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 Michael's Hospital
Address of healthcare service:	George's Street Lower Dún Laoghaire Co. Dublin A96 P902
Type of inspection:	Announced
Date of inspection:	09 and 10 August 2022
Healthcare Service ID:	OSV-0001100
Fieldwork ID:	NSSBH_0011

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

St Michael's Hospital is a Model 2[*] public voluntary hospital. It is a member of and is managed by the Ireland East Hospital Group (IEHG)[†] on behalf of the Health Service Executive (HSE) through a service level agreement. St Michael's Hospital along with St Vincent's University Hospital and St Vincent's Private Hospital is also a member of the St Vincent's Healthcare Group. Services provided by the hospital include:

- acute medical inpatient services
- elective surgery
- emergency care
- high-dependency care
- diagnostic services
- outpatient care.

The hospital is also a referral centre for patients experiencing complications of the pelvic floor.[‡] Patients are assessed by a multidisciplinary team in the Pelvic Floor Centre and complications managed accordingly.

The following information outlines some additional data on the hospital.

Model of Hospital	2
Number of beds	94 inpatient beds 8 day case beds
Number of inpatients on day one of inspection	79

[*] A Model 2 hospital provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, 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, the Royal Victoria Eye and Ear Hospital, the National Maternity Hospital, St Columcille's Hospital Loughlinstown, St Michael's Hospital, Dún-Laoghaire, the Midland Regional Hospital Mullingar, St Luke's General Hospital, Kilkenny, Wexford General Hospital, Wexford and Our Lady's Hospital, Navan. The hospital groups academic partner is University College Dublin (UCD).

[‡] The pelvic floor is a layer of muscles that runs from the pubic bone to the lower spine.

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 an announced inspection at St Michael's Hospital to assess compliance with a number of standards from 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 and St Vincent's Healthcare 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 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.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

[§] *An* inspector 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*.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person centred and safe. It also includes information about the environment where people receive care.

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 August 2022 10 August 2022	09.00 to 17.00hrs 09.00 to 13.00hrs	Danielle Bracken	Lead
		Denise Lawler	Support
		Dolores Dempsey-Ryan	Support

Background to this inspection

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

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

The inspection team visited three clinical areas:

- Emergency department
- Male Floor (general medical ward)
- St Columba's Ward (mixed-medical and surgical ward).

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

- Representatives of the hospital's Executive Council:
- Chief Executive Officer
- Director of Nursing
- Clinical Director, St Vincent's Healthcare Group
- Quality and Risk Manager, St Michael's Hospital
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Assistant Human Resource Director and Medical Manpower lead, St Michael's Hospital
- A representative from each of the following hospital committees:
  - Infection prevention and control

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

- Drugs and Therapeutics
- Irish National Early Warning System (INEWS) and Sepsis
- Delayed Discharge and Bed Management.

Acknowledgements

HIQA would like to acknowledge the cooperation 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 emergency department told inspectors and what inspectors observed in the department

On the day of inspection, inspectors visited the emergency department, which operates 365 days per year, from 8.00am to 8.00pm. Attendees to the emergency department presented by ambulance, were referred directly by a general practitioner (GP) or self-referred. The department provides differentiated medical care for people over the age of 14 years but the hospital has a major trauma bypass protocol[§§] in place whereby patients with trauma injuries, are taken to St Vincent's University Hospital.

Furthermore, attendees that present to the hospital's emergency department either by ambulance or referral (GP or self-referral) with an urgent illness or injuries outside the scope of St Michael's Hospital are assessed, their condition stabilised and transferred to St Vincent's University Hospital for time-critical specialist care and treatment.

In 2020, the overall attendance rate at the hospital's emergency department was 13,029, which equated to an average attendance rate of 1,100 each month or 36 attendances every day. Documentation submitted to HIQA suggests that when compared to 2020, the attendance rate to the hospital's emergency department for a 12-month time frame (July 2021 - July 2022) was stable, with monthly attendances ranging between 1,234 and 1,567, equating to a daily attendance rate of between 40 to 59 people.

The conversion rate (rate of admission of patients to an inpatient ward) for the emergency department over a 12-month time frame (July 2021 - July 2022) was 1%.

The emergency department has a total planned capacity for 12 service users comprising:

- A triage room with one chair and one trolley bay.
- Three single cubicles for the treatment of patients requiring isolation facilities.

[§§] Major trauma bypass protocol is used for major trauma and or multiple serious injuries that could result in significant physical harm or death. These may include serious head, chest, abdominal and skeletal injuries sustained as a result of an accident, sports injury or violent act.

- Resuscitation area comprising two bays for the treatment of patients categorised as major.
- One isolation room without en-suite bathroom facilities used for infection streaming.
- A multi-occupancy area with three treatment bays used as a rapid assessment area.
- An additional single room that was located adjacent from the emergency department where patients prioritised as low-risk were accommodated. There were two toilets in the emergency department for patients' use.

The waiting area in the emergency department comprised eight chairs and inspectors observed one metre physical distancing, in line with national guidance.

The main emergency department comprised three isolation cubicles and one isolation room, a multi-occupancy area and a resuscitation area. The single cubicles or isolation room did not have en-suite bathroom facilities and there was no neutral or negative pressure rooms*** in the department. An additional room located adjacent to the emergency department could also be used as an isolation room, if required. However, because of its distance from the emergency department, only patients categorised as low-risk were accommodated in this room.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment (PPE), in line with current public health guidelines.

Inspectors observed staff actively engaging with patients in a respectful and kind way. Staff took the time to talk and listen to patients and encouraged patients to let them know if they felt unwell while waiting to be reviewed by nursing and medical staff.

On the day of inspection, at 12.00pm, the emergency department was busy, relative to its intended capacity and function. Twelve patients were receiving care and treatment in the department and an additional seven patients were in the waiting area, waiting to be reviewed by the emergency medical team. The majority of patients had self-presented to the department and seven (37%) patients were aged 75 years or older.

Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received in the emergency department on the day of inspection. Staff were described as '*lovely, pleasant, excellent*' and '*they make you feel comfortable*' and the emergency department as '*clean and spotless*'.

*** Negative pressure rooms refer to isolation rooms where the air pressure inside the room is lower than the air pressure outside the room. Therefore, when the room door is opened, potentially contaminated air or dangerous and infective particles from inside the room will not flow outside to non-contaminated areas.

Inspectors observed staff promoting and protecting patients' privacy and dignity. For example, curtains or blinds were pulled to ensure privacy and dignity when patients were being clinically assessed and treatment administered. Patients also spoke of how staff attempted to protect and promote their privacy and dignity. Their experiences were consistent with the hospital's overall findings from the 2021 National Inpatient Experience Survey.[†††]

Patients who spoke with inspectors did not know how to make a complaint, two patients recounted how they would speak with the receptionist if they wanted to make a complaint. This is something hospital management could improve following HIQA's inspection.

HIQA was satisfied that the hospital has systems and processes in place to enable patients to provide feedback on their experiences of receiving care in the hospital's emergency department. Inspectors observed a patient satisfaction box located on a wall in the department where patients could put completed patient experience surveys or comment cards. Completed surveys and comment cards were then collected, reviewed and results collated by nursing management. Thereafter, a report was compiled by the administration team in the nursing division and shared with staff in the department and with hospital management. Inspectors also observed a patient's information board in the waiting room, where relevant patient information leaflets were displayed.

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

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

The Male Floor was a large 35-bedded ward and spanned a number of corridors consisting of six four-bedded multi-occupancy rooms, a five-bedded multi-occupancy room and six single rooms. The single rooms did not have en-suite bathroom facilities, however, the ward had adequate toilet and bathroom facilities for patients. The ward was a mixed ward, accommodating male and female patients, the majority were general medical patients. At the time of inspection, all 35 beds were occupied.

[†††] The National Care Experience Programme, was a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/.

