



Report of an inspection against the *National Standards for Safer Better Healthcare.*

Name of healthcare service provider:	Tallaght University Hospital
Address of healthcare service:	Tallaght Dublin 24 D24 NR0A
Type of inspection:	Unannounced
Date(s) of inspection:	14 and 15 February 2024
Healthcare Service ID:	OSV-0001002
Fieldwork ID:	NS_0068

About the healthcare service

Model of hospital and profile

Tallaght University Hospital (TUH) is a model 4* voluntary public acute hospital. It is a member of the Dublin Midlands Hospital Group.† The hospital provides local, regional and national specialties, it is also the second largest provider of dialysis services in the country and is a designated trauma unit.

Tallaght University Hospital provides access for patients to over 20 medical and surgical specialities, with comprehensive on-site laboratory and radiology support services. The hospital has a directorate structure. The directorates are medicine, perioperative, radiology and pathology.

The following information outlines some additional data on the hospital.

Model of hospital	4
Number of beds	465 inpatient beds plus 94 beds off site. 120 day care beds.

How we inspect

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

During the inspection, inspectors:

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

* Model 4 hospitals admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care and also provide tertiary care and in certain locations, supra-regional care.

† Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012).

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

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
14 February 2024	09.00 – 17.00hrs	Nora O' Mahony	Lead
15 February 2024	09.00 – 17.00hrs	Rosarie Lynch	Support
		Dolores Dempsey-Ryan	Support
		Aedeen Burns	Support
		Niamh McDonnell	Support

Information about this inspection

An unannounced inspection of Tallaght University Hospital was conducted on 14 and 15 February 2024.

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 four clinical areas:

- Emergency department
- Osborne renal ward
- Burkitt medical ward
- Gogarty surgical ward

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

- Representatives of the hospital's Executive Management Team
 - Chief Executive Officer
 - Director of Nursing and Integrated Care
 - Clinical Director
 - Chief Operations Officer
- Director of Quality Safety and Risk Management
- Patient Advice and Liaison Services Manager
- Representative for the non-consultant hospital doctors (NCHDs)
- Director of Human Resource and the Medical Manpower Manager
- A lead representative from each of the following:
 - infection prevention and control
 - medication safety
 - the deteriorating patient
 - transitions of care.
- staff from a range of disciplines in the various clinical areas inspected.

Acknowledgements

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

[‡] 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>

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

Findings for emergency department

On the day of inspection, inspectors visited the emergency department and conducted a walk-through of other areas of the acute floor^{††} areas, including the age related assessment unit (ARAU), the acute surgical assessment unit (ASAU) and the acute medical unit (AMU).

Within the emergency department there were five resuscitation cubicles, eighteen single cubicles, three single rooms and a designated psychiatric assessment area which accommodated two patients. There was also a triage assessment area, a rapid assessment and treatment area, a minor injuries unit, and an ambulatory care area. There was a designed respiratory hub area and a respiratory waiting area, each with four chairs, and a 'sit out area' which accommodated patients on chairs who did not require a trolley. In addition, patients were accommodated on additional trolleys in the department when demand exceeded capacity.

At 11am on the first day of inspection the emergency department was operating well relative to its intended capacity and function, but was considered quiet by staff when compared to the usual activity levels. Patients were accommodated in the designated cubicles, but additional patients were accommodated on trolleys near the nurses' station and outside cubicles. Suitable patients were accommodated on chairs in the 'sit out areas' and the respiratory hub, cared for by the ED circulating nurse. There was a vacant resuscitation cubicle for emergency presentations, and a vacant major cubicle to facilitate patient clinical reviews and assessments to support patient flow.

Inspectors observed staff actively engaging with patients in a respectful and kind manner ensuring patients' needs were responded to. 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.

Inspectors spoke with a number of patients in the emergency department about their experience of the care. Overall, patients were complimentary about the staff and the care they had received. When asked what had been good about the care in the ED so far, patients commented that staff were '*kind and caring*', '*lovely*' and '*couldn't be nicer*'. Patients reported that they were offered snacks while they were waiting. However, one

^{††} Acute floor: the model of care for the efficient streaming and management at the front door of acute hospitals which incorporates the emergency department, acute medical unit, acute surgical assessment unit, frailty teams and other services working in tandem with immediate streaming and access to senior relevant decision makers at the earliest opportunity.

patient did outline that they had not been offered enough food since arriving in the ED the previous evening, and was now fasting.

When asked if anything could be improved, patients spoke of the uncomfortable chairs in the waiting areas and the noise level at night.

Patients who spoke with inspectors did know how to make a complaint. One patient mentioned that he had made a complaint in the past but nothing happened, in contrast other patients said they had nothing to complain about.

Findings for the wider hospital and clinical ward areas

The Gogarty ward was a 31-bedded surgical ward with four six-bedded multi-occupancy rooms and seven single rooms with ensuite facilities. All beds were occupied at the time of the inspection. The Burkitt ward was a 29-bedded medical ward consisting of four six-bedded multi-occupancy rooms and five single rooms with ensuite facilities. At the time of inspection, all beds were occupied. The Osborne ward was a 30-bedded renal ward with four six bedded multi-occupancy rooms and six single rooms with ensuite facilities. At the time of inspection 28 beds were occupied with two patients transfers expected from the emergency department. All wards visited had adequate toilet and bathroom facilities for 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 '*excellent*', '*kind*' and '*obliging*'. Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care. Staff were observed providing required assistance to patients and this was validated by a patient who told inspectors that there was '*no problem getting assistance when needed*' and '*they [staff] go above and beyond*'.

A number of patients did comment that more staff were needed as '*staff were run off their feet*'. Patients were not familiar with the hospital's complaints process but outlined that they would talk to a member of staff if they had a complaint.

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

Capacity and Capability Dimension

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

the hospital. Inspection findings from the theme of workforce are presented under national standard 6.1.

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 integrated corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services.

The Chief Executive Officer (CEO) had overall responsibility for the governance of the hospital and reported to the hospital's Board. The CEO and senior hospital managers attended monthly performance meetings with the Dublin Midlands Hospital Group.

The Clinical Director provided clinical oversight and leadership at Tallaght University Hospital. The Director of Nursing and Integrated Care was responsible for the organisation and management of nursing services at the hospital.

Executive Management Team

Tallaght University Hospital Executive Management Team (EMT) was chaired by the hospital's Chief Executive Officer and met twice a month. The EMT reported to the hospital's Board. The EMT had collective responsibility to implement strategies, policies and systems to review performance, risk, quality and to continuously improve the services provided to patients. The EMT had appropriate membership with senior managers representing directorates, nursing, quality safety and risk management (QSRM), finance, information communication technology, human resources, facilities and estates. Minutes of EMT meetings, submitted to HIQA, showed that the meetings followed a structured format, they were action oriented, with actions monitored from meeting to meeting. Member of the EMT attended monthly performance meetings with the Dublin Midlands Hospital Group.

Quality, Safety and Risk Management Executive Governance Committee

The Quality, Safety and Risk Management (QSRM) Executive Governance Committee was the main committee assigned with overall responsibility to develop, deliver and evaluate the quality and safety programme within the hospital. This Committee was chaired by the Director of QSRM, met monthly and reported to the EMT and the hospital's Board. A meeting action log was maintained and monitored from meeting to meeting. Membership was appropriate, with good attendance at meetings.

The QSRM Executive Governance Committee received and reviewed annual reports from the sub-committees that reported into it such as – the Infection Prevention and Control Governance Committee, the Medication Safety Committee and the Clinical Handover Committee. The Committee provided reports to the EMT, the hospital's Board and at

monthly performance meeting with the Group on activity and performance indicators, incidents, reviews, medication safety, risks, infection prevention and control and quality improvements.

Infection Prevention and Control Governance Committee

The hospital's multidisciplinary Infection Prevention and Control Governance Committee was responsible for the governance and oversight of infection prevention and control and antimicrobial stewardship at the hospital. The Committee was chaired by the Deputy CEO and met quarterly, with good attendance at meetings. Meetings followed a structured agenda with actions monitored from meeting to meeting. The Infection Prevention and Control Governance Committee reported to QSRM Executive Governance Committee with a reporting line from the chair to the EMT. Through evidence provided, HIQA was satisfied with the governance and oversight of infection prevention and control practices at the hospital.

Drugs and Therapeutics Committee

The hospital's Drugs and Therapeutics Committee was assigned responsibility for the governance and oversight of medication safety practices at the hospital. The Committee was chaired by a medical consultant and reported to the QSRM Executive Governance Committee. This committee met six times a year with actions monitored from meeting to meeting. The hospital also had a Medication Safety Committee which reported to the Drugs and Therapeutic Committee and the QSRM Executive Governance Committee. There was clear evidence of the Medication Safety reporting mechanism to the QSRM Executive Governance Committee, however similar reporting evidence was not seen by inspectors for the Drugs and Therapeutics Committee. This should be reviewed by the hospital following this inspection. Overall, HIQA was satisfied with the governance and oversight of medication safety at the hospital.

