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:	St Columcille's Hospital
Address of healthcare service:	Bray Rd Loughlinstown Co. Dublin D18 E365
Type of inspection:	Announced Inspection
Date of inspection:	22 June 2022
Healthcare Service ID:	OSV-0001101
Fieldwork ID:	NSSBH_0007

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

St Columcille's Hospital is a Model 2[*]statutory, public acute hospital. It is a member of, and is managed by the Ireland East Hospital Group (IEHG)[†] on behalf of the Health Service Executive (HSE).

Services provided by the hospital include:

- acute medical in-patient services
- day surgery
- outpatient care
- diagnostic services.

The hospital has an injury unit and a medical assessment unit. Acute injuries, such as suspected broken bones, muscle sprains, minor facial injuries and head injuries or suspected concussion (fully conscious patients, who did not experience loss of consciousness after a head injury) are treated in the injury unit.

The medical assessment unit manages low-risk referrals from general practitioners (GPs), self-referrals and referrals from other hospitals. Patients who attend the medical assessment unit and whose clinical condition deteriorates are transferred to a Model 3[‡] or Model 4[§] hospital. In the first five months of 2022 (January-May), the hospital had a total of 2,661 referrals to its medical assessment unit, of which 97 (4%) were admitted to the hospital, which equated to an admission rate from the unit (conversion rate) of 4.3%. On average five patients were admitted from medical assessment unit each day. The hospital has a national speciality in obesity

---

[*] A Model 2 hospital provides the majority of hospital activities including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.
[†] The Ireland East Hospital Group comprises seven hospitals. These are the Mater Misericordiae University Hospital, St Vincent's University Hospital, Cappagh National Orthopaedic Hospital, Royal Victoria Eye and Ear Hospital, the National Maternity Hospital, St Columcille's Hospital Loughlinstown, St Michael's Hospital, Dun-Laoghaire, Dublin, the Midland Regional Hospital Mullingar, St Luke's General Hospital, Kilkenny, Wexford General Hospital and Our Lady's Hospital, Navan, the hospital groups academic partner is University College Dublin (UCD).
[‡] A Model 3 hospital is a hospital that admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine, and critical care.
[§] A Model-4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis () and an Emergency Department, including a Clinical Decision Unit onsite.

management and is a referral centre for bariatric surgery. The National Gender Service (NGS) is also based in the hospital.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	117
Number of inpatients on date of inspection	101

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a one-day announced inspection at St Columcille's Hospital to assess compliance with the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, healthcare inspectors** reviewed relevant information about the hospital. This included any previous inspection findings, information submitted by the hospital and Ireland East Hospital Group, unsolicited information and other publically available information. During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service

- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital

- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors

- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

A summary of the findings and a description of how the hospital performed in relation to the 11 national standards assessed during the inspection are presented in the following sections under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors at a particular point in time — before, during and following the on-site inspection at the hospital.

** Inspectors refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.

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.

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

Compliance classifications

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

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

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

Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector
22 June 2022	09:00hrs to 17:55hrs	Dolores Dempsey Ryan
		Denise Lawler
		Danielle Bracken

Background to this inspection

This inspection focused on 11 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.[§§]

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

- Representatives of the hospital's Executive Management Team:
  - General Manager
  - Clinical Director
  - Director of Nursing.
- Quality and Safety Manager who was also covering for the Complaints Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Human Resource Manager
- A representative from each of the following committees:
  - infection prevention and control
  - drugs and therapeutics
  - deteriorating patient
  - delayed discharge.

[††] 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 Organisation. 2016. Available on line from
https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

In addition, the inspection team visited two clinical areas:

- St Joseph's Ward (medical ward)
- Lourdes Ward (medical ward).

Acknowledgements

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

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

On the day of inspection, inspectors visited two clinical areas, St Joseph's Ward and Lourdes Ward.

St Joseph's Ward was a 29-bedded ward consisting of four multi-occupancy rooms each with four beds and two multi-occupancy rooms each with six beds. There was one single room without en-suite bathroom facilities. The ward had two showers and five toilets. One of the five toilets could be assigned for a patient who was either confirmed or suspected to be infected with a multi-drug resistant organism. There were 24 patients on the ward and five beds were unoccupied at the time of inspection. The ward was a mixed ward, accommodating male and female medical patients, including patients with dementia.

Lourdes Ward was a 35-bedded ward consisting of six multi-occupancy rooms each with four beds and one multi-occupancy rooms with eight beds. There were three single rooms without en-suite bathroom facilities. There were 33 patients on the ward and two beds were unoccupied at the time of inspection. There was also a medical observation unit in room three of the ward, that had three beds and an additional bed could be opened as an escalation bed, if required for patients whose national early warning system[***] triggered. The ward was a mixed ward, accommodating male and female medical patients.

Inspectors observed staff actively engaging with patients in a respectful and kind way, and took time to talk and listen to patients. Staff were focused on ensuring patients' needs were promptly responded to. For example, inspectors observed staff responding in

---

[***] The Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Health Service Executive. Irish National Early Warning System (INEWS) V2. National Clinical Guideline No.1. Dublin: Health Service Executive. 2020. Available online from: https://www.gov.ie/en/collection/cc5faa-national-early-warning-score-news/.

a timely way to patient call bells and assisting patients with care needs. This was validated by patients who described staff as '*very caring and knew your needs'*. Feedback about the care received in both wards was very positive and complimentary of staff. Patients described staff as '*great'* and '*very nice'*. Patients also recounted how staff '*would help you with anything',* and '*could not do enough for you'*. One patient told inspectors that they '*would come back to the hospital again'* if needed.

The experience recounted by patients on the day of inspection was consistent with the hospital's overall findings from the 2021 National Inpatient Experience Survey.[†††] The survey showed that 81% of patients said they had a 'good' or 'very good' overall experience in the hospital, which was slightly below the national average of 83%.

Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing assistance with care needs. Inspectors observed effective communication between staff and patients and the appropriate use of tools to assist patients who had difficulties communicating. Tools such as a dry-erase white board were used to facilitate effective communication. Inspectors also observed the use of a white-board, located over a patient's bed, where topics that the patient was interested in or was comfortable talking about were listed. Staff told inspectors that these two tools had improved staff-patient engagement and communication for the better.

There was evidence that the hospital had systems and processes in place to enable patients to provide feedback on their inpatient experience. Inspectors observed the HSE's 'Your Service, Your Say'[‡‡‡] leaflets displayed in the wards visited. In addition, patients could complete a patient satisfaction form and leave it in a suggestion box strategically located throughout the ward. Patient satisfaction forms were collected, reviewed and the results collated by staff from the quality and patient safety department.

Of note, half of the patients who spoke with inspectors did not know how to make a complaint, two patients recounted how they would speak to the nurse manager or doctor if they wanted to raise an issue or complain.

Overall, there was consistency with what inspectors observed, what patients told inspectors about their experiences of receiving care and the findings of the 2021 National Inpatient Experience Survey.

[†††] The findings of the National Inpatient Experience Survey are available at:
https://yourexperience.ie/inpatient/national-results/
[‡‡‡] 'Your Service, Your Say' is the name of the Health Service Executive's complaints process for all users of HSE funded services. In addition to being a complaints process, 'Your Service, Your Say' is also a way to provide feedback on care and services received to the HSE.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.4) from the two themes of leadership, governance and management and workforce. The hospital was found to be compliant with one standard (6.4) and partially compliant with the remaining three standards (5.2, 5.5 and 5.8) assessed. Key inspection findings leading to these judgments are described in the following sections.

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

Inspectors found that the hospital had formalised corporate and clinical governance arrangements in place, but at the time of inspection, these structures were being reviewed and updated by the executive management team. Inspectors were informed that the hospital had experienced a significant change of personnel at senior management level over the preceding eight months whereby, owing to promotional opportunities and other circumstances, the general manager, director of nursing, general service manager, human resource manager and quality and safety manager had all changed. In any hospital a change of this extent would impact on business continuity, as was the case in St Columcille's Hospital.

Members of the executive management team were clear on their role, area of responsibility and accountability. The hospital was governed and managed by the general manager who, reported to the chief operating officer of the Ireland East Hospital Group, who in turn reported to the chief executive officer of the hospital group. The clinical director provided clinical oversight and leadership at the hospital, and had oversight of training for non-consultant hospital doctors. The director of nursing was responsible for the organisation and management of nursing services. The clinical director and director of nursing were members of executive management team.

The hospital had corporate and clinical governance arrangements in place that defined the roles, accountability and responsibilities for assuring the quality and safety of healthcare services. However, inspectors found that, at the time of inspection, there was some discrepancy in the governance and oversight arrangements as set out in the hospital's organisational structure charts, documents submitted to HIQA and what senior management told inspectors on the day of inspection.

Executive Management Team

The newly reorganised executive management team comprised appropriate members, which included the general manager, operational deputy manager, director of nursing, clinical director, quality, safety and risk manager, logistics manager and heads of other departments. The team met informally in February and formally on 28 June 2022 (post HIQA's inspection) and the terms of reference for the team were being drafted at the time of HIQA's inspection.

Members of the hospital's executive management team attended performance meetings between the hospital and hospital group every month where items such as workforce and operational issues, patient-safety incidents, the top five risks on the hospital's risk register and quality improvement initiatives were discussed. Inspectors was satisfied that the performance meetings were well attended by representatives from the hospital and hospital group, and that actions were progressed from meeting to meeting.

Before the establishment of the new executive management team, responsibility for the day-to-day operational management of the hospital was assigned to a general management team. This general management team comprised the hospital's general manager, operational deputy manager, human resource manager, service manager, quality and safety manager, support service manager and other heads of departments. The general management team did not meet every week, in line with its terms of reference.

