compliant**

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

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