Emergency response steering group

The Emergency Response Steering (ERS) Group had oversight of the implementation and monitoring of the national early warning systems in line with national guidance including Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool. This Committee was chaired by a medical consultant and reported to the EMT. The Committee was also responsible for the functionality of the emergency response team at the hospital and the hospital's ERS Governance Subgroup which reviewed cases with issues related to compliance to the TUH ERS protocol. The ESR Governance Subgroup proposed terms of reference 2023, outlined that this committee reported to the EMT. This should be reviewed to reflect practice following this inspection.

The implementation of sepsis management for adults was under the remit of the Sepsis Steering Committee that was chaired by the Director of QSRM and reported to the QSRM Executive Governance Committee.

Unscheduled Care Group

The Unscheduled Care Group managed the flow and experience of unscheduled patients through the hospital and onward into the community. It provided a forum for the management and review of activity and performance metrics related to unscheduled care within TUH, and adherence to national standards and targets. This Group was chaired by the Chief Operations Officer and met monthly, although in the terms of reference the frequency of meetings was outlined as every two weeks. The Group reported to the EMT. Actions from this group were monitored from meeting to meeting through the group's action log.

The hospital had formalised corporate and clinical governance arrangements in place. These governance arrangements outlined the roles, accountability and responsibility for providing assurance of the quality and safety of services at the hospital. The governance arrangements and quality and safety outcomes were publically available through the hospital's published annual reports and through publicly reported metrics. Governance arrangements in place at the hospital had a focus on the quality and safety outcomes for people using the service. However, the hospital should ensure that meeting frequency and reporting structures outlined in committee's terms of reference reflect current practice.

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

The hospital's acute floor, which included the ED, was under the governance of the Medical Directorate led by a Clinical Director who represented the ED at the EMT, the QSRM Executive Governance Committee and the hospital's Board. Emergency Medicine Consultants reported to the Medical Clinical Director. In the previous report in 2022, staff expressed the view that more direct representation from the emergency department at management level might be beneficial, considering the size, activity and complexity of issues within the department. The hospital did consider this feedback, and outlined the representation of the Acute Floor* provided by the medical directorate at management level. On this inspection, emergency staff reiterated the need for more direct representation at management level to ensure continued focus on patient safety.

There was evidence of strong medical and nursing leadership in the ED. An emergency medicine consultant was the lead consultant in the ED. Senior clinical decision-makers^{##} at consultant or registrar level were on-site in the ED 24/7. Consultants in emergency medicine were on site Monday to Friday 8am to 8pm or 8am to 6pm and on call outside these hours. There were consultant led wards rounds in the ED at intervals throughout the day and at weekends.

A clinical nurse manager 3 (CNM3) had operational oversight of the department Monday to Friday and reported to the assistant director of nursing (ADON). There was a CNM2 on duty each shift they had overall responsibility for the nursing services out of hours and at weekend. The CNM2 escalated all issues to the out of hours nursing office.

In 2023, the overall attendance rate at the hospital's emergency department was 55,476 which equated to an average daily attendance rate of approximately 151 patients, a 6% increase on 2022. The hospital's attendance rate was low in comparison to other similar sized model 4 hospitals, although many of the other model 4 hospitals have higher inpatient bed capacity. Inspectors were informed that the increase in over 75 year old patients presenting to the ED impacted on the admission rates and the patient's lengths of stay. This increase also impacted delayed transfer of care as the hospital was challenged with availability of community supports for this aging population. The percentage of patients over 75 years of age attending the ED had risen by 14% in 2023 when compared to 2022, and by 44% in February 2024 when compared to the same time frame in 2023. In 2023, 60% of these over 75 year old patients were admitted to the hospital. This was the highest conversion rate for patients over 75 year of age of all model 4 hospitals. However, the number of over 75 year old patients attending the hospital was still low in comparison to other model 4 hospitals, and comprised 14.6% of all ED attendances at the time of inspection.

At 11am on the day of inspection the emergency department was functioning reasonably well. There were 41 patients registered in the emergency department, which was low in comparison to the department's usual activity level.^{##} The average waiting time from registration to triage was seven minutes, which was compliant with the 15 minutes triage time recommended by the HSE's emergency medicine programme. The average wait from triage to medical assessment was 41 minutes. Despite the low attendances to the ED, the average time from medical assessment to decision to admit was 5.8 hours and the average time from decision to admit to admission to an inpatient bed ranged from 40 minutes to 2 days and 11 hours. The patient waiting the longest time for an inpatient bed required isolation, and was currently accommodated in a single ensuite room within the ED.

^{##} 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 previous week's attendance at this time ranged from 55-88.

The hospital was non-compliant with the HSE's key performance indicators for patient experience times*** for all patients in the department at 11am with 46% of the ED attendees in the department over nine hours. Sixteen admitted patients were accommodated in the ED under the care of a specialist consultant awaiting an inpatient hospital bed.

Attendees to the emergency department presented by ambulance (37%) were referred directly by a general practitioner (GP) (17%) or self-referred (76%). The percentage of GP referrals was lower than it had been on the previous inspection of 21%. Inspectors were informed that the low GP referral rate may reflect the low number of GPs in the hospital's catchment areas.

The conversion rate (rate of admission of patients to an inpatient ward) for the emergency department in 2023 was 29.9%, which was higher than most other model 4 hospitals. Inspectors were informed that the Charleson comorbidity index, which predicts 10-year survival in patients with multiple comorbidities, tended to be higher in patients attending the hospital. This correlated with a high deprivation index for some of the hospital's catchment area.

The hospital had systems and processes in place to support patient flow as outlined below. However, at the time of inspection some of these systems were not functioning as intended.

- The hospital's acute medical unit (AMU) (eight cubicle) and the age related assessment unit (ARAU) (4 cubicles for patient over 75 years of age) were adjacent to the ED. Medical patients, within set criteria, were streamed from the ED to these units Monday to Friday. The units were under the clinical governance of an acute medical consultant. On the day of inspection the AMU was functioning as designed to support patient flow. The ARAU was accommodating inpatients waiting for an inpatient bed, and therefore was not functioning as intended. To support patient flow, ARAU staff streamed and cared for suitable patients in free spaces within the AMU.
- On the day of inspection the acute surgical assessment unit (ASAU) was not fully functioning as an ASAU to support patient flow. Five cubicle were used to accommodate admitted patients awaiting an inpatient bed. One bed was used to accommodate a patient for acute surgical assessment.
- A Senior Intervention Following Triage (SIFT) model was set up in the hospital to facilitate early senior clinical decision-making and appropriate diagnostics post triage with a view to reducing the Patient Experience Time (PET). The SIFT, proposed to operate daily Monday to Friday was still not fully operational each day.

*** 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.

It was operational on the day of inspection as staff were available to be allocated to same due to the low numbers of patients awaiting medical review.

- The hospital's transition/ discharge lounge operated daily Monday to Friday and accommodated ten patients each day. Suitable patients were transferred from the emergency department to the transition lounge for continued care and management until discharge.
- ED diagnostic technicians were in post to support earlier access to diagnostics following triage.
- The Gerontological Emergency Department Intervention multidisciplinary team was operational at the time of inspection. This team undertook a comprehensive geriatric assessment for patients 75 years of age and older to support admission avoidance or timely discharge with appropriate supports in place.
- A computerised tomography (CT) scanner was operational within the emergency department which expedited access to CT scans.
- The hospital had a number of clinical pathways in place to streamline the patient journey through the ED such as – respiratory, cardiology, deep vein thrombosis and urology pathways.
- Since the last inspection in 2022, the hospital had introduced a pathfinder service. Pathfinders is a collaborative service staffed by health and social care professionals and the HSE's National Ambulance Service. The aim of this service is to avoid transfer to the emergency department following a 999 call for patients over 65 years of age with low acuity, by providing treatment at the scene if appropriate, and or referral to community health and social care service.

The Chief Operations Manager, the Patient Flow manager and the Discharge Planner attended a weekly meeting of the Community Hospital Integration Forum (CHIF) DSK WWC CHO7 DMLHG.⁺⁺⁺ This Group was set up initially to support the winter plan but continued, and expanded across all care groups with a focus on delayed transfers of care and unscheduled care.

Continuous and effective flow of patients within the hospital is essential for optimal service delivery in the ED. The average length of stay (ALOS) reported by the hospital for medical patients year to date 2024 was 10.3 days (national target ≤ 7.0) and for surgical emergency inpatients was 7.2 days (national target ≤ 6.0) and surgical elective inpatient was 5.6 (national target ≤ 5.0). All average lengths of stay were higher than the national. On the day of inspection, the hospital had 12 patients with delayed transfers of care (DTOC), which was a significant improvement on the 2023 figures (average 31 DTOC).

⁺⁺⁺ Community Hospital Integration Forum Dublin South, Kildare and West Wicklow Community Healthcare Organisation Area 7 Dublin Mid Leinster Hospital Group.

This improvement reflected the good work done by the hospital in conjunction with their community partners.

The hospital's key performance indicators for patient experience times (PETs)^{***} from January to September 2023 had improved on the same time frame in 2022, but were still significantly lower than the national targets, and lower than the national average for all hospitals. See Table 1 below.

Table 1: TUH average patient experience times for January to September 2023, compared to HSE targets and the national average score January to September 2023 and the hospital's average score January to September 2022.