The general management team last met in October 2021. This indicated that for a period of four months, no meeting of the senior management team occurred until the newly established executive management team met informally in February 2022. HIQA did raise this with hospital management on the day of inspection. Management told HIQA that while this was the case, members of the general management team were also members of the Clinical Governance Committee and that this committee was the hospital's main governance and oversight committee, which had met every month, over the four month period to monitor the performance, and quality and safety of services at the hospital. Minutes of meetings of the Clinical Governance Committee submitted to HIQA confirmed this.

Two organisational charts setting out the hospital's reporting structures were submitted to HIQA as part of the pre-onsite documentation, data and information request. These charts detailed the direct reporting arrangements for senior managers and various governance and oversight committees. However, inspectors noted that the reporting arrangements for two of the committees — Clinical Governance Committee and the Quality and Safety Committee — set out on the organisational structure charts were not consistent with what was outlined to HIQA by senior management on the day of inspection.

The executive management team outlined to inspectors their plans to revise, reconfigure and strengthen the hospital's corporate and clinical governance structures and these plans were bring progressed at the time of inspection.

Clinical Governance Committee

The Clinical Governance Committee was the main committee assigned with overall responsibility for the governance and oversight for improving the quality and safety of healthcare services at the hospital. The committee included the senior management team and was chaired by the Clinical Director. It was responsible for ensuring that governance systems were in place and functioning appropriately in all departments of the hospital. Other governance committees — the Infection Prevention and Control Committee, Drugs, Therapeutics Committee and Sepsis and INEWS (Irish National Early Warning System) Committee — reported to the Clinical Governance Committee every month.

The Clinical Governance Committee met monthly to review and consider reports from the various committees that reported into it. Reports and status updates were provided on the risks on the hospital's risk register, patient-safety incidents, complaints management, clinical audit activities and findings, scheduled care and unscheduled care activity, feedback on patient experiences, service improvement initiatives and mandatory staff training. The committee also approved clinical policies, procedures, protocols and guidelines, which were stored on the hospital's intranet.

While it was clear to inspectors that the Clinical Governance Committee had oversight of the relevant issues that impacted or had the potential to impact on the provision of the high-quality, safe healthcare services at the hospital, the terms of reference for this committee submitted to HIQA (dated 2011), were 11 years old. They need updating to reflect the revised, strengthened and rationalised committee structure outlined by the executive management team at the time of inspection.

Quality, Safety and Risk Committee

The hospital's quality and patient safety team had oversight of the systematic monitoring of services provided at the hospital. The quality and patient safety department had recently experienced a significant change in staff, this included the redeployed of staff into a senior managerial role. The quality and patient safety department experienced a significant change in staffing from August 2020 to March 2022. During this period, the quality and safety manager also assumed a senior managerial role. The quality and safety manager's post was unfilled from October 2021 to February 2022, but was filled in March 2022. Other appointments to the quality and patient safety department in quarter two 2022, included the appointment of a patient liaison officer[§§§] and a quality and safety co-

---

[§§§] Patient Liaison Officer - The primary purpose of a Patient Liaison Officer is to serve as a key point of contact between patients and medical providers. They are an intermediary who answers questions and addresses concerns patients may have during and after receiving care.

ordinator. The quality and patient safety team was short one whole-time equivalent (WTE)**** quality and safety co-ordinator.

The hospital had a Quality, Safety and Risk Committee (previously known as the Integrated Quality Safety and Risk Committee), which comprised 17 sub-committees focusing on key areas. The committee was chaired by the operational deputy general manager and membership included the hospital's general manager, operational deputy manager, senior managers, and a quality and risk representative. The committee had oversight of the risks impacting the quality and safety of services, patient-safety incidents, complaints management, audit activities and findings, performance against key performance indicators, quality and safety improvement initiatives and staff uptake of mandatory and essential training. The committee was tasked with providing hospital management with assurances of the quality and safety of healthcare services at the hospital.

Minutes of meetings of the Quality, Safety and Risk Committee submitted to HIQA showed that the committee had not met each month, in line with its terms of reference. At the time of HIQA's inspection, the committee had not met since October 2021 (eight months). Given the functions and responsibilities of the committee, this was a concern for inspectors, which was discussed with the general manager on the day of inspection. At the time, inspectors sought information on the alternate structures and processes in place to provide the senior management team with assurances on the quality and safety of services at the hospital over the eight month period that the committee had not met.

The hospital's general manager confirmed to inspectors that some sub-committees of the Quality, Safety and Risk Committee had met and that the chairs of those sub-committees had oversight of the hospital's performance against key performance indicators and potential risks to patients. The general manager also told inspectors that collated performance data was reported and presented at meetings of the Clinical Governance Committee and at performance meetings between the hospital and hospital group every month and these served as a further means to provide assurances on the quality and safety of services. The director of nursing also assured HIQA that collated data on nursing metrics was submitted to the Clinical Governance Committee and this provided assurance on the quality of nursing care provided at the hospital.

Inspectors noted however, that not all of the 17 sub-committees of the Quality, Safety and Risk Committee had a formalised reporting arrangement to that committee. Therefore, inspectors were not fully assured that the Quality, Safety and Risk Committee and its sub-committees were functioning as they should be and that the hospital's quality assurance mechanisms were fully effective in assuring hospital management about the quality and safety of healthcare services provided at the hospital.

**** Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

Inspectors also noted from minutes of meetings of the Quality, Safety and Risk Committee that meetings were not well attended by all committee members. The quality safety and risk manager confirmed this on the day of inspection and explained that the redeployment of staff from the quality and patient safety department in quarter four of 2021 had a significant impact on the workings of the committee from October 2021 to March 2022. Hospital management believed that the new appointments in the quality and patient safety department would improve attendance and workings of the committee.

Hospital management told inspectors that all of the hospital's corporate governance structures were being revised with the aim of consolidating, rationalising and enhancing the workings of the different committees. HIQA was satisfied that the Ireland East Hospital Group were aware and supportive of management's plans to reconfigure and strengthen the hospital's corporate governance structures. There was also evidence that the Ireland East Hospital Group's quality and safety team were providing ongoing support to hospital management every week. The quality and safety teams at hospital and hospital group levels had collaborated and developed a working document aligned to the HSE's Patient Safety Strategy 2019-2024,[††††] which was used to assess the quality and safety of healthcare services at the hospital.

On the day of inspection, inspectors were not fully assured that the hospital's governance arrangements and quality assurance mechanisms were effective in assuring the delivery of high-quality, safe and reliable healthcare services. While the Clinical Governance Committee were meeting, the Quality, Safety and Risk Committee was not, and the Executive Management Team was newly established and had only met formally in June 2022. Following the inspection, HIQA subsequently corresponded with hospital management and sought further information and assurance on the hospital's governance and oversight arrangements.

In their response, hospital management provided a revised organisational structure chart which outlined the new reporting relationships of the various governance and oversight committees. The organisational structure chart showed that the Quality, Safety and Risk Committee had been reconfigured and was renamed the Quality and Safety Executive Committee. HIQA was provided with the terms of reference (dated June 2022) for the newly reconfigured Quality and Safety Executive Committee.

At operational level, HIQA was satisfied that the hospital had clear lines of accountability with devolved autonomy and decision-making for the four areas of known harm. The hospital had the following four committees in place, all were operationally accountable and reported to the Clinical Governance Committee:

- Infection Prevention and Control Committee

[††††] Health Service Executive. *Patient Safety Strategy; 2019-2024*. Dublin: Health Service Executive. 2019. Available online from https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf.

- Drugs and Therapeutics Committee
- Sepsis and INEWS Committee
- Delayed Discharge Committee.

Infection Prevention and Control Committee

The hospital's multidisciplinary infection prevention and control committee was responsible for the governance and oversight of infection prevention and control at the hospital. The committee was operationally accountable and reported to the Clinical Governance Committee every month. The committee was chaired by the hospital manager and met every three months in line with its terms of reference. Membership of the committee included members of the hospital's infection prevention and control team, representatives from the senior management team, an antimicrobial pharmacist and representatives from public health. A number of sub-committees reported into the Infection Prevention and Control Committee, including that related to antimicrobial stewardship.

The Infection Prevention and Control Committee had oversight of the hospital's performance against key infection prevention and control performance indicators (including antimicrobial stewardship), auditing findings, infection prevention and control related patient-safety incidents, infection prevention and control related risks, relevant infection prevention and control policies and staff education and training. The committee approved and monitored the progress in implementing the annual plan for infection prevention and control, and received updates on the progress of implementation from the hospital's infection prevention and control team every three months. The plan is discussed in more detail under national standard 5.5.

Minutes of meetings of the Infection Prevention and Control Committee submitted to HIQA, were comprehensive and showed that meetings followed a structured format, were well attended and that actions were progressed from meeting to meeting. HIQA was satisfied that there was governance and oversight of infection outbreaks, including COVID-19 at hospital and hospital group levels.

Drugs and Therapeutics Committee

The hospital had a Drugs and Therapeutics Committee who was assigned with responsibility for the governance and oversight of medication safety practices at the hospital. The committee was operationally accountable and reported to the Clinical Governance Committee every month and submitted formal reports to this committee every three months. The committee was chaired by a consultant endocrinologist and met monthly in line with its terms of reference. Membership of the committee comprised appropriate representatives, which included a consultant endocrinologist, chief pharmacist, antimicrobial pharmacist, specialist registrars, director of nursing and a representative from the quality and safety department.

The committee had oversight of the hospital's antimicrobial stewardship programme, medication errors, medication alerts, medication patient-safety incidents, audit activities, policies, procedures, protocols and guidelines, and staff education and training. The committee was responsible for devising the annual plan for medication safety and reported annually on the progress made in implementing actions in this plan to the Clinical Governance Committee. This plan is discussed in more detail under national standard 5.5.

Minutes of meetings of the Drugs and Therapeutics Committee submitted to HIQA showed that meetings were well attended, action orientated and actions were progressed from meeting to meeting. In addition to reporting to the Clinical Governance Committee every month, the Drugs and Therapeutics Committee reported to the hospital group as part of the performance meeting held every month. The chief pharmacist was also a member of St Vincent's University Hospital's Drugs and Therapeutics Committee and attended meetings of that committee every month.

