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:	Midland Regional Hospital Portlaoise
Address of healthcare service:	Block Rd Ballyroan Portlaoise Co. Laois
Type of inspection:	Announced
Date(s) of inspection:	04 and 05 April 2023
Healthcare Service ID:	OSV-0001075
Fieldwork ID:	NS_0034

1.0 Model of Hospital and Profile

About the healthcare service

Midland Regional Hospital Portlaoise is a Model 3* public acute hospital managed by the Dublin Midlands Hospital Group† on behalf of the HSE. Services provided by the hospital include a 24-hour Emergency Department service (ED), an Acute Medical Assessment Unit/ Acute Surgical Assessment Unit (AMAU/ASAU), and a range of inpatient and outpatient general medical, surgical, obstetrics, gynaecology and paediatric services. It serves a population within the counties of Laois, Kildare, Carlow, Offaly and North Tipperary.

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	139 inpatient beds 13 additional day beds

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the National Standards for Safer Better Healthcare as part of 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:

*Model-3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute Medicine and critical care.

†The Dublin Midlands Hospital Group is made up of seven hospitals—St. James's Hospital, Tallaght University Hospital, Naas General Hospital, Midland Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, Coombe Women and Infants University Hospital and St. Luke's Radiation Oncology Network.

‡ 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)

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

About the inspection report

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

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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
04 April 2023	08:50 – 17:15hrs	Aoife Healy	Lead
		Geraldine Ryan	Support
05 April 2023	09:00 – 16:20hrs	Emma Cooke	Support

Information about this inspection

An announced inspection of Midland Regional Hospital Portlaoise was undertaken on 04 and 05 April 2023.

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 the clinical areas:

- Dunamaise ward (surgical ward)
- Slieve Bloom ward (acute medical ward)
- Emergency Department (ED)
- conducted a walk-through of the Acute Medical Assessment Unit/Acute Surgical Assessment Unit (AMAU/ASAU).

The inspection team spoke with the following staff:

- representatives of the hospital's Senior Management Team:
  - general manager
  - interim director of nursing
  - clinical director
- Non-consultant hospital doctor (NCHD)
- representatives from each of the following hospital committees:
  - Quality Safety and Risk Committee
  - Infection Control and Hygiene Committee
  - Deteriorating Patient Committee
  - Drugs and Therapeutics Committee
  - Transitions of Care.

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

Acknowledgements

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

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

Inspectors visited the three clinical areas including the ED, Dunamaise ward and Slieve Bloom ward, as well as conducting a walk- through of the AMAU/ASAU. The ED had capacity for 19 bays, including three bays in resus and one isolation bay, and five chairs on the corridor. The AMAU/ASAU had capacity for 10 bays and one en-suite isolation room. Dunamaise ward had capacity for 33 beds, which comprised four six-bedded rooms, one two-bedded room, five single en-suite rooms and two secure rooms which shared a bathroom. Slieve Bloom ward had capacity for 11 beds comprising two five-bedded rooms and one single en-suite room. All beds in Dunamaise ward were occupied on the day of inspection, and one bed on Slieve Bloom ward was vacant.

Inspectors spoke with patients about the care they received in the hospital. Feedback was positive and patients reported that they were treated with kindness and respect and were happy with the level of care they received. When asked to describe their experience, patients commented that staff were *'really nice' and 'always friendly'*, and '*so helpful'*. Patients told inspectors *'it is the most wonderful place'*. When asked if there was anything that could be improved about their experience, one patient's family member commented that communication between medical specialties could be better so as to reduce waiting time for patients to be seen by other specialties they have been referred to. Another patient commented that the space in the six-bedded rooms on the surgical ward was limited, and as a result they could not sit out of bed as there was insufficient space for a chair.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the patients spoken with. Patients commented that they *'don't want to leave. I am being waited on hand and foot'.* Patients explained that they did not have to wait long for anything that they requested from staff. Patients spoken with knew who to speak to if they wished to raise an issue and commented that they could speak with staff if they had a concern or complaint.

Overall, there was consistency in what patients told inspectors about their experiences of the care they received and what inspectors observed in the clinical areas visited.

Capacity and Capability Dimension

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

Inspectors found that while the hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety for some aspects of healthcare, the hospital's Quality and Safety Executive Committee, responsible for governance and oversight of quality and safety at MRHP, had not met since 2020. Furthermore, some committees would benefit from having clearly defined, assigned time-bound actions.

Of note, a high-risk letter was issued by HIQA to the Dublin Midlands Hospital Group (DMHG) following the inspection regarding the absence of a formal by-pass protocol with the DMHG for MRHP patients that require timely treatment for stroke. In a letter of response, the CEO of the DMHG outlined the interim arrangements in place for the timely treatment of patients presenting to MRHP with stroke.

The hospital was governed and managed by the general manager, who was accountable to the DMHG chief operations officer, who in turn reported to the chief executive officer (CEO) of the DMHG. Organisational charts setting out the hospital's reporting structures detailed the direct reporting arrangements for hospital management, governance and oversight committees. The hospital's reporting and accountability relationship to the DMHG was clearly outlined on the organisational charts and reflected integrated corporate and clinical governance arrangements.

The clinical director at MRHP provided clinical oversight and leadership to consultants and non-consultant hospital doctors (NCHDs). The interim director of nursing (DON) and director of midwifery (DOM) were responsible for the organisation and management of nursing and maternity services, and reported to the group director of nursing and midwifery services.

Senior Management Team

MRHP Senior Management Team (SMT) was established as the senior operational board of the hospital and was responsible for the day-to-day operational and strategic management of MRHP. Inspectors were provided with terms of reference (ToR) and minutes for the most recent meetings. This documentation detailed that the team, chaired by the hospital's general manager, met in line with their ToR. Meetings were action orientated, however actions were not always time-bound or assigned to individuals. The SMT was accountable to the DMHG, via monthly performance meetings. Meetings with DMHG were action orientated and actions assigned to individuals, however, actions were not time-bound.

Hospital management had established several hospital committees through which to govern services and address matters in relation to the four key areas of risk: Infection Prevention and Control, Medication Safety, Deteriorating Patient and Transitions of Care (ToC).

Quality and Safety Executive Committee

MRHP Quality and Safety Executive Committee was established as the overarching committee with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. There were seven sub-committees under the quality and safety structure, who had oversight for the quality and safety of the various specialties within the hospital (Medical, Emergency Medicine, Peri-Operative, Paediatric/Special Care Baby Unit, Radiology, Pathology, and Maternity Quality & Safety Specialty Committees). However, inspectors noted that none of the committees representing the four areas of risk (Infection Prevention and Control, ToC, Deteriorating Patient and Medication Safety) reported into the Quality and Safety Executive Committee, but reported instead to the SMT. Management acknowledged this arrangement, and communicated to inspectors that as part of a review of the existing governance structures for quality and safety, plans were in place to reconvene the Quality and Safety Executive Committee, which had not met since November 2020.

Inspectors were provided with a document which detailed that the existing governance arrangements for quality and safety, which was formed through the hospital's participation in a Clinical Governance Development Project established by the National Quality & Patient Directorate in 2012, was under review. This had been discussed at SMT also. There was evidence from SMT meeting minutes reviewed that matters pertaining to quality, safety and risk were discussed at SMT. The review of existing quality and safety arrangements for MRHP should be progressed to ensure that structures are in place to provide the necessary oversight for quality and safety at the hospital.

Infection Prevention and Control Committee

The hospital's Healthcare Associated Infection Committee (HCAI), responsible for the governance and oversight of infection prevention and control (IPC), was a multidisciplinary committee, chaired by the consultant microbiologist and accountable to the hospital's SMT, via the Quality & Safety Executive Committee. At the time of the inspection, the HCAI committee was reporting directly to the SMT, in the absence of a functioning Quality & Safety Executive Committee. The committee had agendas for each meeting, which included items for discussion under the themes of the National Standards for Safer Better Healthcare. The ToR stated that the HCAI committee should meet quarterly, however, there was no evidence of a meeting having taken place in quarter three of 2022.

Minutes of meetings reviewed demonstrated that meetings were well attended and that items discussed were being progressed, however, the minutes would benefit from having clearly defined time-bound actions. It was evident from SMT meeting minutes that there was opportunity for the HCAI committee to provide updates to the SMT. It was noted that there were no new updates under 'Infection control' in any of the SMT meeting minutes reviewed by inspectors. Some updates in relation to IPC were provided under other items minuted.

Inspectors received a copy of the 'Infection Prevention and Control Team Plan for Midlands Regional Hospital at Portlaoise' for 2023, which was being implemented by the IPC team. From evidence gathered, it was evident that there was governance and oversight of infection prevention and control practices at MRHP.

Drugs and Therapeutics Committee

The Drugs and Therapeutics Committee was responsible for the governance and oversight of medication safety practices at the hospital. The committee, chaired by the clinical director, with the chief pharmacist and interim DON as vice-chairs, was operationally accountable and reported to the SMT and the Quality and Patient Safety Executive Committee, when operational. Minutes and agendas of meetings provided, showed that the committee met quarterly in line with its ToR.

The committee had a standardised agenda and actions assigned to members, however, actions were not always time-bound. Inspectors reviewed a copy of 'Midland Regional Hospital Portlaoise Medication Safety Programme' which was overseen by the Drugs and Therapeutics Committee, however, due to pharmacy resourcing shortages, inspectors were informed that the programme was not being implemented in its entirety at the time of inspection.

Deteriorating Patient Committee

The Deteriorating Patient Committee was responsible for the governance and oversight of matters associated with the recognition and response to the deteriorating patient, including responsibility for the oversight of the implementation of the national Early Warning Systems — Irish National Early Warning System (INEWS)[‡‡], Irish Paediatric Early Warning System (PEWS)[§§], Irish Maternity Early Warning System (IMEWS) V2[***] and sepsis guidelines at the hospital. Two sub-committees reported to the overarching Deteriorating Patient Committee — the Deteriorating Child Committee, chaired by a consultant paediatrician and the Maternity Services Irish Maternity Early Warning Systems Committee, chaired by a consultant obstetrician.

These committees reported to the hospital's SMT via the Deteriorating Patient Committee and met bi-annually in line with the ToR. The ToRs for the Deteriorating Patient

[‡‡] Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

[§§] The Irish Paediatric Early Warning System (PEWS) applies to infants and children admitted to paediatric inpatient settings. It does not apply to infants within maternity and neonatal units. This National Clinical Guideline is relevant to all healthcare professionals working in paediatric inpatient settings.

[***] The Irish Maternity Early Warning System (IMEWS) V2 applies to women with a confirmed clinical pregnancy and for up to 42 days in the postnatal period, irrespective of age or reason for presentation. Exclusions are women in labour, high dependency, recovery and critical care settings. This NCG is relevant to all clinical staff in hospitals providing care to those women.

Committee and the Maternity Services Irish Maternity Early Warning Systems Committee were in draft format at the time of inspection. A ToR was not available for the Deteriorating Child Committee.

The aforementioned committees would benefit from having standardised agendas and time-bound assigned actions.

Unscheduled Care Group

The hospital had an Unscheduled Care Group which was chaired by the general manager and met in line with its ToR. Meetings were action orientated with actions assigned to individuals, however, actions were not always time-bound. Inspectors met with lead representatives for ToC within the hospital and it was evident that considerable work had been undertaken in relation to ToC, including the rollout of a pilot project for the contract of two private ambulances to support transitions of care at the hospital.

In summary:

- The hospital needs to continually monitor and assess the effectiveness of the formal stroke by-pass protocol arrangement with the DMHG, for patients of MRHP who require timely treatment for stroke.
- The hospital needs to recommence Quality and Safety Executive Committee meetings, as the committee had not met since 2020. This is required to ensure that there are structured and appropriate governance and oversight arrangements in place in relation to quality and safety at the hospital.
- A number of meeting minutes reviewed evidenced that meetings followed an agenda, however, some committees would benefit from having clearly defined, time-bound actions that are assigned to individuals for all committee meetings that take place.

Judgment: Partially compliant

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

Effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm.

Findings relating to the Emergency Department

On the day of inspection, it was evident that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the

management of unscheduled care in the ED and AMAU/ASAU. It was also evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the ED and the AMAU/ASAU and that operationally, the ED and AMAU/ASAU were functioning well.