	Average % of all patients admitted or discharged within:			Average % of patients aged 75 or over admitted or discharged within:	
	6 hours	9 hours	24 hours	9 hours	24 hours
HSE Target	70%	85%	97%	99%	99%
National average Jan-Sept 2023	56.9%	73.5%	95.4%	54.3%	90.7%
TUH Jan – Sept 2023	36%	51.2%	88.3%	38%	80.9%
TUH Jan – Sept 2022	32.6%	46.9%	87.6%	32.2%	79.6%

The process in place needs to be enhanced by the hospital to build upon the slight improvements in PETs seen in 2023. To support this, the Unscheduled Care Governance Group had just set up two sub groups to develop and enhance ED pathways and to improve ED processes.

A risk outlined on the corporate risk register related to the insufficient inpatient bed to meet demand of catchment demographics with an aging population and increasing complexity of care requirements. The hospital outlined the existing controls in place, many of which were observed on the day of inspection such as use of escalation capacity and transfer of patients to external beds offsite. Additional controls outlined included the development of a 120 bedded building, comprising single and isolation rooms (including 35 replacement beds). This building project was progressing through the early stages of development. In the interim the hospital was seeking approval for a 60 bed modular build to manage the difference between demand for inpatient beds and the current capacity in the hospital.

Findings relating to the wider hospital and other clinical areas

^{***} Patient experience time (PET) measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

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

Infection, prevention and control

The hospital had an overarching infection prevention and control programme as per national guidelines^{§§§}. The infection prevention and control (IPC) team and the antimicrobial stewardship team produced quarterly and annual reports that were monitored and reviewed by appropriate governance structures. They developed plans that set out objectives to be achieved in the coming year.

As part of the IPC programme, the IPC team provided input into refurbishment and building works at the hospital.

Medication safety

The hospital's pharmacy service, which was led by the hospital's chief pharmacist, was found to be have below the required level of staffing. The current and ongoing deficits in pharmacy staffing both from unfilled posts were impacting on the hospital's ability to provide a comprehensive clinical pharmacy service across all areas of the hospital. At the time of inspection the hospital was challenged with recruitment for senior pharmacist posts. Inspectors were told that the hospital was currently short 7.5 senior pharmacist posts. To continue to provide clinical services, the hospital was employing three basic grade pharmacists with supports in place with a view to them upskilling and gaining experience so that they may become eligible to apply for senior pharmacist posts. The hospital was also providing additional upskilling for pharmacy technicians to take on additional roles relevant to their scope and skills, to free up pharmacists time to provide clinical services. The impact of pharmacist shortages was seen in the lack of clinical pharmacy service in the ED and in two adult surgical wards, with reduced services in some areas being provided by a basic grade pharmacist rather than senior grade pharmacist. The risks associated with pharmacist shortages had been identified by the hospital and escalated to the hospital's corporate risk register. The hospital should continue with recruitment efforts to fill these vacant posts.

Deteriorating patient

The hospital had clinical leadership at consultant level for implementation of the early warning systems at the hospital. At the time of inspection, the emergency response data coordinator post was vacant, despite recent recruitment campaigns. Inspectors were informed that this vacant post impacted on education, audit, analysis and policy

§§§ National Clinical Effectiveness Committee. National Clinical Guidelines No. 30. Infection Prevention and Control. 2023. Available on line from: <https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-summary-report>

development related to the emergency response activity in the hospital. The hospital should continue with recruitment efforts to fill this vacant post.

Transitions of care

The hospital had arrangements in place to monitor issues that impacted effective and safe transitions of care. The hospital's bed manager, discharge planners and head of unscheduled care had oversight of scheduled and unscheduled care activities and issues contributing to delayed discharges at the hospital. Daily bed management meetings were held throughout the day to support patient flow through the hospital, with a focus on the ED. Weekly meetings were held to review patients with delayed discharges and patients with lengths of stay over 14 days. As mentioned earlier, weekly CHIF meetings were held with community partners to progress complex discharges.

The hospital's comprehensive electronic dashboards demonstrated real-time data on all stages of the patient's journey. The dashboards and reports generated, were used to support patient flow throughout the day. Tailored automated reports were provided to relevant hospital staff to support real-time monitoring of the hospital's metrics and facilitated comparative analysis from previous time periods.

The Hospital's Clinical Handover Policy outlined the initiative required to meet the requirements of the National Clinical Effectiveness Committee' Guideline No. 11 'Clinical Handover.' Implementation of this policy was managed by the Clinical Handover Committee with oversight by the QSRM Executive Committee.

In summary, it was evident that the hospital had defined management arrangements in place at the hospital to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. But operationally, patient flow within the hospital was not functioning as it should. The mismatch between availability and demand for inpatient beds resulted in admitted patients being accommodated in the ED. This resulted in increased PETs, a decrease in efficiency and increased patient risk. Admitted patients were also accommodated in the AMU and ASAU, which impacted the effective running of these units.

Judgment: Partially compliant

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

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital collected and collated data related to patient-safety incidents, complaints and compliments, patient surveys, workforce and risks, and gathered and

published**** a range of national key performance indicators (KPIs)**** related to the quality and safety of the services provided.

Collated performance data and KPIs were monitored at department and directorate level meetings, and reported at meetings of the EMT and the QSRM Executive Governance Committee and at performance meetings between the hospital and hospital group.

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 the QSRM Executive Governance Committee, with risks escalated as required to the EMT and the hospital's Board and discussed at monthly performance meeting with the Dublin Midlands Hospital Group.

Patient safety incidents

The hospital had systems in place to identify, monitor and analyse patient-safety incidents with appropriate oversights in place. Examples of the sharing of learning from incidents to improve the quality and safety of services was provided during the inspection.

Complaints

Complaints and compliments were tracked and trended by the Patients Advice and Liaison Service (PALS). Implementation of recommendation arising from complaints was tracked by the PALS. 85% of complaints were resolved within the 30 working days, which was compliant with the national target of 70%.

Audit activity

The hospital's Clinical Audit Committee had responsibility for the development and implementation of the hospital clinical audit programme including the development of an annual clinical audit plan. The committee registered and tracked audits in progress and monitored implementation of recommendations. The Clinical Audit Committee reported to the EMT through the QSRM Executive Governance Committee. Quality improvement plans for audit recommendations and re-audit plans were seen for some but not all of the audits reviewed by HIQA. This may be an area for improvement for the hospital.

Feedback from people using the service

Findings from the National Inpatient Experience Survey were coordinated by the PALS and relevant quality improvement plans (QIPS) developed. Findings and QIPS were reported

**** The HSE's Performance Assurance Report (PAR) provides an overall analysis of key performance data from Divisions, such as Acute, Mental Health, Social Care, Primary Care, Health and Wellbeing as well as Finance and HR. The activity data reported is based on Performance Activity and Key Performance Indicators outlined in the current National Service Plan. [Performance Reports - HSE.ie](https://www.hse.ie/eng/services/publications/kpis/key-performance-indicator-metadata-2023.html)

**** HSE Acute Division Metadata. 2023. Available online from:

<https://www.hse.ie/eng/services/publications/kpis/key-performance-indicator-metadata-2023.html/>

to the EMT and QSRM Board Committee. The PALS also coordinated the TUH patient experience survey with patients access to this survey available through a number of forums

In summary, the hospital was monitoring performance against key performance indicators, and information from monitoring was being used to improve the quality and safety of healthcare services. Examples of quality improvement initiatives implemented in response to monitoring was provided by the hospital, but there remained opportunities to expand this across findings from all monitoring activity. Overall, inspectors were assured that hospital management were identifying and acting on opportunities to continually improve the quality and safety of healthcare services at the hospital.

Judgment: Substantially Compliant

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

Findings from the emergency department

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare for the ED. The emergency department had seven whole-time equivalent (WTE) consultants in emergency medicine who were responsible for the day-to-day functioning of the department. The consultants were clinically accountable and reported to medical Clinical Director. The consultants were supported by 32 WTE non-consultant hospital doctors, all these positions were filled following a successful overseas recruitment campaign. Senior clinical decision-makers^{****} at consultant or registrar level were on-site in the ED 24/7.

The emergency department had an approved complement of 65 whole time equivalents (WTEs)^{§§§§} nursing staff, with all nursing positions filled at the time of inspection. However, short and long term absences did impact on daily rosters. For example, on the day of inspection the ED had been short seven nursing shifts, five shortages had been filled by agency nurses and two shifts were unfilled. Nursing staff were supported by 17 WTE healthcare assistants.

Staff in the emergency department had access to infection prevention and control nurses who visited the department daily. Staff also had access to a consultant microbiologist for

^{****} 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.

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

advice. The clinical pharmacist service had previously been provided to patients in the ED, but inspectors were told by that this service was currently unavailable in the ED. A pharmacy technician visited the department daily for stock control. Security staff were on duty in the emergency department 24/7.

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 training, and this was overseen by the clinical nurse manager grade 3.

HIQA found that staff attendance and uptake at mandatory and some essential training could be improved, especially training on infection prevention and control and the Irish National Early Warning System.