Sepsis and Irish National Early Warning System (INEWS) Committee

The hospital had a Sepsis and INEWS Committee who was assigned with responsibility for overseeing the implementation of the national sepsis and INEWS guidelines at the hospital. This committee was operationally accountable and reported to the Clinical Governance Committee every month. The committee, chaired by a consultant microbiologist, met every three months, in line with its terms of reference. Membership of the committee included the hospital's general manager, antimicrobial pharmacist, a non-consultant hospital doctor representative and an assistant director of nursing from the Ireland East Hospital Group. Minutes of meetings of the committee submitted to HIQA showed that the committee had oversight of audit activities related to sepsis and INEWS, performance data, relevant policies and staff uptake of relevant education and training. Meetings were well attended, action orientated and actions were progressed from meeting to meeting.

Delayed Discharge Committee

The hospital had a multidisciplinary Delayed Discharge Committee chaired by a consultant physician who was operationally accountable and reported to the Clinical Governance Committee every month. Membership of the committee included the hospital's general manager, members of the health and social care team and clinical nurse managers. Minutes of meetings submitted to HIQA showed the committee did not meet monthly in line with its terms of reference. When the committee met, meetings were well attended, action orientated and actions were progressed from meeting to meeting.

The hospital had recently appointed a discharge coordinator who was assigned with responsibility for discharge planning, which included co-ordinating complex discharges. The hospital had also recently introduced a weekly length of stay meeting. This meeting was the forum where the hospital's performance against key performance indicators

related to length of stay was discussed and actioned. The meeting was attended by the hospital's general manager, members of the health and social care team and nurse managers.

The hospital had no formal bed management committee with responsibility for safe transitions of care. Collated data on scheduled care and unscheduled care activity, inpatient bed capacity and patient transfers was reported to the Clinical Governance Committee every month and reviewed at the performance meetings between the hospital and hospital group The bed manager from St Columcille's Hospital attended meetings of the bed management committee in St Vincent's University Hospital. The hospital presented collated data on activity at the hospital's medical assessment unit and the local injury unit, the number of delayed discharges, inpatient bed capacity and patient transfers at meetings of St Vincent's University Hospital's bed management committee.

In summary, some governance and oversight committees had not met in line with their terms of references and in some cases — Quality, Safety and Risk Committee — had not met in eight months. In addition, terms of reference for the main governance committee — Clinical Governance Committee — was 11 years old and required review. The terms of reference of the Quality, Safety and Risk Committee had no date, which would not be in keeping with effective governance processes. At the time of inspection, the newly revised Quality and Safety Executive Committee, the main committee with responsibility for assuring hospital management on the quality and safety of healthcare services had not formally met and the Executive Management Team had only formally met once.

Inspectors acknowledged the reconfiguration of corporate governance arrangements underway at the hospital, but were not fully assured that hospital management had complete oversight of the quality and safety of services provided at the hospital.

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.

In relation to the four areas of known harm, infection prevention and control, medication safety, deteriorating patient and transitions of care, St Columcille's Hospital had management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services but these arrangements needed strengthening and improvement.

The Quality, Safety and Risk Committee, was not fully operational and functioning as per its terms of reference, therefore HIQA was concerned that the management structures and processes were not as robust and effective as they should be in ensuring the quality and safety of healthcare provided to people who use the service.

The management arrangements in place in relation to the four areas of known harm are discussed in more detail below.

Infection, prevention and control

The hospital had an infection prevention and control team comprising;

- a consultant microbiologist

- one WTE infection prevention and control nurse

- one WTE antimicrobial pharmacist.

In addition, the hospital had 24/7 access to a consultant microbiologist and surveillance scientist in St Vincent's University Hospital.

The hospital did not have an overarching infection prevention and control programme[‡‡‡‡] as per national standards.[§§§§] However, the infection prevention and control team had developed an annual plan that set out the eleven objectives to be achieved in relation to infection prevention and control in 2022. These objectives focused on education, auditing activities, infection prevention and control surveillance and quality improvement.

The hospital's infection prevention and control team reported on progress in implementing the actions in the annual plan to the Clinical Governance Committee every month and annually in its annual report. The annual report of 2021 submitted to HIQA was comprehensive. It comprised a number of reports, including an alert organism surveillance report, a report on infection outbreaks, a summary of infection prevention and control audit findings and a hand hygiene audit report. HIQA noted that some of the reports had identified recommendations to improve infection prevention and control practices at the hospital, but time-bound action plans to support the implementation of these recommendations were not developed. Action plans can provide a framework to implement recommendations from reports and ensure that identified changes are made to improve healthcare services.

The hospital had a proactive multidisciplinary antimicrobial stewardship team, which comprised the antimicrobial pharmacist and the consultant microbiologist, supported by the clinical pharmacists who reported to the Drugs and Therapeutics Committee. The antimicrobial stewardship team were responsible for implementing the hospital's antimicrobial stewardship programme.[*****] The team was operationally accountable and

---

[‡‡‡‡] 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.

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

reported to two committees — Drugs and Therapeutics Committee and Infection Prevention and Control Committee. The antimicrobial stewardship team developed an annual plan and reported on the progress in implementing the plan annually. The antimicrobial stewardship annual report of 2021 submitted to HIQA showed that the objectives set for that year were achieved and quality improvement interventions were introduced to improve antimicrobial stewardship practices at the hospital.

Medication safety

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

- four WTEs pharmacists, which included the chief pharmacist and three clinical pharmacists

- two WTEs pharmacy technicians.

The Drugs and Therapeutics Committee developed an annual plan for 2022 that detailed ten medication safety objectives to be achieved this year. The objectives included a focus on education, especially on insulin, medication incident reporting, relevant auditing activities and monitoring performance against key performance indicators for antimicrobial prescribing. The Drugs and Therapeutics Committee reported on the progress in implementing the actions in the annual plan to the Clinical Governance Committee every month and annually in its annual report. The annual report of 2021 submitted to HIQA, detailed a wide range of quality improvement initiatives implemented to improve medication safety at the hospital, which included adding a thromboembolism (VTE) prophylaxis[‡‡‡‡‡] risk assessment to the medication record.

Deteriorating patient

The hospital did not have a deteriorating patient improvement programme, but the Sepsis and INEWS Committee were responsible for overseeing the implementation of the INEWS and hospital's sepsis programme. The committee had developed an annual plan for 2022, which identified seven key areas of focus in relation to the deteriorating patient. These included education on sepsis and INEWS, relevant auditing activities, monitoring performance against relevant key performance indicators, implementing national guidelines and expanding the INEWS link nurse programme. The Sepsis and INEWS Committee reported on progress in implementing the annual plan to the Clinical Governance Committee every month and annually. It was evident from the annual report of 2021 submitted to HIQA, that the hospital were proactive in auditing compliance with

---

[†††††] Clinical pharmacy service - is a service provided by a qualified pharmacist who promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[‡‡‡‡‡] Venous thromboembolism (VTE) prophylaxis consists of pharmacologic and non-pharmacologic measures to diminish the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE).

relevant national guidelines on INEWS and sepsis and in introducing quality improvement initiatives to address areas for improvement from these audits.

Transitions of care

HIQA was satisfied that the hospital had arrangements in place to monitor issues that impact effective, safe transitions of care. Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. The hospital's Delayed Discharge Committee and bed manager had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital. Inpatient bed capacity, discharge and transfers into and out of the hospital were discussed at daily huddles§§§§ chaired by the hospital's general manager.

Nursing, medical and support staff workforce arrangements

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

The hospital's interim human resource manager was operationally accountable and reported to the operational deputy manager at the hospital and reported on performance to the human resource director in the Ireland East Hospital Group.

The hospital had adequate workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care. The hospital's total approved complement of staff (all staff) was reported to be between 510-520 WTEs.

The hospital's approved complement of nursing staff was 57 WTEs. At the time of inspection, 48 WTEs nursing positions were filled, which represented a variance of nine WTEs, a difference of 16% between the determined and actual nursing complement. Hospital management told inspectors that they were actively recruiting nursing staff and had recently recruited five nurses who were completing an adaptation programme in St Vincent's University Hospital. The hospital used agency staff and or existing staff nurses from the hospital worked extra shifts to fill shortfalls in the nursing staff roster.

The hospital's total approved posts for healthcare assistants was 12 WTEs and all posts were filled at the time of HIQA's inspection.

The hospital had an approved complement of 11.18 WTEs consultant physicians attending the hospital. Two consultants were due to commence employment at the hospital in quarter four 2022. Consultants in St Columcille's Hospital held joint employment contracts with St Vincent's University Hospital and had sessional commitments to St Columcille's

---

§§§§ A huddle is a short, stand-up meeting — 10 minutes or less — that is typically used at the start of each shift in a clinical setting.

Hospital. The consultant staff were supported by 27.5 non-consultant hospital doctors at registrar, senior house officer and intern grade – 12.5 registrars (two of which were specialist registrars), ten senior house officers and five interns. There were two senior house officer positions vacant and hospital management were working to fill these positions with locum doctors.

The hospital's reported absenteeism rate for 2021 was 7.4%, which was above the HSE's national rate of 3.5%. COVID-19 accounted for 3.3% of the absenteeism rate. The hospital had supports in place to assist staff on long-term absenteeism. This is discussed in more detail under national standard 6.4.

Staff training and education

The Clinical Governance Committee had oversight of staff uptake of mandatory and essential training and it was a point of discussion at the first formal meeting of the Executive Management Team in June 2022. Nursing, medical and support staff confirmed to HIQA that they had received induction training and completed training on a variety of topics in the HSE's online learning and training portal (HSELanD).