St Columba's Ward was an 18-bedded ward comprising 14 single rooms, one of which had en-suite bathroom facilities and a four-bedded multi-occupancy room. This multi-occupancy room had its own toilet and shower. The ward had adequate toilet and bathroom facilities. The ward was a mixed ward, accommodating male and female medical and surgical patients.

Inspectors observed effective communication between staff and patients. Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to patients. This was validated by patients who described staff in the clinical areas visited as '*lovely*', '*very pleasant*', '*very kind and jolly*'. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care.

Staff were focused on ensuring patients' needs were promptly responded to. For example, inspectors observed staff responding in a timely way to patient call bells and promptly assisting patients' care needs. One patient described how the service might benefit from more assistance at night time, but in general patients recounted how their needs were met quickly, telling inspectors '*they [staff] do an amazing job*', '*just ring the bell if you want a nurse or assistance and they come*' and '*you have every facility here*', '*anything you want, they'll [staff] fix it for you*'.

Inspectors also observed a patient satisfaction box located on a wall in each of the two clinical areas visited, where patients could leave completed patient experience surveys or comment cards. Not all patients were clear on the process of making a complaint but patients felt that they could talk to staff if they had any concerns.

Patients' experiences recounted on the day of inspection, were consistent with the hospital's overall findings from the 2021 National Inpatient Experience Survey, where 91% of patients who completed the survey had a 'good' or 'very good' overall experience in the hospital, which was above the national average of 83%.

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

Capacity and Capability Dimension

Inspection findings from the emergency department related to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. Key inspection findings leading to these judgments are described in the following sections.

In addition, inspection findings from the wider hospital and clinical areas visited related 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. 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 with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Two organisational charts setting out the hospital's reporting structures were submitted to HIQA, as part of the pre-on-site documentation, data and information request. These charts detailed the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability relationship to the St Vincent's Healthcare Group was also clearly outlined on the organisational chart. However, the accountability and reporting relationships to the Ireland East Hospital Group was less apparent on the organisational charts submitted to HIQA.

The hospital was governed and managed by the Chief Executive Officer who reported to the St Vincent's Healthcare Group Director of Operations, who in turn reported to the St Vincent's Healthcare Group Board of Directors. The hospital's Chief Executive Officer also reported to the Chief Operating Officer of the Ireland East Hospital Group, who in turn reported to the Chief Executive Officer of the Ireland East Hospital Group.

The Clinical Director of St Vincent's Healthcare Group provided clinical oversight and leadership at St Michael's Hospital. The Director of Nursing was responsible for the organisation and management of nursing services at the hospital. The Director of Nursing was a member of the hospital's senior management team and reported to the hospital's Chief Executive Officer, and had a close working relationship with the Ireland East Hospital Group's Chief Director of Nursing and Midwifery.

Executive Council Committee

St Michael's Hospital Executive Council was the main governance structure at the hospital. Chaired by the hospital's chief executive officer, the council met every month and had collective responsibility for ensuring that high-quality safe healthcare was delivered at the hospital. The council's membership comprised of the senior management team (chief executive officer, director of nursing, director of human resources, the finance manager and the director of operations of the St Vincent's Healthcare Group), two consultant surgeons, two consultant physicians and the Director of Strategy for St Vincent's Healthcare Group. Minutes of council meetings, submitted to HIQA, showed that the meetings followed a structured format, were action orientated and progress in implementing actions was monitored from meeting to meeting.

Patient Safety Committee

The Patient Safety 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, chaired by the hospital's chief executive officer, met every three months and had appropriate membership, however HIQA noted how attendance at meetings by consultants could be improved.

The Patient Safety Committee reviewed and considered reports, both verbal and written from the various sub-committees that reported into it, including the Infection Prevention and Control, Drugs and Therapeutics (including medication safety) Committee and Delayed Discharge Committee. In 2022, the existing Early Warning System (EWS) and Sepsis committees were combined to form the Irish National Early Warning System (INEWS) and Sepsis committee. The INEWS and Sepsis committee did not have a formal reporting relationship to the Patient Safety Committee but did provide updates to this committee every three months. The terms of reference of the Patient Safety Committee required updating to accurately reflect the reporting arrangements for the various sub-committees that reported in to it.

In addition to providing oversight of performance of committees that reported in to it, the Patient Safety Committee also provided updates on the hospital's risk register, reported on patient safety incidents, complaints management, feedback on patient experiences, and progress on implementation of patient safety quality improvements to the hospital's Executive Council.

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 comprised a number of sub-committees that reported into it, these included the Decontamination Committee, the Surgical Site Surveillance Committee and the Environmental Monitoring Committee. 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.

The Infection Prevention and Control Committee was operationally accountable and submitted a report to the Patient Safety Committee every three months and reported annually in an annual infection prevention and control report. The annual report of 2021 submitted to HIQA provided information on the hospital's performance and compliance with relevant infection prevention and control key performance indicators and audit activity. The committee also reported on the measures implemented to manage and mitigate the risks associated with COVID-19. HIQA was satisfied with the governance and oversight of infection prevention and control practices, and infection outbreaks at hospital and hospital group levels.

Drugs and Therapeutics Committee

The hospital had a Drugs and Therapeutics Committee with assigned responsibility for the governance and oversight of medication safety practices at the hospital. The committee was chaired by a consultant and met four times a year, in line with its terms of reference. Membership of the committee included a member from the senior management team, chief pharmacist, a non-hospital consultant hospital doctor representative, director of nursing and quality and risk manager. The committee was operationally accountable and reported to the Patient Safety Committee every three months. The terms of reference for the committee submitted to HIQA was dated 2018.

The Drugs and Therapeutics Committee developed an annual plan that set out the medication safety related objectives to be achieved each year at the hospital. The objectives for 2022 included a focus on medication incident reporting, staff education (topics included high-risk medications such as insulins, anticoagulants and opioids and regular pharmacy newsletters were distributed), patient education (pharmacist referral system in place), relevant auditing activities and monitoring performance with key performance indicators, which included antimicrobial prescribing. Information submitted to HIQA regarding the progress in implementing the medication safety objectives for 2021, showed that the majority of these objective were a work in progress.

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.

Irish National Early Warning System (INEWS) and Sepsis Committee

The hospital did not have a deteriorating patient improvement programme, but the INEWS and Sepsis Committee had oversight of the implementation of national INEWS and sepsis guidelines at the hospital. This committee provided an update to the Patient Safety Committee every three months. The committee was chaired by a consultant physician and membership included the chief pharmacist, a consultant representative from the emergency department and quality and risk manager. At the time of inspection, the hospital were piloting the INEWS version 2 observation chart in one clinical area. The intention was to roll out the use of INEWS version 2 hospital wide before the end of this year.

Delayed Discharge Committee

The hospital had a multidisciplinary Delayed Discharge Committee chaired by the principal social worker who was operationally accountable and reported to the chief executive officer. Membership of the committee included the hospital's chief executive officer, senior social worker, director of nursing and assistant director of nursing. The committee met fortnightly and reviewed information on delayed discharges and measures implemented to enable the timely and safe discharge of patients.

Bed Management Committee

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 hospital's Executive Council every month and was reviewed at the performance meetings between the hospital and hospital group. Representatives from St Michael's Hospital attended monthly bed management meetings led by St Vincent's University Hospital. The hospital presented collated data on activity at the hospital's emergency department, the number of delayed discharges, inpatient bed capacity and patient transfers at meetings of St Vincent's University Hospital's bed management committee.

It was clear to HIQA that the hospital had formalised corporate and clinical governance arrangements in place. The organisational charts required updating to accurately reflect the reporting arrangements to the Ireland East Hospital Group. It was clear to inspectors that the Patient Safety Committee had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at the hospital. However, the terms of reference for this committee and terms of reference of the sub-committees reporting into it required updating.

Judgment: Substantially Compliant

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

Findings relating to the emergency department

St Vincent's Healthcare Group implemented a hub-and-spoke model[‡‡‡] for adult emergency services whereby the care of critically ill patients was centralised at St Vincent's University Hospital and supported by St Michael's Hospital and other hospitals in both St Vincent's Healthcare Group and Ireland East Hospital Group.