Overall, the 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. Attendance at and uptake of mandatory and essential training for nursing staff in the emergency department could be improved.

Findings from the wider hospital and clinical ward areas

The hospital had arrangements in place to plan, organise and manage the workforce. The hospital's total approved complement of staff (all staff) in published data in December 2023 was 3,560 WTEs, an increase of 10% on December 2022. A risk included on the corporate risk registered related to the shortage of skilled clinical staff which impacted the hospital's ability to recruit staff to meet service demands and impacted on the delivery of quality and safe care to patients. This risk was escalated to the Dublin's Midlands Hospital Group.

The hospital's approved complement for nursing was 1,440 WTEs. In January 2024, there was 130 WTE (8.6%) vacancies in the nursing portfolio. There were 33 WTE (13.5%) vacancies in healthcare assistants posts. All consultant posts were filled, and there were 10 vacant non-consultant hospital doctors' posts - six registrars and four senior house officer grades. The vacancies were reviewed monthly through relevant governance groups with ongoing national and international recruitment where appropriate.

Inspectors were informed that the hospital had recently undertaken an active overseas recruitment campaign and at the time of inspection a large number of nurses were undergoing adaptation in various wards throughout the hospital. Inspectors were informed that following the adaptation process, these nurses would take up position in the hospital and fill the majority of vacant nursing posts.

The number of nurses undergoing adaptation was higher than usual at the time of inspection, due to issues in 2023 outside the control of the hospital. This provided

challenges to the hospital in terms of the additional supervision and supports required for these nurses. To manage these challenges, additional clinical facilitators had been put in place to support the nurses undergoing adaptation and the staff nurses mentoring these nurses. The positive impact of increased nurse staffing levels may also bring challenges in terms of nursing skill-mix on wards with this high influx of new nurses to the hospital wards. The hospital needs to ensure that ongoing supports and supervision are in place for these new nurses as they take up their new nursing post.

Documentation submitted to inspectors outlined that Burkitt, Osborne and Gogarty wards visited on the day of inspection had, for the most part, their full approved complement of nurses. Osborne ward had a vacant clinical nurse manager 2 post and inspectors were told that this post was under recruitment and due to be filled shortly. However, short and long term leave impacted on staffing levels on wards visited. Shortages were backfilled with agency staff when available. On the day of inspection– Osborne ward was short two staff nurse shifts and had three additional staff nurses two of whom were undergoing adaptation and required supervision and one who had completed adaptation and was awaiting registration. The staffing and skill-mix issues had been escalated to the Clinical Nurse Manager 3 who was providing support.

Medication safety

At the time of inspection 9.5 WTE of the 53.3 WTE pharmacists post were unfilled, a shortfall of 17.8%. Six of the 34.7 WTE pharmacy technicians post were unfilled, a shortfall of 17%. In addition four maternity leave absences were unfilled. The unfilled posts impacted on the availability of clinical pharmacy services in two peri-operative areas. The critical care lead pharmacist and pharmacy clinical services manager posts were also unfilled. As outlined earlier, to support the provision of pharmacy services, the hospital was increasing the number of basic grade pharmacists, supporting them to gain experience, and upskilling pharmacy technicians to take on additional roles relevant to their scope and skills, to free up pharmacists time to provide clinical services.

Infection prevention and control

At the time of inspection the infection prevention and control team had its full complement of staff which included an infection prevention and control assistant director of nursing grade, infection prevention and control clinical nurse specialists and clinical nurse managers, consultant microbiologists, specialist registrars in microbiology surveillance scientists, an antimicrobial stewardship pharmacist and administrative support.

Uptake of mandatory and essential training

There was good oversight of training at local and senior management level at the hospital. There was an opportunity to improve attendance for mandatory training across

all disciplines in areas such as hand hygiene, standard and transmission based precautions and Irish National Early Warning System.

Clinical handover education was incorporated into all Simulation Based Education sessions and evidence of Simulation Based Education training was provided. Medication safety was included in all nurses and doctors induction. Training records from clinical wards visited on the day of inspection outlined that attendance at medication safety training and high-risk medicines management was on average 74% across these wards.

Overall, the hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department and the wider hospital to support the provision of high-quality, safe healthcare. The reduced pharmacy staffing levels were a risk acknowledged by the hospital with ongoing recruitment and alternative strategies put in place to mitigate the risks. Attendance at and uptake of mandatory and essential training across disciplines could be improved.

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.

Findings from the emergency department

People have a right to expect that their dignity, privacy and confidentiality will 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.

***** 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>

Patient's privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles and single rooms. However, there were patients accommodated on trolleys beside the nurse's station and outside other cubicles and their dignity and privacy and confidentiality was compromised.

Staff were observed to be making every effort to maintain dignity and respect for patients in so far as possible when patients were accommodated on extra trolleys around the department. Staff were communicating in quiet voices to try to maintain confidentiality and supporting patients with their individual needs to maintain dignity and respect. Patients who spoke with inspectors were aware of their plan of care.

The hospital had introduced initiatives to improve the patient experience within the department with a dementia friendly cubicles and a sensory room to support dignity and respect for individuals with sensory issues.

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, however, the dignity and privacy for patients on extra trolleys around the ED was compromised.

Findings from the wider hospital and clinical ward areas

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful towards patients and communicated with patients in a manner that respected their dignity and privacy.

There was evidence that patients' autonomy and independence was promoted, for example, patients told inspectors that they were kept informed and updated about their plan of care. Inspectors observed patient information leaflets in the clinical ward areas visited providing information to patients about medical conditions and services available within the hospital. Information boards on wards visited provided information for patients on ward staff roles by uniform and provided information on the ward's routine.

For the most part, the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. For example, through the use of use of privacy curtains, single rooms and en-suite facilities.

Patients' personal information in the clinical areas visited, during the inspection, was not always observed to be protected and stored appropriately. Inspectors observed patients' healthcare records in unsecure trolleys on the corridor of some wards visited and patients' personal identifiable information was visible on white boards and clip boards on corridors of clinical ward areas visited.

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. However, accommodating patients on trolleys beside the nurses' station and outside other cubicles within the ED did impact on a meaningful promotion of the dignity

and privacy for all patients and was not consistent with the human rights-based approach to care supported and promoted by HIQA. In addition, patients' personal information must be protected and healthcare records should be store appropriately.

Judgment: Partially compliant

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

It was evident that a culture of kindness, consideration and respect was actively promoted by all staff within the clinical ward areas visited. This was validated by patients who spoke with inspectors and comments that staff were '*kind and very nice*', '*can't do enough*' and '*very helpful*'.

To support patients the hospital's Patient Advice and Liaison Service (PALs) offered a confidential advice service and was a point of contact for patients, families and carers. The hospital also had a Volunteer Service who provided a 'meet, greet and guide' service for patients.

The hospital's mission statement was displayed throughout the hospital and outlined the hospital's vision, mission and values. Staff who spoke with inspectors outlined that 'staff were proud of the values prompted by the hospital', evidence provided on the day of inspection substantiated this.

Inspectors found evidence of a person-centred approach to care through examples provided by staff such as respecting patient's views and preferences providing options such as music, art or craft therapy.

Patients at end of life were prioritised for a single room when possible, with end of life symbols displayed to support a respectful and quiet environment. The hospital had a limited number of dedicated rooms for patients at end of life which were especially designed to support dignity and respect for the patient and their family.

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

Judgment: Compliant

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

The hospital had a complaints management system in place. The hospital's Patient Advice and Liaison Service was led by the PALS Manager and supported by relevant policies and guidelines. PALS information leaflets were seen on display and accessible on clinical ward areas visited.

The hospital's PALS Manager was the designated Complaints Officer for the hospital 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 ward areas visited.

The hospital reported on the number and type of formal and informal complaints received annually. In 2023, 1,469 complaints had been received by the hospital with 85% of these resolved within 30 working days, exceeding the national HSE target of 75%.

Recommendations from complaints were monitored by the PALS and evidence of sharing of learning and quality improvement implemented in response to complaints was provided by the hospital. Feedback on complaints was provided at relevant Directorate meetings and to the clinical areas that were the subject of the complaint.

Collated data and information on the hospital's compliance with national guidance and standards on complaint management was reported and reviewed at relevant governance committees such as the EMT, the QSRM Execute Governance Committee and the hospital's Board.

The hospital offered multiple opportunities and methods for patients to raise concern or make a complaint and provide feedback. However, on the day of inspection, patients who spoke with inspectors were not all familiar with the hospital's complaints process, but outlined that if they had a complaint they would speak to a member of staff.

Overall, the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

On the day of inspection, inspectors visited three clinical ward areas. There was evidence of general wear and tear observed with paintwork and wood finishes chipped. This did not facilitate effective cleaning. Due to a lack of storage facilities some ward corridors and rooms on wards visited by inspectors were cluttered with equipment.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical

areas. Inspectors noted that a number of hand hygiene sinks in wards visited did not conform to national requirements.⁺⁺⁺⁺ Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms.

The clinical ward areas visited had a dedicated cleaner Monday to Friday, with hospital cleaners allocated to cover cleaning requirements out of hours. The cleaning supervisors had oversight of the cleaning schedules in the clinical ward areas visited.