The hospital had a training matrix system,****** which tracked staff uptake of mandatory and essential training, but hospital management told HIQA that this system required improvement. Nursing staff attendance at mandatory and essential training was monitored by ward managers in their respective clinical areas. Further details on staff uptake of mandatory and essential training is provided under national standard 3.1.

In summary, the hospital had arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm. However, the key governance structure assigned with responsibility to oversee the quality and safety of services — Quality, Safety and Risk Committee — was not fully functioning as it should be. In addition, a number of sub-committees were not reporting to the Quality, Safety and Risk Committee, in line with the organisational organogram submitted to inspectors. Therefore, it was not clear to inspectors how progress on implementing annual plans and planned objectives related to the four areas of known harm was being adequately supported, promoted and monitored, and how assurances on progress or lack of progress, was provided to the Executive Management Team. The training matrix system in place to monitor and track staff uptake of mandatory and essential training also required improvement.

Judgment: Partially compliant

****** Training matrix system is a tool used in an organisation for tracking, monitoring and displaying staff training compliance and achievements.

> 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, but HIQA found there was scope for significant improvement in this area.

Quality and Safety Committees[††††††] are responsible for the monitoring of quality improvement plans, driving the implementation of service-wide improvements and safeguards in quality and safety. The Quality, Safety and Risk Committee at St Columcille's Hospital had not met for eight months, this meant that the mechanism to assure senior hospital managers about the quality and safety of healthcare services was not as effective as it should be.

Monitoring service's performance

The hospital collected data on a range of different clinical measurements related to the quality and safety of healthcare services, in line with the national HSE reporting requirements. Data was collected and reported every month for the HSE's hospital patient safety indicator report (HPSIR). Data relating to unscheduled care, scheduled care, patient-safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services was collated and reviewed at meetings of the Clinical Governance Committee and at performance meetings between the hospital and hospital group every month.

The hospital reported on the rate of clinical incidents to the National Incident Management System (NIMS),[††††††] However, HIQA noted that the hospital had not reported on the rate of clinical incidents to NIMS in 2021 or year to date for 2022. Hospital management confirmed the hospital was an outlier in the reporting of clinical incidents and were working to improve this. While there was evidence that the reporting of clinical incidents had improved (from 19% of in quarter one 2021 to 87% of incidents in quarter two of 2022), the rate of reporting to NIMS was still below the HSE's national target of 90%.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks. The hospital's Risk Register Committee had oversight of the risk management structures and processes. The committee was operationally

---

[††††††] Health Service Executive. *Quality and Safety Committees. Guidance and Resources*. Dublin: Health Service Executive. 2016. Available online from:
https://www.hse.ie/eng/about/who/qid/governancequality/boardquality/quality-and-safety-committees-guidance-and-resources-2016.pdf
[††††††] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

accountable and reported to the Clinical Governance Committee. Membership of the committee included the hospital's general manager, quality safety and risk manager, director of nursing and other heads of departments. Minutes of meetings submitted to HIQA showed that this committee had not met each month in line with their terms of references. The hospital's corporate risk register submitted to HIQA contained risks in relation to the four key areas of known harm were recorded on the register along with controls and actions to mitigate the risks. These risks are outlined further in national standard 3.1.

Audit activity

The hospital had a Clinical Audit Committee who had oversight of the audit activity at the hospital. The committee was chaired by the clinical director and was operationally accountable and reported to the Clinical Governance Committee. According to the committee's terms of reference (dated 2017), it should meet a minimum of six times a year. However, the committee had not met since April 2021 (14 months). HIQA was told that during the 14 months when the committee did not meet, the Clinical Governance Committee had oversight of audit activity and resultant findings. However, minutes of meetings from 2019 and 2021 submitted to HIQA showed that attendance at meetings in quarter one and two of 2021 was poor. Staff in the clinical areas visited told inspectors that audit findings were shared with staff at the daily huddle and through the hospital's electronic system.

Management of serious reportable events

The hospital's Clinical Incident Review Group had oversight of the management of serious reportable events which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. The Clinical Incident Review Group, chaired by the hospital's general manager met six-monthly in line with its terms of references (dated 2017). Membership of the committee included the hospital's general manager, the clinical director, the director of nursing and the quality safety and risk manager. The committee had not met recently and hospital management told HIQA that this was because there no serious reportable events in 2021.

Management of patient-safety incidents

The quality and safety department tracked and trended patient-safety incidents and submitted a patient-safety incident summary report to the Clinical Governance Committee every month. Patient-safety incidents were rated by severity, category and location, with slips, trips and falls being the most common incidents reported at the hospital in 2021. Patient-safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3.

National Inpatient Experience Survey

Findings from National Inpatient Experience Survey were reviewed at meetings of the Clinical Governance Committee. The hospital's quality and safety department were assigned responsibility for developing quality improvement plans to improve the experience of people using the service. They, together with the office of the HSE's National Director Operational Performance and Integration, progressed the implementation of a number of person-centred initiatives to improve healthcare services at the hospital. For example, the hospital had introduced a red tray to identify patients who required assistance with meals.

In summary, the hospital were monitoring performance against key performance indicators in the four areas of known harm and there was evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvements initiatives were implemented in response to medication safety incidents and audit findings related to sepsis and INEWS, infection prevention and control and mediation safety. However, three committees that were responsible for monitoring the hospital's performance and improving the quality and safety of services — Quality, Safety and Risk Committee, Clinical Audit Committee, Clinical Incident Review Group — had not met as per their terms of reference. The Quality, Safety and Risk Committee had not met for eight months and the Clinical Audit Committee had not met in 14 months. In addition, the hospital fell short of the national target for reporting clinical incidents within 30 days of the date of notification on the NIMS.

Overall, inspectors was not fully assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital.

Judgment: Partially compliant

Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare.

The hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare. Staff had access to and were aware of how to access occupational health services, an employee assistance programme and relevant policies, procedures, protocols and guidelines on, dignity and respect at work, and the reporting and management of workplace accidents and incidents. Nursing, medical and support staff told inspectors they were supported when accessing these supports and also felt encouraged to raise concerns about the quality and safety of healthcare services in the hospital.

Inspectors observed a good working atmosphere between management and staff in the clinical areas visited and observed information on how to access an employment

assistance programme displayed in staff areas. Non-consultant hospital doctors who spoke with inspectors felt supported and included in multidisciplinary teams, and as members of relevant governance committees. They were satisfied with rostering arrangements, but did feel that the hospital would benefit by having a non-consultant hospital doctor lead on site in the hospital. This was brought to the attention of senior hospital management on the day of inspection.

The hospital had implemented the HSE's model — Assist Me[§§§§§§] — to assist and support staff involved in a patient-safety incident. Nursing staff had participated in a staff survey in quarter one and two of 2022. The findings of the survey were being collated at the time of HIQA's inspection. However, HIQA was provided with a copy of a 'Great Place to Work' survey carried out in 2019, which showed that 63% of the staff felt that the hospital was a great place to work. However, when compared to other organisations with similar staff numbers, the hospital's score was below the average score (greater than 90%). Staff had suggested some changes to improve the working and caring environment, which included improving the staff-to-patient ratio and communication between hospital departments and staff. Inspectors observed how some of the suggested improvements had been implemented at the hospital. For example, the layout of one clinical area had changed to enable patients with dementia to access a sensory garden. Daily huddles were introduced to enhance staff communication.

Overall, HIQA was assured that the hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare.

Judgment: Compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. The hospital was found to be compliant with standard 1.7, substantially compliant with five standards (1.6, 1.8, 2.8, 3.1 and 3.3) and partially compliant with the remaining standard (2.7) assessed. Key inspection findings leading to these judgments are described in the following sections.

[§§§§§§] The "ASSIST ME" model is a communication tool that can be used to assist staff who are upset, anxious or in a distressed state following a patient safety incident.

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 as being respectful, kind and caring towards people using the service. For example, staff were observed seeking patient's consent for procedures, responding in a timely manner to patient call bells and were attentive to patient's individual needs.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, inspectors observed that privacy curtains were drawn when patients were being assessed and receiving care. Notwithstanding this, the clinical areas visited had a limited number of single rooms without en-suite bathroom facilities. Patients with an infection risk were sometimes cohorted in a ward, which is consistent with national guidance,******* but the lack of en-suite bathroom facilities meant these patients had to use individual commodes in the ward area, which had the potential to impact on their privacy and dignity.

Corridors were observed to be clutter free and patients could mobilise with ease. Patient's independence was encouraged, for example at mealtimes, staff supervised meals and offered assistance when required. The hospital had introduced a person-centred initiative to identify patients who required assistance with meals.

The hospital had also implemented the 'Get up-Get Dressed-Get Moving' initiative to encourage and prepare patients for discharge home with patients encouraged to dress in their day clothes. Compliance with this initiative was audited.

Patient's personal information in the clinical areas visited during the inspection was observed to be protected and stored appropriately.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA. However, the limited number of en-suite bathroom facilities did impact on the ability to promote and protect a patient's privacy and dignity, especially those cohorted for infection prevention and control purposes.

Judgment: Substantially compliant

******* Health Protection Surveillance Centre. *Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting*: V2. Dublin: Health Protection Surveillance Centre. July 2022. Available online from: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/acutehospitalsguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf.

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. HIQA observed effective communication approaches used by staff to support patients who could not communicate clearly and had difficulty communicating. Staff communicated in a sensitive manner with patients and their families. Staff were observed using a dry-erase white-board to communicate more effectively with one patient. The patient appeared very comfortable using this tool.

The speech and language therapists had introduced a quality improvement initiative — 'caring conversations on people with dementia' — to support staff when communicating with patients with dementia. The initiative comprised seven types of interventions, including one called 'five things about me' whereby five things about a patient was written on a white board located over the patient's bed as a method to engage and communicate more effectively with the person. HIQA observed the initiative in use and its effectiveness in the clinical areas visited on the day of inspection.