There was evidence of strong clinical and nursing leadership in the ED and the AMAU/ASAU. Operational oversight of day-to-day workings of the department was the responsibility of the on-site clinical nurse manager Grade 3 (CNM3), who reported to the assistant director of nursing (ADON). The on-site consultant in emergency medicine, was supported by NCHDs and reported directly to the clinical director. The CNM3 was supported by a CNM2 on each shift and a CNM2 had responsibility for nursing services in the ED out-of-hours and at weekends. Staff reported that concerns relating to the ED or AMAU/ASAU were escalated to the CNM3 who then escalated to the ADON or clinical director as required. Patient flow through the ED and AMAU/ASAU was supported by the CNM2 for admitted patients who acted as the conjugate for the flow of patients from the ED and AMAU/ASAU to the wider hospital.

The hospital's Unscheduled Care Group had oversight of activity and performance within the ED and AMAU/ASAU, including patient flow through the department and surge capacity at the hospital. Chaired by the general manager, the group was accountable to the hospital's SMT and met in line with their ToR. The group provided detailed reports to the Quality and Patient Safety Team and there was evidence in meeting minutes from the SMT and the DMHG performance meeting that scheduled and unscheduled care was discussed.

Outside of core working hours, clinical oversight of the ED was the responsibility of the ED consultant, on site until 6pm and then on-call until 12am. A medical consultant had clinical oversight of ED between 12am and 8am, with surgical and gynaecological ED patients seen by their respective specialty consultants during those hours.

MRHP had 32,700 ED attendances to September 2022. ED attendances for the same period to September 2019 were 30,448. This was an increase of 2,252 attendances on 2019. In 2022, monthly ED attendances ranged from 2,850 in January to 3,631 in December.

The majority of patients were referred by a GP or self-referred. Inspectors were informed that hospital management were not successful in securing a GP post for the ED as part of the HSE'S winter plan[†††]. Inspectors observed that the AMAU/ASAU was functioning intermittently as an AMAU/ASAU, due to the need to use it as an overflow area for the ED. This was dependant on the number of presentations in the ED on a particular day. On the first day of inspection, six of the 10 bays in the AMAU/ASAU were occupied by

[†††] The HSE Winter Plan October 2022- March 2023 is a comprehensive plan to support acute and community services this winter to respond to anticipated high levels of emergency attendances and admissions across the acute sector, long waiting times in Emergency Departments (EDs) and high occupancy rates across acute hospital settings.

patients from the ED, however, on day two of the inspection, the AMAU/ASAU had reverted to its original function. On the two nights prior to the inspection, the AMAU/ASAU acted as surge capacity for the hospital.

Continuous and effective flow of patients within the hospital is essential for optimal service delivery in the ED. The average length of stay (ALOS) for medical patients reported in 2022 was 3.9 days (KPI target ≤7.3) and for surgical patients the ALOS was 2.9 days (KPI target ≤5.6), which was significantly below the national target. Inspectors found a good structure in place in relation to bed management and patient flow throughout the hospital, guided by a bed management policy and this was further evidenced through meetings with lead representatives for ToC.

Inspectors were informed that the pathway for referral to the AMAU/ASAU was through the ED. All patients presenting to the ED were assessed for symptoms of COVID-19 and were seen by an ANP to determine the care pathway they required. On the day of inspection, inspectors found the ED to be functioning well. All patients had been triaged and prioritised in line with the Manchester Triage System[‡‡‡] and referred to the most appropriate pathway which included the AMAU/ASAU. Patient Experience Times (PET) are discussed in more detail in standard 3.1.

Inspectors found good systems and processes in place at the hospital to manage the demand in activity and to support continuous flow of patients. Inspectors reviewed detailed reports managed by the bed management and patient flow team, which included detail of inpatient activity, current ED patient summary by area, the previous day's activity for ED including numbers waiting at 8am and lodged patients, intensive care bed availability and the number of elderly patients categorised as inpatients or in ED over nine hours. The hospital had a formalised structure in place whereby board rounds were held each weekday morning in each clinical area with updates provided on each patient in relation to their occupancy of an inpatient bed or their requirements for effective discharge. A copy of a daily situational report reviewed, outlined the number of patients in each clinical area throughout the hospital, including transfers in and out of MRHP and any delayed discharges or concerns relating to bed management and patient flow. Of note, the bed management/patient flow team operated five days per week, Monday to Friday. This will be discussed further in standard 6.1.

Overall, on the days of inspection, it was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the ED and AMAU/ASAU. There was evidence that the bed management and patient flow structures in place were effective to ensure flow of patients from the ED to AMAU/ASAU and clinical areas within the hospital. Notwithstanding this, bed capacity in the hospital

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

was a challenge and this was further demonstrated by the use of the AMAU/ASAU to board patients who were awaiting an inpatient bed.

Findings relating to the wider hospital and other clinical areas

The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas and these are discussed in more detail below.

Infection, prevention and control

The hospital had a formalised overarching infection prevention and control programme[§§§] as per national standards.[****] Considerable work was being undertaken in relation to IPC on site and inspectors reviewed documentation of IPC audits undertaken. This will be discussed further under Standard 3.1.

The hospital had documented and escalated concerns in relation to the lack of an on-site consultant microbiologist. Arrangements at the time of inspection were such that consultant microbiologist cover was being provided remotely from the United Kingdom (UK), for a period of approximately four months prior to the inspection. This was due to the hospital's ongoing challenges to recruit to the advertised post. This will be discussed further in Standard 6.1. Furthermore, inspectors were informed that it was hoped that the antimicrobial stewardship (AMS) programme for MRHP, which was paused due to resourcing shortages would be reinstated with a clinical pharmacist receiving training to take-up the post of antimicrobial pharmacist at the time of inspection. The hospital had completed a risk assessment in relation to the lack of an on-site consultant microbiologist and the absence of an AMS programme for the hospital. Both were included in the hospital's risk register. This is further discussed in Standard 3.1.

Medication safety

The hospital had a clinical pharmacy service,[††††] which was led by the hospital's chief pharmacist. The hospital had approval for 8 WTE clinical pharmacists, 1 WTE chief pharmacist and 5.63 WTE pharmacy technicians, however the actual workforce was as follows;

- 5 WTE pharmacists, which included the chief pharmacist

[§§§] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service.

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

[††††] 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.

- 5.23 WTE pharmacy technicians (5.63 WTE approved posts), one of whom worked off site at another service linked to MRHP.

Inspectors were informed of the ongoing challenges that the hospital faced to recruit to the advertised posts. This is a reflection of the challenges to recruit to clinical pharmacy posts nationally. Inspectors were informed that in the weeks following the inspection, due to further staffing changes, the hospital would be operating with 37.5% of its approved compliment of clinical pharmacists in post, which would result in further limitations to the clinical pharmacy service at MRHP.

Hospital pharmacy services were available on site Monday to Friday, 9.00am to 5.00pm. Outside of these hours, access to pharmacy services was via nursing administration. Inspectors were informed that the chief pharmacist provided out-of-hours cover by phone, but this was not a formalised arrangement. Out-of-hours pharmacy arrangements were noted on the hospital's risk register. Furthermore, the chief pharmacist provided pharmacy support to two other services in addition to MRHP. Inspectors were concerned about the sustainability of this arrangement in view of significant clinical pharmacy shortages in the hospital and this was discussed with senior management. The shortage of pharmacists was noted as a risk on the hospital's risk register.

The hospital had a formal medication safety programme. It was acknowledged on the day of inspection that medication reconciliation and antimicrobial stewardship in particular were impacted by the shortage of pharmacy staff. This is discussed further under Standard 3.1.

Deteriorating patient

Inspectors met with representatives from three deteriorating patient committees, as described in standard 5.2. At the time of inspection, the hospital had implemented PEWS, IMEWS V 2 and INEWS V 2. The existing structure was such that PEWS, INEWS and IMEWS each had an individual lead, namely a paediatric consultant, the hospitals head obstetrician and a medical consultant respectively. The Deteriorating Child Committee and the Maternity Services Irish Maternity Early Warning System Committee reported to the overall Deteriorating Patient Committee, with the overall lead for the deteriorating patient programme being a medical consultant, who was chair of the Deteriorating Patient Committee.

At the time of inspection, the policy to support the implementation of IMEWS required review. The hospital had a 'Patient Flow Escalation Policy' in place which was just overdue review.

It was evident that considerable work had been undertaken in relation to the implementation of INEWS V 2, IMEWS V 2 and PEWS guidelines. There was evidence of a number of audits being undertaken in relation to INEWS V 2 documentation, including the

hospital's participation in a national INEWS audit, as well as trending of incidents, which will be discussed further in Standard 2.8.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. The Lead for ToC was the clinical director of the hospital. The team consisted of an ADON for patient flow, a discharge coordinator, an operations manager for bed management and discharge, a bed manager CNM3 and a Community Intervention Team (CIT) Outpatient Parenteral Antimicrobial Therapy (OPAT) coordinator. Inspectors were informed that all requirements for beds at MRPH was coordinated by the patient flow team. The hospital had introduced a number of measures implemented to support safe transitions of care, which included:

- updating the hospital's bed management policy and development of a draft policy to guide the transition of patients to a transitional care unit locally
- daily multidisciplinary team (MDT) board rounds, attended by the community public health nurse (PHN) each Wednesday, to discuss patients for discharge who might require community services
- a CIT OPAT pathway — a nurse-led pathway (1 WTE) that liaises with CIT OPAT to facilitate clinical interventions to patients within their own homes
- contract of a private ambulance service for the hospital to support transfer of patients.

Inspectors were informed that a frailty team was in the process of being set up, with recruitment underway at the time of inspection.

Lead representatives for transitions of care within the hospital stated that the hospital had good links with community services, however, the shortage of community beds was an ongoing challenge for MRHP. At the time of inspection, MRHP had arrangements in place to ensure that patients eligible for transitional, rehabilitation and stepdown care were transferred, dependant on a bed being available, to one of six community hospitals in the hospital's catchment area.

In summary, while effective management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital and in relation to the four areas of known harm, there was scope for improvement:

- Management need to review and risk assess the sustainability of the extensive remit of clinical pharmacy services, in light of existing clinical pharmacy resourcing deficits.

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.

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. The hospital reported on a suite of key performance indicators (KPIs), and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks. There was oversight of the management of serious reportable events and serious incidents, in line with the HSE's Incident Management Framework[‡‡‡‡].

Monitoring service's performance

The hospital collected data on a range of clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported monthly for the HSE's hospital patient safety indicator report (HPSIR), including:

- Rate of medication incidents as reported to NIMS per 1,000 beds
- % of hospitals with implementation of INEWS in all clinical areas of acute hospitals (as per 2019 definition).

Of note was that the hospital was not in a position to submit data in relation to the following KPI, due to the absence of a formal AMS programme, at the time of inspection:

- % of acute hospitals implementing the national policy on restricted antimicrobial agents

Although some activities were being undertaken to drive improvements in relation to compliance with these KPIs, it was not clear to inspectors if formal quality improvement plans (QIPs) associated with these KPIs were in place at the time of inspection.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risk. On review, the hospital's corporate risk register detailed existing controls and actions taken to date in response to identified risk. Actions

‡‡‡‡ The purpose of the IMF is to provide an overarching practical approach, based on best practice, to assist providers of HSE and HSE funded services to manage all incidents (clinical and non-clinical) in a manner that is cognisant of the needs of those affected and supports services to learn and improve. Health Service Executive. *Incident Management Framework.* Dublin: Health Service Executive. 2020. Available on line from https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/hse-2020-incident-management-framework-guidance.pdf

were assigned to a risk owner, however, some risks were past their action due date and required review.

Risk data was included in quarterly assurance reports to SMT. From a review of meeting minutes and the risk register submitted to HIQA, it was clear that risks were discussed at the hospital's SMT and escalated to the DMHG where required, for discussion at the DMHG Performance Meetings. Risks are discussed further in Standard 3.1.