Cleaning of equipment was assigned to healthcare assistants and nurses, and there was a system in place to identify equipment that had been cleaned. However, on the day of inspection some equipment observed by inspectors was in need of cleaning. Hazardous material and waste was safely and securely stored in each clinical ward areas visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

One area visited by inspectors was undergoing refurbishment at the time of inspection. As a consequence supplies were stored in an inappropriate area. Clean supplies on another wards were stored in an unsuitable environment. This was brought the attention of the CNM on the day of inspection with an improvement observed on the second day of inspection.

The hospital outlined that it had insufficient single rooms to isolate patients with communicable infectious diseases or to protect those vulnerable to infection. This risk was escalated to the corporate risk register with controls in place to mitigate the risks, in so far as possible. The infection prevention and control nurses visited wards daily to support and advise on single room prioritisation in line with the hospital's isolation policy.

The design of the negative pressure rooms⁺⁺⁺⁺ on clinical wards visited was not in line with best practice and guidance. This risk was identified by the hospital and included on the IPC risk register with actions outlined to mitigate the risks. Inspectors were informed that the hospital did have a number of appropriately designed negative pressure rooms in other areas of the hospital.

In summary, on the day of inspection there were opportunities to improve the physical environment to support the delivery of high-quality, safe, care. Storage facilities for equipment was a challenge resulting in some clutter on corridors and rooms. Some equipment observed was in need of cleaning, and clean supplies were stored adjacent to

⁺⁺⁺⁺ 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

⁺⁺⁺⁺ Negative pressure rooms are rooms where the air pressure inside the room is lower than the air pressure outside the room. This means that when the door is opened, potentially contaminated air or other dangerous particles from inside the room will not flow outside into non-contaminated areas. Some negative pressure rooms require an anteroom, which is an airlock room that provides a safe area for healthcare professionals to change into or out of protective clothing, transfer or prepare equipment and supplies, and can protect other rooms from contamination if pressure is lost within the negative pressure room.

the dirty utility on some wards inspected. The design of some negative pressure rooms was not in line with approved standards and there was insufficient isolation rooms in the hospital to accommodate patients with communicable infectious diseases.

Judgment: Partially compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services 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 monitored and reviewed information from multiple sources that included; patient-safety incident reviews, complaints, risk assessments and patient experience surveys. Inspectors observed quality boards on display in clinical area visited, which displayed information on compliance with monitoring and audit.

The hospital developed a clinical audit plan which outlined priority audits for the year ahead with oversight of progress of these audits and implementation of recommendations monitored by the Clinical Audit Committee.

Infection prevention and control and antimicrobial stewardship monitoring

The hospital was actively monitoring and evaluating infection prevention and control and antimicrobial stewardship practices at the hospital. The Infection Prevention and Control Governance Committee had oversight of IPC and AMS audit and monitoring. IPC audit and monitoring results were tracked and trended by the hospital and findings shared with staff. Performance indicators in relation to the prevention and control of healthcare-associated infection were monitored by the hospital and reviewed at relevant governance committees. Bug buster bulletins were developed and distributed by the IPC team to share information with staff.

Monthly environmental audits were undertaken by the hospital. Environmental audit results viewed by HIQA showed that the clinical areas visited on the day of inspection had achieved an overall high level of compliance (from 83% to 92%). The hospital completed monthly hand-hygiene audits and took part in bi-annual national hand-hygiene audits. A hand-hygiene improvement strategy was implemented in 2023 with evidence of implementation of required actions. However, there was still opportunity for improvement with hand-hygiene compliance target for monthly audits on clinical ward areas visited on the day of inspection. In 2023 - Ruttle ward was 90% compliant 6 of 12 months, Gogarty ward was 90% compliant 8 of 12 months, and Osborne ward was 90% compliant 10 of 12 months.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety related practices at the hospital such as allergies, weights, positive patient identification, venous thrombosis embolism prophylaxis and Sound-Alike-Look-Alike Drugs (SALAD) errors with recommendations actioned and re-audits completed to demonstrate improvements in practice. The hospital was monitoring Nursing and Midwifery Quality Metrics which included a component of medication safety.^{§§§§§} Monthly results provided demonstrated good compliance against the medication safety metrics.

Deteriorating patient monitoring

The hospital collated performance data of the hospital's deteriorating patient through monthly monitoring of the INEWS observation chart on selected wards and an escalation and response audit which included the use of the ISBAR^{*****} communication tool for the deteriorating patient. Audits of a pilot of the Irish Maternity Early Warning Score (IMEWS) in progress at the hospital at the time of inspection were also undertaken to guide the introduction of the IMEWS observation chart. The early warning system was monitored as part of the patient's monitoring and surveillance component of the Nursing and Midwifery Quality Metrics, results seen by HIQA demonstrated good compliance.

Transitions of care monitoring

Evidence of monitoring of clinical handover and the use of ISBAR₃⁺⁺⁺⁺⁺ for both nursing and medical staff was provided to HIQA of audits undertaken in 2021 and 2022, with limited evidence of audits undertaken in 2023 provided. There was opportunity for improvements in the undertaking of audit in relation to the transition of care and implementation of recommendation and re-audit to demonstrate improvement in practice.

Overall, there was opportunity for improvement in the monitoring and evaluation of healthcare services provided at the hospital, especially in relation to medication safety and transitions of care. Healthcare practices should be monitored and audited regularly, with implementation of recommendations monitored with re-audited to ensure improvements in practice.

Judgment: Substantially compliant

^{§§§§§} Wrist band legible and correct, medication record identifications correct, allergy status recorded, legible prescription, medicine formulary available, medicine at prescribed frequency, minimum dose interval specified, independent verification of medicine, medicine related education.

^{*****} ISBAR₃: Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk. Inter-departmental and shift clinical handover should be conducted using the ISBAR₃ communication tool.

⁺⁺⁺⁺⁺

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

Findings related to the emergency department

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. Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at Unscheduled Care Committee, EMT, the hospital's Board, and performance meetings with the Dublin Midlands Hospital Group.

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 by the emergency medicine consultant lead, clinical nurse manager 3 and ADON with review at the Emergency Department Clinical Operations Group with oversight by the Unscheduled Care Group. Risks related to the emergency department were recorded on the hospital's corporate risk register. Risks not managed at hospital level were escalated to the EMT. Some risks on the ED risk register were overdue for review and should be assessed and updated by the hospital.

As outlined under standard 5.5 the PETs for January to September 2023 were non-compliant with national target and below the national average for all hospitals. Data submitted by the hospital from October 2023 to January 2024, while still non-compliant with national standards, demonstrated an improvement in over 24 hour PETs for all attendees (90%) and for attendees 75 years and over (87%).

At 11am, the hospital was non-compliant with national PET targets, 21 patients (51%) were in the department over six hours, 19 patients (46%) were in the department over nine hours and five patients (12%) were in the department over 24 hours. Five patients in the department were 75 years of age and over – three of these patient were in the department over nine hours. There were no 24 hours breaches for patients 75 years or over.

The percentage of ED patients who left the department before completion of treatment remained high at 14% in comparison to other hospitals in published data for 2023 and the national target of less than 6.5%. However, this rate was much improved on the rate identified on the previous inspection of 23%. The hospital had a system in place to follow up patients who left the ED prior to completion of treatment. Review and management of this metric should be continued by the hospital to build on the current improvement.

Infection prevention and control

The hospital had a system in place to assess patients for communicable infectious diseases on arrival at the hospital. A prioritisation system was used to allocate patients to single and isolation rooms in the ED.

Infection prevention and control nurses visited the department daily. Staff had 24/7 access to a consultant microbiologist for advice.

Minimum physical spacing of one metre in line with national guidance was not maintained for patients on additional trolleys in the ED. The ED was generally clean but there was a number of areas of general wear and tear observed, with paint work and wood finishes chipped, this did not facilitate effective cleaning. The department was on average 63% compliant in environmental audits carried out in November 2023, with significant opportunity to improve in the areas of equipment and personal protective equipment. Hand-hygiene audit undertaken in the ED had poor compliance at 43%. A re-audit in December had seen a rise to 75% compliance which was however, still below the national target of 90%. Inspectors were informed that feedback was provided to staff at safety huddles.

Medication safety

At the time on inspection there was no clinical pharmacist assigned to the emergency department. A pharmacy technician did visit the department daily to replace pharmacy stock. Staff in the department had access to a consultant microbiologist.

Deteriorating patient

The hospital were using the INEWS observation chart was used for admitted patients in the ED to support the recognition and response to a deteriorating patient in the emergency department. The ISBAR^{*****} communication tool was used when requesting reviews of patients. Inspectors were informed that introduction of the Emergency Medicine Early Warning System (EMEWS) was in planning at time of the inspection. This should be progressed by the hospital to support the recognition and response to the deterioration of all patients in the emergency department

Transitions of care

Two multidisciplinary safety huddles, at 9am and 2pm were held in the emergency department to discuss the status of all patients in the department and identify patients that were of concern. Inspectors were informed that the ISBAR communication tool was not formally used for internal and external patient transfers from the emergency department. However, an ED to ward clinical nursing handover form (pilot version) incorporating ISBAR

***** ISBAR :Identify, Situation, Background, Assessment, Recommendation.

was provided to inspectors – this should be implemented to support adherence to national guidance. Lack of adequate inpatient bed capacity impacted on the time patients spent in the ED, on the day of inspection 16 admitted patient were accommodated in the ED.