In 2021, the speech and language therapists set a target that 90 patients with dementia would be screened for cognitive-communication impairment over a nine month time frame (March-October 2021) so as to enable an individual communication profile to be developed and support strategies implemented for these patients. This initiative was implemented and audited. The objectives of screening 90 patients was achieved over an eight month period. Staff across a number of grades and professions were also provided with training on the initiative in 2021 and 2022.

Catering staff who spoke with inspectors knew patients well and were aware of patient's food preferences and catering needs. Catering staff were observed asking patient's about their food and drinks preferences, and providing the patient with their preferred choice.

HIQA found evidence of a person-centred approach to care for vulnerable patients receiving care. For example, in one of the clinical areas visited, a number of patients were vulnerable and had additional care needs that required them to be cared for in an environment that was quiet and calm. The environment was quiet and calm and signage was clearly displayed to remind staff and visitors to ensure the maintenance of a quiet and calm environment. Patients with dementia also had easy and direct access to a dementia-friendly sensory garden from one of the clinical area visited.

Overall, HIQA were assured that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The hospital had a complaints management system and used the HSE's complaints management policy 'Your Service Your Say.'[†††††††] The hospital's operational deputy manager was the designated person assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints.[‡‡‡‡‡‡‡] HIQA were assured that all complaints were recorded on the hospital's electronic system within the time frame set out by the HSE.

There was a culture of complaints resolution in the clinical areas visited. For example, a complaint relating to missing property (dentures) was investigated by the appropriate person (quality, safety and risk manager, the patient liaison officer and nursing and hospital management). Following the investigation, a patient's property checklist was introduced to ensure patients had their own property, such as dentures, glasses and hearing aids. Staff were reminded of the importance of using the checklist at the 7.30am daily huddle.

The Clinical Governance Committee had oversight of the effectiveness of the hospital's complaints management process. Complaints (verbal and written) were tracked and trended to identify the emerging themes, categories and departments involved. Almost half (29) of the complaints received in 2021 related to communication. Inspectors noted that the hospital's complaint's dashboard report did not contain information on recommendations or quality improvement initiatives to address emerging trends. Collated data and information on the hospital's compliance with national guidance and standards on complaint management was submitted to the Clinical Governance Committee and to the Ireland East Hospital Group's complaint managers and patient liaison forum every month.

The hospital formally reported on the number and type of complaints verbal and written, received annually. However, the HSE 'Your Service Your Say' annual feedback report[§§§§§§§] (2021) showed that of the 43 complaints received in 2021, 67% were resolved within 30 working days which was below the national HSE's target of 75% for investigating complaints. The appointment of new staff to the quality and safety department should help to remedy this.

[†††††††] 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.

[‡‡‡‡‡‡‡] Office of Ombudsman. *Learning to Get Better Progress Report*. Dublin: Office of Ombudsman. 2018. Available online from: https://www.ombudsman.ie/publications/reports/learning-to-get-better-pr/LearningTGBProgressFINAL.pdf.

[§§§§§§§] 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

Feedback on complaints was generally provided to staff who were the subject of the complaint or the clinical area involved. However, there was no evidence of sharing the learning from complaints or the complaints resolution process at a wider hospital or hospital group level, which is an opportunity missed. Information relating to independent advocacy services was displayed on an information board in one clinical area visited.

Overall, HIQA were assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. However, hospital management should instil a practice of sharing the learning from complaints and the complaints resolution process to improve services and help reduce recurrence of similar issues in other clinical areas. Hospital management should ensure that all complaints are resolved in line with set national targets.

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 overall the hospital's physical environment was well maintained and clean with few exceptions. There was evidence of general wear and tear observed, with paint work and wood finishes chipped, this did not facilitate effective cleaning. Hospital maintenance was centralised and managed by the HSE offsite. The lack of maintenance service onsite was identified as a risk by senior management and was recorded on the hospital's corporate risk register.

In the clinical areas visited, there were multi occupancy rooms with no en-suite bathroom facilities. There were limited isolation room facilities, with one single room in one clinical area visited and three single rooms in the other clinical area visited. This is an infection prevention and control risk and was recorded on the hospital's corporate risk register. The hospital had implemented processes to ensure appropriate placement of patients — the infection prevention and control nurse liaised with bed management regarding the appropriate placement of patients daily.

In the time frame from February to June 2022, the hospital had eight COVID-19 outbreaks, outbreak reports indicated existing infrastructure (open bays, bed spacing, number of single rooms and shared toilets) as a potential contributory factor of the outbreaks. One ward in the hospital was designated for the management of COVID-19 patients. In one clinical area visited, four patients were cohorted in a four-bedded room with no en-suite bathroom facilities, however, each patient was provided with their own designated commode, which was consistent with national guidance. These patients also had access to a shower designated for their use only. Inspectors found the door of the

ward where these patients were accommodated was open, which is not consistent with national guidance. This was brought to the attention of the clinical nurse manager. Patient charts were stored outside all clinical areas, including isolation rooms.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage (World Health Organization (WHO) 5 moments of hand hygiene) clearly displayed throughout the clinical areas. Inspectors noted that hand hygiene sinks throughout the unit conformed to national requirements.******** Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical areas visited. Staff were also observed wearing appropriate personal protective equipment in line with current public health guidelines.

Corridors of both clinical areas were wide and clutter free, and facilitated ease of access and uninhibited mobilisation, especially for patients who use walking aids. Doors in the clinical areas were alarmed to ensure patients' safety.

Clinical nurse managers had oversight of the cleaning and cleaning schedules for their respective clinical areas, and were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe. Household staff had dual responsibilities which included catering, cleaning and hygiene duties, but hospital management assured HIQA that there was a clear separation of cleaning and catering duties. Terminal cleaning†††††††† was carried out by designated cleaning staff. Cleaning of equipment was assigned to healthcare assistants who had protected time to complete this task. In both clinical areas visited, equipment was clean and in one area there was a system in place to identity, equipment that had been cleaned — a green tagging system was used. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately and managed by an external contractor.

In summary, HIQA was not fully assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. There was a lack of single rooms and en-suite bathroom facilities which increased the risk of cross infection. There was evidence of wear and tear observed throughout the clinical areas visited, which did not facilitate effective cleaning. Access to maintenance services was an issue recorded on the hospital's corporate risk register.

Judgment: Partially compliant

******** Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf
†††††††† Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided. HIQA found that the hospital had monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments and patient experience surveys. HIQA found there was a consistent approach to audit across the clinical areas visited on the day of inspection.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee had an agreed audit plan for 2022 and were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of environmental, equipment, and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Findings from environmental audit were shared with the staff in clinical areas. An infection prevention and control audit summary report submitted to HIQA showed that the clinical areas visited on the day of inspection had achieved a high level of compliance (over 95%) with infection prevention and control practices in 2021.

HIQA was satisfied that the hospital acted on audit findings in relation to infection prevention and control practices, and where areas for improvement were identified, a time-bound action plan was developed and implemented and a re-audit conducted. For example, in April 2022 one clinical area had scored 93% overall for infection prevention and control practices. A time-bound action plan was devised to action areas identified as needing improvement. Actions taken included improving isolation signage and increasing staff awareness of infection prevention and control practices. When re-audited in May 2022, the clinical area achieved 100% compliance with good practices.

Hand hygiene audits were completed twice a year in all clinical care areas. In quarter two 2022, the hospital's overall compliance with effective hand hygiene practices was 92%, above the HSE target of 90%. However, the results of this audit indicated that the compliance for medical staff required improvement. Accordingly, the consultant microbiologist provided training to medical staff and when re-audited in June 2022, the compliance levels for medical staff had increased to 87%. However, compliance is still below the HSE's target of 90%, therefore further work is needed to reach the national target.

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

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

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

The hospital's clostridium difficile rate was below the national rate in 2021. Furthermore, data from the hospital patient safety indicator report indicated that the hospital had no new cases of hospital acquired staphylococcus blood stream infections, clostridium difficile or CPE in the first quarter of 2022.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study and reporting on compliance with antimicrobial stewardship key performance indicator every three months. In quarter one and two 2021, the hospital was not compliant with the HSE's target of ≤ 30% for the antimicrobial prescribing indicator related to patients on IV (intravenous) therapy that are eligible for PO (orally) therapy. A quality improvement initiative — an antimicrobial advisory sticker for healthcare and medication records — was introduced to improve compliance with the indicator and when re-audited in quarter three and four of 2021, the hospital scored significantly lower (8% in quarter three and 11% in quarter four of 2021), than the national target. This is commendable.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example between May and June 2022 audits were completed in the following areas:

- Completion of allergy status on the patient's medication administration record.

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

- Appropriate storage of insulin and labelling of insulin pens.
- Compliance with venous thromboprophylaxis.
- Conducting medication reconciliation.

Two insulin-related audit reports, completed in June 2022 were submitted to HIQA. The first audit focused on insulin storage and the second audit focused on the prescribing and documentation of insulin medication. The clinical areas visited on the day of inspection had achieved 91% compliant with the practice of labelling insulin pens with individual flag labels, but areas for improvement in relation to the documentation of insulin were identified. Both audit reports made recommendations however, time-bound action plans were not developed to action measures to improve medication safety practices. This was discussed with representatives from the Drugs and Therapeutics Committee on the day of inspection. Notwithstanding this, there was evidence that, some initiatives were introduced to improve medication safety practices at the hospital. This included ongoing education sessions on insulin use for medical and nursing staff. Education and training and risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Overall, HIQA was not fully assured that identified areas of improvement related to medication safety audits were always acted on and corrective actions implemented to improve medication safety practices at the hospital.

Deteriorating patient monitoring

The hospital collated performance data on the early warning system, including sepsis and this was reported to the Sepsis and INEWS Committee. Compliance with national guidance on the early warning system was monitored as part of the committee's annual audit plan. The hospital participated in the national sepsis audit.

It was evident from the INEWS audit (dated May 2022) that both clinical areas visited on the day of inspection had achieved a high level of compliance (97%-100%) with INEWS escalation protocols and that patients were reviewed by the medical team within the recommended time frame.