On the day of inspection, there was evidence of good collaboration and integration with the emergency department at St Vincent's University Hospital. Medical staff in St Michael's Hospital had direct access, via a video conference platform, to medical staff in the emergency department at St Vincent's University Hospital emergency department. This is a good example of hospitals across different sites working collaboratively to provide safe

‡‡‡ The hub-and-spoke is a model where service delivery is arranged in a network configuration consisting of an anchor establishment (hub) which offers a full array of services, complemented by secondary establishments (spokes) which offer more limited service, routing patients needing more intensive and critical services to the hub for treatment and care.

and effective patient care, and to ensure that patients are cared for in the most appropriate site.

HIQA was satisfied that the hospital had defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and management of unscheduled and emergency care. There was evidence of strong clinical and nursing leadership in the emergency department. Operational governance and oversight of day-to-day workings of the department was the responsibility of the on-site consultant in emergency medicine supported by non-consultant hospital doctors. Outside core working hours,[§§§] medical oversight of the emergency department was provided by an on-call consultant in emergency medicine in St Vincent's University Hospital. At hospital group level, two governance structures — Ireland East Hospital Group: Unscheduled Care Lead Governance Group and the Emergency Department Clinical Operations Group — had oversight of operational processes in the hospital's emergency department including those that impacted patient flow and capacity.

On the day of inspection, the emergency department appeared to be functioning well. On arrival to the emergency department, all attendees were promptly assessed for signs and symptoms for COVID-19 and streamed to the most appropriate care pathway, in line with national guidance. Self-presenting attendees checked in at reception and waited to be called for triage.

At 12.00pm, there were 19 patients in the emergency department — seven patients were in the waiting area and 12 patients were in the main emergency department receiving care and treatment. All patients had been triaged and prioritised in line with the Manchester Triage System.[****] The average waiting time from registration to triage was five minutes.

The majority (15) of patients were prioritised as yellow category (priority level 3, aim for medical review within 30 minutes, less urgent cases). Staff could view the status of all patients in the department — their prioritisation category levels and waiting times — via the hospital's electronic operating system. Staff in St Vincent's University Hospital also had access to the electronic operating system and could view the same information.

On the day of inspection, patient's waiting times from triage to medical review ranged from 4 minutes to 14 minutes. Two patients were waiting for 3 hours and 10 minutes, both had been medically reviewed, treatment had being commenced and they were awaiting follow-up medical review. The hospital were compliant with the HSE's key performance indicators for patient experience times[††††] for all patients in the department

[§§§] Core working hours is consider Monday to Friday 9.00am to 5.00pm.
[****] Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.
[††††] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

at 12.00pm. At that time, no patients were boarding in the department while awaiting an inpatient bed.

The hospital had systems and processes in place that were functioning as they should to support continuous and effective patient flow through the emergency department. These included:

- a pathway of care for patients with suspected deep vein thrombosis,[‡‡‡‡] which was in line with St Vincent's University Hospital deep vein thrombosis guidelines
- a pathway for surgical (orthopaedics) patients, whereby these patients were assessed, stabilised and transferred to St Vincent's University Hospital's emergency department
- a multidisciplinary meeting was held three times a week to discuss discharge and transfer of patients
- the implementation of a frail elderly programme with a focus on coordinating discharge for these patients
- supporting and improving integrated discharge planning from the hospital to the community and primary care area, with oversight by the Ireland East Hospital Group and Community Healthcare East Winter Action team.

The hospital had limited access to diagnostic services, specifically computerised tomography (CT) scans.[§§§§] The hospital had implemented a workaround, whereby, patients needing a CT scan were transferred to St Vincent's University Hospital. Therefore, depending on the findings of the scan, patients were either transferred back to St Michael's Hospital for further care and treatment or were admitted to St Vincent's University Hospital. If needed, a non-consultant doctor at registrar grade from St Michael's Hospital would accompany patients to St Vincent's University Hospital for a CT scan.

The safe interdepartmental and external transfer of patients within and outside the hospital was supported by a formalised up-to-date policy that used the Identify, Situation, Background, Assessment, Recommendation (ISBAR)[*****] format and a number of templates designed to facilitate the effective sharing of key patient information.

Overall, it was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department and that operationally, the department was functioning well. Improving access to diagnostic

‡‡‡‡ Deep vein thrombosis occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs.
§§§§ Computerised tomography (CT) scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside the body.
***** Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

services at the hospital will ensure the timely intervention and commencement of treatment for people who attend the emergency department.

Findings relating to the wider hospital and other clinical areas

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

Infection, prevention and control

The hospital had an infection prevention and control team comprising:

- 0.3 whole-time equivalent (WTE)[†††††] consultant microbiologist (on site at St Michael's Hospital one day per week)
- 1.0 WTE clinical nurse manager grade 3
- 1.5 WTE clinical nurse specialist or clinical nurse manager grade 2.

The hospital had 24/7 access to a consultant microbiologist and surveillance scientists 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 infection prevention and control plan that set out objectives to be achieved in relation to infection prevention and control in 2022. These objectives focused on infection prevention and control staff education, relevant audit activity, environmental hygiene monitoring, surveillance monitoring (including surgical site infections), liaison services, decontamination activity, antimicrobial prescribing and infection prevention and control policy development.

The hospital had an antimicrobial stewardship team who were responsible for implementing the hospital's antimicrobial stewardship programme.[******] The team comprised a consultant microbiologist with sessional commitments at both St Michael's Hospital and St Vincent's University Hospital, who were supported by a clinical pharmacy service. The hospital did not have an identified pharmacist with a specific remit for antimicrobial stewardship, this role was shared by all clinical pharmacists. The

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

[‡‡‡‡‡] 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.

antimicrobial stewardship team was operationally accountable and reported to two committees — Drugs and Therapeutics Committee and Infection Prevention and Control Committee.

Medication safety

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

- four WTE pharmacists, which included the chief pharmacist and three clinical pharmacists
- three WTE pharmacy technicians.

Deteriorating patient

The hospital had a dedicated clinical nurse manager grade 2 who was assigned responsibility for coordinating INEWS and sepsis activity at the hospital. The hospital's INEWS and Sepsis Committee had oversight of the implementation of national INEWS and sepsis guidelines at the hospital.

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 patient flow coordinator had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital. Inpatient bed capacity, patient discharge and transfers into and out of the hospital were discussed at the 7.30am daily huddles. A daily site report detailing the hospital's unscheduled care activity was submitted to the Ireland East Hospital Group every morning. Weekly meetings were also held on all inpatient seven-day clinical areas to discuss and identify issues with patient admission and discharge, and support effective patient flow through the hospital.

The hospital also participated in scheduled care meetings held at Ireland East Hospital Group level, and unscheduled care meetings held with the Ireland East Hospital Group and local Community Health Organisation 6 (CHO6) services.[‡‡‡‡‡‡]

Nursing, medical and support staff workforce arrangements

An effectively managed healthcare service ensures that there are sufficient staff available

[††††††] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[‡‡‡‡‡‡] Community Health Organisation – services offering healthcare outside of acute hospitals, such as primary care, social care mental health and other health and wellbeing services.

at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

The hospital's Director of Human Resources was operationally accountable and reported to St Michael's Hospital chief executive officer and also reported on performance to the Director of Human Resources in the Ireland East Hospital Group every month.

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) in June 2022 was 410 WTE.

The hospital's approved complement of nursing staffing was 180 WTE. At the time of inspection, 171.5 WTE nursing positions were filled, which represented a variance of 8.5 WTE (5%) between the approved and actual nursing complement. Hospital management told inspectors that they were actively recruiting nursing staff to address the variance. In the interim, existing nursing staff from the hospital worked extra shifts to fill shortfalls in the nursing staff roster and agency staff were used occasionally. The hospital's total approved posts for healthcare assistants was 37 WTE and all healthcare assistants posts were filled at the time of HIQA's inspection.