Management of patient-safety incidents

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported directly to the National Incident Management System (NIMS),^{§§§§§§} in line with the HSE’s incident management framework. Feedback on patient-safety incidents relevant to the area was provided to the clinical nurse manager 3 by the quality and risk manager. Inspectors were informed that automatic alerts regarding new incidents was not currently provided to line managers. This was an area for improvement for the hospital which was under review at the time of inspection. In the interim, line managers were routinely checking the NIMS to keep up to date with reported incidents.

Management of complaints

Complaints related to the emergency department were managed locally, in line with the hospital’s complaints policy with oversight from the clinical nurse manager 3 and ADON and emergency medicine consultant lead as required. There were two Patient Liaison Officers dedicated to the ED 6/7 days. Since the introduction of this role the hospital reported a reduction in complaints. Complaints related to the department were tracked and trended by the patient safety and risk manager and feedback was provided to the department staff. PALS manage complaints received regarding ED and feedback is provided to the department staff.

Findings from the wider hospital and clinical ward areas

The hospital had systems and processes in place at the hospital to identify, evaluate and manage immediate and potential risks to people using the service in the four areas of known harm which were the focus of this inspection. The QSRM Executive Governance 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 hospital’s Board and as appropriate to the Dublin Midlands Hospital Group. Risks were recorded on the corporate risk register with existing controls and additional required actions to manage and reduce these risks.

High-rated active risks recorded on the hospital’s corporate risk register related to HIQA’s monitoring programme included- staff shortages, patient flow pressure and pressure on bed capacity, insufficient inpatient beds, insufficient isolation facilitates and the pharmacy

^{§§§§§§} 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).

aseptic unit. The hospital's corporate risk register had existing controls in place and additional actions required outlined to manage and reduce the risks.

Another risk identified by the hospital and included on the corporate risk register was the challenges meeting demand for enhanced care observations for vulnerable patients with safety risks. To support care for these patients, the hospital had introduced an Enhanced Care Observation and Assessment Care Plan supported by a decision making algorithm and an Enhanced Care Observation Policy, staff education and a communication pathway. The initiative was being piloted on a number of clinical ward areas with positive feedback from staff on pilot wards visited by inspectors. The hospital was endeavouring to recruit dedicated healthcare assistants for this role, but funding for these posts has not been approved at the time of inspection. Enhanced care requirements were discussed at clinical handover by the senior nursing team morning and night.

Infection prevention and control

The infection prevention and control team maintained a local risk register of potential infection risks. As mentioned under standard 2.7, the design of some negative pressure rooms were not in line with best standards and the associated risks were recorded on the local infection prevention and control risk register, with controls in place to mitigate the risks. Risks that could not be managed locally by the infection prevention and control team were escalated to the hospital's EMT and recorded on the hospital's corporate risk register.

A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks. Outbreaks reports and quality improvement plans were viewed by inspectors. Inspectors found that the management of infection outbreaks at TUH was in line with national guidance.

Medication safety

One of the highest rated risks on the hospital's risk registered related to the hospital's aseptic unit not operational due to water damage – risk mitigation actions were in place and the hospital was well advanced on a plan to rebuild the unit.

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 high-risk medicines. However, the storage and segregation of refrigerated medicines and low molecular weight heparins required improvement on some wards visited by inspectors. This was brought to the attention of the clinical nurse managers on the day of inspection.

The unfilled pharmacist posts discussed under standards 6.1 impacted on availability of clinical pharmacist services in the ED and two peri-operative areas, and the lack of a critical care lead pharmacist and pharmacy clinical services manager. As outlined earlier the hospital had employed basic grade pharmacists to senior grade pharmacist post. The basic grade pharmacists were assigned roles appropriate to their level of expertise with supports

in place. The hospital identified challenges to this strategy in the short to medium term, but outlined that it was the best opportunity to resolve the challenges in the long term. The risks associated with pharmacist shortages were identified by the hospital and escalated to the corporate risk register.

Medication reconciliation was undertaken for patients on admission to wards with an assigned clinical pharmacist. Clinical pharmacists were accessible to staff for support and advice. The consultant microbiologist was accessible to ward staff 24/7. Wards also had pharmacy technician services for medication stock control.

Deteriorating patient

The hospital had systems in place to recognise, respond to and manage the deteriorating patient. The Irish National Early Warning Score (INEWS) version 2 observation chart was used for all adult (non-pregnant) inpatients and an ISBAR communication tool was used to escalate care. The Emergency Response Team was available to review, manage and escalate care of the deteriorating patient.

To date the hospital had not implemented the Irish Maternity Early Warning System (IMEWS) in line with National Clinical Guidelines No. 4 (2019). The hospital used the INEWS observation chart for pregnant women with specific approved protocols for escalation. At the time of inspection, inspectors were told that the hospital was at an advanced stage of implementation of the IMEWS. The IMEWS should be used for the hospital care of a woman with a confirmed clinical pregnancy and for up to 42 days in the postnatal period.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. The hospital had a number of transfer and discharge templates to facilitate safe transitions of care.

The Clinical Handover Committee were responsible for implementing the national clinical guidance for clinical handover^{*****} and were actively progressing the use of ISBAR₃ for nursing and medical handover.

Policies, procedures and guidelines

Inspectors reviewed a selection of policies, procedures and guidelines relevant to the focus of this inspection. Policies reviewed were for the most part up to date and accessible to staff through the hospital's electronic system.

In summary, 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,

***** Communication (Clinical Handover) in Acute and Children Hospital Services. National Clinical Guideline No 11

medication safety, the deteriorating patient and transitions of care. There was a lack of clinical pharmacist services in the ED and two surgical wards. The ED risk register required reviewing and updating. The IMEWS and EMEWS had yet to be implemented to support the identification, response and management of the deterioration of specific cohorts of patients. ISBAR should be used to support transitions of care. Refrigerated medicines and low molecular weight heparins should be stored and segregated appropriately. However, potential risks still remain with areas for improvements, such as PETs for patients in the ED. Despite recent improvements in the hospital's 24 hour PETs, overall PETs still fell significantly short of national targets. This created a risk of harm for patients who were in the ED for prolonged periods of time.

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 had recently moved to direct reporting of patient safety incidents to the National Incident Management System (NIMS). This should support timely reporting of incidents. The percentage of incidents reported onto NIMS within 30 days of notification of the incident in 2023, was only 28% significantly below the national target of 70%.

Extreme and major incidents as a percentage of all incidents reported as occurring was 0.5%. This was compliant with the national target. The hospital's rate of reviews completed within 125 days of category 1 incidents from the date the service was notified of the incident was only 43% in 2023. This was non-compliant with the national target of 70%.

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. 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 relevant governance committees the QSRM Executive Governance Committee, EMT and at performance meetings with the Group.

Management of serious reportable events

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious incidents which occurred at the hospital and were responsible for ensuring that all serious patient-safety incidents were managed in line with the HSE's Incident Management Framework. The SIMT was chaired by the Director of QSRM and

met monthly, or more frequently if required. The SIMT reviewed and monitored new and ongoing serious incidents and the associated reviews and recommendations. In addition, serious incidents and serious reportable events were also discussed at EMT and the hospital's Board.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events related to the clinical areas visited were reported directly to the National Incident Management System, in line with the HSE's Incident Management Framework. The hospital's patient quality and risk manager tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the QSRM Executive Governance Committee. Incidents were rated by severity, category and location. Patient-safety incidents were also discussed at monthly performance meetings with the Dublin Midlands Hospital Group. Feedback on patient-safety incidents was provided to clinical nurse managers and evidence of learning from incidents was provided to inspectors.

QSRM forwarded IPC related patient-safety incidents to the IPC team for review and action. The QSRM also provided a quarterly report of IPC related patient-safety incidents which was presented at quarterly IPC Governance Committee meetings.

Medication related patient-safety incidents were reviewed by the medication safety pharmacist and categorised in terms of severity of outcome using an evidenced based tool. Medication safety incidents were reported and reviewed at relevant governance forums and learning was shared through Patient Safety Learning Notices.

Overall, 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 safety incident and incidents related to the deteriorating patient and transitions of care. The relevant governance committees had oversight of the management of these incidents. The Senior Incident Management Team, EMT and the hospital's Board had oversight of serious incidents. There was an opportunity for improvement in the timely completion of category 1 incident reviews, and the hospital needs to ensure the timely reporting of incidents onto the NIMS.

Judgment: Substantially compliant

Conclusion

HIQA carried out an unannounced inspection of Tallaght University 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.

The hospital had formalised corporate and clinical governance arrangements in place. Governance arrangements in place at the hospital had a focus on the quality and safety outcomes for people using the service.