Audit activity

Inspectors were informed by members of SMT that MRHP audit committee had recently been reinstated. From documentation received by HIQA, audit activity was overseen by relevant governance committees and reports submitted to SMT in the absence of the MRHP Quality and Safety Executive Committee. The MRHP Quality and Safety Executive Committee had recently recruited a clinical audit facilitator Grade VI. Inspectors received a schedule of IPC and medication safety audits to be undertaken in 2023, which was included as part of the IPC team plan and the medication safety programme respectively. However, a formal audit plan for all key risk areas would better support the hospital's work in relation to audit. Audits will be discussed further in Standard 2.8.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) reported to the DMHG CEO, and had oversight of the management of serious reportable events (SREs) and serious incidents which occurred in the hospital. SIMT were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT was chaired by the hospital's general manager and membership included the clinical director, interim DON, DOM, quality and patient safety manager, a consultant obstetrician (maternity and obstetric incidents), and other hospital representation as deemed appropriate by the general manager. The minutes of SIMT detailed discussions in relation to serious incidents and SREs current at that time. A formal notification process was in place for reporting of category 1 serious incidents and serious reportable events to the DMHG. Evidence from meeting minutes confirmed that SREs were also discussed at SMT, evidencing good oversight of SREs within MRHP. Inspectors were informed by staff in clinical areas visited that learning from SREs was discussed at ADON and CNM 2 meetings and shared via CNM2 and ward safety huddles. The hospital was also a member of the DMHG Serious Incident Management Forum (SIMF), where serious reportable events which met specific criteria were discussed at DMHG level.

Management of patient-safety incidents

The hospital reported clinical incidents through the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. Of note is that a previous backlog in uploading incidents to NIMS had been rectified, due to increase in resources to the quality and patient safety team. While it was evident that new structures

and processes were being embedded within the quality and patient safety team, inspectors noted opportunities for improvement and enhanced oversight in relation to tracking and trending of incidents by the quality and patient safety team. It was evident that medication safety incidents were discussed at the Drugs and Therapeutics Committee and that all incidents were discussed at the hospital's SMT. The hospital also published a detailed Annual Incident Management Report and inspectors observed a copy of this for 2021, with the 2022 report not yet completed. Patient-safety incidents related to the four areas of harm are discussed further in Standard 3.3.

Feedback from people using the service

The hospital had a QIP in place in response to findings from the National Inpatient Experience Survey (NIES) 2022. This QIP was overseen by the hospital's Quality and Patient Safety Committee, however, the QIP did not contain timeframes for completion of actions. Inspectors did however note that a QIP listed had been actioned, whereby a patient discharge information leaflet was available for patients on discharge.

The consumer affairs manager was responsible for oversight, tracking and trending of complaints. Complaints were discussed at the hospital's SMT and there was opportunity as detailed in DMHG performance meetings to discuss complaints also. Complaints will be discussed in more detail in Standard 1.8.

In summary 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. However:

- While there was evidence that the risk register was regularly reviewed, some risks were past their action due date and required updating.
- There was a lack of clarity regarding the role of the quality and patient safety team in relation to the tracking and trending of incidents, which needs to be addressed.
- A QIP to address findings from the NIES 2022 did not contain timeframes for completion of actions.

Judgment: Substantially 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. Notwithstanding that, there were a number of vacancies across the majority of disciplines at MRHP.

Overall, inspectors found that hospital management were planning, organising and managing their staffing levels to support the provision of high-quality, safe healthcare.

Inspectors met with lead representatives from HR, whose work was guided by a formalised HR operational plan for MRHP 2023-2025.

Findings relating to the Emergency Department

Staffing levels in the ED were maintained at levels to support the provision of 24/7 emergency care at the time of inspection, however, inspectors were concerned about the sustainability of medical cover in view of medical staffing shortages. The hospital had approval for 2.8 WTE emergency medicine consultants. At the time of inspection, two WTE emergency medicine consultants were in post, one of whom was employed directly by the hospital, one who was employed under a HSE contract, and a 0.8 WTE locum consultant. Out-of-hours cover was provided two nights each per week by one of the two WTE consultants and one night was covered by a locum consultant, mid-week. Weekend cover was provided by the two WTE consultants and a locum consultant, on a rotation of every third weekend. Where additional cover was required for periods of leave, a second locum consultant was available to cover these hours. Inspectors were informed that a business case had been submitted to the DMHG for one WTE emergency medicine consultant post, to replace the existing 0.8 WTE locum post arrangement in place at the time of inspection. This was raised at SMT and information provided to inspectors post the inspection indicated that the recruitment process for this post had progressed. The sustainability of maintaining continuity and contingency with the existing two WTE emergency medicine consultants, supported by a locum consultant, to meet the demands of a very busy ED was discussed with medical staff and senior hospital management. Senior hospital management informed inspectors that they had raised the matter with the DMHG through the performance meeting structure. The progression of the recruitment process for an additional WTE emergency medicine consultant is necessary in order to provide and sustain high quality, safe and reliable care within the emergency department going forward.

Emergency medicine consultants were supported by 16 NCHDs, all at registrar grade. At the time of inspection, there were no SHO's or interns employed in the ED.

A CNM3 had responsibility for the nursing staff within the ED during core working hours, was supernumerary and reported to the ADON for ED. As previously noted, the CNM3 was supported by a CNM2, who provided oversight outside of core working hours and at weekends. A CNM2 for admitted patients supported patient flow from the ED, rostered Monday to Friday, and reported directly to the CNM3. The hospital had approval for 39.4 ED staff nurses, however the actual number of ED staff nurses on the day of inspection was 33.9 WTE. Nursing staff were supported by a workforce of eight healthcare assistants (HCAs), however, the hospital had approval for 11.5 WTE HCAs at the time of inspection. Staffing in the AMAU/ASAU comprised of two staff nurses, one CNM2 and a HCA each day for the hours the unit operated, 07:30-18:00.

Where staffing deficits occurred, the hospital relied on agency staff to fill these posts, however, it was noted that the majority of shifts that required filling in the ED were filled

by the hospital's own cohort of ED staff who took on extra shifts. Risk assessments had been completed to reflect challenges related to staffing deficits.

Findings relating to the wider hospital and other clinical areas

The hospital had workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care, however, there was a need for additional resources in some of these areas and this had been identified and escalated through the relevant governance channels. There was evidence that staffing levels and vacancies were discussed in detail both at the SMT and the performance meetings with the DMHG. For example, there were ongoing challenges regarding recruiting to the post of consultant microbiologist, as noted in Standard 5.5. During a meeting with lead representatives from HR, inspectors were informed that due to not being able to fill the previously advertised post, the specifications of the post had been amended to 1 WTE specific to MRHP, with 1 in 4 cover across three hospitals, MRHP, Midland Regional Hospital Tullamore and Midland Regional Hospital Mullingar. Furthermore, inspectors were informed of challenges regarding recruitment of clinical pharmacists, as noted in Standard 5.5. MRHP had approval for 8 WTE clinical pharmacists and 1 WTE chief pharmacist. However, at the time of inspection there were 4 WTE clinical pharmacists in post, which was due to be reduced, resulting in the clinical pharmacy team operating at 37.5% of its approved compliment in the weeks following the inspection. Deficits in staffing was noted as a risk on the hospital's risk register and risk assessments with regards to deficits in clinical pharmacy staffing and the vacant consultant microbiologist post had also been completed.

The hospital's approved complement of nursing staffing was 302.16 WTEs. At the time of inspection, 284.8 WTEs nursing positions were filled, which represented a variance of 17.36 WTEs between the approved and actual nursing complement. However, in clinical areas visited, over a previous four week period there was a deficit of one to two staff members for 12 shifts and in the second clinical area there were six shifts where there was a deficit of one to two staff per shift. In the first clinical area, there was no redeployment of staff to backfill this deficit and in the other clinical area, staff were redeployed when there was a deficit of two or more staff only.

Hospital management told inspectors that they were actively recruiting nursing staff to address the variance. The hospital's total approved posts for HCAs was 67.68 WTEs, of which there was a deficit of 9.34 WTEs at the time of inspection.

At the time of inspection, there were 26 approved consultant posts at MRHP, all of which were filled through a mixture of permanent and locum consultants. Four consultants were not on the specialist register with the Irish Medical Council at the time of inspection and arrangements were in place to ensure that clinical oversight was provided for these consultants by the clinical director of MRHP and the clinical leads from their specialist

areas. The consultant staff were supported by 97 NCHDs, including 51 registrars (3 specialist registrars), 39 Senior House Officers (SHO) and seven intern grade.

Of note was that the bed management/ patient flow team, which comprised of four staff members, was operational Monday to Friday during core working hours. Given the crucial role this team played in the transitions of care for patients within the hospital and in the admission and discharge process, consideration should be given to the need for additional WTE posts to continue to support effective and efficient transitions of care at MRHP inclusive of weekends.

Staff training

Findings relating to all areas inspected

There was room for improvement with regards to uptake of mandatory and essential training for staff. Training records provided to inspectors for the hospital demonstrated that improvements are required in staff training compliance across a number of areas. Of note is that training compliance differed somewhat when broken down by clinical areas inspected. For example, hospital-wide compliance for training in relation to IPC, specifically standard based precautions, transmission based precautions, donning and doffing and hand hygiene required improvement. Compliance for all of the aforementioned was 87% for nursing staff, 82% for HCAs, 51.3% for doctors, 30% for housekeeping/cleaning staff and 73% for health and social care professionals. This requires improvement, and in particular compliance with hand hygiene training, being well below the HSE's target of 90% for some staff cohorts.

Training compliance for nursing and HCAs for IPC (standard based precautions and transmission based precautions), hand hygiene and donning and doffing PPE in two clinical areas inspected, Slieve Bloom and Dunamaise wards, was as follows:

- IPC — 56% of nurses and 67% of HCAs in one clinical area and 36% of nurses and 33% of HCAs in the second clinical area.
- Hand hygiene — 56% of nurses and 33% of HCAs in one clinical area and 21% of nurses and 33% of HCAs in the second clinical area.
- Donning and doffing — 81% of nurses in one clinical area and 52% of nurses in the second clinical area.

Hand hygiene training compliance was significantly below the overall hospital average and the HSE target of 90%. Similarly, in the ED, only 36% of ED nursing staff, 24% of ED HCAs and 87% of household/cleaning staff had completed hand hygiene training. Compliance with IPC was also significantly below the hospital average for nursing staff, with 24% of nursing staff having completed training on standard and transmission based precautions and 65% having completed training on donning and doffing PPE. Compliance was 80% for household/cleaning staff for standard and transmission based precautions and donning and doffing PPE.

Inspectors received a copy of the IPC staff training notice which was circulated to staff throughout the hospital, detailing the monthly IPC education plan for the hospital. Inspectors were further informed by lead representatives for IPC that each month the IPC team choose a relevant IPC topic and advised staff of the necessary HSELand online training modules that complemented the topic. The CNM for each clinical area was requested to advise staff of available training at nursing handover and during safety pause meetings.

Hospital-wide training compliance on INEWS V 2 was 73% for nursing staff and 52% for doctors. However, in the ED only 38% of nursing staff had completed this training. Compliance was 75% and 87% respectively for nursing staff in two clinical areas inspected. ISBAR training was included as part of the INEWS V 2 training.

61% of nursing staff at MRHP were trained in IMEWS, and 68% of paediatric nursing staff were trained in PEWS. Overall, 90% of nursing staff had completed basic life support training. Data was also submitted for dementia and end-of-life training undertaken, however, compliance was low for this training.

Medication safety training compliance across the hospital required improvement, with 70% of nursing staff having completed medication safety education. However, only 25% of nursing staff in the ED had completed this training. Compliance with medication safety training was 75% and 69% respectively for nursing staff in the two clinical areas inspected. Inspectors were informed by lead representatives for medication safety that the hospital medication safety plan had been hampered by the deficits in clinical pharmacy staff and the need to prioritise other areas of work.

It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement efforts following HIQA's inspection.

In summary:

- The reliance on two emergency medicine consultants and a locum emergency medicine consultant to maintain in hours and out of hours emergency medicine consultant cover for the ED is not sustainable in the long-term and must be addressed.
- While completion of mandatory and essential training was recorded and there was oversight of training compliance at a local level, uptake of training requires improvement across all disciplines.
- Hospital management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients.