The hospital had an approved complement of seven consultants. All consultants were on the specialist register with the Irish Medical Council and all held joint employment contracts with St Vincent's University Hospital. The consultant staff were supported by 32 non-consultant hospital doctors at registrar, senior house officer and intern grade – 14 registrars (three of which were specialist registrars), 14 senior house officers and four interns. On the day of inspection, two non-consultant hospital doctor's positions were unfilled — one registrar grade and one senior house officer grade. Hospital management were actively recruiting to fill these positions.

The hospital's reported absenteeism rate for 2021 was 5.2%, which was above the HSE target of 3.5% for that year. Supports in place to address absenteeism is discussed in more detail under national standard 6.4.

Staff training and education

Nursing and healthcare assistant staff attendance at mandatory and essential training was monitored at clinical area level by clinical nurse managers. Essential and mandatory training attendance by non-consultant doctors was recorded on the National Employment Record (NER) system.[§§§§§§] While the attendance and uptake of mandatory and essential training was being recorded at local clinical area level, a greater level of oversight of staff uptake of mandatory and essential training was needed by the senior management team.

[§§§§§§] National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

HIQA was satisfied that work in this regard was underway at the time of inspection. Staff uptake of mandatory and essential training is discussed in greater detail under national standard 3.1.

In summary, HIQA was assured that the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm in the emergency department, wider hospital and clinical areas visited on the day of inspection. However, a greater level of oversight of staff uptake of mandatory and essential training was needed at a senior management team level. Hospital management were actively working to recruit medical and nursing staff to fill vacant posts and this is needed to reduce the reliance on staff working extra shifts to fill absences on nursing rosters.

Judgment: Substantially Compliant

Inspection findings relating to the Emergency Department

The following section outlines findings from the inspection as they related to the Emergency Department. Findings and judgments are presented under three (6.1, 1.6 and 3.1) of the four national standards from the *National Standards for Safer Better Healthcare* relating to the themes of workforce; person-centred care and support; and safe care and support.

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

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. A senior clinical decision-maker[*******] at consultant level was on site in the hospital's emergency department each day when the department was operational. The emergency department had one WTE consultant in emergency medicine who was responsible for the day-to-day functioning of the department. The consultant was operationally accountable and reported to the hospital's chief executive officer and had a professional reporting relationship with the Clinical Director of St Vincent's Healthcare Group. The consultant had weekly sessional commitments in the emergency department at St Vincent's University Hospital. Consultants in emergency medicine from St Vincent's University Hospital provided consultant cover in the emergency department at St Michael's Hospital when required.

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

The consultant in emergency medicine at St Michael's Hospital was supported by non-consultant hospital doctors at registrar grade. The hospital was not an approved training site for non-consultant doctors on the basic training scheme or higher specialist training scheme in emergency medicine. The hospital had approval for six WTE non-consultant hospital doctors. On the day of inspection, four (66%) of these positions were filled and two (34%) positions were unfilled. These two positions were filled by non-consultant hospital doctors on temporary or locum contracts. The hospital had one specialist registrar on rotation from St Vincent's University Hospital. Hospital management discussed the challenges and active measures they were taking to improve the recruitment of non-consultant hospital doctors to the hospital's emergency department.

The emergency department had an approved complement of 15.75 WTE nursing staff, with 13.75 WTE (87%) nursing positions filled on day of inspection. The variance between the approved and actual nurse staff complement was two WTE (13%). Hospital management were actively recruiting to fill nursing vacancies. The department had its full complement (six WTE) of nursing staff rostered on duty on the day of inspection, this included two nurses deployed to the department to cover short-term absenteeism. A clinical nurse manager grade 3 was rostered on duty on the day of inspection and had overall nursing responsibility for the department. Nursing staff were supported by a 0.5 WTE healthcare assistant who was available four days a week.

Staff in the emergency department had access to an infection prevention and control nurse who visited the department every day. Staff also had access to clinical pharmacists for advice on antimicrobials and an antimicrobial microbiologist from St Vincent's University Hospital. A pharmacy technician attended to the emergency department's medication stock control every day. Security staff were on duty in the emergency department 8.00am to 8.00pm.

Uptake of mandatory and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The emergency department had a system in place to monitor and record staff attendance at mandatory and essential training, and this was overseen by the clinical nurse manager grade 3.

HIQA found that staff attendance and uptake at mandatory and essential training could be improved, especially training on sepsis and Manchester Triage System.

Training records for nursing staff showed that:

- 95% of nurses were compliant with hand hygiene practices - above the HSE's target of 90%
- all nurses were up to date in basic life support training
- all nurses were up to date with training on the national early warning system

- 68% of nurses were up to date in training on sepsis
- 83% of nurses were up to date in training on the Manchester Triage System.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. This was despite the fact that there was a variance of two WTE on the approved complement of non-consultant hospital doctors and two WTE on the approved complement of nursing staff in the emergency department. Attendance at and uptake of mandatory and essential training for nursing staff in the emergency department could be improved, especially training on sepsis and the Manchester Triage System.

It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement efforts following HIQA's inspection. HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with mandatory training.

Judgment: Substantially Compliant

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

People have a right to expect that their dignity, privacy and confidentiality would be respected and promoted when attending for emergency care.[††††††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department, and to be responsive to their individual needs. Staff provided assistance and information to patients in a kind and caring manner.

Patient's privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles and multi-occupancy rooms. This was validated by

[††††††††] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services patients who spoke with inspectors and was consistent with the hospital's overall findings from the 2021 National Inpatient Experience Survey, where 75% of patients who completed the survey considered their overall experience of the hospital as very good (national score was 54%). Also in that year, the hospital achieved higher than the national average score in survey questions related to the emergency department. More specifically, with regard to:

- communication with doctors and nurses in the emergency department, the hospital scored 8.6 (national average - 8.0)
- privacy when being examined or treated in the emergency department, the hospital scored 9.0 (national average - 8.3)
- being treated with respect and dignity in the emergency department, the hospital scored 9.6 (national average - 8.8).

The majority of patients who completed the hospital's patient satisfaction survey for April to June 2022 were also very positive about the care received in the emergency department.

Staff in the emergency department were observed actively engaging and communicating with patients in a respectful, kind and sensitive way. To support effective communication and identification of people providing care, staff wore a badge with '*Hello My Name is...*'

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 in the emergency department and this is consistent with the human rights-based approach to care supported and promoted by HIQA.

Judgment: Compliant

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

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the emergency department in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times.

Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at meetings of relevant governance and oversight committees — Executive Management Council and performance meetings with the St Vincent's Healthcare Group and Ireland East Hospital Group.

Performance data collected on the day of HIQA's inspection showed that at 12.00pm the hospital was compliant with all of the national key performance indicators for the emergency department. However, performance data over a 12-month time frame submitted to HIQA showed that 1% of patients who attended the department between July 2021 and July 2022 waited more than six hours after registration to be discharged or admitted to an inpatient bed.

Findings from the 2021 National Inpatient Experience Survey showed that the:

- national average for people waiting less than 6 hours in the emergency department before being admitted to an inpatient bed was 29.1%. The rate for the emergency department at St Michael's Hospital was 59.7%.
- national average for people waiting 6-12 hours in the emergency department before being admitted to an inpatient bed was 34.6%. The rate for the emergency department at St Michael's Hospital was 35.8%.
- national average for people waiting 12-24 hours in the emergency department before being admitted to an inpatient bed was 22.7%. The rate for the emergency department at St Michael's Hospital was 4.5%.

Hospital management had developed a quality improvement plan to address findings from the National Inpatient Experience Survey related to communication and information provision but not related to patient experience time in the emergency department.

Risk management

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at department level with oversight of the process assigned to the clinical nurse manager grade three. Completed risk assessment forms for the department were sent to the hospital's quality and risk manager who provided feedback on the effectiveness of the controls and actions applied to manage the risk, to the clinical nurse manager grade three.