The hospital had defined management arrangements in place to manage and oversee the delivery of care in the four areas of known harm which were the focus of this inspection. But operationally, patient flow within the hospital was not functioning as it should. The mismatch between availability and demand for inpatient beds resulted in admitted patients being accommodated in the ED. This resulted in increased PETs, a decrease in efficiency and increased patient risk. Admitted patients were also accommodated in the AMU and ASAU, which impacted on the effective running of these units.

The hospital monitored performance against key performance indicators, and information from this process was being used to improve the quality and safety of healthcare services. Examples of quality improvement initiatives implemented in response to monitoring was provided by the hospital, but there remained opportunities to expand this across all monitoring findings.

Workforce management arrangement were in place at the hospital to support the provision of high-quality, safe healthcare. Risks associated with the reduced pharmacy staffing levels were acknowledged by the hospital with ongoing recruitment and alternative strategies were put in place to mitigate the risks. Attendance at and uptake of mandatory and essential training across disciplines could be improved.

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. However, accommodating patients on trolleys beside the nurses' station and outside other cubicles within the ED did impact on a meaningful promotion of dignity and privacy for these patients. In addition, patients' personal information must be protected and healthcare records stored appropriately. A culture of kindness, consideration and respect for people accessing and receiving care at the hospital was promoted by the hospital's management and staff.

There were opportunities to improve the physical environment to support the delivery of high-quality, safe, care which included the need for appropriate storage of supplies and equipment and the cleaning of equipment. There was insufficient isolation rooms in the hospital to accommodate patients with communicable infectious diseases.

The hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. There was opportunity for improvement in the monitoring and evaluation of healthcare services provided at the hospital, especially in relation to medication safety and transitions of care.

There were systems in place to identify and manage potential risk of harm associated with the four areas of known harm which were the focus of this inspection. However, potential risks still remain, with areas for improvements such as PETs for patients in the ED. Despite recent improvements in the hospital's 24 hour PETs, overall PETs still fell significantly short of national targets. This created a risk of harm for patients who were in the ED for prolonged periods of time. There was opportunities for improvement in the provision of clinical pharmacy services on all clinical wards, the implementation of the IMEWS and EMEWS to support the identification, response and management of the deterioration of specific cohorts of patients and the use of ISBAR3 to support transitions of care. 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 was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

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

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

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

Capacity and Capability Dimension

Theme 5: Leadership, Governance and Management

National Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant

Theme 6: Workforce

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

Quality and Safety Dimension

Theme 1: Person-Centred Care and Support

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant

Theme 2: Effective Care and Support

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

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

Appendix 2 Compliance plan submitted by Tallaght University Hospital

No.	Issue identified by HIQA	SMART Interim Action	Due Date- Interim action	Persons Responsible for interim actions	SMART Long Term Action	Due Date - Long term action	Persons Responsible for long term actions
5.5	The HSE's key performance indicators for patient experience times with 46% of the ED attendees in the department over nine hours.	A project has commenced to focus on non-admitted under the governance of the Urgent and Emergency Care (UEC) Projects group. Aim is to meet 6 hour and 9 hour non-admitted targets. Due to the different contributing factor across a 24 hours period the initial aim is to reach compliance during core working hours.	31st August 2024	Non-Admitted project group & Office of the COO	Continue to rollout non-admitted PET compliance into the 4 -12 midnight time slots and lastly into the 12am – 8am timeslots	4pm – 12 by 31/12/2024. 12am - 8am 28/02/ 2025	Non-Admitted project group & Office of the COO
5.5	Sixteen admitted patients were accommodated in the ED under the care of a specialist consultant awaiting an inpatient bed	Maximise patient flow including ambulatory pathways and use of offsite beds to consistently achieve amber (RAG) trolleygar status at 08.00 on 75% of days for example QIP on ward transfer times commencing May 2024	31st Oct 2024	EUC Project Group, Patient flow, Office of the COO	1. Provide additional inpatient beds to TUH. Capital project approved by HSE Estates- currently in design phase. 2. Operationalise ECC with a specific focus on chronic diseases	1. Q3 2028. 2. Q1 2025	1. HSE Estates, Dir F&E. 2. DoN and Integrated Care, CHO 7
5.5	The ARAU was accommodating inpatients waiting for an inpatient bed, and therefore was not functioning as intended	ARAU beds form part of the agreed TUH Escalation Policy. Dependent on escalation status, we aim to reduce utilisation of ARAU beds for IP from 75% to 50%	Immediate and ongoing	EUC Project Group, Patient flow, Office of the COO	1. Provision of modular build with net increase of 5 IP beds 2. Two additional IP (Lynn and Burkitt) through reconfiguration of clinical space	1. Q2 2025 2. Q3 2024	EMT & HSE

5.5	The acute surgical assessment unit (ASAU) was not fully functioned as an ASAU to support patient flow.	ASAU beds form part of the agreed TUH Escalation Policy. Dependent on escalation status, we aim to reduce utilisation of ASAU beds for IP from 87% to 50%	Immediate and ongoing	EUC Project Group, Patient flow, Office of the COO	1. Provision of modular build with net increase of 5 IP beds 2. Two additional IP (Lynn and Burkitt) through reconfiguration of clinical space	1. Q2 2025 2. Q3 2024	EMT & HSE
5.5	The SIFT, proposed to operate daily Monday to Friday was still not fully operational each day	SIFT is occurring Monday-Friday with the support of diagnostic technicians. It is performed interchangeably by consultants / Registrars and is balanced between the need to focus on PET times for patients >75 years presenting to the department. There is a business case under consideration to support additional registrar staff dedicated to this area.	28/06/2024	Clinical Lead ED Clinical Director	SIFT 24/7 dependent on approval to recruit 4 additional ED registrars	Q1 2025	Clinical Lead ED Clinical Director Executive Management Team
5.5	Deteriorating Patient: the emergency response data coordinator post was vacant	Interviews for Emergency response data coordinator are scheduled for 13th May 2024. All above interim actions will continue following appointment, some handing over of duties will occur but interim actions will remain pertinent and are required and accepted as long term actions	Q2 2024	PeriOp ADON			

5.5	The average length of stay (ALOS) reported by the hospital for medical and surgical patients is greater than the national average	The addition of a patient navigator and a focus on delayed and complex discharges is having an positive effect. DTOCs are now below the national target threshold of 20 and work is ongoing to improve flow through the UEC project group. Background: Much of the population in the catchment area of TUH have increased comorbidities compared to age matched patients nationally. Action: Patient flow continue to work with primary clinical teams, diagnostic departments and discharge planning to streamline the performance of rate limiting investigations and also organisation of Home Care Supports or transitional discharge arrangements. Significant progress has been made on this front in 2024. An electronic Patient Flow Information System will be introduced in Q4 2024 to enhance this information flow.	Immediate and ongoing	UEC project Group, Patients Flow & Office of the COO Clinical Directors	1. Provide additional beds to TUH to facilitate introduction of speciality specific wards 2. Continue to develop and implement ambulatory care pathways to include renal stone, headache, seizure pathway, DVT and PE pathway and abdominal pain	1. Q1 2028 2. End Q4 2024	1. HSE Estates and Dir F&E 2. CDs, DoN and COO
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5.5	The hospital should continue to recruit pharmacists to fill vacant posts	Continue to recruit newly qualified and/or experienced community pharmacist to fill existing vacancies. Utilise vacant senior roles to facilitate recruitment of basic grade pharmacists in the short to medium term. Net increase of 5 WTE recruits achievable by Q4 2024 from February 2024 baseline. Support newly recruited pharmacists development including postgraduate qualifications appropriate to role and service to commence. Continue projects to improve skill mix, reducing our dependence on Pharmacists where feasible, redirecting pharmacists time to patient facing roles whilst offering greater job satisfaction for both Pharmacists and Technicians. Two Medication History Technicians in place for Q3 2024 with a third in place for Q1 2025. Continue to recruit Senior/Specialist Grade Pharmacists at every opportunity acknowledging the significant national shortage of Senior/experienced pharmacists. Ensure eligible and suitable internal candidates are afforded opportunities of Senior roles as soon as possible to facilitate restoration of services and retention of valued staff. Implement new Advanced Specialist roles at earliest opportunity to facilitate service	Net increase of 5 WTE Pharmacist recruits achievable by 31/12/2024. Two Medication History Technicians in place for 1/07/2024 with a third in place for 01/03/2025. 2 Basic Grade Pharmacists eligible for Senior Roles by 31/12/ 2024. Advanced Specialist roles to be implemented by 31/12/2024 if launched by the HSE in 28/06/2024.	Head of Pharmacy with support from Human Resources and Executive Management Team	If successful, further develop skill mix options in the Pharmacy Service utilising technicians and pharmacy aides where possible to provide services within their scope of practice offering support to develop skills where possible. This will facilitate redirection of pharmacists to patient facing roles. Utilise medicines management technology such as Pharmacy robotics, electronic prescribing medicines administration and automated dispensing cabinets to support pharmacists to ensure pharmacists maximises time in patient facing activities. Introducing technology will facilitate recruitment and retention of staff. Ensure eligible basic grade pharmacists recruited have the opportunity to	Q4 2026	Head of Pharmacy with support from Human Resources and Executive Management Team
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		provision and retention of experienced staff.			<p>progress to senior and specialist roles thus ensuring progression, retention and restoration of services including inpatient beds and Emergency Dept. Restore Clinical Pharmacy Service to Adult inpatients beds to a team based service.</p> <p>Clinical pharmacy service complement to be at least 60% Senior Pharmacist. Continue to monitor and test the market for senior specialist pharmacist roles to recruit including international option e.g. UK</p>	
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1.6	The dignity and privacy for patients on extra trolleys around the ED was compromised.	While focussing on reducing numbers of patients admitted in ED and awaiting a bed (see actions above), we will continue to focus on maintaining dignity and privacy including ongoing provision of patient comfort packs, investment in additional patient privacy screens and ongoing communication about plan of care with support from Patient Liaison Officers (order screens by end Q2 2024)	ongoing	ADON for ED	1. Reduce admitted and non-admitted PETs in order to reduce number of patients within ED at any time. 2. Increase IP bed capacity	1. Q4 2024 2. Q1 2028	1. EM Lead / ADON 2. HSE Estates and TUH F&E
1.6	White boards- Patients' personal information in the clinical areas must be protected.	1. Follow TUH Policy re Patient Personal Information - communication to be issued to staff 2, Repair damaged white boards	Q2 2024	1. DON and CDs. 2 F&E	An electronic Patient Flow Information System will be introduced in Q4 2024 to enhance this information flow.	Q4 2024	ICT, Clinical Directors, Nursing Ward CNMs, COO Office
1.6	Health record storage	Comply with TUH Policy and Communication to Issue in this regard	Immediate	DPO / COO / CDs / DoN	The implementation of the EPR will allow for health care records to be stored in a secure electronic format maintaining. Access to confidential data and information is role-based and an audit trail is in place to enable tracking of access to data subjects' personal data and information.	Q4 2024	EPR Steering Committee