Judgment: Partially compliant

Quality and Safety Dimension

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. The clinical areas, ED and AMAU/ASAU were observed to be busy, but calm environments.

Findings relating to the Emergency Department and AMAU/ASAU

In the ED and AMAU/ASAU, although space was somewhat limited, relative to the number of presentations to the department, the physical environment promoted to the best of its ability, the privacy, dignity and confidentiality of patients receiving care. Inspectors observed patients accommodated in individual cubicles surrounded by privacy curtains. There was also a separate secure area comprising of a single room with toilet facilities for patients, when required. Inspectors did not observe any patients being accommodated on trolleys, however, two patients were accommodated on chairs, where a cubicle was not available and both patients communicated to inspectors that they had not been waiting long on chairs and had been moved there following initial examination and while awaiting further tests. Inspectors did not observe patients receiving treatment on chairs. Inspectors observed a designated sensory bay in the main ED also, which was noted as good practice in accommodating patients with specific needs. There was no audio-visual separation for paediatric patients, however, paediatric patients were treated in cubicles, surrounded by privacy curtains. Single rooms were available and were used mainly for isolation purposes.

What inspectors heard and observed in the ED and AMAU/ASAU in terms of patients' privacy being upheld aligned with the findings from the 2022 NIES, where with regard to the following questions:

- 'Were you given enough privacy when being examined or treated in the Emergency Department?', the hospital scored 8.9, which was above the national average of 8.1
- 'Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?', the hospital scored 9.5, above the national average of 8.7.

Findings relating to other clinical areas

In clinical areas visited, an inspector observed patient names and the patient's doctor name on display behind each patient's bed. This was brought to the attention of the CNM1 on the day of inspection. Of note was that the six-bedded rooms on a surgical ward did not allow for one metre distance between patients' beds, and this impacted on patients' privacy and dignity, with some patients having to stay in bed as there was no space for a chair next to the bed to allow patients to sit out. A risk assessment had been completed in relation to this and it was noted as a risk on the hospital's risk register.

What inspectors heard and observed in the clinical areas in terms of patients' privacy being upheld aligned with the findings from the 2022 NIES, where, with regard to the following questions:

- 'Were you given enough privacy while you were on the ward?', the hospital scored 9.3, above the national average of 8.6
- 'Were you given enough privacy when discussing your condition or treatment?' the hospital scored 8.7, above the national average of 8.2
- 'Were you given enough privacy when being examined or treated?', the hospital scored 9.5, above the national average of 9.1
- 'Did the staff treating and examining you introduce themselves?', the hospital scored 8.6, which was below the national average of 8.7.

Patient's personal information in clinical areas visited was not observed to be protected and stored appropriately in some instances. For example, in both clinical areas, patients' healthcare records were observed to be stored in unlocked cabinets on main corridors, meaning that files could be accessed by passers-by and patient names on display over patient beds. This was brought to the attention of staff during the inspection.

In summary:

- Patients' privacy and dignity was impacted by the layout of the six-bedded rooms on a surgical ward inspected.
- Patients' personal information in some clinical areas visited during the inspection, was not observed to be protected or stored appropriately in some instances.

Judgment: Substantially compliant

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

It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients whom inspectors met with were complimentary of the staff and the care provided to them. The results of the NIES 2022 found that 62.8% of patients reported overall they had a 'very good' experience while in

the hospital, which was above the national average of 53.1%. This aligned to what inspectors were told by patients they spoke with on the day of inspection. One patient described the staff as *'really nice' and 'always friendly'*, noting that nurses were always so helpful. Another patient told inspectors *'it is the most wonderful place'* and noted that '*anything they want or need is got for them instantly'* and that they '*never have to wait long for anything'*. Another patient communicated to an inspector that they *'don't want to leave. I am being waited on hand and foot'.* Patients were observed by inspectors having a hot meal in the ED, while awaiting discharge or admission.

The hospital scored the same as the national average for the following:

- 'Overall, did you feel you were treated with respect and dignity while you were in the hospital?', scoring 8.9.

Inspectors observed information leaflets of '*Your Service Your Say*' §§§§on display throughout the hospital. Patients told inspectors that they could raise a concern with the person in charge or one of the nurses.

Inspectors were informed of a quality improvement initiative implemented in the ED as a result of feedback from patients, whereby staff introduced themselves when first meeting the patient and then reintroduced themselves when they returned to the patient for different stages of care. The purpose of this was that patients would become familiar with staff caring for them on a first name basis. Furthermore, inspectors observed MRHP QIPs for 2022 in the quarterly QPS reports, which included the introduction of a hospital patient information leaflet of who patients could speak with if they had a worry or fear while in hospital. A patient discharge information leaflet was also developed following the results of the NIES, which outlined who patients could contact if they required further information or support on discharge from hospital.

In summary, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for patients at MRHP.

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.

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

The consumer affairs manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. The hospital's Quality and Patient Safety Committee had oversight of hospital complaints and data on complaints was included in QPS reports which were shared with SMT. Formal complaints were discussed at the SMT meetings and where required, at the hospital's performance meeting with the DMHG.

All complaints were managed in line with the HSE's complaints management policy *'Your Service Your Say.'* The hospital formally reported on the number and type of written complaints, received annually. The HSE *'Your Service Your Say'* annual feedback report (2021)[*****], which is the most recent publicly available data, showed that the hospital received 75 formal complaints in 2021, 37 (49%) of which were resolved within the required timeframe of 30 working days. Inspectors reviewed a QPS report for Q3 2022 which noted that 20 complaints were received in Q3 of 2022, one was withdrawn and of the 19 remaining, five (26%) of those were resolved in less than 30 days.

Inspectors observed *'Your Service Your Say'* information posters and leaflets on display throughout the hospital as well as information on advocacy services for patients. Patients who spoke with inspectors said they would talk to staff if they wanted to make a complaint.

Staff who spoke with inspectors were familiar with '*Your Service Your Say'* and were aware of the complaints process within MRHP. There was a culture of complaints resolution at a local level in the clinical areas visited and this process was described to inspectors by staff. Data on formal complaints was being captured by the hospital and inspectors were informed that stage one complaints were dealt with at point of contact within each clinical area. Data in relation to stage one complaints was not captured on the complaints management system and information on verbal complaints was not being captured at the time of inspection. Details of any complaint received, when submitted through '*Your Service Your Say'*, was shared directly with the management in that clinical area. Feedback was shared with staff directly involved in the complaint and learning was shared with all staff at staff huddles also. Inspectors were informed of a quality improvement initiative which arose following a complaint in relation to patients who present to the hospital with no change of clothing or night clothes and have to remain in that clothing for prolonged periods of time. An initiative was put in place whereby the hospital partnered with a local provider to provide 'squirrel packs' to patients who require them, which include pyjamas and essential toiletries for patients.

[*****] Health Service Executive. Managing Feedback within the Health Service. 'Your Service Your Say'; 2021. Available on line from: https://www.hse.ie/eng/about/who/complaints/ncglt/your-service-your-say-2021.pdf

Inspectors were informed that staff were encouraged to complete HSELand complaints management online training, however, there was no training log to indicate if staff had completed the training. Inspectors were further informed that the Patient Safety Manager provided training on complaints management to ADONs in February 2023.

In summary while the hospital had a robust system in place to manage complaints:

- The hospital would benefit from recording, tracking and trending information on written and verbal stage one complaints.
- A formal training log to record staff training on complaints management would be of benefit.

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 and observed that some improvements were required in terms of cleanliness and maintenance of the physical environment. In the 2022 NIES, the hospital scored 9.5, which was above the national average of 9, in relation to the cleanliness of the hospital room or ward. The hospital scored just above the national average of 8.5 for cleanliness of toilets and bathrooms, scoring 8.6.

The clinical areas visited had limited isolation facilities to accommodate placement of people who required transmission-based precautions. Isolation facilities in one clinical area with capacity for 11 patients comprised of one single en-suite room, while isolation facilities in another clinical area, with capacity for 33 patients, comprised of five single en-suite rooms, with an additional two secure rooms which shared a designated bathroom. Appropriate signage was in place where rooms were being used for isolation purposes. Lack of sufficient isolation rooms in clinical areas was noted as a risk on the hospital's risk register.

Staff were observed to be wearing appropriate personal protective equipment (PPE) in line with current public health guidelines and patients had access to facemasks in both clinical areas. Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available in clinical areas and hand hygiene signage was clearly displayed throughout the clinical areas. Inspectors noted that some hand hygiene sinks did not conform to national requirements.[†††††] Inspectors received a copy of a risk assessment in relation to this, noting that existing control measures included the

[†††††] 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

replacement of sinks and taps on a phased basis, subject to funding availability. The risk of MRHP's non-compliance with the required standards in relation to this aspect of IPC was noted on the hospital's risk register.

Staff communicated that there was sufficient cleaning resources to each clinical area, with cleaners available 8am to 8pm 7/7, and via bleep system outside of those hours, and prompt access to maintenance services when required. Inspectors observed the use of the green clean tagging system in clinical areas, however, in one clinical area an inspector observed that some equipment which had been green tagged on the day of inspection was not appropriately cleaned. This was brought to the attention of the CNM1. Inspectors observed appropriate segregation of mops. Terminal cleaning was conducted by cleaning staff.

It was brought to the attention of the CNM1 in charge of one clinical area, that physical distancing of one metre was not maintained between beds in the six-bedded rooms on the surgical ward, which, as noted in Standard 1.6, limited patients ability to sit out of bed and had the potential to compromise patient care, for example, insufficient space to mobilise patients using a hoist. There was insufficient storage space in the six-bedded rooms on this ward for patients' personal belongings. A risk assessment had been completed in relation to this and it was noted as a risk on the hospital's risk register. In all clinical areas visited privacy curtains were clean and changed as required.

Inspectors noted in one clinical area that keypads providing secure access to a number of rooms were broken and in need of immediate repair. This was brought to the attention of the CMN1 during the inspection.

Appropriate storage of supplies in some areas visited required review, as an inspector observed boxes of sterile supplies and PPE stored in boxes on the floor. Furthermore, the dirty utility in one clinical area was cluttered and access to the sink was blocked by clinical and general waste bins. This was brought to the attention of the CNM1. Appropriate segregation and storage of linen was observed. The clean utility in one clinical area required attention also, with limited space for medication preparation due to the storage of a number of items in the medication preparation space. Furthermore, an inspector observed that on one occasion, sharps were not being disposed of in a safe manner as the sharps bin was open and overfilled, posing a risk to staff of needle stick injuries.

A male changing room in one clinical area was not being used for its intended purpose. This space was cluttered and used to store equipment including bed mattresses, tilted chairs, commodes and a hoover. A risk assessment had been completed regarding the lack of storage space in this clinical area in February 2022. Furthermore, inspectors reviewed a risk assessment for the risk of spread of infection as a result of inadequate changing facilities for staff due to poor infrastructure, further highlighting the need to ensure that rooms are used for their intended purpose.

At the time of inspection, building works were underway, which included upgrades to the hospital main reception area which was nearing completion at the time of inspection, upgrades to the air handling unit in the Special Care Baby Unit (SCBU) which was also nearing completion at the time of inspection and a major build of a new Respiratory Assessment Unit and an extension to the existing paediatric unit, due to be completed by February 2025. While inspectors received documentation outlining measures taken by external contractors to reduce risk of potential spread of aspergillus in relation to the MRHP ventilation upgrade works in SCBU, the hospital would benefit from undertaking a risk assessment in relation to this matter.

In summary:

- There was insufficient isolation facilities in the clinical areas visited.
- Physical distancing of one metre was not maintained between beds in the six-bedded rooms on the surgical ward, which impacted patients' ability to sit out of bed, resulted in insufficient storage for patients' belongings and had the potential to impact on patient care in certain situations. Management need to address this as a matter or priority.
- Cleaning of equipment in one clinical area required attention.
- The phased replacement of hand hygiene sinks needs to be progressed in order for the hospital to be compliant with national requirements.
- Keypads providing secure access to a number of rooms required repair and should be addressed as a matter of urgency.
- Storage arrangements for equipment required review to ensure that rooms were used for their designated purposes.

Judgment: Partially compliant

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

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. This provided assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level.