Risks related to the emergency department were recorded on the hospital's corporate risk register. The hospital's executive council had oversight of the risks recorded on this register. The effectiveness of actions and controls implemented to manage and mitigate risks were reviewed and updated at meetings every three months of the Patient Safety Committee. Risk not managed at hospital level were escalated to the St Vincent's Healthcare Group and Ireland East Hospital Group.

Infection prevention and control

A COVID-19 management pathway was in operation in the emergency department. On arrival to the department, attendees were screened for signs and symptoms of confirmed or suspected COVID-19. If symptomatic or COVID-19 positive, the attendee was immediately referred to the triage nurse who directed them to a designated COVID-19 area. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single cubicles and isolation room. Staff confirmed that terminal cleaning[‡‡‡‡‡‡‡] was carried out following suspected or confirmed cases of COVID-19.

Minimum physical spacing of one metre was maintained in the waiting area and emergency department, in line with national guidance. The emergency department environment was generally clean and well maintained. Notwithstanding this, the department was 88% compliant in an environmental audit carried out in July 2022 and while a time-bound action plan was developed to improve compliance, this is an area requiring improvement. The dirty utility room in the department was observed by inspectors to be small and restrictive in size.

There was evidence of auditing of clinical practice related to the four areas of known harm in the emergency department. Audits submitted to HIQA included, an audit of the:

- ordering Troponin I in the emergency department
- the management of patients presenting in the emergency department of St Michael's Hospital with chest pain
- waiting time for patients attending the emergency department of St Michael's Hospital to obtain a Doppler Ultrasound[§§§§§§§] for suspected deep venous thrombosis.

HIQA noted that time-bound action plans to support the implementation of corrective actions to address findings from the audits of clinical practice in the emergency department were not developed. Action plans provide a framework to ensure that identified changes are made to improve healthcare services, this is an area for improvement that can be readily addressed following HIQA's inspection.

Medication safety

No clinical pharmacist was assigned to the emergency department, but inspectors were informed that a pharmacist came to the department when available or requested. A pharmacy technician did visit the department daily to replace pharmacy stock. Inspectors observed a high-risk medication list and a SALAD[********] list displayed in the medicine room

[‡‡‡‡‡‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.
[§§§§§§§] A Doppler ultrasound is a non-invasive test that can be used to estimate the blood flow through blood vessels by bouncing high-frequency sound waves (ultrasound) off circulating red blood cells.
[********] 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.

in the emergency department. Staff in the department had access to clinical pharmacists for advice on antimicrobials and an antimicrobial microbiologist from St Vincent's University Hospital.

Deteriorating patient

The hospital was using the INEWS observation chart to support the recognition and response to a deteriorating patient in the emergency department but were not auditing compliance with national guidance on INEWS. The ISBAR communication tool was used when requesting reviews of patients.

At the time of inspection, INEWS version 2 observation chart was being implemented on a trial basis in one clinical area and the plan was to roll out this version across the hospital later in the year.

Two multidisciplinary safety huddles, at 12.00pm and 4.00pm were held in the emergency department to discuss the status of all patients in the department and identify patients that were of concern. Anaesthesiologists were onsite in the hospital during core working hours. Outside core working hours, anaesthesiologist cover for the hospital was provided by the anaesthesiology team in St Vincent's University Hospital.

Transitions of care

The ISBAR communication tool was used for internal and external patient transfers from the emergency department. The hospital had also introduced a number of templates to support safe transitions of care from the emergency department, these included an admission template, an internal transfer checklist and external transfer checklist. These templates and checklists were comprehensive and contained relevant patient information. Delayed transfers of care further compounded the issue of availability of inpatient beds at the hospital and impacted on waiting times in the emergency department. On the day of inspection, the hospital had 13 delayed discharges. Hospital management attributed the delay in transferring patients mainly to limited access to step down, rehabilitation and transitional beds in the community.

Management of patient safety incidents

HIQA was satisfied that patient safety incidents and serious reportable events related to the emergency department were reported to the National Incident Management System (NIMS),[††††††††] in line with the HSE's incident management framework. Feedback on patient safety incidents was provided to the clinical nurse manager grade three by the quality and risk manager.

Management of complaints

[††††††††] 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).

HIQA was assured that complaints related to the emergency department were managed locally, in line with the hospital's complaints policy by nurse management with oversight from the clinical nurse manager grade three. Complaints relating to the department were tracked and trended by the quality and risk manager and feedback on emerging trends and themes was provided to the nurse manager. Complaints management training was provided to staff in the emergency department. Of note, on the day of inspection, the patients who spoke with inspectors did not know how to make a complaint. This is something that could be addressed by hospital management following this inspection. Overall, on the day of inspection HIQA were assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm. However, auditing of clinical practice could be improved. Auditing is an essential and effective way to improve and sustain compliance with evidence-based practices and national guidance. Following this inspection, the hospital should ensure that clinical audits are carried out to provide assurance on the quality and safety of clinical practice and the services provided in the emergency department and at wider hospital level.
Judgment: Substantially Compliant

Inspection findings relating to the wider hospital and clinical areas

This section of the report describes findings and judgments against selected national standards (from the themes of leadership, governance and management (5.2 and 5.8), workforce (6.4), person–centred care and support (1.6, 1.7 and 1.8), effective care and support (2.7 and 2.8) and safe care and support (3.1 and 3.3).

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. These arrangements were outlined in the hospital's Quality Improvement and Patient Safety Programme 2022. The hospital's quality and risk manager and the quality and patient safety leads at Ireland East Hospital Group had collaborated and developed a working document (Quality and

Patient Safety Profile) 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. This document set out the arrangements for reporting, monitoring analysing and learning from data and information about services relating to:

- service performance with national key performance indicators
- risk management
- patient-safety incidents
- feedback from people using the service.

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).

The hospital collated performance data for unscheduled and scheduled care, including data on emergency department attendances and patient experience times, bed occupancy rate, average length of stay, scheduled admissions and delayed transfers of care.

The hospital also collected and collated data relating, to patient safety incidents, infection prevention and control, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the Patient Safety Committee every three months and monthly meetings of the hospital's Executive Council, and performance meetings between the hospital and hospital group.

The hospital reported clinical incidents through the National Incident Management System (NIMS). While there was evidence that the timely reporting of clinical incidents (percentage of incidents created within 30 days of date of notification) had significantly improved (from 16% in quarter one 2021 to 92% in quarter two of 2022), work was needed to ensure that the rate of reporting to NIMS was sustained, in order to consistently achieve 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 in clinical areas. The hospital's corporate risk register was reviewed at meetings of the Patient Safety Committee and meeting of the Quality, Safety and Risk sub-committee of the St Vincent's Healthcare Group. The hospital's top five rated risks were reported monthly to the Ireland East Hospital Group. Documentation submitted to HIQA showed the risks, along with the controls and actions implemented to

[‡‡‡‡‡‡‡‡] 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.

mitigate the risks, in relation to the four key areas of known harm were recorded on the hospital's corporate risk register. These risks are outlined further in national standard 3.1.

Audit activity

The hospital had a Clinical Audit Committee and the hospital was represented on the St Vincent's Healthcare Group Clinical Audit Committee. The Clinical Audit Committee had oversight of the audit activity at the hospital.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital and were responsible for ensuring that all patient safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT was chaired by the hospital's chief executive officer. Membership of the committee included a consultant physician or surgeon. The terms of reference of the SIMT did not detail meeting frequency, but HIQA noted from documentation submitted that the team met every month. In addition, serious incidents and serious reportable events were also discussed at meetings of the hospital's Executive Council. Hospital management had identified that the number of serious reportable events in relation to harmful falls occurring in the hospital had increased in 2022. An investigation was carried out to determine if there were any common contributing factors across all cases of falls. The investigation did not identify any common contributing factors.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System, in line with the HSE's Incident Management Framework. The hospital's quality and risk manager tracked and trended patient-safety incidents and submitted patient safety incident summary reports to the Patient Safety Committee. 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 were also discussed at performance meetings with the Ireland East Hospital Group. Feedback on patient safety incidents was provided to clinical nurse managers by the quality and risk manager. Patient safety incidents related to the four areas of known harm are discussed in more detail under national standard 3.3.