The hospital had implemented quality improvements initiatives as a result of audit findings (January and May 2022) related for the deteriorating patient. At the time of inspection, the hospital was trialling the use of a sticker to be used on the INEWS chart. This sticker acted as a visual reminder for medical staff to review the modified INEWS escalation and response protocol, which was in place on the previous day and required updating every 24 hours to continue to be valid for the patient.

Other structures in place included the use of the white-board, ward huddles and a medical on-call handover sheet to identify patients for medical review. A 'watcher patient'

system was also introduced whereby patients that staff were concerned about and patients whose INEWS scores were triggering were prioritised for review.

The hospital audited compliance with the seven indicators of sepsis management every three months and audit findings for quarter one and two 2022 showed that 'Sepsis 6' had been appropriately implemented at the hospital.

The hospital did not audit compliance with national guidance on clinical handover or the use of the Identify, Situation, Background, Assessment and Recommendation (ISBAR)§§§§§§§§ communication tool. National guidelines********* recommends that clinical handover practice be monitored and audited regularly by the relevant quality and patient safety committee of the healthcare organisation to assure the Executive Management Team that any necessary continuous quality improvements were put in place. This needs to be addressed.

Transitions of care monitoring

Performance in relation to transfers and discharges were monitored using the HSE's hospital patient safety indicators. The hospital reported on the number of inpatient discharges, number of beds subjected to delayed transfer of care and the number of new attendances to the local injury unit and the medical assessment unit every month. Performance data in relation to patient transfers and discharges was reported and discussed at meetings of the hospital's Delayed Discharge Committee and at the Bed Management Committee meetings with St Vincent's University Hospital every month. Patient flow and hospital activity were also discussed at the multidisciplinary daily huddles. This will be discussed further under national standard 3.1.

Overall, HIQA was satisfied that the hospital were systematically monitoring, evaluating healthcare services provided at the hospital. However, HIQA noted that time-bound action plans were not developed in response to medication safety audit findings therefore, evidence of continual improvement, especially related to medication safety was limited. The hospital was not auditing compliance with national guidance on clinical handover and the use of the ISBAR communication tool and further work was required to improve hand hygiene practices among medical staff.

Judgment: Substantially compliant

---

§§§§§§§§ Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre) communicating with other members of the multidisciplinary team, and upon discharge and or transfer to another health facility.
********* National Clinical Effectiveness Committee. Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No.11;2015. Available online from: https://assets.gov.ie/11588/48b91100bd2f483bbe4b88e1a3ae7b0b.pdf

The hospital had systems and processes in place to proactively identify, evaluate and manage immediate and potential risks to people using the service. Risks in relation to the four areas of known harm were recorded on the hospital's corporate risk register, which was reviewed monthly at meetings of the Clinical Governance Committee.

The Risk Register Committee was the governance structure assigned with responsibility to review and manage risks that impact the quality and safety of healthcare services. The committee was chaired by the hospital general manager and reported to the Clinical Governance Committee every month. Risks that could not be managed at hospital level were escalated to the Ireland East Hospital Group.

The hospital's risk register had controls and actions in place to mitigate the recorded risks. High-rated active risks recorded on the hospital's corporate risk register related to this monitoring programme included:

- Infection prevention and control: risk due to a lack of single rooms and en-suite bathroom facilities leading to potential risk of cross infection and COVID-19 risk.

- Medication safety: risk of medication errors because the hospital did not have a specific system in place for the management of warfarin dosage. There was a dedicated anticoagulant section in the medication administration record, which included a section specific to the management of warfarin administration.

- Transitions of care: risk associated with limited information technology (IT) support and limited integration of IT systems leading to potential harm to people who use healthcare services.

- Infrastructure: risk due to maintenance services located off site leading to delays in responding to essential and urgent maintenance requests.

Infection Prevention and Control

The infection prevention and control team maintained a local risk register and risk rated all actual and potential infection risks. Inadequate single en-suite rooms was one of the high-rated risks recorded on the local infection prevention and control risk register. Risks that could not be managed locally by the infection prevention and control team were escalated to hospital management and recorded on the hospital's corporate risk register.

Outbreak preparation and management

HIQA was satisfied that the hospital screened patients for multi-drug resistant organisms at point of entry to the hospital and that patients with a confirmed infection were isolated within 24 hours of admission or diagnosis as per national guidance. The hospital had a

designated ward for confirmed cases of COVID-19, patients testing positive for COVID-19 were cared for and treated there.

The hospital had eight outbreaks of COVID-19 between February and May of 2022. A multidisciplinary outbreak team was convened to advise and oversee the management of COVID-19 outbreaks. Infection prevention and control COVID-19 summary reports submitted to HIQA were comprehensive and outlined control measures, potential contributing factors and recommendations to reduce recurrence of a similar outbreak. However, there was no quality improvement plan devised to enable the implementation of recommendations set out in infection outbreak reports.

Medication safety

HIQA was satisfied that the hospital had implemented risk reduction strategies for high-risk medicines. The hospital had a list of high-risk medications. Inspectors observed the use of risk reduction strategies to support safe use of medicines in relation to anticoagulants, insulin and opioids.

The hospital had developed a medication prescription and administration record which included:

- an antimicrobial prescribing chart
- a section to support safe prescribing, monitoring and administration of antimicrobials requiring therapeutic drug monitoring
- a specific section to enhance safe prescribing of anticoagulants.

The hospital had developed a list of sound-alike look-alike medications (SALADs).[†††††††††] Medication reconciliation was undertaken on admission for all relevant patients by the clinical pharmacist. The practice was audited and the latest audit findings (June 2022), showed that medication reconciliation was conducted in 97% of all relevant patients. Recommendations were made to ensure medication reconciliation is carried out for all patients, but there was no time-bound action developed to enable the implementation of audit recommendations.

It was evident that the clinical pharmacist was accessible to staff and visited clinical areas daily. The consultant microbiologist and antimicrobial pharmacist visited the clinical areas once a week.

Deteriorating patient

The hospital had implemented the INEWS version 2 observation chart. The hospital had systems in place to manage patients whose early warning system triggered. The hospital

---

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

had allocated three beds in a four-bedded room in one of the clinical areas visited by inspectors as a medical observation unit. The other bed in this four-bedded room was used as an escalation bed for patients who's INEWS score triggered to a score of seven. Staff in this unit were trained to care for patients needing a closer level of observation, this included the use of cardiac monitors and peripherally inserted central catheter (PICC) lines.††††††††† A cardiologist carried out ward rounds in the observational unit every Monday and was otherwise available on the telephone when needed.

Safe 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 support safe and effective discharge planning. The hospital had a discharge co-ordinator to facilitate effective discharge planning.

A structured multidisciplinary meeting was carried out once a week in each clinical area to review and discuss the progress, discharge plans and rehabilitation needs of all patients. A daily huddle was held at 10.30am and a bed management meeting at 11.00am where information on admissions and discharges was discussed. The ISBAR communication tool was not used for shift handover, but the hospital had devised a structured template for sharing information during clinical handover.

An inter-ward handover sheet was used to share patient information during internal transitions of care, but notably the sheet was not consistent with the ISBAR format. The medical on-call handover sheet was structured using the ISBAR format.

HIQA noted that the discharge and transfer templates in use did not facilitate the recording of the patient's infection status. This was brought to the attention of the consultant microbiologist and infection prevention and control nurse on the day of inspection.

Policies, procedures and guidelines

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

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included a safe use of medicines policy and procedures. Prescribing guidelines including antimicrobial prescribing was accessed to staff at the point of care through an application on smart phones.

The hospital had implemented national guidance on INEWS and ISBAR.

---

††††††††† Peripherally inserted central catheter line – a tube inserted through a vein near the heart to allow medications or liquid nutrition to easily enter the body.

Policies, procedures, protocols and guidelines related to the four areas of know harm were accessible to staff via the hospital's Intranet and in hard copy format in clinical areas visited. The hospital had no formal document management system in place. The hospital would benefit from a documentation management system to assist in document control and ensure clinical staff have access to up-to-date versions of relevant policies, procedures, protocols and guidelines, related to the four areas of known harm.

Uptake of mandatory and essential training

Hospital management were planning to introduce a new centralised training record system. Clinical staff were required to complete INEWS and sepsis training every two years and hand hygiene training yearly. On the day of inspection, there was evidence that clinical nurse managers had oversight of the uptake of training for their clinical area. The hospital had mandatory training programmes for infection prevention and control, medication safety and the national early warning system.

Training for infection prevention and control included mandatory training on hand hygiene and standard and transmission based precautions.

Staff uptake of mandatory training in hand hygiene for quarter two 2022 was:

- 96% for nursing staff - above the HSE target of 90%

- 84% for healthcare assistants - below the HSE target of 90%

- 65% for medical staff - below the HSE target of 90%.

Staff uptake of mandatory training in standard and transmission based precautions in the last two years was:

- 82% for nursing staff

- 83% for healthcare assistants

- 19% for housekeeping staff including cleaning staff

- 33% for health and social care professionals.

- records for uptake of mandatory training in standard precautions and transmission-based precautions for medical staff were not submitted to HIQA.

Staff uptake of mandatory training in donning and doffing of personal protective clothing in the last two years was:

- 100% for both nursing staff and healthcare assistants.

- records for uptake of mandatory training in donning and doffing of personal protective clothing for medical staff were not submitted to HIQA.

Staff uptake of the flu vaccine was reported as 70% in 2021, below the HSE target of 75%. Increased uptake of flu vaccine needs to be promoted by hospital management.

Staff uptake of COVID-19 vaccinations was reported as 92% in 2021, above the HSE target of 75%.

Training relevant to medication safety was set out in the medication safety annual plan. This included induction training relating to prescribing and high alert medicines. The hospital had used a number of innovative ways to increase non-consultant hospital doctors' attendance at medication safety education sessions. These included:

- consultant teaching sessions on 'medication error of the month'
- using smart phones
- conducting a medication safety quiz twice yearly.