National performance indicators and benchmarks in line with HSE national reporting requirements were used by the hospital to measure the quality and safety of the service it provided. Furthermore, inspectors were informed of the recent recruitment of an audit coordinator, which was a new post for MRHP. This post was responsible for audit across the hospital, including for the four key areas of risk reviewed as part of this inspection.

Infection prevention and control monitoring

Inspectors were provided with evidence that the IPC Committee was actively monitoring and evaluating infection prevention practices in clinical areas. At the time of inspection, a COVID-19 pathway remained in place for all patients who presented to ED. Management reported that this pathway was working well and this was observed by inspectors during inspection.

Inspectors were informed through meetings with staff in clinical areas and IPC lead representatives that an annual IPC audit plan was in place which included audits in relation to hand hygiene, Peripheral Vascular Catheter (PVC) care bundles and Carbapenemase-producing *Enterobacterales* (CPE) screening.

In line with the HSE national reporting requirements, the hospital was submitting the following data as part of the national HPSIR. Indicators included:

- rates of *Clostridium difficile* infection (public report December 2022- 12 cases/10,000 bed days)
- hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) blood stream infections (public report December 2022 – 3 cases/10,000 bed days)
- number of CPE cases (public report December 2022 – 4 cases).

Inspectors were informed that twice yearly audits of compliance with CPE screening are undertaken, with the most recent results from 2022 showing 100% compliance with CPE screening requirements.

The IPC team had oversight of hand hygiene compliance for each clinical area and minutes of quarterly HCAI committee meetings demonstrated that results were reviewed at each quarterly meeting. Inspectors were informed that where a ward scored below 75% in an audit, an action plan was required to address poor compliance. Data was available from one clinical area inspected for January 2023 where they scored 70%, which was below the national target of 90%. The most recent data available for the second clinical area inspected was from October 2022, demonstrating 93.3% compliance with hand hygiene practices.

Inspectors were informed that environmental audits were undertaken by the domestic supervisor in the clinical areas inspected on a quarterly basis and that HCAs conducted weekly audits of equipment to check that it had been cleaned to the required standard, however, copies of audits requested by inspectors were not submitted to HIQA. Results of the March environmental audit was pending at the time of the inspection. As noted in Standard 2.7, the green clean equipment tagging system was in place in clinical areas. Inspectors observed a quality care board on display at the nurses station in one clinical area visited, which displayed Test Your Care Metrics data and PVC care bundle audit results.

The IPC team monitored outbreaks and inspectors reviewed documented evidence of detailed outbreak reports being completed, as discussed in Standard 3.1.

IPC audit results were included in an overall quarterly report to the QPS Committee. While these reports were beneficial in providing an overall view of IPC audit results for MRHP, the report would benefit from having formalised QIPs with time-bound, assigned actions to address audit findings.

Antimicrobial stewardship monitoring

As noted in Standard 5.5 inspectors were informed that the hospital's AMS programme had been paused due to deficits in resourcing, however, during the inspection, inspectors were informed that arrangements were in place for a clinical pharmacist to be trained with a view to taking on the post of AMS pharmacist. As a result, audits in relation to antimicrobial stewardship practices were not being undertaken at the time of inspection. The hospital had documented evidence of this and its inability to contribute to national AMS KPIs and other data sets, on the hospitals risk register. This will be discussed further in Standard 3.1.

Medication safety monitoring

There was some evidence of monitoring and evaluation of medication safety practices at the hospital, for example through Test Your Care metrics and an audit of the consumption of concentrated potassium ampoules per quarter.

Findings from the nursing metrics audits undertaken indicated that there was room for improvement in relation to some aspects of medication management practices. For example, audits from January, February and March 2023 demonstrated that improvements were required in relation to recording of a patient's weight on a medication record (February 65%), the legibility of prescriptions (January 86%, February 24% and 0% in March), and the minimum dose interval specified on the patient's record (88% in February). During March, clinical areas audited scored 75% in relation to the medication trolley being locked. Where areas scored below 100% compliance, an action plan was developed and implemented and the metric was measured the following month to assess if improvements had arisen as a result.

On review of patient healthcare records, it was noted that all healthcare records reviewed had the patient's allergy recorded. As noted in Standard 5.5, inspectors were informed through meetings with lead representatives from medication safety that medication reconciliation was only being completed on request, largely for patients on high-risk medications, and this was due mainly to pharmacy staffing deficits, as discussed in Standard 6.1.

Inspectors noted the opportunities taken to engage with staff and deliver informal training on medication safety. On World Patient Safety Day, 17 September 2022, a presentation entitled 'Medication without Harm' was delivered to nursing staff, which included information on the basic principles of medication safety, data on medication related incidents and actions taken, results of quality care metric audits and results of the NIES in relation to medication safety. Inspectors were informed that a medication

awareness stand was set up in the front hall of the hospital as an opportunity to provide medication safety information to staff across a half-day session in March 2023.

Although the audits shared with inspectors had clearly defined actions, management need to ensure that all actions are assigned to individuals and are time-bound. Risk reduction strategies in relation to medication safety are discussed further under Standard 3.1.

Deteriorating patient monitoring

The Deteriorating Patient Committee had oversight of audit of compliance with national guidance on INEWS V 2, IMEWS and PEWS and compliance with national guidance on clinical handover or the use of the ISBAR communication tool and there was evidence of this being discussed at Deteriorating Patient Committee meetings.

The hospital took part in a HSE audit of compliance with national clinical guideline (NCG) No. 1 INEWS V 2, in October 2022. Findings highlighted a number of areas of good practice, including there being a Deteriorating Patient Committee in place responsible for the governance of INEWS, evidence that INEWS was discussed at meetings, an ongoing training programme related to NCG 1 V2 and a programme of ongoing audit related to NCG 1 V2. The audit found that improvements were required also, including:

- that all local policies, procedures and guidelines (PPGs) are reviewed and updated as appropriate in accordance with NCG1 V2
- that systems are in place to confirm that staff have read, understood and agreed to comply with the requirements of NCG 1 V2
- that all relevant staff have completed the mandatory INEWS training in accordance with NCG1 V2
- that management and staff conducting INEWS audits have common understanding of what is being asked and that all staff conducting audits receive appropriate training
- that the minimum standard of assessment of observations is implemented as per recommendation 5 in NCG V2
- that all events surrounding a call for assistance (time of call, response, plan of care and outcome) are documented in the nursing and medical notes of the healthcare record as per recommendation 22 of NCG V2.

HIQA received documentation detailing actions to be undertaken, to address the recommendations from the HSE INEWS V 2 audit, including timeframes for which actions were to be implemented. According to the update on the action plan submitted to HIQA, the majority of actions were implemented within the allocated timeframes, with some actions ongoing indefinitely due to the nature of same, for example, ensuring that mandatory training is completed and provision of training and education on INEWS.

Inspectors were informed that each month, 5 PEWS and 10 INEWS observation charts were audited. Feedback from audits was shared with staff, coordinated by nurse practice

development. Each audit had an associated list of recommendations which were assigned to individuals. Results of audits were shared with staff at a number of meetings including the ADON huddles and in the clinical areas at morning and 2pm huddles.

Inspectors received a copy of MRHP Medical/Surgical Q1 and Q2 Sepsis audit 2022 Dublin Midlands Hospital Group. The aim of the audit was to systematically review the healthcare records of medical and surgical patients with a diagnosis of infection with organ dysfunction, sepsis or septic shock, as identified by Hospital Inpatient Enquiry (HIPE). Out of a total of 14 forms audited, average compliance was 61.08%. Some areas for improvement were identified and inspectors received a copy of an action plan in response to audit findings, with clearly defined, time-bound actions which were assigned to individuals. Inspectors were informed of a recent sepsis audit in one of the clinical areas inspected, where compliance with completion of the chart required improvement. An action plan was developed following the audit and education was provided to staff by the practice development team.

Inspectors noted quality initiatives in place in the ED, whereby sepsis boards were on display throughout the department as a visual aid to staff in raising awareness of sepsis. Furthermore, inspectors were informed of the sepsis box which was rolled out in each clinical area to assist in the prompt management of sepsis patients. Pop-up information stations were also set up in corridors to share information with staff on areas identified as requiring improvement from audits.

Transitions of care monitoring

Transitions of care at MRHP was supported by the unscheduled care team who had measures in place to support effective patient flow. The unscheduled care team was monitoring activity data in relation to ToC, including ED attendances, TrolleyGAR‡‡‡‡‡, ED PET for all patients and patients aged 75 years and over. Inspectors were provided with copies of minutes of meetings of the unscheduled care committee, which compared data from 2019 to 2022 and detailed, for example, a 34% reduction in 8am trolley data YTD 2019 and an overall increase in ED activity of 10% November YTD 19 versus 2022.

Inspectors were informed that no formal audit plan in relation to ToC was in place, however considerable work was being undertaken in the absence of a formal plan. The hospital was monitoring KPIs, including Average Length of Stay (ALOS) for all inpatients, which was 2.7 days (September 2022, most recent data publicly available), which was below the target set by the HSE of 4.2 days.

Inspectors were informed that daily MDT meetings took place in each clinical area, which were attended by the ADON patient flow. A daily situational report was sent by the shift leader at 8am which provided the bed management/patient flow team with an overview of bed status in each clinical area, including predicted discharges from a clinical area,

‡‡‡‡‡ The HSE system known as TrolleyGAR enables daily monitoring of ED performance and helps trigger the hospitals' response during busy periods.

conclusion, elective admissions and any areas of concern regarding patient flow and bed management.

Inspectors received a copy of a clinical handover audit which included a review of 52 episodes of clinical handover using ISBAR$_3$ for all clinical areas, which commenced in March 2023. The audit involved the use of an observational audit tool for shift clinical handover, which inspectors received a copy of, and the Excel nursing handover (Communication) ISBAR$_3$ template. At the time of inspection the audit report had not yet been finalised, however inspectors were informed that recommendations would be included in the final report. Plans were in place for the nurse practice development team to undertake the following audits during April 2023:

- safety pauses and huddles
- interdepartmental handover
- practices in relation to utilising ISBAR to communicate the deteriorating patient.

The hospital had implemented a number of actions in relation to improving performance at clinical handover, including:

- additional on-site training provided by the Regional Centre of Nursing and Midwifery Education, HSE
- education for all nursing staff at induction
- ISBAR education provided at INEWS, IMEWS, PEWS and Sepsis training.

In summary:

- A formal audit plan for all key risk areas would better support the hospital's work in relation to audit. In line with this, the IPC and medication safety programmes would benefit from having formalised QIPs with time-bound actions to address all audit findings.
- Further work is required to continue to drive improvements regarding completion of INEWS documentation and sepsis forms.
- Compliance with completion of medication safety documentation requires improvement.

Judgment: Substantially compliant

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

There were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. The hospital's SMT had oversight of risks, in the absence of a functioning Quality and Safety Executive Committee, as discussed in Standard 5.2. Committees responsible for oversight of each of the four key areas of risk reported to the SMT. There

was evidence that the risk register was discussed at SMT level from meeting minutes reviewed by inspectors. Furthermore, QPS quarterly reports included data on the number of new risks identified in that quarter and the total number of risks currently on the risk register were categorised by theme, for example, 'unscheduled care, recruitment/HR, waiting lists and healthcare-associated infections. Details of the risk and risk rating were also included in this report, which was shared with SMT. Risks that could not be managed at hospital level were escalated to the DMHG.

Risks noted on the hospital's risk register included:

- risk to patient and staff safety due to poor infrastructure including lack of isolation rooms
- risk of harm due to supply of incorrect medications or delay in treatment due to failure to find/access medications out of hours
- COVID-19
- clinical pharmacy staffing levels impacting ability to undertake medication reconciliation on admission and discharge as standard practice
- no antimicrobial stewardship programme due to shortage of clinical pharmacy staff
- risks associated with lack of spacing between beds in the six-bedded rooms on the surgical ward
- risk associated with no on-site consultant microbiologist cover.

Risks identified had controls and an action owner, however, not all risks had defined timelines.