Feedback from people using the service

Findings from the National Inpatient Experience Survey were reviewed at meetings of the Patient Safety Committee. The hospital's quality and risk manager was assigned responsibility for developing quality improvement plans to improve the experience of people using the service. The hospital had developed and were implementing quality improvement plans to address findings from the National Inpatient Experience Survey 2021. In summary, at wider hospital level, 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 improvement initiatives were implemented in response to audit findings, patient safety incidents and feedback from people using the service. Overall, inspectors were assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital.

Judgment: Substantially Compliant

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

St Michael's 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. 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.

Hospital management were committed to supporting the health and wellbeing of staff. The hospital did not have access to the HSE's Employee Assistance Programme (EAP) but hospital management had arranged for the delivery of psychological support workshops for staff in quarter one 2022. The hospital had a Healthy Ireland Committee that focused on implementing initiatives to enhance staff health and wellbeing. Staff also had access to support and wellbeing resources through a dedicated page on the St Vincent's Healthcare Group intranet.

Inspectors observed a good working atmosphere between management and staff in the clinical areas visited. Non-consultant hospital doctors felt supported by consultant colleagues, particularly in relation to learning and development opportunities and were satisfied with rostering and on-call arrangements. Inspectors noted from speaking with staff in clinical areas that many of them had worked for several years in the hospital and enjoyed working there.

The Hospital's Workforce Strategy and Plan for 2022 set out the hospital management's plans to recruit and retain staff, and work with staff to review their training and development needs and to support staff in achieving these. Hospital management should progress with the provision of an employee assistance programme as indicated to inspectors on the day of inspection. 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: Substantially Compliant

Quality and Safety Dimension

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

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. For example, staff were observed being responsive and attentive to patient's individual needs, they offered assistance at meal times, helped patients to mobilise and spoke softly to patients.

Nursing staff promoted independence by encouraging patients who could mobilise independently to do so. Corridors were observed to be narrow, however, the lack of space did not inhibit patients when mobilising unaided or aided.

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. There were single rooms in the clinical areas visited – six single rooms in one clinical area and 14 single rooms in the other clinical area. Only one of these 20 single rooms had en-suite bathroom facilities. The lack of en-suite bathroom facilities meant patients with an infection risk or mobility issues had to use commodes, which had the potential to impact on their privacy and dignity. There was a family room in one clinical area visited, that was used to afford privacy when carrying out patient assessments and or delivering bad news.

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

These findings were consistent with the overall findings from the 2021 National Inpatient Experience Survey, where with regard to:

- privacy in the clinical area, the hospital scored 9.6 (national average - 8.7)
- staff introducing themselves when treating and examining the patient, the hospital scored 9.4 (national average - 8.7).

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 rooms with en-suite bathroom facilities did result in some patients with a known infection or mobility issues using commodes, which had the potential to impact of their privacy and dignity.

Judgment: Substantially Compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. This was validated by patients who spoke with inspectors. At the time of inspection, the hospital were in the process of issuing name badges to all staff members. The aim was to help patients distinguish staff grades and for patients to identify staff providing care and treatment. Nursing staff in the clinical areas visited were observed to be wearing name badges.

The hospital aimed to provide patients with choice regarding meals, while taking in to account, individual needs and preferences. Results from the 2021 National Inpatient Experience Survey showed that the hospital scored 8.9 for choice of food, this was higher than the national average of 8.5.

The hospital, in conjunction with local community services, had implemented the 'Social Prescribing' initiative that provided patients with information on healthy lifestyle and health interventions to help them make informed decisions that support and improve their health and wellbeing.

HIQA found evidence of a person-centred approach to care, especially for vulnerable patients receiving care. For example, staff were observed being responsive to patients that were agitated and disorientated on the corridor and communicated calmly and effectively with them, accompanying them back to their rooms. In one ward area visited, inspectors observed an advanced nurse practitioner specialising in the care of older persons, carrying out a ward round and liaising with staff in relation to patient needs.

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's chief executive officer was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of complaints resolution in the clinical areas visited. The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*'.[§§§§§§§§] While there was no evidence of formalised quality improvement plans to address complaints, the hospital had addressed complaints informally at a local level and actions had been taken to improve practice based on complaints received. For example, the hospital had responded to complaints relating to missing personal belongings (dentures and hearing aids) and the limited number of channels on television sets. The hospital formally reported on the number and type of complaints, verbal and written, received annually. The HSE '*Your Service Your Say*' annual feedback report[*********] (2021) showed that of the 42 formal complaints received in 2021 (excluding withdrawn or anonymous complaints), 35 (83%) of them were resolved within 30 working days, exceeding the national HSE target of 75% for investigating complaints. The Patient Safety Committee had oversight of the effectiveness of the hospital's complaints management process. Verbal and written complaints were tracked and trended to identify the emerging themes, categories and departments involved. Collated data and information on the hospital's compliance with national guidance and standards on complaint management was submitted to the Patient Safety Committee and to the Ireland East Hospital Group's complaint managers and patient liaison forum every month. The quality and risk manager attended this forum on behalf of St Michael's Hospital. Feedback on complaints was generally provided to staff in the clinical area that were the subject of the complaint. 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 documented in the hospital's 'Complaints Policy and Procedures' document, however, inspectors noted that staff in the clinical areas visited were not aware of independent advocacy services.

[§§§§§§§§] 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.

[*********] 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

Overall, HIQA was 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 and noted good practice in relation to in-house patient satisfaction surveys.
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. 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 PPE in line with current public health guidelines. Environmental cleaning was carried out by an external contract cleaning company and terminal cleaning was being carried out by designated cleaning staff. The clinical areas visited had a dedicated cleaner. Cleaning supervisors and clinical nurse managers had oversight of the cleaning and cleaning schedules in the clinical areas visited, and were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe. Cleaning of equipment was assigned to healthcare assistants. In both clinical areas visited, the equipment was observed to be clean and there was a checklist system in place to identity equipment that had been cleaned. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately. The hospital had implemented processes to ensure appropriate placement of patients – the infection prevention and control nurse liaised with bed management on the placement

[†††††††††] 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 of patients daily. One ward in the hospital was designated for the management of COVID-19 patients. In the clinical areas visited, there were multi-occupancy rooms with no en-suite bathroom facilities. There were isolation facilities in both clinical areas visited but the majority of isolation rooms did not have en-suite bathroom facilities. This is an infection prevention and control risk and this risk was recorded on the hospital's corporate risk register.

On the day of inspection, inspectors observed that the entry doors to the clinical areas visited were not closed and secure. Given the profile and vulnerability of some of the patients (people with dementia) accommodated in both clinical areas, HIQA was concerned that patients could potentially wander out of the clinical area or abscond. The hospital had reported a number of incidents of absconding in 2021. This potential patient safety risk was raised with the senior management team on the day of inspection. Inspectors were assured that risk assessments had been carried out and corrective measures were introduced to mitigate the risk. There was evidence that the hospital were planning to install a security system to reduce the risk of absconding by vulnerable patients later in 2022.

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, especially vulnerable patients. There was a lack of en-suite bathroom facilities, which increased the risk of cross-infection. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to enhance the physical environment and security of patients, especially vulnerable patients at the hospital.

Judgment: Partially Compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services and provide assurances to hospital management, and to the hospital group on the quality and safety of the services provided at wider hospital level. 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.

Infection prevention and control monitoring

HIQA was satisfied that the Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Infection prevention and control audit summary reports submitted to HIQA showed that the clinical areas visited on the day of inspection had achieved a high level of compliance (over 90%) with environmental and patient equipment infection prevention and control practices in 2021. Audit findings were shared with clinical staff and time-bound action plans developed to address areas requiring improvement. Both clinical areas visited were compliant with the HSE's target of 90% for hand hygiene practices.