The uptake of mandatory training in medication safety in the last two years was:

- 71% of nursing staff
- records for uptake of mandatory training in medication safety for medical staff were not submitted to HIQA.

The uptake of mandatory training in INEWS and sepsis in the last two years was:

- 97% of nursing staff – above HSE target of 85%
- 61% of medical staff – above the minimum of 50% set by the HSE, but significantly below the HSE's target of 85%.

Other training was also provided for staff, such as

- antimicrobial stewardship to nursing and medical staff
- caring conservations and dementia champion training provided to all professions to enable effective communication with patients who have dementia
- delirium algorithm.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk and harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. Efforts were made by hospital management to provide mandatory training over the period of the COVID-19 pandemic. Notwithstanding this, staff attendance at and uptake of mandatory and essential training is an area that could be improved. 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.

Judgment: Substantially compliant

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

The hospital had a patient-safety incident management system in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The quality and safety department submitted an incident summary report to the Clinical Governance Committee and to performance meetings with the hospital and hospital group every month.

Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported — slips, trips and falls. The quality and safety manager provided feedback on patient-safety incidents to staff in clinical areas. Information relating to patient-safety incidents was also shared with staff at the daily huddle.

HIQA was satisfied that the hospital had systems and processes in place to manage and respond to patient-safety incidents in the four areas of known harm. The hospital were tracking and trending infection prevention and control patient-safety incidents and there was evidence that the Quality, Safety and Risk Committee had oversight of the management of these incidents.

Medication patient-safety incidents were reviewed by the chief pharmacist who categorised the incidents in terms of severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. All incidents categorised D§§§§§§§§§ and above were inputted onto the NIMS. The hospital were tracking and trending medication patient-safety incidents, and the Drugs and Therapeutics Committee had oversight of the management of these incidents. Information on medication patient-safety incidents was shared with nurse managers and relevant reports were shared on the hospital's electronic system.

In 2021, the hospital had 330 medication patient-safety incidents, the majority (278 incidents) were related to prescribing. Nearly a third (30%) of medication patient-safety incidents reported that year were related to high-risk medicines — anticoagulants and insulin.

There was evidence that, following medication related patient-safety incidents, the hospital had introduced a number of quality improvement initiatives to improve practices at the hospital. These initiatives included the facilitating of educational sessions on safe prescribing practices, medication safety and insulin use by the chair of the Drugs and Therapeutics Committee and the chief pharmacist.

The hospital did not track and trend patient-safety incidents in relation to the deteriorating patient or transitions of care.

---

§§§§§§§§§ Category D: an error occurred that reached the patient and required monitoring to confirm that it results in no harm to the patient and/or required intervention to preclude harm.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents as they relate to infection prevention and control and medication safety. Hospital management need to ensure that there is a system in place to ensure the tracking and trending of all patient-safety incidents in relation to the four areas of known harm, that quality improvement initiatives from patent-safety incident reviews are devised and implemented and that learning from patient-safety incidents is shared with staff to reduce the potential recurrence of the incident.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of St Columcille's Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. The hospital was found to be;

- compliant with two national standards (1.7, 6.4)
- substantially compliant with five national standards (1.6, 1.8, 2.8, 3.1, 3.3)
- partially compliant with four national standards (5.2, 5.8, 5.5 and 2.7).

Capacity and Capability

St Columcille's Hospital had formalised corporate and clinical governance arrangements in place although the corporate arrangements required strengthening. At the time of inspection, hospital's corporate governance arrangements were being reconfigured and rationalised. However, while acknowledging this, HIQA was not fully assured that hospital management had complete oversight of the quality and safety of services provided at the hospital and that the governance arrangements were fully effective in providing assurance on the quality and safety of healthcare service at the hospital. As identified in this report, the main governance committee — Quality and Safety Executive Committee — with responsibility for assuring hospital management on the quality and safety of healthcare services had not formally met. The Executive Management Team only met informally in February and formally in June 2022 (following HIQA's inspection). Furthermore, there were discrepancies in the reporting arrangements for the various sub-committees of the Quality and Safety Executive Committee to those outlined on the day of inspection and the organisational structure charts submitted to HIQA.

While the hospital had systematically monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services, HIQA was not fully assured that the hospital was systematic monitoring performance on a continual basis to identify and act on all opportunities to improve healthcare services.

The hospital had occupational and other support systems in place to support staff in the delivery of high-quality, safe healthcare. There was oversight of the uptake of mandatory and essential training. However, the training matrix system for maintaining training records centrally required improvement. Significant work was required to meet national targets for mandatory and essential training, especially in the area of infection prevention and control, across all professions and staff grades. 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. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital, which is consistent with the human rights-based approach to care promoted by HIQA. Patients who spoke with inspectors were positive about their experience of receiving care at the hospital and were very complimentary of staff. The hospital had implemented quality improvement initiatives to support and protect more vulnerable patients and to act on findings from the National Inpatient Experience Surveys.

The hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect people using the service. There was a lack of single rooms and en-suite bathroom facilities which increased the risk of cross infection. There were also challenges with accessing maintenance services, which were located offsite.

HIQA was satisfied that the hospital had systems in place to monitor and improve services. However, there was limited evidence that findings of audits, especially those in relation to medication safety, were actioned. Therefore, evidence of continual improvement of healthcare services was limited. In addition, the hospital was not auditing compliance with national guidance on clinical handover and the use of the ISBAR communication tool. Action plans from audit activity can provide a framework to implement recommendations from reports and ensure that identified changes are made to improve healthcare services.

HIQA was satisfied that, in relation to the four areas of known harm, the hospital had systems in place to identify, prevent or minimise unnecessary or potential risk and harm associated with the provision of care and support to people receiving care at the hospital. However, the hospital needs to monitor and ensure that any patient-safety incidents

related to the deteriorating patient or transitions of care are identified and managed. Quality improvement initiatives arising from reviews of patent-safety incidents should also be implemented and learning from patient-safety incidents shared with staff to reduce the possible recurrence of the incident.

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 implementing actions to enhance and strengthen the governance arrangements and physical environment at the hospital.

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

Compliance classifications

An assessment of compliance with the 11 national standards assessed during this inspection of St Colmcille's Hospital 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.

National Standard	Judgment
Capacity and Capability	
Theme 5: Leadership, Governance and Management	
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.	Partially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially compliant
Theme 6: Workforce	
Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare.	Compliant

National Standard	Judgment
Quality and Safety	

Theme 1: Person-Centred Care and Support	
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
National Standard	Judgment
Quality and Safety	
Theme 2: Effective Care and Support	
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	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for St Columcille's Hospital

Compliance Plan for St Columcille's Hospital OSV-0001101

Inspection ID: NSSBH_0007

Date of inspection: 22 June 2022

Introduction This document sets out a compliance plan for service providers to outline intended action(s) following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare*. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.
This compliance plan only relates to:

- standards that were deemed **partially or non-compliant** by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

It is the service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the standard(s) that the organisation had failed to meet.

Instructions for use

The service provider must complete this plan by:

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

The provider's compliance plan should be SMART in nature:

- Specific to the standard.
- Measurable so that it can monitor progress.
- Achievable.
- Realistic.
- Time bound.

Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems they have in place to ensure compliance with a particular standard, under which a partially or non-compliance judgment has been identified.
- Service providers should change their systems as necessary to bring them back into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent action and plans for improvement related to high risks already identified by HIQA during inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate action(s) to address the areas of risk previously identified by HIQA inspectors may result in continued monitoring, including further inspection activity. It may also result in further escalation to the relevant accountable person and or to the HSE, in line with HIQA policy.

Long-term and medium-term work to meet compliance with the standards

HIQA recognise that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the service plans to improve the level of compliance with the relevant national standard.

In addition to detailing longer term solutions, HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on short and medium term mitigation measures to manage risks and improve the level of compliance with standards should be included on the compliance plan
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance Plan

Compliance Plan Service Provider's Response

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

Specific

Executive Management Team (EMT)
- Review and revise TOR, members, and roles within the EMT committee
- EMT chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking
  - Reminder notifications of meetings

Quality Safety Executive Committee (QSE)
- Review and revise TOR, members, and roles within the QSE committee
- QSE chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking

- o Reminder notifications of meetings

Clinical Governance Committee
- Review and revise TOR, members, and roles within the CGC committee
- Clinical Governance chairperson to identify a committee secretary for responsibility of:
  - o Create a yearly schedule of meetings and submit to the QSR department
  - o Room booking
  - o Minute taking
  - o Reminder notifications of meetings

Quality, Patient Safety and Risk Department (QSR)

To achieve and deliver strong governance and to continually enhance accountability arrangements, the QSR department will utilise the ISBAR tool and introduce templates as a monitoring arrangement for identifying and acting on opportunities to continually improve quality and safety;

- Committees will need to identify key priorities that they plan to address. To be most effective, objectives are: achievable; realistic; time bound; explicit; measurable; within the scope/remit of their committee.
- Revise and implement a new reporting structure, with clear organogram dissemintated to all committees
- Engage and monitor committee activity and attendance compliance via the reporting structure above
- Implement a standard agenda template to include risk, audit and QIP's on a rolling basis
- Requirement for an annual committee report identifying actions, outcomes, and recommendations for the year ended and action plan for the subsequent year to come
- Develop and manage a committee activity database

Measurable

Monitor compliance of activity and attendance – by developing and managing a committee activity database to include the following:
- Annual schedule
- Quorum achieved
- TOR revised annually
- Committee Annual Report (incorporating the ISBAR tool) completed and submitted to QSR department at year end (template developed by QSR department - quantifiable goal, QIP, observable results desired and when, how to be achieved)

All committees will be required to complete the above templates and forward to the Quality, Safety & Risk department on an annual basis or otherwise recommended. Furthermore in order to facilitate members' diaries and promote maximum attendance, the frequency and dates of meetings for a full calendar year be identified and submitted to the QSR department and entered on to the committee activity database which will be monitored and reported to the Quality Safety Executive committee on a monthly basis.