Findings related to the Emergency Department

There were effective and robust systems and processes in place in MRHP to identify, evaluate and manage immediate and potential risks to people attending the ED. Performance data was collected on a range of different quality indicators related to the ED, in line with the HSE's reporting requirements. This included the number of presentations to and admissions from the ED, DTOC, ALOS and ambulance turnaround times. The hospital's compliance with quality indicators was reviewed at the unscheduled care meetings, which were held every eight weeks or more often as required. The unscheduled care group sent risk reports to the quality and patient safety team and an exceptional report to the DMHG Management Team.

Inspectors were informed that the waiting time from registration to triage was a challenge, with patients sometimes not being seen within the 15 minutes required. On the days of inspection, inspectors observed the CNM3 checking triage times regularly and putting actions in place to reduce time to triage. On the first day of inspection, at 11am, the waiting time from:

- registration to triage ranged from three minutes to 58 minutes. The average waiting time was 36 minutes.

- triage to medical review ranged from three minutes to three hours 32 minutes. The average waiting time was one hour 21 minutes.
- medical assessment to admission ranged from 30 minutes to 13 hours 8 minutes. The average waiting time was eight hours 24 minutes.
- decision to admit to actual admission to an inpatient bed ranged from immediate to 34 hours and 58 minutes. The average was one hour 24 minutes.

Data on PETs collected on the day of inspection, showed that at 11am 35 patients were registered in the department, of a total 108 patients who attended on that date. Of the 35 registered at 11am:

- 2.8% (1 patient) of attendees to the ED was in the department for more than six hours after registration. MRHP was in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- No attendees to the ED were in the department for more than nine hours after registration. MRHP was in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- No attendees to the ED were in the department for more than 24 hours after registration, which was in line with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- MRHP was in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration. There were no patients aged 75 years and over in the ED greater than six hours after registration.

Inspectors did a look-back on PET at four different points in time in the preceding 24-hour period and did not observe any significant variance in PET times for six, nine or 24- hours of registration. Inspectors received PETs for February 2023, where the average percentage of all attendees who were admitted or discharged within:

- six hours of registration was 61.9% (national target 70%)
- nine hours of registration was 83.2% (national target 85%)
- 24 hours of registration was 99.5% (national target 97%)
- >75 years six hours of registration was 34.8% (national target 95%)
- nine hours of registration was 69.2% (national target 99%)
- 24 hours of registration was 99.5% (national target 99%).

Infection prevention and control

The hospital had a number of policies, procedures and guidelines in place in relation to IPC, however some of these required review. Although risk was not a standing item on the agenda of Infection Control and Hygiene meetings, risk was discussed under a

number of items in meeting minutes provided. The Infection Prevention and Control Team had an annual plan for 2023, which included an audit schedule.

Inspectors observed the COVID-19 pathway in place for patients attending the ED, which was overseen by an advanced nurse practitioner (ANP). All patients presenting to ED were required to complete a COVID-19 questionnaire and were assessed for signs and symptoms of COVID-19 by an ANP. Point of care testing (POCT) for COVID-19 was available at MRHP. Patients who tested positive for COVID-19 were placed in an isolation room for assessment and treatment. All admitted patients to MRHP were screened for CPE. Patients who tested positive for CPE were triaged directly to an isolation room for treatment. Inspectors were informed of the facility to record a patient's IPC status on the hospital's Integrated Patient Management System (iPMS).

As noted in Standard 5.5, consultant microbiologist cover was provided remotely from the United Kingdom (UK), for MRHP and Midland Regional Hospital Tullamore. This risk was noted on the hospital's risk register and a risk assessment had been completed. Inspectors spoke with staff who engaged with the consultant microbiologist, and met directly with the consultant microbiologist, who noted that they were assured that the current level of support, all be it remotely, was working well and that staff were able to obtain the relevant advice and support in a timely manner when required. Senior management informed inspectors that arrangements regarding the post were currently being reviewed with a view to making some amendments to the previously advertised post. The absence of an AMS pharmacist and the resultant impact of having no AMS programme at MRHP was also noted on the hospital's risk register.

Inspectors reviewed an MRSA outbreak management report submitted to HIQA. The report was comprehensive, outlined control measures and actions taken to mitigate the risk to patient safety, and recommendations to reduce the risk of reoccurrence of an outbreak. Inspectors also noted from minutes of Infection Control and Hygiene meetings that the hospital had detected legionella in a sample taken in March 2022 and that action was taken to address this outbreak. Inspectors were provided with results of the most recent legionella testing carried out which showed that legionella was not detected.

Staff in clinical areas reported that they received good support from the infection prevention and control team. Where IPC concerns were identified, the IPC team promoted IPC related eLearning for staff.

Of note, all patient charts reviewed by inspectors had patients' multidrug-resistant organisms (MDROs) status or other transmissible infection status recorded. Only two of the six patient charts reviewed had COVID-19 or flu vaccination status recorded.

As noted under Standard 2.7, there were limited isolation facilities in clinical areas visited. Staff informed inspectors of the process in place for prioritisation of patients who required isolation rooms, which was guided by the IPC and bed management teams.

Staff uptake of flu vaccination for nurses and HCAs was below the HSE's target of 75%, at 56.5% and 45.2% respectively. Of note is that the data provided to HIQA represents only those who received the vaccine within the hospital and does not take account of uptake rates for those who may have received the vaccine outside of the workplace. The flu vaccination uptake rates within the hospital should be an area of focus for management following the inspection.

Medication safety

As noted in Standard 5.5 a clinical pharmacy service was available at the hospital. However, it was acknowledged that the service was restricted due to staffing deficits in recent times. Notwithstanding this deficit, staff who spoke with inspectors in the clinical areas visited stated that they felt supported by the clinical pharmacy team.

Inspectors reviewed a number of risk assessments relating to clinical pharmacy deficits, including one from the ED of the risk associated with accessing medications out-of-hours in the absence of formal out-of-hours clinical pharmacy cover and the impact of there being no pharmacist-led AMS programme due to lack of pharmacy resources. Inspectors received documentation noting that the antimicrobial pharmacist annual plan for 2022 was on hold due to ongoing pharmacy staff shortages. At the time of inspection, this had not resumed.

The hospital had a formal medication safety programme in place for 2023, which had been approved by the Drugs and Therapeutics Committee. In this document it was noted that the Drugs and Therapeutics Committee had compiled a list of high-risk medications and high-risk patient groups and processes to guide prioritisation of decisions. It was further communicated by lead representatives from medication safety whom inspectors met with that there was a need for a process in place in relation to prioritisation due to pharmacy resourcing deficits.

Inspectors were provided with a copy of a 'Medication Management & Safety at the Midland Regional Hospital Portlaoise' leaflet, which contained details for staff on range of medication safety related matters, such as initiatives undertaken in relation to medication safety, information on high risk drugs and signposting to various medication safety related resources. The information leaflet also contained information for staff on where to seek information or advice on medication safety matters out of hours.

The pharmacy service had a suite of policies and guidelines to support medication safety, which were available for staff in the pharmacy folder on the hospital's quality management system online portal system and through a dedicated medicines application.

Inspectors observed the use of risk reduction strategies to support safe medication practices, including the use of red aprons for medication rounds and appropriate storage and labelling of insulin. The hospital had also developed a list of high-risk medications,

sound-alike look-alike medications (SALADs), and antimicrobial IV administration lists, which were on display in medication preparation areas.

Medication reconciliation was an area which required improvement and this was acknowledged by the lead representatives for medication safety also. Inspectors received a copy of a risk assessment highlighting the reduced number of pharmacist conducted medication reconciliations resulting in medication incidents/missed medication incidents, as a result of pharmacy resourcing deficits. Inspectors were informed by staff in clinical areas that medication reconciliation was undertaken only on request. Findings from the NIES highlighted the need for provision of information for patients about medications prescribed to them on discharge. Inspectors were provided with a patient discharge information leaflet, which contained a series of questions for patients to ask prior to discharge in relation to their medication, with a view to promoting medication safety.

Medication stock control was carried out by the pharmacy technician.

Deteriorating patient

Measures were in place to identify and reduce the risk of harm associated with the delay in recognising and responding to people whose condition acutely deteriorates. Inspectors were informed that the early warning system, INEWS V 2, was implemented in clinical areas and IMEWS and PEWS were implemented in maternity and paediatric clinical areas respectively. EMEWS had not been rolled out in the ED at the time of inspection, however, INEWS V 2 was implemented in its place. Staff spoken with were aware of the system and described when and to whom to escalate care of a patient using INEWS V 2. Staff reported that in general they did not experience difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. However, it was noted in the most recent minutes available to inspectors from the Deteriorating Patient Committee that there were challenges in reviewing patient parameters every 24-hours at weekends due to having only one Registrar on site during core hours. This concern was further reiterated in a meeting with lead representatives for the deteriorating patient, where it was noted that a risk had been identified in terms of delayed review of patients in escalation. Inspectors did not receive a requested risk assessment regarding this and it was not noted as a risk on the hospital's risk register.

A sample of patients' healthcare records reviewed on inspection showed that in the case where care of a patient was escalated, on one occasion this was not done so in line with protocol. The ISBAR communication tool was used to support communication between staff in relation to a patients care. Evidence of this was observed in the clinical area.

The policies to support the implementation of INEWS V 2 and PEWS were up to date at the time of inspection, however, the IMEWS policy required review.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and to support safe and effective discharge planning. However, as noted in Standard 5.2, concern was raised by hospital senior management and some staff whom inspectors met with during the inspection, regarding the absence of a formal by-pass protocol with the DMHG for MRHP patients that require timely treatment for stroke. Inspectors received a copy of a risk assessment undertaken in the ED in relation to this. As noted in Standard 5.2, the hospital needs to continually monitor and assess the effectiveness of the formal stroke by-pass protocol arrangement with the DMHG, for patients of MRHP who require timely treatment for stroke.

Inspectors reviewed a sample of patient healthcare records and discharge documentation and noted that all included the patient's MDRO or other transmissible infection status, however, not all contained information on patients COVID-19 vaccination status.

The ISBAR tool was in use in the hospital. ISBAR structure was used for clinical handover and a formal ISBAR tool was used for escalation of a patient. Inspectors observed evidence of a white ISBAR sticker in use for patient medical notes.

The hospital had protocols in place to support escalation and the transfer of patients into and out of the hospital, including:

- Standard Operating Procedure for Completion of Public Health Nurse Referrals in Midland Regional Hospital Portlaoise to Liaison Public Health Nurse in Laois Community Care
- Protocol for Transfer of Patients requiring Complex Surgery from MRH Portlaoise to accepting hospitals
- Bed Management Guideline, Midland Regional Hospital, Portlaoise
- Patient Flow Escalation Policy
- Draft MRHP Transitional Care Unit- Abbeyleix- Operational Governance Policy.

The SMT noted to inspectors that some PPG's were in the process of being updated at the time of inspection.

In summary, there were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm. However,

- The hospital needs to continually monitor and assess the effectiveness of the formal stroke by-pass protocol arrangement with the DMHG, for patients of MRHP who require timely treatment for stroke.
- Measures should be in place to ensure that where escalation of care is required, it should be done so in line with guidelines.
- A number of hospital policies required review.
- Arrangements regarding medication reconciliation for patients requires review and should be in place for all patients on admission and discharge.

- Not all patient healthcare records and discharge documentation included the patient's COVID-19 or vaccination status.
- Staff uptake of flu vaccination for nurses and HCAs was below the HSE's target of 75% and should be an area of focus for management following the inspection.

Judgment: Partially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital's SIMT provided a governance structure to the hospital's management of category one incidents and other SREs which occurred in the hospital, to ensure that all incidents were managed in line with the HSE Incident Management Framework 2020. Meeting minutes and quarterly reports for QPS Steering Meetings reviewed by inspectors indicated that incidents were managed appropriately, and with the required level of oversight.

Inspectors were informed that the senior accountable officer, the general manager who was the chair of SIMT, notified and updated the DMHG in line with the DMHG SI/SRE Formal notification process. The SIMT also reported to the DMHG Maternity Serious Incident Management Forum (SIMF). Minutes reviewed indicated that SREs were discussed. The SIMT ToR, clearly outlined its objectives, roles and responsibilities, detailing that once immediate safety issues were satisfactorily addressed, meetings were held fortnightly while reviews were ongoing.