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

In line with 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 in quarter one of 2022, the hospital had:

- no new cases of hospital acquired clostridium difficile
- one new case of CPE
- one case of hospital acquired staphylococcus blood stream infection. HIQA was satisfied that the hospital had investigated this case appropriately and shared the learning with staff to reduce the incidence of recurrence.

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

[‡‡‡‡‡‡‡‡‡] 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 reporting on compliance with seven antimicrobial stewardship key performance indicators every three months. In quarter one 2022, the hospital was 50% compliant in the metric for indication in medication record. Compliance in quarter two for this indicator increased to 100%. In quarter one of 2022, the hospital achieved the required level of compliance (50%) for the metric related to the course length and review date specified, but performance with this metric fell to 14.3% in quarter two of 2022. The hospital's performance with key performance indicators were reviewed at meetings of both the Infection Prevention and Control Committee and Drugs and Therapeutics Committee. Educational presentations on antimicrobials had been provided to doctors by a microbiologist and pharmacist to increase compliance around antimicrobial prescribing.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, for example audits were carried out in:

- venous thromboembolism (VTE) prophylaxis[§§§§§§§§§]
- controlled drugs
- time critical medications to treat epilepsy and Parkinson's disease
- intravenous iron products.

There was evidence that initiatives were introduced to improve medication safety practices at the hospital. This included ongoing education sessions in relation to medication errors, high-alert medications and administration of intravenous medication. A revised medication record was introduced in July 2022 with specific colour-coded sections for anticoagulation and antimicrobials, including guidance to reduce the likelihood of medication errors. Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital collated performance data through test your care metrics relating to the escalation and response of the acutely deteriorating patient, although the hospital were not locally auditing healthcare records for compliance against national guidance on INEWS and sepsis.

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 senior managers that any necessary continuous quality improvements were put in place. Lack of audit against national guidance on

[§§§§§§§§§] Venous thromboembolism (VTE) prophylaxis consists of pharmacologic and non-pharmacologic measures to diminish the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE).

INEWS, sepsis and clinical handover, including the use of the ISBAR tool should be addressed by hospital management.

Transitions of care monitoring

Performance in relation to transfers and discharges was monitored using the HSE's hospital patient safety indicators. The hospital reported on the number of inpatient discharges, number of beds subjected to delayed transfer of care and the number of new attendances to the emergency department 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 was systematically monitoring and evaluating healthcare services provided at the hospital. However, the hospital was not auditing compliance with national guidance on clinical handover, the use of the ISBAR communication tool, INEWS and sepsis. Auditing of clinical practice is essential to ensure that care and services provided at the hospital are in line with standards and guidance, they identify areas for improvement and provides hospital management and people who use the service with assurances on the quality and safety of the care and services provided.

Judgment: Substantially Compliant

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

The Patient Safety Committee was assigned with responsibility to review and manage risks that impact the quality and safety of healthcare services. Risks that could not be managed at hospital level were escalated to the St Vincent's Healthcare Group and Ireland East Hospital Group. The top five risks on the hospital's risk register were reviewed at performance meetings with the Ireland East Hospital Group every month.

High-rated active risks recorded on the hospital's corporate risk register related to HIQA's monitoring programme included: insufficient en-suite single rooms, risk of medication errors, lack of on-site anaesthesiologist cover outside core working hours and limited radiology services. The hospital's corporate risk register, had controls and actions in place to manage and reduce recorded risks.

Infection prevention and control

The infection prevention and control team maintained a local risk register of potential infection risks. Inadequate en-suite bathroom facilities 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.

Infection 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.

In 2022, the hospital had four outbreaks of COVID-19 and one outbreak of norovirus. A multidisciplinary outbreak team was convened to advise and oversee the management of COVID-19 outbreaks and an outbreak team was also convened to oversee the management of the norovirus outbreak. Infection prevention and control COVID-19 and norovirus summary reports submitted to HIQA were comprehensive and outlined control measures, potential contributing factors and recommendations to reduce recurrence of a similar outbreak. However, time-bound action plans were not developed to action recommendations made on these 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 had been recently updated in July 2022 containing colour-coded specific sections, which included:

- medication reconciliation
- anticoagulants - including comprehensive venous thromboembolism risk assessment and prescribing guidance
- antimicrobials - including intravenous therapy review after day 2 with an automatic stop prior to day 10 unless re-prescribed and a dedicated section for antimicrobials requiring therapeutic dose monitoring.

The hospital had developed a list of sound-alike look-alike medications (SALADs). Medication reconciliation was undertaken on admission for all relevant patients by clinical pharmacists. It was evident that clinical pharmacists were accessible to staff and visited clinical areas daily. The consultant microbiologist visited the clinical areas once a week. Wards also had pharmacy technician services for medication stock control.

Deteriorating patient

The hospital were piloting the INEWS version 2 observation chart in one clinical area. The hospital had systems in place to manage patients whose early warning system was triggered. This included an ISBAR communication tool which was placed in the patient's chart. The hospital had a five-bedded high dependency unit, which provided care for patients whose INEWS score triggered up to a score of seven. Staff in this unit were trained to care for patients needing a higher level of observation, this included the use of cardiac monitors and peripherally inserted central catheter (PICC) lines.[**********] Patients requiring a more intensive level of observation and monitoring were transferred by ambulance to St Vincent's University Hospital.

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. At the time of inspection, the transfer of patient care policy and discharge policy were in draft format awaiting approval by the hospital's Policy Committee. A multidisciplinary meeting was held once a week in each clinical area to review and discuss the progress, discharge plans and rehabilitation needs of all patients. A daily bed management and nursing administration meeting was held at 7.30am where information on patient admissions and discharges was discussed. The ISBAR communication tool was used by nursing staff for shift handover. The hospital had a number of transfer and discharge templates to facilitate safe transitions of care. The patient's infection status was recorded on the discharge and transfer templates. The hospital also used a template sticker when recording verbal instructions and laboratory results that was then inserted in to the patient's healthcare record.

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 and transmission-based precautions, outbreak management, managements of patients in isolation and equipment decontamination.

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of medication, high-alert medicines and sound alike look alike drugs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care through an application on smart phones.

[**********] 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.

All policies, procedures, protocols and guidelines were accessible to staff via the hospital's intranet and some, including infection prevention and control documents were accessible in folders located in clinical areas. The hospital had no computerised document management system in place, however all policies, procedures, protocols and guidelines were given a unique identifier and all were approved by the hospital's Policy Committee. The hospital would benefit from a documentation management system to assist in document control and ensure clinical staff have access at the point of care to up-to-date versions of relevant policies, procedures, protocols and guidelines.

Uptake of mandatory and essential training

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. Nursing, medical and support staff who spoke with inspectors confirmed to HIQA that they had received induction training and had completed training on a variety of topics on the HSE's online learning and training portal (HSELanD).

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 in the last two years was below the HSE target of 90%:

- 70% for nursing staff
- 62% for healthcare assistants
- 65% for medical staff
- 35% for health and social care professionals.

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

- 66.5% for nursing staff
- 66.5% for healthcare assistants
- 85.4% for medical staff
- records for health and social care professionals were not submitted to HIQA.

Staff uptake of the flu vaccine was reported as:

- 72.2% for nursing staff - below the HSE target of 75%
- 53.3% for healthcare assistants - below the HSE target of 75%
- 56.4% for medical staff- below the HSE target of 75%

- 100% for cleaning staff
- 100% for health and social care professionals.

Increased uptake of flu vaccine needs to be promoted by hospital management.

Training relevant to medication safety was set out in the medication safety annual plan. The uptake of mandatory training in medication safety in the last two years was:

- 34.9% 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:

- 89.3% of nursing staff NEWS - above HSE target of 85%, 29% INEWS version 2, 56% sepsis
- 29.26% of medical staff INEWS version 2, no records supplied for sepsis training.