Achievable

Each committee chair will receive communication via email with the introduction of the new reporting structure utilising the ISBAR tool

This should ensure safe delivery of quality care with clear roles, responsibilities, authority, and accountability for the quality and safety of services and will enable members at all levels to exercise their personal and professional responsibility for the quality and safety of services provided.

- **Identify**: gaps in governance as identified by HIQA - Revise all TOR to include organogram reporting structure
- **Situation:** Report on key priorities, achievements and PPPG's developed
- **Background:** Evaluation of progress made, difficulties and pressures faced**,** how they will overcome them
- **Assessment:** Audits, Risks identified and QIP's
- **Recommendation:** Action plan, outcomes, implementation of Observations / Recommendations

Realistic

- Committees are operationally accountable to the Hospital manager and should provide the reports to the Quality, Patient Safety and Risk department for monitoring and overview dissemination to the Quality and Safety Executive Committee
- The Quality, Safety and Risk Coordinators will be available to oversee, support, provide guidance and monitor the implementation of the ISBAR tool and will communicate to committee's on their roles, responsibilities and compliance of using the report templates.

Timely

- Committee Annual Report template (incorporating the ISBAR tool) will be disseminated to all committee chairs by the end of September 2022.
- All committee annual reports will be disseminated to the Quality Safety Executive committee by the end of January of the subsequent year.
- QSE feedback will be sent directly to the chair of the committee by the end of February of the new year 2023.

Timescale: **Quarter 1, 2023**

National Standard	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Outline how you are going to improve compliance with this 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

Infection, Prevention and Control

An overarching infection prevention and control programme in line with Standard 2.1 of the National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services 2017 will be developed for approval by the hospital's Infection Prevention and Control Committee at their first meeting in 2023 (February).

The programme will be based on:

- Best practice
- Evidence-based guidelines
- National Clinical Effectiveness Committee's National Clinical Guidelines
- Other national clinical guidelines
- National recommendations
- National Standards and relevant legislation

This will reflect the size, complexity and speciality services of the hospital.

Time-bound action plans will be developed to address recommendations made in all future infection prevention and control reports (including outbreak reports)

Nursing, medical and support staff workforce arrangements

Interim actions and measures to mitigate risks associated with non-compliance with standards (Training Matrix).

- The Human Resources Manager has sent a Hospital-wide email to outline the process of reporting on HSE Mandatory Training.
- The Human Resources Department are liaising with the Quality, Security and Risk Department:
  - Review the Training Matrix
  - Identify reporting process
  - Establish a database for Mandatory Training reporting
  - Developing a feedback reporting / communication tool to Service Managers and QSE
- The Human Resources Department will disseminate a Mandatory Training matrix to the Department / Line Managers which they will maintain.
- Mandatory Training will be downloaded from HSELanD and updated on the Mandatory Training Matrix.
- This database will be completed for trial by November 2022 and live by January 2023.

- This data will subsequently be reported monthly to QSE committee.

Quality Safety Executive Committee (QSE)
- Review and revise TOR, members, and roles within the QSE committee
- QSE chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking
  - Reminder notifications of meetings

Timescale: **Quarter 1, 2023**

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

Quality Safety Executive Committee (QSE)
- Review and revise TOR, members, and roles within the QSE committee
- QSE chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking
  - Reminder notifications of meetings.

Clinical Audit Committee (CAC)
- Review and revise TOR, members, and roles within the CAC committee
- Create an annual audit schedule
- RRC chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking
  - Reminder notifications of meetings.

Clinical Incident Review Group (CIRG)

- Review and revise TOR, members, and roles within the CIRG committee
- RRC chairperson to identify a committee secretary for responsibility of:
  - Create a yearly schedule of meetings and submit to the QSR department
  - Room booking
  - Minute taking
  - Reminder notifications of meetings.

NIMS reporting - KPI 30 days

Introduction of incident reporting process to include the following procedure:

- All incident reports to be submitted to QSR within 48 hours of incident
- QSR to input received incidents on to NIMS within five working days of receipt
- Quality, Safety & Risk Coordinator backfill has been recruited (awaiting start date)
- Incident Management Education and information sessions introduced monthly
- NIMS 30 day KPI communicated to all heads of departments
- Hospital to promote an incident reporting culture within a JUST culture to strengthen reporting so KPI is achieved.

Timescale: **Quarter 1, 2023**

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

The following have been identified as high risks and placed on the hospital risk register which has been escalated to the Ireland East Hospital Group:

1. Due to inadequate in-patient facilities there may be compromised patient care leading to serious harm and there is a potential risk of cross infection which may lead to harm to service users. also due to Covid 19 there will be delays in managing waiting lists which may lead to poorer patient outcomes and increasing waiting lists
2. Due to a lack of single rooms and en-suite facilities there is a potential risk of cross infection which may lead to harm to service users.
3. Due to a lack of a dedicated maintenance budget for SCH there is no routine maintenance being completed which could jeopardise integrity of the infrastructure leading to patient and staff safety concerns.
4. Due to the move of the maintenance department off site there is a risk of delay in essential/urgent maintenance being completed in a timely manner. This may jeopardise the services of SCH, an acute hospital (24/7 services) and the safety of patients and staff.

No.	Risk Criteria	Risk Title & Description	Primary Risk Category	Date Entered	Existing Controls	L	I	Initial	Review Date	Risk Status	Actions Required	Action Owner	Action Due Date	Action Completion Date	Action Status	Action Update	L	I	Revised Risk
1	Operational	Due to inadequate in-patient facilities there may be compromised patient care leading to serious harm and there is a potential risk of cross infection which may lead to harm to service users. also due to Covid 19 there will be delays in managing waiting lists which may lead to poorer patient outcomes and	Harm to a Person	8-Mar-19	The infection prevention and control team work closely with bed management and the Co-Horting of patients with the same infection utilising 2 & 4 bedded rooms. Scheduled care team working on waiting lists with clinicians. Departments are risk assessing their space in accordance to HSE guidance.	3	5	15	******	Open	Bid to minor capital funding for HCAI improvements to be completed for 2019	Hilary Flynn	26-Jun-20	23-Jul-20	Complete	part of 'living with covid' funding request	3	5	15
											Business case for new hospital block to be developed	Hilary Flynn	26-Jun-20	23-Jul-20	Complete	funding to improve bathrooms on Lourdes MOU and St Anne's Wards part of 'living with covid' funding request			
											Development control plan required	Hilary Flynn	26-Jun-20	1-Jun-21	Complete	Escalated to IEHG			
2	Operational	Due to a lack of single rooms and ensuite facilities there is a potential risk of cross infection which may lead to harm to service users.	Harm to a Person	8-Mar-19	The infection prevention and control team work closely with bed management and the ward teams. Co-horting of patients with the same infection utilising 2 and 4 bedded rooms. On 2017, 2018, 2019 & 2020 risk register	5	3	15	******	Open	Business case for new hospital block to be developed.	Hilary Flynn	26-Jun-20	23-Jul-20	Complete	part of 'living with covid' funding request	5	3	15
											A/W decision for new hospital block	Ger Sheridan	1-Jun-22		On-going	Business case submitted			
											Bid to minor capital funding for HCAI improvements to be completed for	Hilary Flynn	26-Jun-20	23-Jul-20	Complete	part of 'living with covid' funding request			
11	Operational	Due to a lack of a dedicated maintenance budget for SCH there is no routine maintenance being completed which could jeopardise intregrity of the infrastructure leading to patient and staff safety concerns.	Harm to a Person	18-Jul-19	Staff report all issues by email. Maintenance Manager monitors all requests and prioritises. Department Managers complete a risk assessment for any works that will require funding	4	4	16	******	Open	Maintenance budget for SCH required	Hilary Flynn	1-Jun-22		On-going	Requirement report escalated to IEHG. Reviewed 26/03/2020 no change 22/07/20 await feedback from G Hegarty Head of Estates	4	4	16
													1-Jun-22						
													1-Jun-22						
		Due to the move of the maintenance department off site there is a risk of delay in essential/urgent maintenance being completed in a timely manner. This may jeopardise the services of SCH, an acute hospital (24/7 services) and the safety of patients and staff.	Harm to a Person		Maintenance Manager escalates any urgent issues to HSE estates and the General Manager. Concerns discussed with HSE estates and IEHG. Staff report all issues by email. Oncall service for out of hours facilities emergencies available						Concerns escalated to IEHG & HSE estates	Hilary Flynn	30-Apr-19	30-Apr-19	Complete	Requirements for on site maintenance escalated to IEHG	4	5	20
													30-Apr-19	30-Apr-19	Complete				
													30-Apr-19	30-Apr-19	Complete				
													30-Apr-19	30-Apr-19	Complete				

The hospital infection prevention and control policies are designed to mitigate the risk of transmission of infection particularly in light of the small number of single rooms.

Where sufficient single rooms are not available for the placement of patients with transmissible infections, cohorting is utilised. Relevant hospital IPC policies include

- Transmission based precautions
- Management of patients with infectious disease
- Influx of infectious patients
- Management of patients with MRSA
- Management of patients with VRE
- Management of patients with CPE
- Management of patients with C difficile
- Management of patients with COVID 19.

To reduce cross infection the Discharge Cleaning team are notified when a patient is discharged from isolation and follow procedures outlined in the following polices:

- Cleaning after discharge of a patient in isolation policy
- Cleaning after discharge of a patient.

Timescale: **In Place**

Service Provider Use	
Service Provider	St. Columcille's Hospital
CEO/ General Manager/ Master Signature	
Date	07.09.2022

HIQA Official Use	
Date Reviewed	
Authorised Person(s)	
Signature	