2.7	There was evidence of general wear and tear observed with paintwork and wood finishes chipped. This did not facilitate effective cleaning.	1. In order to address minor infrastructure TSD strategy is for focussed initiatives for each of the 'failure' types. Employed the services a flooring repair specialist to continuously address flooring defects for a 6 month period. This is having a difference in the ward areas. 2. Surveyed all the windows in the ward block and are now implementing the repairs identified from the report (a significant undertaking).3. Our in house painter is working through the ward area to address defects identified, following in behind the flooring contractor. 4. The inpatient bed room refurbishment programme is ongoing 5. There is an initiative to refurbish the Dirty Utilities.	Implementation ongoing	Director of Facilities & Estates	1. TSD seeking to increase resources to manage infrastructure deficits. 2. A new maintenance manager will be employed dependent on HSE approval.	1. Q1 2025 2. Q2 2025	Director of Facilities & Estates
2.7	A number of hand hygiene sinks in wards visited do not conform to national requirements.	Many of the wash hand basins in the wards pre-date the national standards. In all recent renovation works we upgrade the wash hand basins as a standard. Phased upgrading of remaining sinks is ongoing. Full audit of IP sinks in order to establish work plan	Q3 2024	Director of Facilities & Estates	Sink upgrade project based on audit findings	Q3 2026	Director of Facilities & Estates

2.7	Insufficient single rooms to isolate patients with communicable infectious diseases or to protect those vulnerable to infection.	Business in submission for modular unit for in patient beds, to be delivered in advance of ward block development. Seek to have delivery within 18 month time frame. Solution includes for additional 18 single rooms.	2025	Director of Facilities & Estates	We currently have an initiative to develop a new ward block, which will add 96 single rooms to our bed base in addition to converting 32 beds, which are currently in multi-bed accommodation to single rooms. 8 of the beds within the ward block will have the full isolation facility.	2028	Director of Facilities & Estates / HSE Estates
2.7	System in place to identify equipment that had been cleaned. However, some equipment was in need of cleaning.	Patient Equipment Cleaning Operative for deep clean of patient equipment commenced in March 2024 to assist areas to clean patient equipment. Clean as you go emphasised during audits CNM complete hygiene audits and equipment spot check is completed as part of this audit	30/09/2024	Director of Nursing & Integrated Care	Evaluation of Patient equipment cleaning operative in maintaining clean equipment in areas will be evaluated in 6 to 8 months. Continue to emphasise clean as you go for patient equipment in clinical areas. Continue to provide feedback based on various audit results. Discussed in IPC compliance group meeting	Q1 2025	Director of Nursing & Integrated Care

2.7	The design of the negative pressure rooms on clinical wards visited was not in line with best practice and guidance. Risk on the hospitals RR with actions to mitigate the risks.	No short term action for TUH Comment - The hospital is aware that & does not classify the 'negative pressure' room referred to as an isolation room that accords with best practice and guidance. The hospital is increasing the number of compliant isolation rooms through campus development, 3 added as a result of Vartry Renal unit development & 12 added as part of ICU expansion.		Director of Facilities & Estates	Future ward developments planned with isolation room capability - new ward block development planned with 2 compliant isolation rooms per ward	Q1 2028	Director of Facilities & Estates and HSE Estates
3.1	Hand Hygiene Audit taken in ED had poor compliance at 43%. A re-audit in December had seen a rise to 75%, which is still below the national target of 90%.	Hand hygiene improvement plan in place: Monthly hand hygiene audits circulated to staff at handover huddles DAO IV light box used in clinical areas with assistance of IPC CNM for education purposes Sending staff to clinical skills workshops Sending adaptation nurses to additional education sessions Hand hygiene refreshers for NCHDs 5 moments cards to be distributed Bare below elbow audits weekly Each member of staff should have individual hand gel Hand hygiene task force May 2024	Q2 2024	ADON / CNM3 /Clinical Lead ED and IPC CNM2	Have ED Shift lead CNM2s and CNM1s trained as hand hygiene auditors to increase awareness and sustain improvements. Improve mandatory training compliance with improved staffing levels	Q4 2024	ED ADON / IPC CNM2
3.1	Some risks on the ED risk register were overdue for review and should be assessed and	The ED risk register will be assessed and updated by ED Risk Lead, ED Clinical Lead and Clinical Director.	Q2 2024	ED Risk Lead ED Clinical Lead Clinical Director			

	updated by the hospital						
3.1	The introduction of the Emergency Medicine Early Warning System (EMEWS) was in planning at time of the inspection. This should be progressed by the hospital to support the recognition and response to the deterioration of all patients in the emergency department.	Start date for implementation of phase one on Monday July 1st. 60% of ED staff have completed their face to face training with ED clinical facilitators. Completion of online EMEWS module on HSEland to be completed by all staff prior to implementation of phase 1-staff have received email communication re same	End Q2 2024	ADON / CNM3 /Clinical Lead ED and IPC CNM2	Nerve centre (system replacing Symphony)- estimated end of Q4 2024 required before implementation of Phase 2. Additional nurse staffing requirements (approximately 5 additional nurses for waiting room) needed before implementation of phase 2. DON, Safe Staffing Framework) has included staff for EMEWS in the calculation of the staffing requirement for each ED nationally.	Q1 2025	DON
3.1	ISBAR communication tool was not formally used for internal and external patient transfers from the emergency department.	ISBAR tool laminated on nurses workstation as prompt and guide for ED nurses handing over to ward areas Implement ISBAR for internal and external patient transfers	Q2 2024 Q4 2024	ED CNMS and ED Quality Lead	Integrate ISBAR into EPR for Clinical Handover	Q1 2025	ICT Synergy Lead, CCIO, ED Clinical Facilitator

3.1	The storage and segregation of refrigerated medicines and low molecular weight heparins required improvement on some wards visited by inspectors	Pharmacy, together with colleagues in Nursing and Dietetics to review current storage arrangements with a view to resolving. Outcomes to be achieved: • Only Medications to be stored in the Medication Fridges in clinical areas • Review storage of low molecular weight heparins with a view to segregating products to avoid possible selection error	Q3 2024	Head of Pharmacy Director of Nursing Head of Dietetics	Introduction of Medication Management technology including Automated Dispensing Cabinets which will facilitate improved storage and selection processes for all medicines.	Q 4 2026	Head of Pharmacy
3.1	The IMEWS should be used for the hospital care of a woman with a confirmed clinical pregnancy and for up to 42 days in the postnatal period.	In April- May 2024, all clinical staff (nurses and doctors) are completing the IMEWS eLearning program on HSE land and attending face-to-face education in clinical areas. IMEWS training records are maintained locally. The percentage of nursing staff who have completed INEWS V2 training will be measured in May and is a plan in place to achieve a minimum of the target of 85% nurses are trained prior to introducing iMEWs	Q2 2024	ERS Governance Committee	IMEWS V2 National Clinical Guideline No. 4 has been adopted in TUH. In May 2024, the IMEWS V2 observation chart will be used for all pregnant and postpartum women up to 42 days.IMEWS will be supported through the application of quality improvement methods, such as engagement strategies, education and measurement to ensure successful implementation, sustainability and future progress. IMEWS education	Q1 2025	ERS steering group

				will be included in induction programs for newly joined staff. IMEWS training will be a part of all education on clinically deteriorating patients. An ongoing IMEWS clinically based training program will be in place for all staff in the in the Hospital		
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