Inspectors reviewed copies of the quarterly reports for the QPS meetings for the hospital, which gave a detailed breakdown of incidents that occurred at the hospital. A total of 429 incidents were reported to NIMS in 2022. The report also included an overview of incidents reported to the DMHG, as per the DMHG SI/SRE formal notification process and a comparison of the number of incidents reported per annum 2018 to 2022. An overview of incidents reported during each quarter was also included in the report. Staff in clinical areas were aware of the incident management process and described that information in relation to incidents is shared with them by the CNM of their clinical area during safety huddles and also through a communications folder which is available for staff to view. Training was provided by the quality and patient safety team to staff on how to complete incident report forms, however, it was acknowledged by the team that further work could be done from a quality and patient safety perspective to support shared learning from incidents with staff.

Where incidents occurred in relation to one of the four key risk areas, inspectors reviewed documentary evidence that incidents were discussed at SMT and/or the relevant

governance meeting for which the incident related to. Inspectors were informed that measures were taken to address any immediate risks, and where necessary quality improvement initiatives were undertaken. Examples of such initiatives include the introduction of alert stickers for direct oral anticoagulants (DOACs) as a result of a trend in incidents related to medication errors for DOACs and the introduction of purple syringes for ease of recognition of medication administration route, as a result of an incident whereby a per oral medication was given intravenously. Inspectors were informed that learning from medication safety incidents was also shared with staff via a quiz to test staff knowledge on a particular topic where there was a recognised trend in incidents.

Overall, inspectors were 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.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Midland Regional Hospital Portlaoise to assess compliance with national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was judged to be:

- compliant in two national standards (1.7 and 3.3)
- substantially compliant in five national standards (1.6, 1.8, 2.8, 5.5 and 5.8)
- partially compliant in four national standards (2.7, 3.1, 5.2 and 6.1).

Capacity and Capability

While MRHP had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of some aspects of healthcare, the hospital needs to recommence meetings of the Quality & Safety Executive Committee, to provide the required governance and oversight arrangements for quality and patient safety at the hospital.

A high-risk letter was issued by HIQA to the Dublin Midlands Hospital Group (DMHG) following the inspection regarding the absence of a formal by-pass protocol with the DMHG for MRHP patients that require timely treatment for stroke. The CEO of the DMHG outlined the interim arrangements in place for the timely treatment of patients presenting to MRHP with stroke. The hospital needs to continually monitor and assess the effectiveness of these arrangements.

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, however, there was scope for improvement. Management need to review and risk assess the sustainability of the extensive remit of clinical pharmacy services, in light of existing clinical pharmacy resourcing deficits, which is impacting MRHP's ability to implement its medication safety programme as intended.

The hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the management of clinical areas visited during the inspection. It was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care of patients and that operationally, the clinical areas were functioning well. The hospital had management arrangements in place in relation to the four areas of known harm for the wider hospital and clinical areas.

Systematic monitoring arrangements were in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on a suite of key performance indicators, and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital. Risk management structures and processes were in place to proactively identify, manage and minimise risk. There was evidence of good oversight of risks, however, some risks on the risk register were past their action due date and required review. There was oversight of the management of serious reportable events and serious incidents, in line with the HSE's Incident Management Framework. While it was evident that structures and processes were being embedded in relation to quality and patient safety, there was opportunity for improvement and enhanced oversight in relation to tracking and trending of incidents.

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare require continued focus. There were a number of vacancies across the majority of disciplines at MRHP, and of note within the pharmacy department, an emergency medicine consultant post and recruitment of a permanent consultant microbiologist post. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

The hospital promoted a person-centred approach to care. Staff made every effort to support the privacy and dignity of patients, however, this was somewhat hampered by the physical environment in some clinical areas visited. In particular, patients' privacy and dignity was impacted by the layout of the six-bedded rooms on a surgical ward inspected. Improvements in practice were required to ensure that patients' personal information is protected at all times in all clinical areas.

Inspectors observed staff being kind, caring and respectful towards patients. It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the areas visited. Patients who inspectors met with were complimentary of the staff and the care provided to them. Inspectors found that service users' complaints were responded to and were managed in line with the HSE's complaints management policy *'Your Service Your Say'*. However, the hospital would benefit from recording, tracking and trending verbal complaints.

The clinical areas visited by inspectors required some improvements in terms of cleanliness and maintenance of the physical environment. The physical environment in all three areas posed a number of challenges to staff and patients, including the limited isolation, en-suite, toilet and shower facilities throughout the hospital, as well as challenges in relation to storage of equipment. The phased replacement of hand hygiene sinks needs to be progressed, as well as repairs to keypads providing secure access to a number of rooms.

The hospital had systems in place to monitor, evaluate and continuously improve services. Audits were undertaken across the four key risk areas, however the hospital would benefit from having a clear programme of audit in place to guide audit activity and also ensuring that time-bound, assigned action plans were developed as standard in response to all audit findings.

There was evidence that there were systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm, and that there was oversight of risks. PETs on the day of inspection showed that only one patient was in the ED for more than six hours after registration. All other PETs were in line with national targets. Improvements were required also in relation to medication reconciliation and completion of elements of healthcare records and discharge documentation. Management should ensure that patients are reviewed in line with protocol and where escalation of care is required, it should be done so in line with protocol.

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.

MRHP as a member of the DMHG, needs to be supported within group and national structures to effectively address issues in relation to hospital infrastructure and resources.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the *National Standards for Safer Better Healthcare.*

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	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for Midland Regional Hospital, Portlaoise

OSV-0001075

Inspection ID: NS_0034

Date of inspection: 04 and 05 April 2023

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

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

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

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

Action 1 relating to the Standard 5.2

Deteriorating Patient Committee/Drugs and Therapeutics Committee/Infection Prevention and Control Committee

Specific:

- Deteriorating Patient Committee and subcommittees due to meet at the end of Q3 and Quarter 4 2023.
- All Committee's outlined above TORs to be reviewed to include the standardised agenda items by the Committee chairs. Draft reviewed TORs to be circulated with next meeting agenda items for signoff by the committee.
- TOR for the Deteriorating Child Committee is finalised and approved.
- Draft template for TOR's and Meeting Minutes across committees to be reviewed to ensure capturing of agreed time bound actions and named responsible person. To be circulated to all committees by the QPS manager
- Feedback from HIQA report to be entered on the agenda for next committee's in Q4 by relevant Committee Chair

- Meetings and actions going forward will have an assigned person responsible and agreed time bound actions. These will be reflected in the committee meetings. All committees now compliant

Measurable: This will be monitored and identified in the final TORs and minutes approved at the Committee meetings.

Achievable: Final HIQA report and compliance action plan to be circulated to the individual committee chair from the Senior/Executive Management team through the Committee Chair to be actioned at next scheduled committee meeting.

Realistic: *Responsible:* Individual Committee chair and QPS manager

- Chair Deteriorating Patient Committee, Nurse Practice Development Co-ordinator Co-chair
- Chair Drugs and Therapeutics Committee
- Chair of the Infection Prevention and Control Committee.

Timebound: Scheduled Committee meetings: Quarter 4 2023 and ongoing for each meeting.

Action 2 relating to Standard 5.2

The hospital needs to recommence Quality and Safety Executive Committee meetings, as the committee has not met since 2020. This is required to ensure that there are structured and appropriate governance and oversight arrangements in place in relation to quality and safety at the hospital.

Specific:
- QPS will be reconvening the quarterly QPS executive committee meetings in Q4 2023.
- Terms of reference are currently under review.
- A feedback document for all Q&S committees to feedback into the Q&S executive committee is currently being developed.

Measurable: Minutes will be taken at each meeting

Achievable: All committee members will be notified a month in advance of the meeting. Meeting dates will be agreed at the beginning of the year

Realistic: QPS Manager will be responsible.

Timebound: *Responsible individual*: QPS Manager. QPS Manager will circulate TOR for review by SMT by week ending 8th of September.

Action 3 relating to Standard 5.2

The hospital needs to continually monitor and assess the effectiveness of the formal stroke by-pass protocol arrangement with the DMHG, for patients of MRHP who require timely treatment for stroke. Formal on-line meetings take place the third Thursday of each month with representation from DMHG, MRHP, TUH and NGH. Most recent meeting in July with no issues.

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

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

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

(a)

Action 1 relating to Standard 6.1

Training and Education

Specific:

- Feedback of HIQA Report to line managers all services, nurse managers, Infection Prevention and Control CNSps and Nurse Practice Development Department
- Inclusion of Report feedback in staff meetings
- Re-circulation of Mandatory training requirements including IPC list to nursing and HCA staff and relevant service managers.
- Drive by relevant line managers, CNMs, CNSps and CSF for engagement in e-learning and submission of certificates of completion in all departments, particularly the ED.
- Release of staff where rosters and activity allows to complete e-learning and mandatory training
- Innovation in delivery of training to meet the clinical demands of the services, department based training.
- Include training compliance in one to one PDP and performance achievement meetings with staff.
- Reports generated on HSEland with list of staff completing e-learning. Review of the reporting system within HSEland expand the reporting capability in the system

to capture compliance. To be escalated to DMHG and HSELand administrators via the SMT and QPS department
- Risk Assessment and Business case to be developed to upgrade Education and Training database

Measurable: Monthly training attendance maintained by line managers, compliance statistics reviewed line managers. In the case of nursing compliance will be maintained and reviewed by CNM and ADON, supported by the Nurse Practice Development. Reported to the Director of Nursing as a standard monthly report.

Achievable:

- Through the line manager's roles and responsibilities, supported with data collection and recording database.
- Risk Assessment relating to Training Database submitted to Senior Management Team for review

Realistic:

- Responsible Departmental line managers.
- Departmental CNM with support of the Nurse Practice Development Department

Timebound: Timescale: Q4 with ongoing actions, monitoring and review. Ongoing due to addition of new recruits and the requirement to complete updates and renew compliance.

Action 2 relating to standard 6.1

Emergency Medicine Consultant Rosters.

Specific:

- The progression of the recruitment process for an additional WTE emergency medicine consultant is being progressed in order to provide and sustain high quality, safe and reliable care within the emergency department.

Measurable: Recruitment of permanent post initiated DIME post 1521. For further progression to CAAC.

Achievable: Temporary Consultant appointed Q3 2023.

Realistic: HR/Medical Manpower progressing the recruitment of the permanent Consultant post in conjunction with DMHG.

Timebound: Q3 2024.

Action 3 relating to standard 6.1

Hospital management must continue to progress with recruitment efforts to address staff vacancies across the hospital to support the provision of high-quality and safe care to patients.

Specific: The hospital has a workforce and recruitment plan in place to recruit for vacancies in all disciplines at MRHP, inclusive of rolling campaigns for specialist areas and International Recruitment for Nursing and HCSPs.

Measurable: Business case and Hire forms are reviewed by MRHP HR/Finance when received from Line Managers and submitted to the DMHG bi-monthly paybill.

Achievable: Approved posts are progressed to existing panels or new recruitment campaign is progressed with DMHG HR Department.

Realistic: Recruitment is actively progressed by MRHP to DMHG for advertisement and contracting.

Timebound: Ongoing.

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

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

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

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

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

Action 1 relating to standard 2.7

Cleaning of equipment

Specific:

- Feedback results/report to line managers to include compliance action plan report
- Education and training of staff whose role and responsibilities is the cleaning of equipment
- Education of staff to be supported by IPC

- Availability of equipment cleaning flowsheets and PPPGs.
- Staff awareness of PPPGs through Q pulse and incorporated into Orientation and induction programs.
- Staff supported by line manager in meeting compliance with standards and PPPGs
- Staff must access the suite of PPPGs relevant to cleaning of equipment and patient environments which are available on q pulse. Staff must acknowledge via q pulse they have read and agree to adhere to the PPPG via q pulse.
- Equipment cleaning rota and maintenance of records of cleaning to be maintained

Measurable:

- Cleaning and standard compliance must be overseen by the line managers.
- Equipment cleaning to be incorporated into environmental hygiene audits. Rolling schedule in place for environmental audits. All audits on MEG

Achievable: Through increased spot checks and scheduled environmental audits. Education and training of the staff

Realistic: Responsible Department Manager to monitor compliance in collaboration with IPC team, Domestic Services or the relevant line managers.