In summary, HIQA was satisfied that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. 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 significantly improved. It is essential that hospital management ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address uptake and oversight of mandatory and essential training.

Judgment: Partially Compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The hospital did not use the National Incident Report Form (NIRF) for the reporting and documentation of patient-safety incidents. The hospital had their own incident report forms, which are structured on the NIRF, for general incidents they used a risk management occurrence form and used a dedicated medication incident report form to report medication patient-safety incidents.

The hospital's rate of reporting of clinical incidents into the NIMS had improved (from 16% in quarter one 2021 to 92% in quarter two 2022). At the time of inspection, the hospital's quality and risk manager did not have administrative support to facilitate the timely data entry into NIMS. The hospital plan to commence a project at the end of 2022, in collaboration with the Ireland East Hospital Group, to explore the possibility of electronic point of occurrence entry on to NIMS.

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, pressure ulcers and medication errors. The hospital tracked and trended patient safety incidents in relation to the four key areas of harm and an incident summary report was submitted to the Patient Safety Committee every three months and to the Ireland East Hospital Group every month.

In general, feedback to staff in clinical areas was provided informally by clinical nurse managers, clinical pharmacists and the infection prevention and control team. Inspectors observed shared learning notices displayed. Inspectors also noticed that monthly data on patient falls and pressure ulcers were being tracked and displayed at clinical area level on noticeboards.

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. In 2021, the hospital had 41 medication patient safety incidents, none of these incidents were a major incident. The most frequently reported medication patient safety incidents reported in 2021 were high-risk medicines - anticoagulants, antimicrobials and insulin. Medication safety newsletters were used to increase staff awareness and knowledge, and reduce the recurrence of medication related patient-safety incidents. Medication safety newsletters were also displayed in staff areas of the clinical areas visited on the day of inspection.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm. The hospital were tracking and trending infection prevention and control patient-safety incidents, medication incident and incidents related to transitions of care. Deteriorating patient was not a specific category when incidents were tracked and trended. There was evidence that the Patient Safety Committee had oversight of the management of these incidents and that the Senior Incident Management Team and the Executive Council had oversight of serious incidents and reportable events. Hospital

management should ensure that compliance with timelines for data entry into NIMS is sustained.
Judgment: Substantially Compliant

Conclusion

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

Capacity and Capability

St Michael's Hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. There was evidence of good collaborative and integrative working arrangements with St Vincent's University Hospital. The network configuration of service delivery, through the hub-and–spoke model between St Michael's Hospital and St Vincent's Hospital was an effective structure that enabled the provision of high-quality care and ensured patients were provided with the right care in the right place based on their assessed needs.

On the day of inspection, the hospital's emergency department was busy, relative to its intended capacity, and was functioning well. Attendees to the department were not waiting for long periods to be triaged and or medically reviewed. On the day of inspection, the emergency department was compliant with national HSE targets related to patient experience times. However, over a 12 month period (July 2021 - July 2022), the emergency department had experienced delays in patient experience times, with 1% of attendees having to wait more than six hours after registration to be discharged or admitted to an inpatient bed.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. However, the hospital was not systematically monitoring compliance with national standards and guidance on a continual bases 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. However, the oversight and uptake of essential and mandatory training 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. People who spoke with inspectors were positive about their experience of receiving care in the emergency department and wider hospital and were very complimentary of staff. The hospital were aware of the need to support and protect more vulnerable patients and had developed a plan 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 en-suite bathroom facilities which increases the risk of cross-infection. There were also challenges relating to the security of vulnerable patients and the risk of absconding. This was confirmed by hospital management on the day of inspection and a plan to improve security was in place.

HIQA was satisfied that the hospital had systems in place to monitor and improve services. However, the hospital was not auditing compliance with national guidance on clinical handover and the use of the ISBAR communication tool or escalation and response in relation to acute clinical deterioration. HIQA noted that time-bound action plans were not developed in response to some audit findings, therefore evidence of continual improvement was limited.

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.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with mandatory training and improvements of the physical environment at the hospital.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection of St Michael'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.

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management **Judgment relating to overall inspection findings**	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
National Standard	**Judgment**
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.	Substantially Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare.	Substantially Compliant
Quality and Safety Dimension	
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
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.	Partially 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 Michael's Hospital

Compliance Plan for St Michael's Hospital OSV-0001100

Inspection ID: NSSBH_0011

Date of inspection: 09 and 10 August 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 necessitate continued monitoring including further inspection activity. It may also result in further escalation in the HSE to the relevant accountable person 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

<table>
<tr><th>National Standard</th><th>Judgment</th></tr>
<tr><td>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.</td><td>Partially compliant</td></tr>
<tr><td colspan="2">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

1) Lack of Ensuite Bathroom Facilities

a) St Michael's Hospital at all times strives to ensure service users' dignity, privacy and autonomy are respected and promoted. To mitigate the risk associated with lack of access for all patients to ensuite bathroom facilities, St Michael's will continue to identify particular bathrooms to be used by specific cohorts of patients or in some cases, individual patients depending on the isolation requirement.

b) St Michael's will continue to escalate the lack of sufficient ensuite accommodation via the Risk Register to Ireland East Hospital Group (IEHG) and St Vincent's Healthcare Group (SVHG) Working with IEHG and SVHG as part of development plans, ensure that existing patient accommodation is upgraded to include ensuite facilities for all patients and new patient accommodation plans will include ensuite facilities for all patients.

2) Risk of Vulnerable Patients absconding

a) St Michael's Hospital (SMH) Bed Manager and Nursing Management risk assess the individual patients' accommodation needs. In order to reduce the risk of absconsion by vulnerable patients, staff will ensure that doors will be kept closed at entry points to wards that accommodate vulnerable patients. Staff-only swipe access will be installed at the rear stairwell on St Columba's ward.

b) A business case will be submitted to IEHG for funding to install controlled access to all ward areas.</td></tr>
<tr><td colspan="2">Timescale:
1) a) Immediate b) Ongoing
2) a) Immediate b) Q2 2023 subject to funding from IEHG and tender process</td></tr>
</table>

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

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

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

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

Improve staff attendance at mandatory and essential training

St. Michael's Hospital is committed to the provision of safe systems of work for employees and the patients in its care. The provision of mandatory training for staff is an integral part of this process. St. Michael's Hospital Management team is committed to ensuring that staff attend the required mandatory training as defined by the Hospital.

a) Key Interim Actions:

1. A mandatory training matrix will be developed which will itemise all prescribed mandatory training per discipline, including the methods of delivery and the applicable refresher periods.
2. Engagement with key stakeholders across the hospital to establish a Mandatory Training Governance Committee, which will oversee and drive compliance with staff mandatory training. This committee will undertake a review of the recording and reporting mechanisms currently in place with the aim of increasing the efficiency and accuracy of training evidence records.
3. Develop mandatory training non-compliance reports for distribution to managers on a quarterly basis. Undertake a risk assessment to identify the outstanding training needs for high-risk staff roles and prioritise accordingly for onsite mandatory training places.
4. Continue to record and escalate the risk of low attendance at mandatory training programmes via the Risk Register to Ireland East Hospital Group (IEHG) and St Vincent's Healthcare Group (SVHG).
5. Build training mandatory requirements into the on-boarding and probationary process for new staff.
6. Undertake a review to ensure that appropriate funding is available for the provision of required mandatory training initiatives.

b) Long-term plans requiring investment:

1. Seek approval and funding from IEHG to dedicate a resource to the role of Training & Development Officer.
2. Improve the IT functionality of the current learning and development portal/ current HR information system.

Timescale for (a) Key Interim Actions:
1-4 Q4 2022
5-6 Q1 2023

Timescale for (b) Long-term plans requiring investment:
1 Q2 2023
2 Q2 2023

Service Provider Use	
Service Provider	St Michael's Hospital Dun Laoghaire Co Dublin
CEO Signature	
Date	04.10.2022

HIQA Official Use	
Date Reviewed	
Authorised Person(s)	
Signature	