Time bound:

- Feedback to line managers immediate. Ongoing support and education to the responsible staff.
- Responsible staff requested by line manager to access the suite of PPPGs relevant to the cleaning of equipment available via Q Pulse, Timeframe September 2023

Action 2 relating to standard 2.7

Isolation Facilities

Specific:

- 39 rooms available in MRHP/21 ensuite/14 ante room/8 negative pressure. The number of rooms has increased from 15 prior to 2020
- Ongoing schedule of works
- On hospital Risk Register

Measurable: Requirements for additional isolation rooms are included in the current Development Control Plan.

Achievable: Development Control Plan with HSE Estates appointed Architects for development of design brief to enable future development of the hospital and provision of isolation facilities. Through development of the design brief, planning approvals, future HSE capital investment.

Realistic: HSE Estates and SMT responsible for progressing the DCP to enable further development of the hospital.

Timebound: Design brief Due for completion Q1 2024.

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

how mitigation of risk within the existing situation will be addressed

- Alerts on IPMS system from point of Triage alerting IPC requirements. This alerts the patient flow team to the requirement for isolation facilities
- Policies and Procedures in place to guide and inform on cases that require isolation
- Daily review by Patient Flow Team, Consultant ward rounds and in collaboration with the IPC team to review demand and prioritising for isolation cases.
- Constant review of best evidence in line with National Guidance on cases and scenarios that require isolation
- Risk assessments when no isolation facilities available with consideration to Cohorting of cases based on National Guidelines.

Action 3 relating to standard 2.7

Physical Distancing and storage for patients

Specific: Development Control Plan requirements compiled by MRHP and HSE Estates in Q 3 2022. HSE Estates appointed Architect company in Q2 2023 to develop design brief for future expansion of the hospital. This will address patient accommodation and storage requirements.

Measurable: Requirements for additional accommodation and storage are included in the current Development Control Plan and will be part of future development of the hospital.

Achievable: Through development of the design brief, planning approvals, future HSE capital investment.

Realistic: HSE Estates and SMT responsible for progressing the DCP to enable further development of the hospital.

Timebound: Design brief Due for completion Q1 2024.

Action 4 relating to standard 2.

The phased replacement of hand hygiene sinks needs to be progressed in order for the hospital to be compliant with national requirements.

Specific:

- Work schedule in place under the schedule of minor capital works

- Work ongoing with most departments completed.

Measurable: Within the minor capital workschedule

Achievable: As per the minor capital workplan. Through development of the design brief, planning approvals, future HSE capital investment

Realistic: Based on funding approval.

Timebound: Q2 2024

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

how mitigation of risk within the existing situation will be addressed

- Risk Assessment and Action Plan in place to include
  Water management and control by external company and Maintenance Department
  Legionella testing 6 monthly
  Specific cleaning of taps and sinks as outlined in PPPGs and water flushing as per PPPG IPC No 28
  Adherence to AMRIC Hand hygiene guidelines
  Hand Hygiene only designated sinks with appropriate signage
  Planned replacement programme in place.

Action 5 relating to standard 2.7

Storage of Equipment and storage arrangements for equipment required review to ensure that rooms were used for their designated purposes

Specific:

- Constraints with storage through the hospital on the hospital risk register**.**
- Awareness with line managers with appropriate storage of equipment
- Appropriate use of stores Kanban services to avoid over ordering of stocks
- Appropriate review of schedule of accommodation with rooms appropriately designated to storage with signage.

Measurable:

- Daily monitoring by the line manager
- Schedule of Health and Safety audits

Achievable: Review by line manager, request to maintenance to upgrade signage as necessary.

Realistic: Constraints with storage through the hospital on the hospital risk register**.**

Timebound. Q 4

Action 6 relating to standard 2.7

Keypads providing secure access to a number of rooms required repair and should be addressed as a matter of urgency.

Specific:

- Review of all keypads by the departmental managers
- Request to maintenance for upgrade or repair where necessary.

Measurable:

- Daily monitoring by the line manager
- Feedback to line manager and SMT when works complete.

Achievable: Review by line manager, request to maintenance to upgrade signage as necessary.

Realistic: Can be achieved at local level with line manager and Maintenance department

Timebound: Immediate with some already replaced

Timescale:

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

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

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

Action 1 relating to Standard 3.1

Medication Safety Monitoring

Specific:

Nursing Quality Care Metrics

- Action Plans in place on TestyourCare, supported and monitored by the Nurse Practice Development Co-ordinator and the Departmental ADONs, reported monthly to the Director of Nursing and the DMHG Performance meeting.
- CNM2 Medication Management in post since April 2023
- Drive ongoing by the CNM2 medication management on Education and Training to the MDT in relation medication safety, legible prescriptions, minimum frequency, recording weight and allergy status
- Medication Management PPPGs to be reviewed.

Measurable: Monitored and Audited through Nursing and Midwifery Testyour Care System

Achievable:

- Platform for Metrics Collection in place currently with roles and responsibilities for collection.
- Draft 1 of PPPGs circulated to Stakeholders August 2023

Realistic: *Responsible:* Nurse Practice Development Co-ordinator/ADON, CNM 2 Medication Management & Department CNM2s

Timebound:

- Ongoing education and monitoring
- PPPGs Draft 1 circulated to Stakeholders August 2023. To be signed off Q4

Action 2 relating to Standard 3.1

Medication Reconciliation

Specific: The progression of the recruitment process for Senior Pharmacist vacancies are being progressed in order to provide and sustain high quality, safe and reliable care within the Pharmacy department

Measurable: The most recent campaign was interviewed early August 2023- no suitable candidate was identified

Achievable: Requested new campaign to be advertised Sept 23

Realistic: Further Interviews proposed for Oct 2023

Timebound: Q1-2024

Action 3 relating to Standard 3.1

Specific: Transitions of Care

- Audits of the nursing clinical handover completed in Q2, action plan developed
    - Feedback results to CNMs and ADON September 2023
    - Information session in departments to highlight the standards and actions
    - Ongoing education and training at induction for new staff
    - Clinical handover a standing item on the RCNME training schedule
    - Circulation of Clinical Handover PPPGs to all staff via Q pulse for reading and acknowledging via q pulse.
    - Review of Nursing Clinical Handover Templates
- Nursing Documentation of transitions of Care under review overseen by the Nurse Practice Development Co-ordinator.
    - Obstetric Peri-operative Document in Draft 3, awaiting approval by Maternity Governance and Healthcare Records Committee prior to printing *Timescale*: Due for Completion end of Q3 early Q4
      Responsible CSF, CNM2 Theatre, ADOM
    - General Peri-operative Document First Draft in development
      Responsible: CSF, CNM2 Theatre, CNM2 Day Services.
      Timeframe : Draft Circulated and agreed and pilot in Q4 with approval/sign off in Q4.
    - Critical Care Transfer Document first draft in development
      Responsible: CSF & CNM2
      TimeFrame: Stakeholder agreement and pilot September 2023. Signoff and printing in Q4
    - ED Protocol 37 Patient Transfer Document. First Draft in development
      Responsible: CNM3 ED, CSF ED
      Timeframe: stakeholder agreement and pilot September 2023 with signoff and printing in Q 4
    - ED ISBAR3 emergency handover Ambulance Red phone telephone. First draft in development
      Responsible: CNM3 ED and CNM3 ED
      Timeframe: stakeholder agreement and pilot September 2023 with signoff and printing in Q 4
    - Nursing Transfer Letter. Reviewed 1st Draft to be developed by September 2023. Circulation to stakeholders with pilot of agreed draft in Q4. Sign off in Q 1 2024 pending pilots.
    - Transitional Care Unit. Transfer Document. In pilot currently Q3, for review Q4 and final approval/signoff *Responsible* CNM2 TCU and Nurse Practice Development Co-ordinator
    - PPPGs relevant to Clinical Handover currently in date reviewed in 2022. PPPGs relevant or impacted by the above documents will be reviewed in accordance with the document approvals.

Measurable: All documents introduced or updated will have a pilot as part of the development and review process which will inform the working group and signoff of the

final document. All documents will be audited for compliance when 3 months of introduction

Achievable: Working Group Convened to oversee and progress QIPs within the transitions of Care action plan. Documents are approved through the Healthcare Records committee that convenes quarterly. This will serve as timelines for actions within the working group.

Timebound: Working group to be convened in September 2023. Responsible Nurse Practice Development Co-ordinator.

Action 4 relating to Standard 3.1

Escalations of Care in line with PPPGs

Specific:

- Review of PPPGs including IMEWS PPPG to be entered as a standing agenda item on the Deteriorating Patient Committees and subgroups.
- *Responsibility:* Nurse Practice Development Co-ordinator and Committee Chair, Consultant Obs/Gynae on Maternity Deteriorating Woman Committee and Medical Consultant on Deteriorating Patient Committee
- Escalation of care and protocols included in all relevant in-house training, education and simulation drills and skills
- Staff must access and acknowledge reading PPPGs on Q pulse.

Measurable: Compliance is monitored through audit plan of INEWS monthly audits.

Achievable: Responsible line managers.

Timebound: Committee meeting in September 2023, Feedback Report to the Committee and all staff in September 2023. Immediate and ongoing actions on induction and including in skills and drills

Action 5 relating to Standard 3.1

Uptake of Flu and Covid 19 vaccinations by HCW

Specific:

MRHP's continuous engagement with Peer Flu and Covid Vaccination Programme commenced for the 2023 flu season in July 2023

- Enrolment of peer vaccinators from each service and department.
- Liaise with the DMHG Vaccination lead
- Provide training to peer vaccinators
- Liaise and collaborate with CVC to support vaccination programme at MRHP

- Bespoke and effective staff communication programme to promote vaccine uptake of HCWs. Utilising all opportunities to communicate with staff at strategic meetings and education meetings
- Support of line managers in communication and release of staff to vaccination clinics.
- Flexible clinics to capture shift patterns
- Engagement and maximise the CVC mobile vaccination unit offering clinics at MRHP
- Liaise with the DMHG Vaccine lead to ensure robust data collection on staff uptake. Feedback of vaccine uptake to managers to gain ongoing support.

Measurable: Utilise Covax national database for recording of vaccinations with training for staff on running statistics in the Covax system.

Achievable: Engagement and planning for the 2023 Vaccination season has commenced. Vaccination lead at MRHP CNM3

Timebound: Planning commenced July 2023 to be in place Q 4 to maximise vaccines uptake before start of flu season.

Action 6 relating to Standard 3.1

Not all patient healthcare records and discharge documentation included the patient's COVID-19 or vaccination status.

Specific:

- Feedback recommendations to the Discharge working group and Infection Prevention and Control Committee
- Bench mark across other services and standardise documentation
- Review of the discharge documentation to include section for Covid-19 status and Vaccination Status.
- Review of the Nursing assessment documentation and admission questionnaires to include a prompt with the vaccination status to include Covid 19 vaccination status.

Measurable: Included in the nursing documentation audit schedule and audit tool.

Achievable: Review of the documentation due and required to incorporate new emerging evidence.

Realistic: Responsibility Nurse Practice Co-ordinator for Nursing Documentation.

Discharge Working Group to review medical and nursing discharge documentation.

Timebound: Q4 2023-Q1 2024

Action 7 relating to Standard 3.1 As per Standard 5.2

The hospital needs to continually monitor and assess the effectiveness of the formal stroke by-pass protocol arrangement with the DMHG, for patients of MRHP who require timely treatment for stroke.

Formal on-line meetings take place the third Thursday of each month with representation from DMHG, MRHP, TUH and NGH. Most recent meeting in July with no issues.

Risk Assessment previously escalated to The Group. Currently under review.

Action 8 relating to Standard 3.1

IPC Guidelines require review and update

Specific:

- National Clinical Guidelines published in July 2023
- Under review with local IPC team for implementation at MRHP
- Ganntt chart and implementation plan to be reviewed.
- Working group to be established to adopt to MRHP processes.

Measurable: Implementation of IPC NCG to be a standing agenda item on the Infection Prevention and Control Committee meetings.

Achievable: Feedback required actions to the Committee chair for inclusion in meeting agenda

Realistic: Responsibility to the Committee Chair

Timebound: Next meeting scheduled Q4 with ongoing quarterly meetings.

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

Timescale: