Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at the Mid-Western Regional Hospital Ennis

6 April 2009

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority established under the Health Act 2007 to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services).

Monitoring Healthcare Quality – Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare.

Health Technology Assessment – Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

Health Information – Advising on the collection and sharing of information across the services, evaluating, and publishing information about the delivery and performance of Ireland's health and social care services.

Social Services Inspectorate – Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.

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1 Executive summary

Introduction

In the late summer of 2008, serious concerns were raised by family members of two patients – the late Ann Moriarty and the late Edel Kelly – about the potential risks to the health and welfare of patients at the Mid-Western Regional Hospital (MWRH) Ennis, following the treatment that their family members had received.

In September 2008, the Health Information and Quality Authority (the Authority), at the request of the Minister for Health and Children and following agreement from the Board of the Authority, announced it would undertake an investigation of the arrangements for providing services at MWRH Ennis. Subsequently, further families came forward to the Authority with concerns in relation to care their family members received across a variety of different services provided at MWRH Ennis.

The Investigation did not set out to undertake a forensic investigation of each of these patients' care. However, the experiences of all the families who came forward informed the investigation and helped to shape the review of the quality and safety of services provided in MWRH Ennis. The Investigation Team met with and interviewed seven families of patients, and or patients, at the outset of the investigation.

Their experiences related to a variety of different services provided at MWRH Ennis and are captured within the various relevant sections of this report. It should be noted from the outset of this report that their courage in coming forward will benefit future patients and enable high quality, safer services to be provided at MWRH Ennis.

The investigation consisted of a review of clinical practices, systems and processes within the services covered by the Terms of Reference. This included a documentation review, at both local and national level, site visits to MWRH Ennis, data analysis, and interviews with patients and their relatives as well as with clinical and non-clinical health services staff.

Findings

International evidence shows that patients with specific conditions obtain safer and better outcomes when treated by clinicians who routinely care for high numbers of patients with such conditions. Patients receive poorer outcomes when they are cared for by clinicians working in systems where they only occasionally care for patients with specific conditions. In this context the Investigation Team concluded that the MWRH Ennis will have an important part to play in providing high quality and safe services for its community. However, the Hospital will need to change the range and types of services it provides for its patients in the future.

Key findings in the area of the planning and provision of clinical services at MWRH Ennis include the following:

- Change for safety must happen. It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively
- Acute, complex and specialist services are not sustainable at MWRH Ennis. This is because there are not sufficient numbers of patients presenting with these conditions to enable professional healthcare teams to maintain their clinical skills and expertise. Continuing these acute services, including acute and complex surgery, cancer surgery, level 2/3 critical care (see Glossary for definition of the levels) and 24-hour emergency department services, in their current structure, exposes patients to potential harm
- MWRH Ennis does not have sufficient volumes of patients attending out of hours to justify emergency department and operating theatre resources being available on a 24-hour basis
- In the course of the investigation, a number of patient safety issues were identified by the Authority. The HSE was notified and interim recommendations were made to address these issues (see Appendix 6). These recommendations must continue to be implemented as an immediate priority.
- The provision of more staff and resources at MWRH Ennis will not address the fundamental issue of professional teams maintaining their clinical skills and expertise in the area of surgery, critical care, emergency care, children's and maternity services. This is dependent on sufficient numbers of patients attending MWRH Ennis with certain conditions.

Key findings in the area of corporate governance and leadership at MWRH Ennis include the following:

- The lack of clarity around local accountability and the authority to make decisions means that there is no single person at hospital level who is fully accountable for the quality and safety of services
- There were limited systems in place for effective clinical governance in order to provide the necessary assurance for patients
- Risk management processes were not pro-active. Adverse events, complaints and claims processes were not formally integrated within MWRH Ennis and therefore the outcomes from these processes are not patient focused.

These findings are serious issues of patient safety that are at the heart of safeguarding the public and therefore the implementation of these changes is a priority and should not be compromised in the current fiscal climate.

The Investigation Team heard from some patients and relatives, who had highlighted concerns in relation to their care and the management of their complaints, describe how they only wanted an acknowledgement that a problem had occurred and or an apology but believed that these were not always forthcoming in a timely way. They also believed that best practice was not complied with in relation to how information and a diagnosis was given to patients and families.

This investigation also found examples of good non-acute care being provided at MWRH Ennis and a committed ethos from Hospital staff. It was clear that there are areas where the work of MWRH Ennis could be greatly expanded, in parallel with the consolidation of acute surgical and emergency department services at an alternative location, in the interests of patient safety.

The Investigation Team makes a number of recommendations as result of its findings; these are highlighted in boxes in Chapters 2, 8 and 9. The recommendations are grounded in international evidence where available and cover the most important areas for promoting quality and safety. The Investigation Team recognises that these areas are interdependent and should be taken together as an integrated package of measures to improve safety and quality. Consequently, the recommendations in this report are presented in "clusters" to facilitate addressing them as integrated issues. Where recommendations have national as well as local dimensions, these are set out in the relevant box. In the interests of brevity the Investigation Team has tried to highlight recommendations in areas of particular importance only.

However, it should be noted that its commentary includes a number of important issues that need to be addressed which are not covered by the recommendations but nevertheless merit action by the HSE.

International evidence also shows a move towards providing the greatest possible amount of safe and appropriate healthcare as close as possible to where people are living, such as enhanced diagnostic testing locally, non-emergency day case surgery and a range of outpatient services. Such services provided in MWRH Limerick could in fact migrate to centres such as MWRH Ennis.

Conclusions

What has driven this investigation is patient safety and quality, and one clear overriding finding arising from the investigation is – change for safety must happen.

It is unsafe to keep the service configuration at MWRH Ennis as it currently is. However, there are significant opportunities for high quality, appropriate services to be provided at MWRH Ennis in the future but these must be safe for the benefit of the public. To promote patient safety and improved quality, the clinical services in MWRH Ennis need to change to provide appropriate, timely local access to non-acute patient care such as diagnostics, day surgery and rehabilitation as part of an integrated regional hospital network.

To do this safely and effectively will require experienced leadership and management skills; detailed planning; communication and coordination. It is important to ensure that the reassignment of existing resources and necessary changes to the infrastructure should take place before the services for patients are moved.

Healthcare is understandably a high priority for people and this is reflected in the concerns of politicians and others both locally and nationally. For changes to be implemented effectively that will result in safer, higher quality of care, people receiving services need to understand the reasons and benefits of those changes.

The Investigation Team recognises the challenge of providing timely and appropriate access to local services whilst at the same time providing safe services that secure the best outcomes for patients. These factors can often be competing but safety must always take precedence.

This means the case for change has to be developed and communicated clearly and effectively to the public. Clinicians and other healthcare workers in hospitals in the midwest regional hospital network, and the local community, need to be fully involved in the change process.

The Investigation Team developed the clear impression, that within the HSE management, at a local, network and national level, there exists a commitment and desire to improve services for patients. The need for change had been acknowledged, although the implementation processes remain a significant challenge.

However, a comprehensive programme of change that is effectively led and managed, needs to be undertaken. This will take time to implement and the HSE should ensure that appropriate facilities, resources and staff are in place throughout the current Mid-Western Hospital Network in order that changes in the location of patient care can be safely accommodated.

The HSE should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital.

In drawing its conclusions at the completion of the investigation, and making its recommendations, the Investigation Team recognises the scale of the transition process and the associated management challenges and are of the opinion that this should be undertaken openly, transparently and through an active process of engagement with the public, local stakeholders and staff so that the difficult discussions that are required for the benefits of safe services take place to build a thriving, appropriate and safer future for MWRH Ennis.

2 Recommendations

Recommendation cluster 1: emergency department services

Local

1.1 Patients with major or complex emergency conditions should not be treated in the emergency department in the Mid-Western Regional Hospital Ennis. In exceptional circumstances where such patients arrive in Mid-Western Regional Hospital Ennis they should be stabilised and transferred, as a priority, to a specialist centre.

1.2 The current provision of a 24-hour emergency care service is unsustainable and should be discontinued. A day-time minor injury service, as indicated by current activity, operating as a satellite of the regional centre should be developed and introduced.

1.3 The Health Service Executive must take prompt action to review the role of the Mid-Western Regional Hospital Ennis emergency department as part of the development of an urgent care network across the Mid-Western Hospital Network.

National

1.4 The Health Service Executive should undertake a strategic review of configuration for emergency care services. This should lead to a prioritised programme of service development aimed at consolidating emergency services in regional centres with smaller hospitals (having a similar activity profile to Mid-Western Regional Hospital Ennis) re-designated for minor injuries.

Recommendation cluster 2: surgical treatment

Local

2.1 The Mid-Western Regional Hospital Ennis should not provide acute, or elective inpatient surgical services. All acute and major surgery, including major elective and cancer surgery, should be transferred to the Mid-Western Regional Hospital Limerick.

2.2 The Health Service Executive should review day surgery provision at Mid-Western Regional Hospital Ennis and consider the feasibility of a new regional surgical service based at Mid-Western Regional Hospital Limerick providing an outreach day-surgery and day-procedure service, including endoscope procedures, in the Mid-Western Regional Hospital Ennis using regionally agreed integrated protocols and care pathways.

2.3 In order to create maximum capacity at the regional centre in Limerick, the day surgery review should include consideration of an extended range of surgical specialties at the Mid-Western Regional Hospital Ennis to allow the transfer of some current elective day surgery activity from the Mid-Western Regional Hospital Limerick to create capacity on that site.

National

2.4 The Health Service Executive should work with the relevant professional bodies, using current international evidence, to identify an indicative selection (basket) of surgical procedures, for which clinical teams should treat a minimum number to maintain their skills. These should then be monitored routinely.

2.5 In order to make the best use of available in-patient beds, the Health Service Executive should work with the relevant professional bodies, using current international evidence, to identify a selection of suitable procedures to be undertaken as day surgery cases (in the absence of agreed contraindications).

2.6 Having identified benchmark activity volumes and suitable day surgery procedures, these should be routinely monitored and reported publicly at facility level. They should then be considered as part of annual service planning at national and local levels.

2.7 A focused review of acute surgical activity should be undertaken as a priority at hospitals with similar activity profiles to the Mid-Western Regional Hospital Ennis to determine whether they are safe according to international best practice.

Recommendation cluster 3: cancer services

Local

3.1 All women with symptoms of breast disease who present to the Mid-Western Regional Hospital Ennis should be referred immediately on to the designated symptomatic breast disease service at the Mid-Western Regional Hospital Limerick. The current breast review clinic at the Mid-Western Regional Hospital Ennis should cease.

3.2 Tailored awareness and education programmes for general practitioners (GPs), community services and the public in the midwest about new regional referral pathways and protocols, in particular for breast disease, should be developed and implemented.

3.3 The Health Service Executive should regularly audit the care pathways of patients with symptomatic breast disease, within the midwestern region, to ensure agreed best practice including access arrangements, is being complied with.

National

3.4 The National Cancer Control Programme Directorate of the Health Service Executive should ensure local service configuration and referral/access/follow up pathways for each designated specialist cancer centre are communicated effectively to GPs and patients.

Recommendation cluster 4: critical care services

Local

4.1 The Mid-Western Regional Hospital Ennis should not care for patients requiring level 2/3 critical care services. Patients requiring level 2/3 critical care services should be taken directly to the Mid-Western Regional Hospital Limerick by the ambulance services. Where patients self-attend, or deteriorate at the Mid-Western Regional Hospital Ennis and require level 2/3 critical care services, they must be stabilised by appropriately trained staff and safely transferred as a priority to the Mid-Western Regional Hospital Limerick, or other appropriate centre with Level 2/3 critical care resources.

4.2 In the interim while acute medical and surgical services are provided at the Hospital, the level of care provided at the Mid-Western Regional Hospital Ennis should be consistent with level 0/1 only.

4.3 The relevant transfer and bypass protocols must be regularly reviewed on a multidisciplinary basis, compliance audited and updated as necessary.

4.4 The Mid-Western Hospital Network should review its provision of critical care services within the region to ensure safe patient services that comply with safe practice guidelines.

National

4.5 The Health Service Executive should review critical care provision in hospitals with a similar resource and activity profile to the Mid-Western Regional Hospital Ennis to ensure that services are being provided within safe practice guidelines. Where this is not the case, appropriate risk management measures, and the necessary service changes, should be implemented and managed to protect patients.

Recommendation cluster 5: general medical services

Local

5.1 The range of general medical services provided at the Mid-Western Regional Hospital Ennis should be reviewed by the Health Service Executive in light of the changes recommended to the emergency department, surgical and critical care services. A clear protocol-driven medical service model should be implemented that specifies which conditions can (and cannot) be treated safely in Mid-Western Regional Hospital Ennis. These protocols should be subject to regular audit.

5.2 The Health Service Executive should seek to ensure that as wide a range of medical services as possible, including out-patients, day procedures, day patient facilities and inpatient services, are safely provided in the Mid-Western Regional Hospital Ennis. These should be fully networked with the Mid-Western Regional Hospital Limerick with clear patient pathways designed and implemented.

5.3 For as long as the acute medical services remain on site, dedicated elderly care services should be re-established to provide an appropriate integrated approach by a multidisciplinary team.

National

5.4 The Health Service Executive should work with the relevant professional bodies to develop a national model for acute medicine that is stratified to allow centres to be designated as fit to provide services up to a certain level so it is clear which centres should provide which services. This acute medicine model should include taking into account the location of other acute services such as surgery, anaesthetics, maternity, children's and critical care at any one centre.

5.5 In order to make the best use of in-patient beds, the Health Service Executive should work with relevant professional bodies to identify a "basket" of conditions suitable (in the absence of agreed contraindications) to ambulatory (non-inpatient) patients requiring medical services.

5.6 Having identified conditions to be managed on an ambulatory basis, these should be monitored routinely and published on an institutional basis. They should then be considered as part of annual service planning at national and local levels.

Recommendation cluster 6: children's services

Local

6.1 Acutely ill children should not be cared for at the Mid-Western Regional Hospital Ennis. The ambulance service should take children directly to the paediatric services in Mid-Western Regional Hospital Limerick. Where children are brought to the Mid-Western Regional Hospital Ennis by other means, they must be stabilised and transferred to the regional paediatric services in the Mid-Western Regional Hospital Limerick.

6.2 There should be immediate cessation of elective inpatient paediatric surgery.

6.3 The Health Service Executive should consider the feasibility of the Mid-Western Regional Hospital Limerick paediatric services providing a paediatric outreach day-surgery service in the Mid-Western Regional Hospital Ennis with integrated regional protocols and care pathways. Any surgical and anaesthetic day-case services must be provided in a child-appropriate environment by healthcare teams competent in the clinical care and resuscitation of children.

National

6.4 The Health Service Executive should ensure that there is a clear national policy for the appropriate care setting for, and management of, acutely ill children and those requiring inpatient surgery.

Recommendation cluster 7: maternity services

Local

7.1 Women with pregnancy-related conditions should not be brought by the ambulance services to the Mid-Western Regional Hospital Ennis. These patients should be brought directly to the Mid-Western Maternity Hospital Limerick. Patients self-presenting to the hospital should be transferred as a priority to the regional centre at Mid-Western Maternity Hospital Limerick.

7.2 The Mid-Western Maternity Hospital Limerick should review the provision of ultrasound scans for women attending its outreach service in the Mid-Western Regional Hospital Ennis to ensure it is consistent with the service provided at its regional centre.

7.3 The Mid-Western Maternity Hospital Limerick should regularly audit its outreach services to ensure they are consistent with services at the regional centre.

Recommendation cluster 8: diagnostic services

Local

8.1 The future role of diagnostic services in the Mid-Western Regional Hospital Ennis should be clearly defined. A strategic review of the radiology and laboratory services should be undertaken leading to these services being outreach services from the Mid-Western Regional Hospital Limerick with centrally agreed integrated protocols and care pathways that will be fit for purpose in supporting the changes in services outlined in this report.

8.2 A quality assurance system, which includes rigorous procedures and protocols for requesting, prioritising, reading and reporting radiology examinations, with defined timelines and volumes, should be implemented, regularly reviewed and compliance audited.

8.3 The Mid-Western Regional Hospital Ennis should implement reliable mechanisms, for example multidisciplinary clinico-radiological meetings, whereby the referring clinician, including GPs, can discuss the imaging findings in complex cases in more detail with the radiologist or other individual who has reported the examination.

8.4 A robust system for the safe, timely management and reporting of all tests, both at local and regional laboratory level, should be developed, implemented and regularly audited. This system should involve the prioritisation of test reporting and protocols for the follow up of the reports by the identified clinician.

Recommendation cluster 9: ambulance services

Local

9.1 The bypass protocols for maternity and children must be fully implemented immediately and the Health Service Executive should systematically evaluate all of its bypass protocols through audit and, as required, identified improvements should be implemented.

9.2 The Health Service Executive must ensure that there are appropriate numbers of suitably qualified ambulance staff to provide a safe emergency and non-emergency patient transport service in the midwest region within an established duty rota that does not rely on an on-call rota for the basic provision of the service.

National

9.3 The Health Service Executive should ensure that the ambulance service has a recognised call prioritisation and dispatch system in place nationally in order to prioritise emergency calls to ensure that the right patient receives the right care by the right professional at the right time. This should be implemented in the midwest region as a priority.

9.4 The Health Service Executive should ensure that the ambulance service develops and implements arrangements to ensure that emergency ambulance crews are not providing transport for patients who do not require emergency care and that appropriate resources are established to better meet the needs for patients requiring non-emergency transportation.

Recommendation cluster 10: admission and discharge

Local

10.1 The Mid-Western Hospital Network should systematically evaluate its bed management processes, through audit, with required improvements implemented and re-evaluated to confirm continuous quality improvement. This should incorporate a robust discharge planning policy, which commences on admission and states that appropriate and open information must be provided to the patient and or their family members and the receiving care provider to ensure transfer and ongoing patient care pathways are safe and of a high quality.

10.2 The Health Service Executive should systematically evaluate all of its discharge protocols, through audit, and, as required, identified improvements should be implemented and the protocols re-evaluated to confirm continuous quality improvement.

National

10.3 The Health Service Executive nationally should further develop and implement an active bed management strategy with appropriate care pathways, access to diagnostics and integrated discharge planning.

Recommendation cluster 11: leadership and governance

Local

11.1 All the acute hospitals contributing to the midwest region acute care system should form a hospital group under an integrated operational governance and management structure, based at the Midwestern Regional Hospital Limerick. The group should be led by a management board with executive accountability and the appropriate skills and experience to discharge these responsibilities and to manage the changes required in the transition of patient services across the areas. Satellite centres should have clear and appropriate day-to-day on-site operational management arrangements.

11.2 This hospital group should be led by a chief executive, who is ultimately accountable for the provision and management of the services provided by the group, and who is accountable to the Network Manager. The chief executive should lead an executive management board consisting of directors, who have the appropriate skills and experience to discharge their responsibilities and who are accountable to the chief executive. This board will be responsible for the provision of all services and implementation and management of the transition of patient services across the area. The smaller hospitals in the group should have clear and appropriate day to day operational management arrangements reporting to the group management board.

11.3 A code of governance should be established that sets out the management board's roles and responsibilities including an oversight role in respect of safety and quality of health services provided. This must include clear lines of accountability and devolved decision making.

11.4 The regional management tier at Network level, in conjunction with the executive management board of the hospital group should focus on strategic governance of the region, stakeholder engagement and performance management and monitoring of the hospitals.

11.5 The HSE should establish an active programme to address historical anomalies in reporting arrangements, in order to achieve clearer lines of accountability for clinicians and managers at hospital level. This should include all clinical consulting teams being appointed to, and organised from, the Mid-Western Regional Acute Hospital Group as part of a regional service.

11.6 Clinical teams in the Mid-Western Regional Acute Hospital Group should come under a unified clinical governance system led by regional clinical specialty groupings based in the regional centre in Limerick. This should incorporate the development of agreed patient pathways owned by the regional clinical departments each under the leadership of a clinical director.

11.7 For as long as an emergency service continues to be provided at the Mid-Western Regional Hospital Ennis, formal clinical accountability and reporting arrangements must be established immediately for emergency care physicians working in the emergency department.

Recommendation cluster 12: responding to concerns and learning from adverse incidents

Local

12.1 The Mid-Western Regional Hospital Ennis should ensure that a proactive patient-centred approach to risk management is taken and implemented throughout the Hospital according to national policies. This should include improving integration between its risk management, complaints, and Freedom of Information systems to facilitate timely, patient-focused responses and to enable shared learning.

12.2 The Mid-Western Regional Hospital Ennis should undertake a regular audit of the views of complainants to ascertain how the Hospitals approach to complaints and concerns can be improved and the necessary changes identified in such audits should be implemented.

12.3 As recommended by the Authority in a previous investigation report[25], the MWRH Ennis should ensure that an effective independent advocacy service for patients is in place in the hospital. These advocacy services should support and facilitate patients coming forward to raise concerns and have them addressed.

12.4 The Health Service Executive should ensure that the new regional risk management structures, in the midwest, have clearly defined lines of responsibility and levels of accountability. The processes must be transparent, patient-focused and have clear learning pathways.

12.5 At a regional level the risk management process should be regularly monitored and audited with the outcomes reported through the national risk management structure to the Chief Executive Officer of the Health Service Executive.

12.6 The Health Service Executive should identify a suitable independent person or organisation, agreed with individuals/persons that request it, to offer mediation with a view to discussing in detail and resolving any residual concerns in the way with which their complaint was dealt.

National

12.7 Risk management and complaints processes in the Health Service Executive and health services generally must include a stage in the process to establish, understand and document the outcomes desired by affected patients/relatives before any investigation or review is undertaken.

12.8 The Health Service Executive should ensure the planned implementation of its new Quality and Risk Framework takes account of the lessons from this investigation and that an appropriate training programme on risk management and feedback is delivered that emphasises the importance of communication and outcomes as well as process.

12.9 The role of the Office of the Ombudsman for public services should be publicised more effectively by the Health Service Executive in relation to the handling of complaints in the health service to ensure complainants understand they can have the handling of complaints reviewed and national learning can be applied throughout the health service.

Recommendation cluster 13: managing change and transition

Local

13.1 The local change programme should be led by an experienced senior manager and the implementation programme must incorporate significant engagement with service user and clinical stakeholders.

13.2 A comprehensive programme of change, that is effectively led and managed, needs to be undertaken. This will take time to implement, and the Health Service Executive needs to ensure that appropriate facilities, resources and staff are in place throughout the current Mid-Western Acute Hospital Network in order that changes in the location of patient care can be safely accommodated.

13.3 The Health Service Executive should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital.

National

13.4 The corporate HSE executive management team should nominate a specific Director accountable for ensuring the development of an implementation plan for these recommendations. This should include a clear timeframe with milestones. Progress against the implementation plan should be made public and reported to the Board of the Health Service Executive.

13.5 There should be regular progress reports to the Minister for Health and Children.

3 Introduction

In the late summer of 2008, family members of two individual patients – the late Ann Moriarty and the late Edel Kelly – who had suffered serious patient safety incidents at the Mid-Western Regional Hospital (MWRH) Ennis were highlighted publicly. These patients had received care from a range of services provided by MWRH Ennis.

The Health Information and Quality Authority (the Authority) initiated a fact-finding process which identified concerns spanning a number of areas including, for example, the diagnosis and treatment of cancer, the care of patients attending the emergency department, the admission, care and discharge of inpatients and the management of complaints.

Following discussions with the Authority, on 23 September 2008, the Minister for Health and Children wrote to the Chairperson of the Authority requesting the Authority, under section 9(2) of the Health Act 2007[1] (the Act), to undertake an investigation into the arrangements for providing services at MWRH Ennis. Following a Board meeting, the Authority confirmed that it would undertake the investigation. The Terms of Reference for the investigation were published on 3 October 2008 and can be reviewed in Appendix 1.

Subsequent to the publication of the Terms of Reference further families, and or patients, approached the Authority in relation to serious concerns that they had regarding care received at MWRH Ennis. The experiences of these families, and or patients, related to a range of services but did not reflect all services at MWRH Ennis. The Investigation Team met with and interviewed seven families of patients, and or patients, at the outset of the investigation.

The Authority's powers to investigate are described in section 9 of the Act. These allow the Authority to investigate where there are reasonable grounds to believe there is a serious risk to the health or welfare of a person receiving services. This means that the Authority's investigations are concerned with current and future risk to service users. Hence, the Authority only looks into individual patients' cases if they are currently receiving services or for past patients where their experiences suggest potential serious system and safety issues in the facility and or the wider health system.

In relation to MWRH Ennis, the experiences and perspectives of the patients, and their relatives, who approached the Authority with serious concerns regarding the care that they had received from MWRH Ennis, were at the centre of this investigation. The investigation did not set out to undertake a forensic investigation of each of these patients' care. However, their experiences informed the investigation and helped to shape the review of quality and safety of services provided in MWRH Ennis. The Investigation Team met with and interviewed the seven families of patients, and or patients, and or their relatives, at the outset of the investigation. Their experiences related to a variety of (though not all) services provided at MWRH Ennis and are

captured within the various relevant sections of this report. It should be noted from the outset of this report that their courage in coming forward will enable high quality, safer services to be provided at MWRH Ennis in the future.

This introduction provides a brief background to the investigation. The methodology used in the investigation is described in Chapter 4. A profile of MWRH Ennis is provided in Chapter 5. National and international developments in healthcare are described in Chapter 6. The findings and recommendations are outlined in Chapters 7, 8 and 9. Chapter 10 sets out the conclusions to the investigation. The report is supported by a number of appendices to provide the reader with background and technical information.

The Investigation Team makes a number of recommendations as result of its findings; these are highlighted in boxes in Chapters 2, 8 and 9. The recommendations are grounded in international evidence where available and cover the most important areas for promoting quality and safety, namely:

- Service configuration and design
- Clinical and service systems and processes for safety
- Clinical and managerial leadership and governance arrangements
- Mechanisms for monitoring quality and learning from adverse incidents
- Practices and procedures for addressing service-user concerns or complaints.

The Investigation Team recognises that the areas above are interdependent and should be taken together as an integrated package of measures to improve safety and quality. Consequently, the recommendations in this report are presented in "clusters" to facilitate addressing them as integrated issues. Where recommendations have national as well as local dimensions, these are set out in the relevant box. In the interests of brevity the Investigation Team has tried to highlight recommendations in areas of particular importance only. However, it should be noted that its commentary includes a number of important issues that need to be addressed which are not covered by the recommendations but nevertheless merit action by the HSE.

In developing standards for a future statutory licensing programme covering both public and private healthcare, the Authority will ensure the relevant aspects of these recommendations are incorporated in the standards and, where necessary, included in regulations to allow statutory enforcement.

Acknowledgements

The Investigation Team would like to thank sincerely those patients and families who courageously shared their experiences for the future benefit of others. They would also like to thank the members of staff in MWRH Ennis, and the wider HSE, for their assistance and constructive participation in the investigation. Finally, the Investigation Team would like to acknowledge the advice and support provided by the Royal College of Surgeons in Ireland and the College of Anaesthetists of Ireland.

4 Methodology

4.1 The Investigation Team

The Authority assembled an Investigation Team incorporating external advisors and Authority staff. The Investigation Team was chaired by Diane Whittingham, Chief Executive of Calderdale and Huddersfield NHS Foundation Trust in England. It included members with expertise in nursing, emergency medicine, geriatric medicine, surgery, critical care, patient advocacy, patient safety, management and governance. Where required, additional professional advice was also provided by the Royal College of Surgeons in Ireland and the College of Anaesthetists of Ireland.

The members of the Investigation Team were authorised to carry out the investigation by the Authority (with the approval of the Minister for Health and Children, and the consent of the Minister for Finance) pursuant to Section 70 of the Health Act 2007. A full list of the Investigation Team is contained in Appendix 2.

4.2 Overall approach

The investigation encompassed a review of clinical practices, systems and processes within the services covered by the Terms of Reference. This incorporated:

- a review of documentation, from local, regional and national levels within the HSE
- site visits to MWRH Ennis
- an analysis of data obtained from MWRH Ennis
- interviews with families of patients and or their relatives
- interviews with clinical and non-clinical health services staff.

This section now describes the approach in more detail.

4.3 Documentation and data review

A list of information and documentation was requested from MWRH Ennis and the National Hospitals Office (NHO) within the HSE. These were reviewed by the Investigation Team. The list of documents requested is included in Appendix 3.

The documents obtained and reviewed covered areas such as the:

- management of patient complaints
- risk management systems
- clinical activity data in relation to the patient services provided (including surgical services, symptomatic breast disease services, children's services)

- governance structure and arrangements
- workforce planning and staffing arrangements
- way information is used to manage the services.

Further documents and information were requested in the course of the investigation from MWRH Ennis and others. This included patient files from MWRH Ennis. Hospital Inpatient Enquiry (HIPE) data concerning activity at MWRH Ennis were provided by the Economic and Social Research Institute.

4.4 Site visits and interviews

Immediately after the Investigation was requested by the Minister for Health and Children, authorised persons from the Authority visited MWRH Ennis to brief staff on the investigation process and visit hospital wards and departments. The Investigation Team itself visited and toured MWRH Ennis later in the course of the investigation.

Based on concerns raised by patients and their families in relation to aspects of care provided at MWRH Ennis and documentation analysis, lines of enquiry were developed and a number of individuals were identified for interview. A total of 49 people were interviewed or contributed to the investigation.

Those interviewed included:

- former patients and relatives of former patients of MWRH Ennis who had raised concerns about the quality and safety of care at MWRH Ennis – in this report these people are referred to as patients and or relatives
- clinical and non-clinical staff at MWRH Ennis, including permanent, temporary and locum staff
- HSE staff in the Mid-Western Hospital Network and at a national level.

The lines of questioning at interview were developed from themes that emerged from the experience of patients and or their family members, reported patient safety incidents, information obtained from the documentation review and new themes that emerged during the interviewing process. Interviews also took account of the Terms of Reference and *Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance.*[2]

Interviews were carried out by two members of the Investigation Team. Some interviewees were accompanied by colleagues or others. All interviews were audio-recorded and transcripts shared with interviewees to review for accuracy.

A coding system was used to categorise information given by interviewees and these codes are outlined in Appendix 4. Information from interviews was collated with documentary and other evidence and used to develop the findings of the investigation.

4.5 Literature review

The Investigation Team conducted a review of the relevant literature to inform the investigative process, the interpretation of findings and to support its recommendations that are made in this report.

4.6 Confidentiality

Throughout the investigation, steps were taken to maintain the confidentiality of material in the Authority's possession. This included security measures for print and electronic documents, such as the use of passwords and replacing the names of individuals and institutions with codes in any copy sent outside the Authority to ensure that they were not identifiable if found or seen by people not associated with the investigation.

5 Profile of Mid-Western Regional Hospital Ennis

It is important for the reader to understand the context surrounding, and services provided by, MWRH Ennis locally and also to understand the quality and safety challenges facing hospitals of a similar size – both nationally and internationally. This chapter, and Chapter 6, provide important information that the Investigation Team believe is relevant before it presents the findings of this investigation.

5.1 Geography and population

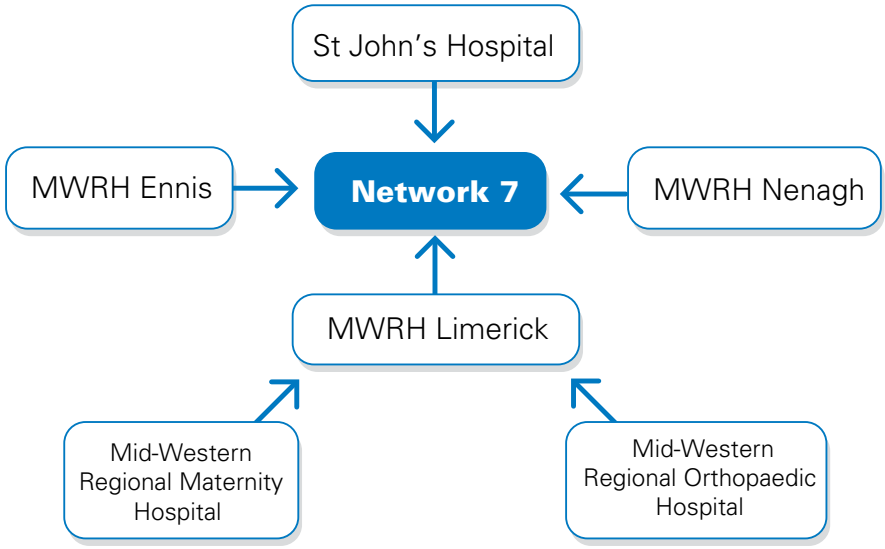
Ennis is the county town of Clare in the midwest of Ireland. MWRH Ennis is located on a single site and is the only acute general public hospital in the county. The area of the county is 3,242 km^2 and its population is 110,950 (2006 Census)[3]. Limerick City borders county Clare, and some of the larger towns in Clare (Ballyglass, Sixmilebridge, Ardnacrusha) are nearer to MWRH Limerick than MWRH Ennis and therefore the catchment population of MWRH Ennis is not the entire county population. Limerick City is 39 kilometres to the southeast of Ennis and most of the road in between is dual carriageway. The next nearest city is Galway, which is 70 kilometres to the north.

5.2 National and local configuration

Public health and social services in Ireland are primarily provided, and or funded by the HSE. Within the HSE, the NHO is responsible for the strategic management of acute hospital services for the country. Delivery of these acute hospital services is managed through eight networks. The MWRH Ennis is part of the Mid-Western Hospital Network – known as Network 7. Figure 1 shows the hospitals in the Network.

The Network provides acute care for the counties of Clare, Limerick and North Tipperary. Patients requiring acute neurosurgical care are transferred to one of the two specialist centres in Beaumont Hospital, Dublin, and Cork University Hospital, usually after diagnostic imaging at MWRH Limerick.

Figure 1



5.3 Physical description of MWRH Ennis

The main Hospital building was designed in 1938 and built in 1946. The building has protected status which limits the physical modifications that can be made to the facility. The former nurses' home is now the library, an outpatient clinic and administrative offices. A building which pre-dates the main hospital on the same site is used for the main outpatient department.

The original main Hospital building houses the following:

- female medical ward (24 beds)
- male medical ward (24 beds)
- surgical ward (24 beds)
- elderly care unit (10 beds) currently re-designated as an overflow ward
- two operating theatres
- intensive care unit (designated as two intensive care beds and four coronary care beds)
- heart stress testing unit
- hospital sterile supplies unit
- emergency department
- radiology department.

The physiotherapy department and cardiac rehabilitation department are located in other prefabricated buildings on the same site. Work is under way on a new building for the radiology department.

5.4 Services at MWRH Ennis

MWRH Ennis is one of the smaller general acute public hospitals in the country.[4] The Hospital has 88 acute beds, six surgical day beds and six paediatric dental beds. (There is also an acute psychiatric facility on site. However, because mental health services are outside the Authority's remit, it was not included in this investigation.)

MWRH Ennis provides patient services in:

- general medicine
- care of the elderly
- surgery (including day surgery)
- emergency care (currently 24-hour service)
- dental
- palliative care
- cardiology
- respiratory care.

Table 1 outlines the outpatient clinics and diagnostic and support services provided at MWRH Ennis.

Table 1: Outpatient clinics

Surgery	Medicine	Diagnostics and support services
General surgery	General medicine	Radiology
Breast review clinic	Diabetes	Laboratory
Antenatal and gynaecology (outreach clinic from Mid-Western Regional Maternity)	Paediatric (outreach from MWRH Limerick)	Physiotherapy
Ear, nose and throat	Geriatric	Echocardiography/ electrocardiography
Orthopaedics	Heart failure (nurse-led)	Cardiac rehabilitation
Urology		Warfarin
Vascular		

5.5 Hospital statistics

The budget allocation for MWRH Ennis in 2008 was €23.5 million.

The patient activity across different types of services in MWRH Ennis is outlined in Table 2.

Table 2: Patient activity in MWRH Ennis

Patient types	2006	2007	2008
Inpatient discharges	5,419	5,242	5,067
Day cases	1,947	2,073	2,075
Outpatients			
New	3,806	3,777	2,986
Returns	11,595	11,613	9,309
Total numbers	15,401	15,390	12,295
Emergency department			
New	17,559	17,172	18,076
Returns	2,605	2,080	1,586
Total attendances	20,164	19,252	19,662

Clinical staffing levels for MWRH Ennis are outlined in Appendix 5

6 Developments in healthcare

The Investigation Team considered that it was vital, in assessing its findings and making recommendations in respect of the quality and safety of services at MWRH Ennis, that it took account of the emerging national and international trends in healthcare as well as the resources available to the HSE. The following section outlines these considerations.

6.1 High reliability healthcare internationally

Healthcare is changing worldwide to promote and provide more consistent, safer care. Increasingly, systems of patient care are being organised and planned to ensure that as much care is delivered at home, or as close to home, as is clinically safe and appropriate.

However, international evidence shows that patients with certain conditions receive safer and better outcomes when treated by clinicians who routinely care for higher numbers of patients with such conditions. Patients tend to receive poorer outcomes when they are cared for by clinicians working in systems where they only occasionally care for patients with specific conditions. [5-7]

This means that, for patients to be safe, consultants and other professionals treating patients who need more complex care, must treat a minimum number of patients in order to constantly maintain and practise clinical skills. Where the minimum numbers of these patients cannot be maintained, investing in resources to increase the number of healthcare professionals in such facilities to continue to provide the service is not the answer to safe, high quality care.

Therefore, developing centres that will treat patients with more complex acute illness and injury is necessary in order to provide the volumes of complex patient cases for clinicians to maintain their clinical skills and continue to practise safely. This implies centralisation of many complex specialist services for example, major accident and emergency; critical care; emergency medicine including cardiology and respiratory medicine; emergency surgery; complex planned surgery; primary diagnosis and initial treatment of cancer; paediatrics and neonatology.

Alongside these changes, clear and agreed protocols that ensure that the patients are treated in the right place at the right time by the right professionals are crucial.

Consequently, the centralisation of complex specialties and services requires effective systems for the retrieval and transport of patients which demands the availability of highly trained advanced paramedics that can provide prompt diagnostic, resuscitation and stabilisation treatment in the community. In addition, ambulance services to support these models of care must efficiently transport patients back to their local setting as soon it is safe to do so.

6.2 The development of healthcare services in Ireland

Several national documents and consultation reports [2; 8;9] have outlined how services in Ireland should be provided in order to maximise patient safety and increase efficiencies. Currently, many healthcare services are being developed to provide clinical networks of acute and non-acute services which involve the development of regional centres and local centres. In order for patients to have the safest care by professionals who can maintain their skills, patients who are acutely ill or injured, and or have major illness, will receive their care in regional centres and the other categories of patients will be able to also receive their care in the local centres.

The local centres will be responsible for ensuring that the whole population has easy access to a wide range of services for primary care, community care and the diagnosis and management of most routine conditions. Regional centres will be responsible for the delivery of acute care for patients with more complex conditions requiring specialist clinical expertise, critical care support and or continuous medical supervision.

There are already examples of services in Ireland in the process of transition towards this model including children's services and cancer services, for example, the diagnosis and treatment of symptomatic breast disease.

6.3 Service reconfiguration in the midwest

In the course of the investigation, the Investigation Team became aware that, following a report by external consultants, the configuration of services provided in acute hospitals in the midwest was under review by the HSE.[10] The report recommended changes in the configuration of acute services in the region and a Reconfiguration Project Group had been convened by the HSE to implement those changes.

7 Introduction to the findings

The main findings of the investigation are based on patient experience, interviews with staff and analysis of supporting documentation and data. As indicated by the Terms of Reference, these findings relate both to MWRH Ennis and the relevant supporting arrangements provided by the HSE.

The patients and relatives that the Investigation Team interviewed were very open in describing how they felt about their and their relative's experience of the services in MWRH Ennis. They talked about a number of services that they had concerns about but they also told the team about their positive experiences of the staff and the care they received in MWRH Ennis.

The main areas of concern as expressed by the patients and relatives who came forward and talked to the Investigation Team were as follows:

- A number of patients highlighted concerns in relation to the management and diagnosis of their or their relative's condition, in particular symptomatic breast disease or an acute illness secondary to breast cancer.
- A recurrent theme highlighted by the patients and relatives interviewed was communication difficulties between them and the staff in the MWRH Ennis and also between the staff and community services. This was especially the case in relation to the communication of clinical information required to ensure the safe and effective continuing care of the patient.
- Another concern that was expressed, by the majority of these patients and relatives interviewed, was around the management of their complaints, particularly as many of these patients said that all they wanted was an acknowledgement that something went wrong and an apology. The patients and relatives that the Investigation Team interviewed talked about their wish that, by them coming forward to the Investigation Team, they would help to make sure that other patients would not have the same experience as they or their relative had.
- Patients and relatives also described to the Investigation Team their concerns about the patient discharge process. They described how they felt that they had not been given enough time to prepare for their or their relatives' discharge home. It was also described to the Investigation Team how patients or their relatives believed that patients had been discharged from MWRH Ennis to the community with inadequate clinical information being given to carers for them to provide the ongoing care that the patients needed.

The findings and recommendations are presented in the next two chapters (Chapters 8 and 9) and the main messages from the findings are summarised at the beginning of these two chapters. The findings are presented as follows:

Chapter 8: Provision of clinical services: findings and recommendations. This includes how services are currently designed and the typical pathways of care that patients follow.

Chapter 9: Corporate governance and leadership: findings and recommendations. This includes the reporting structures and relationships, communications, clinical governance, systems and processes to support safe, effective patient care, complaints and risk management.

In the course of the investigation there were a number of patient safety issues identified by the Investigation Team that were regarded as serious potential risks to the health and welfare of patients. The Investigation Team brought these issues to the attention of the Authority at that time. The Authority formally wrote to the Chief Executive Officer of the HSE on 5 January 2009 (Appendix 6). This letter outlined the patient safety issues identified and made specific interim recommendations for immediate action. The HSE responded to the Authority on 19 January 2009 with an action plan to address the identified risks which included implementation dates for each of the actions identified. These issues and the response of the HSE form part of this report and are highlighted in the relevant sections.

8 Provision of clinical services: findings and recommendations

Key Findings

1 Change for safety must happen. Acute services are not sustainable at MWRH Ennis. It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively.

2 There are not enough patients presenting with acute, complex and or specialist conditions to allow healthcare teams to maintain their clinical skills and achieve the best outcomes for patients. Acute, complex, and specialist services should cease in MWRH Ennis as soon as resources can be organised to safely provide centralised and better integrated services for MWRH Ennis's catchment population. These services include:

- acute and complex surgery including cancer surgery
- level 2/3 critical care (see Glossary for definition of the levels)
- 24-hour emergency department
- maternity
- children's.

The absence of acute surgery and critical care will mean that the provision of acute medicine at MWRH Ennis should be reviewed and a clear medical service model implemented.

3 There are insufficient numbers of consultant staff in general medicine, surgery, anaesthetic and emergency medicine to provide a sustainable 24-hour service for patients attending MWRH Ennis. However, the provision of more staff and resources at MWRH Ennis will not address the fundamental issue of professional teams maintaining their clinical skills and expertise. This is dependent on sufficient numbers of patients attending MWRH Ennis with these conditions.

4 MWRH Ennis does not have sufficient volumes of patients attending out of hours to justify emergency department and operating theatre resources being available on a 24-hour basis.

8.1 Introduction

Within this section, the report will describe the current arrangements for clinical service provision in MWRH Ennis, how these services should be provided, and the recommendations of the Investigation Team.

The Investigation Team looked at a number of departments and services in MWRH Ennis to assess the adequacy of service planning and design for patients.

8.2 Clinical services

Clinical services should be organised to ensure safe and effective care for patients. In an acute hospital this requires cooperation between departments and services to ensure there are no barriers to this care. The most safe and effective services have the right number of staff, with the right skills, treating the right types of patients in the right setting for their needs. Safe services are clearly described with defined roles and responsibilities, a focus on positive patient outcomes and regular systematic monitoring of clinicians' performance.

For the safe and effective management of a patient's care throughout the patient journey, there needs to be an integrated patient-focused approach, from referral through to discharge home or to community services. This patient-focused approach means that patients have timely and appropriate access to services, integrated care throughout their stay and planned discharge to the appropriate healthcare setting in conjunction with the patient, their family, their general practitioner (GP) and community services.

An "integrated care pathway" is a structured approach to patient care which details the essential steps, to be provided by different professionals, in the care of patients with a specific clinical problem. The Investigation Team determined, through interviews with patients and or their relatives, and staff and the review of documentation, that although there were identified care pathways for the management of patients within MWRH Ennis, for example cardiology, these care pathways lacked integration. The Investigation Team also established that there were limited integrated care pathways between MWRH Ennis and other regional and tertiary centres and with primary and community care services. The services at MWRH Ennis have evolved over a number of years but they were operating as independent services with little evidence of integrated management or planning.

MWRH Ennis provided an acute hospital service to the local community. There were a number of specialties and services currently being provided in MWRH Ennis including general medicine, care of the elderly, cardiology, general surgery and level 0/1 critical care in the "intensive care" area. There were no specialist obstetric, paediatric, neurosurgical, or orthopaedic services, or access to dialysis although there were some outreach services provided locally by a team from MWRH Limerick, for example an antenatal clinic.

8.2.1 Emergency care

In MWRH Ennis, Hospital Inpatient Enquiry (HIPE) data and Hospital documentation indicated that the main route of admission to MWRH Ennis was through the emergency department (ED). Currently for prompt diagnostics, treatment and or potential admission, GPs refer patients to the ED as they have limited direct admission rights and there were no alternative routes for assessment and or admission.

At the time of the investigation immediate care within the ED was provided by emergency care physicians who were independent practitioners with no clinical supervision from a consultant in emergency care. Patients were subsequently reviewed by the medical or surgical team, as appropriate, where a decision was taken to admit, transfer or discharge. A consultant in emergency medicine from MWRH Limerick provided four sessions to the ED. The nursing staff within the ED were reported to have many years practical experience working in emergency care. However, the majority did not have formal postgraduate emergency care training. These arrangements could pose risks to patients.

From HSE data supplied by MWRH Ennis, 19,662 patients attended the ED in 2008. Of these, 18,076 were new attendances and 1,586 were returns (see Table 3).

HIPE data records patient admissions and discharges to participating hospitals but it does not record attendances to their EDs. However, for 2008, HIPE data indicates there were 4,055 admissions to MWRH Ennis from the ED (3,618 medical and 437 surgical). This accounts for approximately 93% of all inpatient admissions to MWRH Ennis (see Table 4).

Data indicated that two-thirds of MWRH Ennis's patient workload was for patients with medical conditions and one-third were surgical patients. The principle diagnoses recorded in HIPE data for admission from the ED were chest pain, exacerbation of chronic obstructive pulmonary disease (COPD) and respiratory symptoms (see Table 5). The data also indicated that there were 86 admissions with suspected appendicitis in 2008, with 85 in 2007.

Table 3: Attendances to emergency department

	2006	2007	2008
New	17,559	17,172	18,076
Review	2,605	2,080	1,586
Total patients	20,164	19,252	19,662

Source: Mid-Western Regional Hospital Ennis.

Table 4: Admissions to MWRH Ennis

Admissions	**2006**		**2007**		**2008**	
ALL ADMISSIONS	**Number**	**%**	**Number**	**%**	**Number**	**%**
Medical	5,362	(73%)	5,327	(73%)	4,369	(69%)
Surgical	2,002	(27%)	1,984	(27%)	1,941	(31%)
Total	7,364	(100%)	7,311	(100%)	6,310	(100%)
ALL ADMISSIONS	**Number**	**%**	**Number**	**%**	**Number**	**%**
Elective inpatient	456	(6%)	362	(5%)	313	(5%)
Emergency inpatient	4,937	(67%)	4,866	(67%)	4,055	(64%)
Day case	1,971	(27%)	2,083	(28%)	1,942	(31%)
Total	7,364	(100%)	7,311	(100%)	6,310	(100%)
MEDICAL	**Number**	**%**	**Number**	**%**	**Number**	**%**
Elective inpatient	175	(3%)	137	(2.5%)	132	(3%)
Emergency inpatient	4,428	(83%)	4,415	(83%)	3,618	(83%)
Day case	759	(14%)	775	(14.5%)	619	(14%)
Medical totals	5,362	(100%)	5,327	(100%)	4,369	(100%)
SURGICAL	**Number**	**%**	**Number**	**%**	**Number**	**%**
Elective inpatient	281	(14%)	225	(11%)	181	(9%)
Emergency inpatient	509	(25%)	451	(23%)	437	(23%)
Day case	1,212	(61%)	1,308	(66%)	1,323	(68%)
Surgical totals	2,002	(100%)	1,984	(100%)	1,941	(100%)

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 5: Principal diagnoses from emergency department, MWRH Ennis

Principal diagnosis	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Chest pain – unspecified and other	448	446	276
Unspecified acute lower respiratory tract infection	311	218	172
Chronic obstructive pulmonary disease (COPD)	173	203	151
Syncope and collapse	142	141	121
Urinary tract infection	122	120	93
Atrial fibrillation	114	99	91
Acute appendicitis	99	85	81
Gastritis		70	86

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Please see Glossary for definitions of these conditions.

The main electronic information system within the ED was the Patient Administration System (PAS) which did not gather diagnostic information. Therefore, to form an impression of the casemix presenting to the ED the Investigation Team undertook a random review of attendances to the ED. Utilising the Nurses' Log (a manual record of attendances to the ED maintained by the nurses) the Investigation Team reviewed attendances for one week in the summer and winter of 2008 (770 in total). This review information recorded in the Nurses' Log showed that:

- On average 55 patients attended daily over a 24-hour period
- Between five to 18 attendances were after 8pm and before 8am
- 34% (262) of patients attending were categorised as medical cases
- 60% (464) of patients attending were categorised as surgical cases
- 6% (44) of patients attending were children.

Staff reported, through interview, that pregnant women attended the ED for care. On review of the Nurses' Log, five pregnant women attended over these two weeks. In the absence of a full obstetric service the Investigation Team were of the opinion that pregnant women should not attend the ED in MWRH Ennis.

Overall, based on this snap-shot review, interview and data analysis, the Investigation Team concluded that the majority of those patients presenting to the ED had minor injuries or less complex medical conditions and were mainly presenting between 8am and 8pm.

In order to provide safe care and best outcomes for patients attending the ED with major or complex conditions there needs to be sufficient volumes of patients with these conditions for the professional team within the ED to maintain their skills and expertise.[11-13] The data indicated that there were few patients with major or complex conditions presenting to ED. In view of the above and other recommendations contained within this report which includes removing surgical and critical care services from MWRH Ennis, the Investigation Team is of the opinion that this 24-hour model is not sustainable for an efficient use of resources.

The Investigation Team concluded that, patients with major or complex emergency conditions should not be treated at the ED in MWRH Ennis. In any exceptional circumstances where such patients arrive in MWRH Ennis, they should be stabilised and transferred, as a priority, to a specialist centre.

The Investigation Team is of the opinion that maintaining a 24-hour service for minor injury patients is not sustainable from an efficiency or value for money perspective. Therefore, a day-time minor injury service, as indicated by current activity, operating as a satellite of the regional centre should be developed and introduced. For children who attend the minor injury service there should be an appropriate environment and competent healthcare teams with regionally agreed protocols and care pathways.

Recommendation cluster 1: emergency department services

Local

1.1 Patients with major or complex emergency conditions should not be treated in the emergency department in the Mid-Western Regional Hospital Ennis. In exceptional circumstances where such patients arrive in Mid-Western Regional Hospital Ennis they should be stabilised and transferred, as a priority, to a specialist centre.

1.2 The current provision of a 24-hour emergency care service is unsustainable and should be discontinued. A day-time minor injury service, as indicated by current activity, operating as a satellite of the regional centre should be developed and introduced.

1.3 The Health Service Executive must take prompt action to review the role of the Mid-Western Regional Hospital Ennis emergency department as part of the development of an urgent care network across the Mid-Western Hospital Network.

National

1.4 The Health Service Executive should undertake a strategic review of configuration for emergency care services. This should lead to a prioritised programme of service development aimed at consolidating emergency services in regional centres with smaller hospitals (having a similar activity profile to Mid-Western Regional Hospital Ennis) re-designated for minor injuries and non-acute care.

8.2.2 Surgical services

Internationally, an increasing body of evidence indicates that outcomes for patients are better and fewer errors occur when acute and complex surgical care is provided by professional teams treating higher numbers of patients, using the most appropriate procedures in order to ensure that their skills are maintained for these types of patients. Where the numbers of such patients are below an acceptable level to maintain such surgical skills, providing more resources to surgical services will not address this issue and, in fact, may further reduce the numbers of patients that any one individual treats. Maintaining their skills is dependent on the number of patients attending with these conditions.[14]

Examples in the literature include surgery on the lower large bowel (colorectal surgery). Literature reports that hospitals treating elderly patients with colorectal cancer with high volumes of cases (over 150 cases per year), have lower death rates than hospitals with lower volumes (under 55 cases per year).(15) Guidelines for commissioning of services in the United Kingdom suggests that surgeons should perform a minimum of 20 surgical procedures for colorectal cancer per year.

In MWRH Ennis there were three consultant surgeons up until June 2008. At the time of the investigation there were two consultant surgeons providing a surgical service and three consultant anaesthetists. In addition, there were non-consultant hospital doctors (NCHDs) including one intern, four senior house officers and three registrars on the surgical team. There were no non-consultant hospital doctors in anaesthetic medicine, therefore all anaesthetic cover is provided by the consultants.

From review of the HIPE data for 2008 there were 1,941 day case and inpatient surgical admissions (see Table 6). The HIPE data also indicated that the total number of surgical admissions had been decreasing over the period 2006 to 2008. The majority of the total admissions in 2008 were day cases, 1,323 (over two-thirds of all surgical admissions). Of the total admissions, 437 (23% of total surgical admissions) were emergency inpatient admissions while 181 (9% of total surgical admissions) were planned (elective) admissions. There were, on average, three planned inpatient surgical cases and eight emergency admissions per week.

Table 6: Surgical admissions in MWRH Ennis

Surgical Admissions	2006		2007		2008	
	Number	%	Number	%	Number	%
Elective inpatient	281	(14%)	225	(11%)	181	(9%)
Emergency inpatient	509	(25%)	451	(23%)	437	(23%)
Day case	1,212	(61%)	1,308	(66%)	1,323	(68%)
Total	**2,002**	**(100%)**	**1,984**	**(100%)**	**1,941**	**(100%)**

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

The most common surgical procedures were endoscopies (see Glossary) with the next most common procedure being appendicectomies (71 in 2008) of which 28 were children (see Table 7).

From the HIPE data, volumes of major or complex surgery in MWRH Ennis were low. In 2008, surgeons in MWRH Ennis carried out a total of nine colectomies (removal of large bowel). This indicates that the MWRH Ennis does not see sufficient volumes of patients requiring acute and major surgical procedures to maintain the skills and expertise of clinical staff. The Investigation Team believes this represents potential serious risk to patients.

Table 7: Most frequent surgical inpatient and day case procedures in MWRH Ennis

Inpatient procedure	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Panendoscopy to duodenum with biopsy	192	170	184
Appendicectomy including laparoscopic	118	93	93
Fibreoptic colonoscopy of caecum with or without biopsy	89	75	79
Laparoscopic cholecystectomy	83	77	67
Repair of inguinal hernia, unilateral	50	45	20
Day case procedure	**Patient numbers 2006**	**Patient numbers 2007**	**Patient numbers 2008**
Panendoscopy to duodenum with biopsy	376	396	420
Fibreoptic colonoscopy of caecum with or without biopsy	342	357	346
Removal of tooth	202	201	312
Dilatation and curettage	31	35	28
Removal of wart	23	32	32

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 8: Other surgical procedures in MWRH Ennis

Stomach procedures	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Insertion of percutaneous endoscopic gastrostomy tube	8	7	8
Suture of perforated stomach ulcer	2	1	3
Removal of gastrostomy tube	1	0	3
Partial gastrectomy with gastroduodenal anastomosis	0	1	0
Bowel procedures	**Patient numbers 2006**	**Patient numbers 2007**	**Patient numbers 2008**
Temporary colostomy	1	2	2
Other colostomy	0	1	2
Limited incision of large intestine with anastomosis	3	2	4
Limited incision of large intestine with formation of stoma	1	1	0
Revision of stoma of large intestine	2	1	1
Right hemicolectomy with formation of stoma	0	1	1
Right hemicolectomy with anastomosis	4	5	1
Left hemicolectomy with anastomosis	1	3	2
Sub-total colectomy with formation of stoma	0	0	1
Breast procedures	**Patient numbers 2006**	**Patient numbers 2007**	**Patient numbers 2008**
Simple mastectomy	2	3	0
Fine needle biopsy of breast	2	0	0
Incision and drainage of breast	1	3	1
Excision of lesion of breast	0	7	1

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

The Investigation Team was of the opinion that no acute and major surgery should be provided at MWRH Ennis. Such patients should be referred, as a priority, to a specialist centre. It was also of the opinion that the HSE should consider developing an outreach day-surgery and day-procedure service from MWRH Limerick. Centrally agreed integrated protocols and care pathways will be required for these developments. This will enable a strong and patient-centred day case service to be developed at MWRH Ennis.

The Investigation Team, following review of staffing levels and HIPE data, found that there were insufficient numbers of consultant staff in surgery, anaesthetic and emergency medicine to provide a sustainable, safe, 24-hour service for surgical patients attending MWRH Ennis. Access to safe surgery depends as much on anaesthetic care as surgical skills. Twenty four hour care is not available within the current anaesthetic team. The Investigation Team were also of the opinion that the 24-hour operating theatre service was not sustainable from an efficiency and value for money perspective given the patient activity and workload over the 24-hour working day.

Recommendation cluster 2: surgical treatment

Local

2.1 The Mid-Western Regional Hospital Ennis should not provide acute, or elective inpatient surgical services. All acute and major surgery, including major elective and cancer surgery, should be transferred to the Mid-Western Regional Hospital Limerick.

2.2 The Health Service Executive should review day surgery provision at Mid-Western Regional Hospital Ennis and consider the feasibility of a new regional surgical service based at Mid-Western Regional Hospital Limerick providing an outreach day surgery and day-procedure service, including endoscope procedures, in the Mid-Western Regional Hospital Ennis using regionally agreed integrated protocols and care pathways.

2.3 In order to create maximum capacity at the regional centre in Limerick, the day surgery review should include consideration of an extended range of surgical specialties at the Mid-Western Regional Hospital Ennis to allow the transfer of some current elective day surgery activity from the Mid-Western Regional Hospital Limerick to create capacity on that site.

National

2.4 The Health Service Executive should work with the relevant professional bodies, using current international evidence, to identify an indicative selection (basket) of surgical procedures, for which clinical teams should treat a minimum number to maintain their skills. These should then be monitored routinely.

2.5 In order to make the best use of available in-patient beds, the Health Service Executive should work with the relevant professional bodies, using current international evidence, to identify a selection of suitable procedures to being undertaken as day surgery cases(in the absence of agreed contraindications).

2.6 Having identified benchmark activity volumes and suitable day surgery procedures, these should be routinely monitored and reported publicly at facility level. They should then be considered as part of annual service planning at national and local levels.

2.7 A focused review of acute surgical activity should be undertaken as a priority at hospitals with similar activity profiles to the Mid-Western Regional Hospital Ennis to determine whether they are safe according to international best practice.

8.2.3 Cancer services

The Authority received concerns from patients and relatives in relation to breast cancer diagnosis and treatment received at MWRH Ennis. The Investigation Team heard in interviews with families of patients and or patients, their concerns about their or their relative's breast cancer treatment and their belief that this treatment did not comply with best practice. These concerns dated from prior to September 2007 when the symptomatic breast disease service was transferred from MWRH Ennis to MWRH Limerick. As the Terms of Reference relate to the quality and safety of current services, the symptomatic breast disease service was not a primary focus of this investigation. However, the patients', and or relatives' account of their experience of the service provided important background information for the Investigation Team.

As part of the National Cancer Control Programme in Ireland, centres have been designated to provide multidisciplinary cancer care including surgical treatment for symptomatic breast disease in the first instance. MWRH Limerick was named as a designated centre in September 2007. As part of the transition to this new model, in September 2007 the HSE formally requested that MWRH Ennis (along with another 12 centres) should stop providing symptomatic breast services and surgical treatment. GPs were informed that the service would no longer be provided in MWRH Ennis. The agreed regional protocol was that all new patients with symptomatic breast disease would be referred directly to the breast clinic at MWRH Limerick. Existing review patients would continue to be seen on an interim basis at the review clinic in MWRH Ennis by the local consultant.

Interviews with staff and case note reviews indicated that a small number of patients with primary symptoms, a history of breast cancer, and or symptoms that could be secondary to their diagnosis, continued to self refer or were referred by their GP to the ED and the breast review clinic. These referrals or self-referrals were after the date of transfer of services. Although these patients were managed and referred appropriately by MWRH Ennis, this does raise issues around the awareness of the public and GPs in relation to the transfer of breast services including interim arrangements. In order for women with symptomatic breast disease to receive the best care the Investigation Team were of the opinion that these practices should stop.

The process for change has already begun with the transfer of symptomatic breast disease services to the designated centre. This system facilitates the multidisciplinary team to maintain their clinical skills and expertise, as they are caring for sufficient numbers of patients. The Investigation Team were of the opinion, from their review of case notes and interviews with staff, that there is a need for clear pathways in relation to the care and follow up, including interim arrangements, of patients with symptomatic breast disease.

With significant further changes proposed in the care pathways for patients in the area, the Investigation Team also recommends that the Mid-Western Region Regional Hospitals Network further develops and strengthens their communication with GPs and public health nurses and the public.

Recommendation cluster 3: cancer services

Local

3.1 All women with symptoms of breast disease who present to the Mid-Western Regional Hospital Ennis should be referred immediately on to the designated symptomatic breast disease service at the Mid-Western Regional Hospital Limerick. The current breast review clinic at the Mid-Western Regional Hospital Ennis should cease.

3.2 Tailored awareness and education programmes for general practitioners (GPs), community services and the public in the midwest about new regional referral pathways and protocols, in particular for breast disease, should be developed and implemented.

3.3 The Health Service Executive should regularly audit the care pathways of patients with symptomatic breast disease, within the midwestern region, to ensure agreed best practice including access arrangements, is being complied with.

National

3.4 The National Cancer Control Programme Directorate of the Health Service Executive should ensure local service configuration and referral/access/follow up pathways for each designated specialist cancer centre are communicated effectively to GPs and patients.

8.2.4 Critical care service

In addition to the Investigation team, the College of Anaesthesist of Ireland, provided specific advice in relation to the critical care service in MWRH Ennis.

Best practice would indicate that complex critical care patients requiring multi-organ support should be managed in a level 2/3 critical care unit or in a tertiary specialist centre and that these patients are transferred to the appropriate centre without delay as a matter of priority.[17-19]

The six-bedded unit defined at MWRH Ennis as an "intensive care unit" (ICU), functions as a combined coronary care and a medical high dependency unit, with only two beds identified for patients requiring intensive care. The Investigation Team was informed that the nursing staff working within the area had many years practical experience working within the unit. The nurse:patient ratio was reported in interview to be 1:2. While patients were admitted to the unit under the care of the admitting consultant, there were no defined sessional allocations of consultants to the intensive care component of the unit nor dedicated NCHD intensive care staffing. Consultant anaesthetists had been providing support and, in consultation with the admitting consultant, managed patients who required more critical care. There were no intensivists employed within MWRH Ennis.

Current practices in this unit had been established over a number of years by the consultant anaesthetists with the concept of providing the best level of patient care for the acutely ill patients within the level of resources available. It was reported through interview that there were occasional access limitations to the regional tertiary centre and the regional neurosurgical centre. Although the consultant anaesthetists recognised there were difficulties with providing this service the Investigation Team did not receive evidence of any specific adverse patient event related to the delivery of critical care in MWRH Ennis. It was reported that the transfer of critically ill patients to MWRH Limerick was facilitated and prioritised by personal networking between both centres.

HIPE data for 2008 indicates that there were, on average, 40 admissions per month to the unit with, on average, one patient per month on continuous ventilatory support (see Table 9).

Table 9: Admissions to ICU, MWRH Ennis from 2006 to 2008

ICU	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Total number of patients on continuous ventilatory support	14	12	13
Discharge destination for admissions to ICU	**Patient numbers 2006**	**Patient numbers 2007**	**Patient numbers 2008**
Emergency transfer out	83	97	102
Discharged home	322	270	244
Nursing convalescent home	67	54	43
Others	97	118	89
Total discharges	569	539	478

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 10: Most frequent principal **diagnoses** ICU, MWRH Ennis from 2006 to 2008

Principal (main) diagnoses	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Acute myocardial infarction	50	41	65
Chest pain – unspecified and other	37	31	20
Angina	37	26	28
Atrial fibrillation and flutter	36	20	24
Chronic obstructive pulmonary disease	23	40	31
Unspecified acute lower respiratory tract infection	18	10	11
Syncope and collapse	9	13	16

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 11: Most frequent principal **procedure** ICU, MWRH Ennis 2006 to 2008

Principal procedure	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Allied health intervention – physiotherapy	49	58	49
Mental/behavioural assessment	36	20	25
Bi-level positive airway pressure	29	23	17
Transfusion of packed cells	12	12	13
Cardioversion	11	7	5
Panendoscopy to duodenum with or without biopsy	14	11	9
Bladder catheterisation	1	1	12

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Expert opinion and review of casemix indicated that this unit provided level 0/1 critical care in the majority of cases: that is patient care, which could typically be provided on an acute ward (see Tables 10 and 11), including Bi-PAP (Bi-level Positive Airway Presure) in selected circumstances as per clinical judgement. Small numbers of patients with more complex conditions and specialist needs had been admitted including patients requiring mechanical ventilation. These small numbers were not sufficient to maintain staff skills and expertise in safely managing such complex patient conditions and therefore the potential risk to patients was increased.

In addition, specific concerns were highlighted to and by the Investigation Team with regard to the ability to provide an out-of-hours service by a registered medical practitioner with an appropriate level of training and experience to provide immediate on-site treatment of acute respiratory, circulatory, and airway emergencies, including the immediate management of patients receiving invasive mechanical ventilation. It is acceptable for such emergency care to be provided by emergency physicians, anaesthetists, internal medicine physicians or surgeons with the appropriate competencies but it was unclear, from interview and review of data, that such competencies were available on-site on a 24-hour basis in MWRH Ennis.

The issue in relation to the transfer of patients requiring intensive care including mechanical ventilation was considered by the Investigation Team to be of serious potential risk. The Investigation Team was of the opinion that this needed to be raised as an urgent issue within the HSE. The Authority wrote to the Chief Executive of the HSE on 5 January 2009 (see Appendix 6) when this issue was highlighted and a recommendation for immediate action was made to the HSE.

The HSE responded promptly and provided an action plan for the implementation of the recommendation.

The Investigation Team is of the opinion that MWRH Ennis does not have sufficient volumes of critically ill patients requiring level 2/3 critical care to maintain the skills and expertise of clinical staff in order to provide a safe service. Therefore there should be no level 2/3 critical care facility available within MWRH Ennis.

Recommendation cluster 4: critical care services

Local

4.1 The Mid-Western Regional Hospital Ennis should not care for patients requiring level 2/3 critical care services. Patients requiring level 2/3 critical care services should be taken directly to the Mid-Western Regional Hospital Limerick by the ambulance services. Where patients self-attend, or deteriorate at the Mid-Western Regional Hospital Ennis and require level 2/3 critical care services, they must be stabilised by appropriately trained staff and safely transferred as a priority to the Mid-Western Regional Hospital Limerick, or other appropriate centre with Level 2/3 critical care resources.

4.2 In the interim while acute medical and surgical services are provided at the hospital, the level of care provided at the Mid-Western Regional Hospital Ennis should be consistent with level 0/1 only.

4.3 The relevant transfer and bypass protocols must be regularly reviewed on a multidisciplinary basis, compliance audited and updated as necessary.

4.4 The Mid-Western Hospital Network should review its provision of critical care services within the region to ensure safe patient services that comply with safe practice guidelines.

National

4.5 The Health Service Executive should review critical care provision in hospitals with a similar resource and activity profile to the Mid-Western Regional Hospital Ennis to ensure that services are being provided within safe practice guidelines. Where this is not the case, appropriate risk management measures, and the necessary service changes, should be implemented and managed to protect patients.

8.2.5 Medical services

International evidence would indicate that in order to provide safe care for specific medical conditions, professional teams need to see sufficient numbers of patients with these conditions to maintain their expertise and skills.[5-7]

There were three consultant physicians in MWRH Ennis providing general medicine, cardiology and elderly care. There were 11 NCHDs of which five were registrars and six were senior house officers. The consultant geriatrician managed all medical patients over 80 years of age. The cardiologist had dedicated sessions in MWRH Limerick for invasive cardiac procedures including angiograms. This facilitated ease of access of patients from MWRH Ennis to MWRH Limerick for these procedures.

From review of the HIPE data for 2008, there were 4,369 medical admissions of which 3,750 were inpatient admissions and 619 were day cases (see Table 12). The majority of inpatient admissions were emergency admissions, 3,618 (83% of total medical admission) with small numbers of planned inpatient admissions (132 cases). Therefore the majority of medical admissions were being admitted through the ED.

Table 12: Medical admissions to MWRH Ennis

Medical	2006		2007		2008	
	Number	%	Number	%	Number	%
Elective inpatient	175	(3%)	137	(2.5%)	132	(3%)
Emergency inpatient	4428	(83%)	4415	(83%)	3618	(83%)
Day case	75	(14%)	775	(14.5%)	3618	(83%)
Total	5,362	(100%)	5,327	(100%)	4,369	(100%)

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

HIPE data indicated that the most frequent diagnoses for emergency admissions were non-cardiac related chest pain, respiratory tract infections and exacerbation of chronic obstructive pulmonary disease (COPD) (see Table 13).

Table 13: Most frequent principal diagnoses for medical admissions from the emergency department, MWRH Ennis

Principal diagnosis	Patient numbers 2006	Patient numbers 2007	Patient numbers 2008
Chest pain – unspecified and other	448	446	367
Unspecified acute lower respiratory tract infection	311	218	172
Chronic obstructive pulmonary disease (COPD)	173	203	151
Syncope and collapse	142	141	121
Urinary tract infection	122	120	93

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Through interview it was reported that the elderly care services had been delivered through an elderly care unit with an integrated multidisciplinary approach where medical, nursing and allied health staff for example, physiotherapists, built up expertise in the management of care of the elderly. However, this unit has been re-designated to accommodate patients from the ED who require admission when other wards have no available beds. This could create difficulties in managing an integrated approach and tailoring care to individual needs as elderly patients were now dispersed, and skilled staff redeployed, to wards throughout MWRH Ennis.

While the Investigation Team is cognisant of plans to reconfigure the services it is of the opinion that while acute elderly patients are being admitted to MWRH Ennis a dedicated elderly care service should be re-established to provide optimal, safe, quality care from an integrated multidisciplinary team to elderly patients.

The Investigation Team is of the opinion that the current consultant physician staffing arrangements in MWRH Ennis is not sufficient to provide a sustainable acute medical service. They are also of the opinion – that should, as recommended, the 24-hour emergency department, critical care and acute surgical services be transferred – general medical services should be reviewed and a clear medical service model implemented. Therefore, the future model structures for medicine should be considered in tandem with any future reconfiguration of services within the Midwestern Hospital Network. This should include outpatient, day procedures, and day patient facilities.

Recommendation cluster 5: general medical services

Local

5.1 The range of general medical services provided at the Mid-Western Regional Hospital Ennis should be reviewed by the Health Service Executive in light of the changes recommended to the emergency department, surgical and critical care services. A clear protocol-driven medical service model should be implemented that specifies which conditions can (and cannot) be treated safely in Mid-Western Regional Hospital Ennis. These protocols should be subject to regular audit.

5.2 The Health Service Executive should seek to ensure that as wide a range of medical services as possible, including out-patients, day procedures, day patient facilities and inpatient services, are safely provided in the Mid-Western Regional Hospital Ennis. These should be fully networked with the Mid-Western Regional Hospital Limerick with clear patient pathways designed and implemented.

5.3 For as long as the acute medical services remain onsite, dedicated elderly care services should be re-established to provide an appropriate integrated approach by a multidisciplinary team.

National

5.4 The Health Service Executive should work with the relevant professional bodies to develop a national model for acute medicine that is stratified to allow centres to be designated as fit to provide services up to a certain level so it is clear which centres should provide which services. This acute medicine model should include taking into account the location of other acute services such as surgery, anaesthetics, maternity, children's and critical care at any one centre.

5.5 In order to make the best use of in-patient beds, the Health Service Executive should work with relevant professional bodies to identify a 'basket' of conditions suitable (in the absence of agreed contraindications) to ambulatory (non-inpatient) patients requiring medical services.

5.6 Having identified conditions to be managed on an ambulatory basis, these should be monitored routinely and published on an institutional basis. They should then be considered as part of annual service planning at national and local levels.

8.2.6 Children's services

International evidence would indicate that children should be cared for in environments where there are appropriately trained doctors and nursing staff available to care for them on a 24-hour basis.[20] There are no paediatricians or children's nurses employed by MWRH Ennis.

In 2008, 82 children under 14 years of age were emergency inpatient admissions to MWRH Ennis (see Table 14). There were on average seven emergency admissions a month in 2008. In total there were 444 admissions of children under 14 years of which 359 (81% of total admissions) were day cases. The majority of these day cases were for dental procedures, a service provided by the HSE public dental treatment service.

HIPE data indicated that there were 66 medical admissions in 2008 of which only 18 were planned day case admissions. The children admitted as emergency inpatients, through the ED, were admitted with less complex conditions for example non-specific gastritis, constipation and urinary tract infections.

The data also indicated that of the children admitted as surgical emergencies, the majority had appendicectomy as their principal procedure. On average there were three emergency surgical admissions a month in 2008. These low levels of paediatric medical and surgical activity highlighted issues in relation to achieving the volumes of patients required to maintain clinical expertise.[21]

Table 14: Admissions to MWRH Ennis of children less than 14 years of age

Admission type	Patient numbers 2006		Patient numbers 2007		Patient numbers 2008	
All ADMISSIONS	Number	%	Number	%	Number	%
Elective inpatient	2	(0.6%)	2	(0.6%)	3	(0.7%)
Emergency inpatient	75	(22%)	76	(21.8%)	82	(18.5%)
Day case	264	(77.4%)	271	(77.6%)	359	(80.8%)
TOTAL	341	(100%)	349	(100%)	444	(100%)
MEDICAL ADMISSIONS						
Elective inpatient	0		1		0	
Emergency inpatient	44		48		48	
Day case	26		24		18	
TOTAL	70		73		66	
SURGICAL ADMISSIONS						
Elective inpatient	2		1		3	
Emergency inpatient	31		28		34	
Day case	238		247		341	
TOTAL	271		276		378	

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 15: Principal diagnoses for emergency admissions of children less than 14 years of age in 2008 in MWRH Ennis

2008	Number of children
Acute appendicitis, unspecified	27
Other and unspecified abdominal pain	7
Unspecified injury of head	6
Pain localised to other parts of lower abdomen	5
Constipation	5
Pain localised to upper abdomen	4
Nonspecific mesenteric lymphadenitis	4
Injury to spleen	1
Laceration to kidney	1
Unspecified injury to neck	1

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 16: Principal surgical procedures for emergency admissions of children less than 14 years of age in 2008 in MWRH Ennis

2008	Number of children
Appendicectomy	25
Laparoscopic appendicectomy	3
Repair of wound of skin and subcutaneous tissue of other site, superficial	2

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

Table 17: Principal surgical procedures for day case and inpatients of children less than 14 years of age in 2008 in MWRH Ennis

Procedure	Patient numbers day case	Patient numbers inpatient	Patient numbers total
Removal of tooth or part(s) thereof	303	0	303
Appendicectomy	0	28	28
Male circumcision	17	3	20
Removal of wart	11	1	12
Repair of wound of skin and subcutaneous tissue of other site, superficial	0	2	2
Removal of foreign body from skin and subcutaneous tissue with incision	2	0	2
Excision of lesion of skin and subcutaneous tissue	2	0	2
Lingual fraenectomy	1	0	1
Excision of lesion of testicle	0	1	1
Exploration of scrotal contents with fixation of testis, unilateral	0	1	1
Other repair of peritoneum	0	1	1

Source HIPE data. Please note that the 2008 file is still open and further records will be added and amended.

The Investigation Team was of the opinion that, in the absence of a full paediatric team, acutely ill children should not be cared for at MWRH Ennis. These children should be taken directly to MWRH Limerick by the ambulance service. If they are brought to MWRH Ennis by other means then they must be stabilised and transferred, as a priority, to a specialist centre where staff have the expertise and experience to care for and manage these children and appropriate critical care facilities are available. The Investigation Team was also of the opinion that there should be immediate cessation of elective inpatient paediatric surgery.

Recommendation cluster 6: children's services

Local

6.1 Acutely ill children should not be cared for at the Mid-Western Regional Hospital Ennis. The ambulance service should take children directly to the paediatric services in Mid-Western Regional Hospital Limerick. Where children are brought to the Mid-Western Regional Hospital Ennis by other means, they must be stabilised and transferred to the regional paediatric services in the Mid-Western Regional Hospital Limerick.

6.2 There should be immediate cessation of elective inpatient paediatric surgery.

6.3 The Health Service Executive should consider the feasibility of the Mid-Western Regional Hospital Limerick paediatric services providing a paediatric outreach day surgery service in the Mid-Western Regional Hospital Ennis with integrated regional protocols and care pathways. Any surgical and anaesthetic day case services must be provided in a child-appropriate environment by healthcare teams competent in the clinical care and resuscitation of children.

National

6.4 The Health Service Executive should ensure that there is a clear national policy for the appropriate care setting for, and management of, acutely ill children and those requiring inpatient surgery.

8.2.7 Maternity services

The regional maternity services have been centralised to the Mid-Western Maternity Hospital Limerick. There were no obstetricians, or midwives employed in MWRH Ennis and hence the Hospital does not provide an on-site maternity service. However, weekly consultant-led and midwife-led antenatal clinics were provided by an outreach team from the Mid-Western Maternity Hospital.

The Investigation Team was informed through interview that small numbers of pregnant women continue to self refer or were brought in by ambulance to the ED for assessment of pregnancy-related conditions. It is the opinion of the Investigation Team that there should be a strong communication programme to inform women and the community that there are no on-site maternity services available within MWRH Ennis. It is also the opinion of the Investigation Team that women who self refer to the ED with pregnancy-related conditions should be transferred directly to the regional centre. The ambulance service should take women with pregnancy-related conditions directly to the regional centre.

It was reported from interviews that women attending for their first antenatal visit had their histories recorded in an area with limited privacy. Interviews with staff from the regional centre also indicated that they believed that the antenatal service was not consistent with the service provided in Limerick. In Limerick routine antenatal care involved ultrasound scans provided by specialist obstetric ultrasonographers who were members of the multidisciplinary team. In Ennis, these routine ultrasound scans were not provided by these specialist ultrasonographers.

The Investigation Team was of the opinion that, in order to provide optimal, safe, quality care for women attending this antenatal outreach clinic, there should be consistency of services provided including ultrasound scans.

Recommendation cluster 7: maternity services

Local

7.1 Women with pregnancy-related conditions should not be brought by the ambulance services to the Mid-Western Regional Hospital Ennis. These patients should be brought directly to the Mid-Western Maternity Hospital Limerick. Patients self-presenting to the Hospital should be transferred as a priority to the regional centre at Mid-Western Maternity Hospital Limerick.

7.2 The Mid-Western Maternity Hospital Limerick should review the provision of ultrasound scans for women attending its outreach service in the Mid-Western Regional Hospital Ennis to ensure it is consistent with the service provided at its regional centre.

7.3 The Mid-Western Maternity Hospital Limerick should regularly audit its outreach services to ensure they are consistent with services at the regional centre.

8.2.8 Diagnostic services

Diagnostics include X-rays, ultrasounds, computer tomography (CT) scans, blood tests and tissue samples. Best practice identifies that there are system issues that contribute to error, including excess workload, inadequacy of clinical information available to the radiologist and over reliance on locum radiologists within a department.[22-24] In a previous investigation carried out by the Authority there was a recommendation that the HSE should minimise their reliance on temporary staff.[25]

The Investigation Team acknowledges that the HSE are continuing to develop procedures around recruitment of temporary and locum staff.

The radiology services in MWRH Ennis include plain X-rays, ultrasounds and contrast studies (for example, intravenous pyleogram, barium meals). There was one full-time consultant radiologist in addition to a consultant radiologist from MWRH Limerick who had a commitment to provide one session a week in MWRH Ennis. The fulltime consultant post has been provided by a number of locum radiologists (generally with short six-month contracts) since the last permanent radiologist left in 2001. There were no junior radiology staff or staff in training positions in MWRH Ennis. Therefore, there was a dependence on locum consulting staff.

Interviews, case note and documentation reviews highlighted issues in relation to high volumes of X-rays and scans with a history of long reporting times. In May 2008, in response to complaints received by MWRH Ennis, a standard operating procedure for reporting on X-rays was implemented. This procedure was directed to all members of the radiology department and included the X-rays which were to be prioritised as well as performance indicators for reporting times. Interviews with front-line and radiology department staff indicated that the reporting times had recently shortened although there were still a large volume of X-rays to be reported.

Interviews, case note and documentation reviews highlighted that routine second readings of radiology tests rarely occurred. Although this is not uncommon in healthcare the Investigation Team was of the opinion that second readings can be of benefit in complex and difficult cases and that random second readings are an effective audit tool.

Interviews with families of patients, and or patients, and interviews with staff have highlighted issues in relation to the management of documentation and test reports within the hospital. These interviews highlighted that the systems for ordering, prioritisation and reporting of test results have not always been robust for example in one concern, there was evidence to suggest that an urgent radiology report was not clearly identified as urgent therefore leading to a delay in the result being reported to the appropriate clinician.

The laboratory service was part of the regional network with some tests being provided locally including full blood counts, blood transfusion and culture and sensitivity, while other more specialised tests were sent to the regional laboratory in MWRH Limerick.

The Investigation Team identified, through interviews with staff members, that there is a logging system for all specimens processed in-house in MWRH Ennis. There is no logging system in place for blood or microbiology specimens sent directly by clinicians to the Pathology Department in MWRH Limerick where the request for analysis does not originate from the Pathology Department in

MWRH Ennis. There is also a logging system using ILAB (APEX) – the laboratory information system – for specimens sent to the Pathology Department in MWRH Limerick where the specimen was initially tested in MWRH Ennis and further analysis was required in MWRH Limerick. All histology specimens received in the Pathology Department MWRH Ennis are accompanied by a duplicate form which is signed by the medical scientists in MWRH Ennis and copied before being sent to the Pathology Department in MWRH Limerick. There was limited evidence of a robust system for the timely dissemination of these results to the appropriate clinical team when they were returned to MWRH Ennis from the MWRH laboratory in Limerick. To ensure the safe and timely management and reporting of diagnostic tests the Investigation Team is of the opinion that a robust system to track and ensure dissemination of results to the appropriate clinical teams should be implemented.

In some instances interviews have identified that some tests may not be reported until after the patient had left the care of MWRH Ennis and although there were some systems in place to ensure the appropriate clinician was informed and that follow up occurs, these policies and systems need to be robust and regularly reviewed and audited to ensure safety and quality for patients.

Interviews and documentation identified issues in relation to access to radiology services especially non-urgent scans and CT scanning. There was no CT scanner available on site and the only echocardiogram machine available was in the outpatients department. The lack of a CT scanner could delay diagnosis, management and discharge of patients which may impact on bed management systems. Managers in MWRH Ennis have addressed this issue in the past by accessing diagnostic services elsewhere for example, CT scans in the private sector.

A new building was being developed that has been identified as the location for a new CT scanner. The funding to purchase a new CT scanner was collected by voluntary fundraising. A business plan for this service was submitted to the HSE. The Investigation Team, were informed by the HSE that this service is planned to commence in 2009. However, interviews highlighted a lack of clarity around resources for this new service.

The Investigation Team is of the opinion that, in order to improve the safety and quality of the radiology services, the following recommendations should be implemented:

Recommendation cluster 8: diagnostic services

Local

8.1 The future role of diagnostic services in the Mid-Western Regional Hospital Ennis should be clearly defined. A strategic review of the radiology and laboratory services should be undertaken leading to these services being outreach services from the Mid-Western Regional Hospital Limerick with centrally agreed integrated protocols and care pathways that will be fit for purpose in supporting the changes in services outlined in this report.

8.2 A quality assurance system, which includes rigorous procedures and protocols for requesting, prioritising, reading and reporting radiology examinations with defined timelines and volumes, should be implemented, regularly reviewed and compliance audited.

8.3 The Mid-Western Regional Hospital Ennis should implement reliable mechanisms, for example multidisciplinary clinico-radiological meetings, whereby the referring clinician, including GPs, can discuss the imaging findings in complex cases in more detail with the radiologist or other individual who has reported the examination.

8.4 A robust system for the safe, timely management and reporting of all tests, both at local and regional laboratory level, should be developed, implemented and regularly audited. This system should involve the prioritisation of test reporting and protocols for the follow up of the reports by the identified clinician.

8.3 Ambulance services (including pre-hospital emergency care)

The central ambulance control for the midwest region is located in Limerick. The service was undergoing transition in response to current and planned changes in hospital services that would affect pre-hospital emergency services. Historically, the ambulance would bring patients requiring emergency care to the nearest hospital.

Along with the trend towards centralising complex and specialist services, international evidence has shown that, provided the patient can be stabilised, if they are brought to the most appropriate centre for their needs there are better outcomes for the patient, even if it takes longer for them to reach such centres.

To provide this, an appropriate pre-hospital emergency care service needs to be available. This includes paramedical staff with the appropriate advanced skills supported by expert clinical advice where required, who are able to diagnose, treat, stabilise and maintain patients whilst they are transported to the regional centres. In the midwest, this process had already begun and 12 advanced paramedics were due to be deployed in March 2009.

Due to the longer journey distances being travelled by ambulance crews, the HSE identified a need to increase the overall coverage by ambulance services in this area. Consequently an additional 14 ambulance crews were in the process of being appointed at the time of the investigation. Hence an additional 26 paramedic staff were being appointed to a base-line of 110 staff.

Despite the developments in staffing, the Investigation Team found some aspects of the pre-hospital emergency service in need of further development, a fact acknowledged by those responsible for the service. Currently, a significant amount of the out-of-hours ambulance cover was provided via an on-call arrangement, rather than on-duty cover. This meant that a paramedic crew would be called from home rather than being on-duty waiting for a call and this could add delay to response times. The Investigation Team was informed there were plans for on-call arrangements to be stopped and replaced with full on-duty cover. The Investigation Team believes this is a basic step towards providing a modern pre-hospital emergency service that should be in place.

It is internationally accepted that, for many emergency conditions – including patients suffering from, for example, major trauma and heart attacks – every minute delayed before receiving skilled paramedical and or medical care, can not only increase the risk of additional harm for patients but also increase the risk of them not surviving. Similarly, the sooner patients who have sustained major trauma, cared for by suitably qualified ambulance staff, receive definitive care in a specialist centre equipped to care for these patients, the more likely they are to survive.[26-27]

Additionally, there was currently no differentiation between pre-hospital emergency crews and patient transport crews meaning trained paramedical staff do both. This could mean that, for example, a paramedical crew could be on their way to take a patient home from hospital when an emergency call comes in, potentially delaying the emergency response and disrupting the discharge of a patient. This lack of differentiation between the patient needs for different types of patient transport is a significant patient safety issue which substantially increased the risk for emergency patients and is an inhibitor to the development of modern out-of-hospital ambulatory and emergency service, and needs to be addressed.

In order to facilitate patients being cared for in the appropriate setting, protocols, including ambulance bypass protocols, have been developed and implemented. Bypass protocols are when the patient is brought directly to the most appropriate healthcare setting rather than attending a healthcare setting which may be more local but does not have the appropriate expertise. As referred to elsewhere, the full implementation of bypass protocols for children and maternity patients is an important patient safety issue and the Investigation Team believes these should be formally implemented as a matter of urgency.

An ambulance bypass protocol for patients with major trauma was established in May 2008. Whilst this ambulance bypass protocol for major trauma patients in MWRH Ennis was reported to be working appropriately, there was a lack of clarity over the status and implementation of ambulance bypass protocols for maternity and paediatric cases. It was reported that these protocols had been agreed locally and were to be fully implemented in the first quarter of 2009. However, interviews also informed the Investigation Team that ambulances, on occasion, continued to bring patients to the emergency department (ED) who required more specialised care than was available within MWRH Ennis, for example maternity cases, and therefore these patients required transfer to the appropriate specialist centre.

The Investigation Team recognised this as a potential serious risk to patients and was of the opinion that this needed to be raised as an urgent issue within the HSE. The Authority wrote to the Chief Executive of the HSE on 5 January 2009 (see Appendix 6) and this issue was highlighted and a recommendation for immediate action was made to the HSE.

The HSE responded promptly and provided an action plan for the implementation of the recommendation.

The Investigation Team was concerned that these bypass protocols for maternity and children should be fully implemented, evaluated and audited.

Recommendation cluster 9: ambulance services

Local

9.1 The bypass protocols for maternity and children must be fully implemented immediately and the Health Service Executive should systematically evaluate all of its bypass protocols through audit and, as required, identified improvements should be implemented.

9.2 The Health Service Executive must ensure that there are appropriate numbers of suitably qualified ambulance staff to provide a safe emergency and non-emergency patient transport service in the midwest region within an established duty rota that does not rely on an on-call rota for the basic provision of the service.

National

9.3 The Health Service Executive should ensure that the ambulance service has a recognised call prioritisation and dispatch system in place nationally in order to prioritise emergency calls to ensure that the right patient receives the right care by the right professional at the right time. This should be implemented in the midwest region as a priority.

9.4 The Health Service Executive should ensure that the ambulance service develops and implements arrangements to ensure that emergency ambulance crews are not providing transport for patients who do not require emergency care and that appropriate resources are established to better meet the needs for patients requiring non-emergency transportation.

8.4 Inter-hospital transfers

To facilitate patients being managed in a safe and appropriate healthcare setting the implementation of effective and efficient transfers between these settings is essential. Safe and effective inter-hospital transfers depend on clear and efficient transfer protocols. MWRH Ennis functioned as part of an acute hospital network in the midwest and there was evidence of transfers to regional and specialist centres.

However, interviews with staff and documentation review indicated that although there were some transfer protocols in place (for example patients with burns), they were not comprehensively known by front-line staff; implementation was variable; and they were not regularly reviewed or their compliance audited.

During the investigation, the Investigation Team regarded this as a potential serious risk to patients and believed it needed to be raised as an urgent issue within the HSE. The Authority wrote to the Chief Executive of the HSE on 5 January 2009 (see Appendix 6) highlighting the issue and a recommending immediate action.

The HSE responded promptly and provided an action plan for the implementation of the recommendation.

The Investigation Team is of the opinion that these robust transfer protocols for the safe and timely referral, acceptance and transfer of patients should be fully implemented, evaluated and audited.

Through interviews with staff it was identified that, although clinicians in MWRH Ennis and the regional/specialist/tertiary centre agreed that when a patient required an emergency or urgent inter-hospital transfer, there were no rigorous protocols in place to ensure the safe and timely referral, acceptance and transfer of these patients.

The Investigation Team recognised this as a potential serious risk to patients and was of the opinion that this needed to be raised as an urgent issue within the HSE. The Authority wrote to the Chief Executive of the HSE on 5 January 2009 (see Appendix 6) when this issue was highlighted and a recommendation for immediate action was made to the HSE.

The HSE responded promptly and provided an action plan for the implementation of the recommendation.

The Investigation Team was of the opinion that a robust system should be developed and implemented, by the ambulance services in conjunction with relevant clinical teams and management, for the prioritisation of inter-hospital transfers.

At the time of the investigation, the Investigation Team determined that patients who potentially required acute neurosurgical care, were transferred to MWRH Limerick for a diagnostic scan and then transferred on to one of the neurosurgical centres, in Beaumont Hospital or Cork University Hospital, as appropriate. As these patients are required to be accompanied by appropriate clinical support, including an anaesthetist if the patient is ventilated, clinical staff could be off site for a number of hours as the patient continues to be under the care of the MWRH Ennis clinicians throughout this process. This meant that MWRH Ennis had to redeploy staff or call in off-duty staff to provide on-site clinical cover in their absence.

The Investigation Team recognised this as a potential serious risk to patients and was of the opinion that this needed to be raised as an urgent issue within the HSE. The Authority wrote to the Chief Executive of the HSE on 5 January 2009 (see Appendix 6) when this issue was highlighted and a recommendation for immediate action was made to the HSE.

The HSE responded promptly and provided an action plan for the implementation of the recommendation.

While the Investigation Team is aware that there are plans to reconfigure the services in the midwestern region, it is of the opinion that this recommendation should continue to be implemented to ensure a safe service for patients requiring neurosurgical care.

It was reported, in interviews with staff members, that on occasions inpatients with outpatient or diagnostic appointments in other hospitals, who required ambulance transfer, had to have appointments rescheduled as the arranged transport did not arrive on time. This had been highlighted as an issue to the risk management team and it was reported that this issue was being monitored.

8.5 Bed management

When a decision is made to admit a patient, systems should ensure that it is timely and that the patient is cared for by the appropriate team, in the right location.

As there was no full-time bed manager within MWRH Ennis the admissions nurse or assistant director of nursing on duty had the responsibility of finding an appropriate bed. There was little evidence of an active bed management policy being implemented across the whole Hospital system.

Although interviews indicated that there was some evidence of bed allocation being aligned with infection control policies, due to the high occupancy rates, limited isolation rooms and the demands on beds, it was reported that this was difficult to implement.[28] It was also reported that additional beds were used on wards on occasions. Although the Investigation Team was informed that there was an escalation policy there was little evidence of a robust active escalation policy.

The Investigation Team was of the opinion that to facilitate patient care, an active bed management strategy, including a review of alternate access routes for patients requiring acute services should be implemented.

8.6 Discharge planning

As previously stated, for the safe and effective management of a patient's care throughout the patient journey, there needs to be an integrated patient-focused approach. Best practice indicates that from referral and admission, a patient's discharge is planned in conjunction with the patient, their family, their GP and community care.

Discharge planning, planned from point of admission, is fundamental to ensure that the patient and their families are prepared for their discharge and that an appropriate setting for discharge has been identified, for example home and residential care. Effective discharge planning facilitates safe transfer and the patient's ongoing appropriate care and management. Discharge planning also maximises the number of beds available for admission which facilitates timely admission of patients to the appropriate bed.

There was little evidence of robust discharge planning within MWRH Ennis and a recent national review of bed utilisation, undertaken by the HSE, indicated that only 33% of charts in MWRH Ennis had evidence of discharge planning.[29] The national average was 40%. As part of a national response to this issue it was reported that local workshops and joint implementation groups were established with primary care services in the midwest region. It was also reported that communication forums had been established with the Director of Public Health Nursing and a GP consultation liaison group.

When a patient is ready to be discharged there are usually a number of options depending on the patient's and their families' needs, for example, home, long-term care, convalescent care. However, as in other parts of the country, there were reported issues in relation to access to long-term care beds, intermediate and at-home care services. It was also reported, through interview with staff, that if diagnostic tests to determine management pathways were not undertaken in a timely manner this delayed discharge.

Some interviews with patients, and or their relatives, indicated that communication with patients, their families, and primary care and community services was not optimal. In some cases the families believed they did not have sufficient prior notice that their relative was being discharged.

Interviews with patients, and or their relatives, raised concerns in relation to patients being discharged to a residential care setting or nursing home or GP where the clinical information required for their safe transfer, care and management was not adequately communicated.

An example was reported through interview with families of patients, and or patients, of patients being transferred without comprehensive exchange of clinical information in regards to their medication and ongoing care requirements with serious consequences for patients.

MWRH Ennis reported that it was responding to the highlighted issues by developing standard operating procedures on discharge and discharge summaries. The Investigation Team viewed a community referral form that was being used in the ED.

The Investigation Team was of the opinion that a robust discharge planning process would facilitate the safety and quality of the services provided in MWRH Ennis.

Recommendation cluster 10: admission and discharge

Local

10.1 The Mid-Western Hospital Network should systematically evaluate its bed management processes, through audit, with required improvements implemented and re-evaluated to confirm continuous quality improvement. This should incorporate a robust discharge planning policy, which commences on admission and states that appropriate and open information must be provided to the patient and or their family members and the receiving care provider to ensure transfer and ongoing patient care pathways are safe and of a high quality.

10.2 The Health Service Executive should systematically evaluate all of its discharge protocols, through audit, and, as required, identified improvements should be implemented and the protocols re-evaluated to confirm continuous quality improvement.

National

10.3 The Health Service Executive nationally should further develop and implement an active bed management strategy with appropriate care pathways, access to diagnostics and integrated discharge planning.

9 Corporate governance and leadership: findings and recommendations

Key findings:

1. The lack of clarity around local accountability and the authority to make decisions means that there is no single person at Hospital level who is fully accountable for the quality and safety of services.
2. There were limited systems in place for effective clinical governance in order to provide the necessary assurance for patients.
3. Risk management processes were not pro-active. Adverse events, complaints and claims relating to incidents and Freedom of Information requests were not formally integrated within MWRH Ennis and therefore the outcomes from these processes are not patient focused.
4. Patient expectations were not being met by the complaints process.

9.1 Introduction

Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance (the Commission), published in 2008 and endorsed by Government in February 2009, recognised that modern healthcare systems cannot rely solely on the expertise and professionalism of healthcare professionals to provide safe care. The report established the importance of good governance structures, processes and behaviours which promote accountability and are necessary for safe, effective, sustainable services.[(2)]

An effective system of governance must have clear lines of accountability and levels of authority. In the healthcare setting, allowing decision making and accountability to be as close as possible to the provision of care for patients, promotes responsiveness to patients' needs and allows staff to take responsibility for the delivery of care. In addition, recognising that all healthcare carries some risk, clear systems for identifying, anticipating and mitigating risks are important aspects of services oriented to promoting safety and improvement. This should include responding effectively to complaints or adverse incidents to ensure patients' concerns are addressed adequately and lessons are learnt for the benefit of future service users.

When these concepts are applied specifically to clinical treatment and decisions about patient care it is known as "clinical governance". This includes the important concept of "clinical audit" which involves clinicians reviewing systematically how well care is being provided, for example by looking back at how treatment has turned out for a selected group of patients and identifying opportunities to improve.

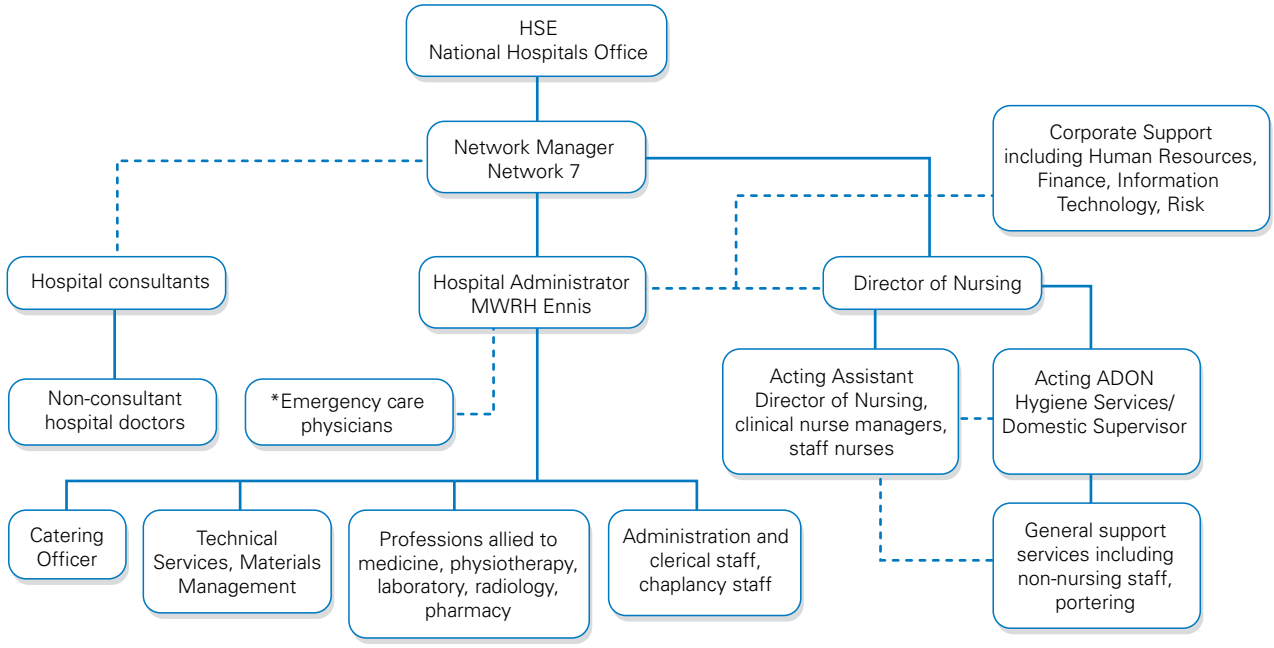
This section outlines the Investigation Team's findings in MWRH Ennis in respect of these issues.

9.2 Leadership, management and reporting relationships

MWRH Ennis is one of six hospitals in the National Hospitals Office (NHO) Mid-Western Hospital Network. The current structure for the Mid-Western Hospital Network is that the hospital administrators from MWRH Ennis and Nenagh and the General Manager from MWRH Limerick report directly in to the Network Manager. The Network Manager reports and is accountable to the Director of the NHO. The Director of the NHO, Assistant National Directors and Network Managers meet forthnightly. The Investigation Team was also informed that the eight network managers meet with the assistant national directors in the NHO on a weekly basis. It was reported that the Network Manager was responsible and accountable for the delivery of activity targets and financial control, maintaining budget control, patient safety and customer care. It was also stated that the networked hospitals provide monthly reports including budget, staffing, activity profile and quarterly STARSweb reports to the NHO.

Figure 2 summarises the reporting relationships in place at MWRH Ennis. Within MWRH Ennis, the Hospital Administrator and the Director of Nursing (DoN) report directly to the Network Manager. However, in relation to budgetary matters the DoN reports to the Hospital Administrator. The consultants have an administrative reporting relationship with the Network Manager.

Figure 2: Reporting relationships within MWRH Ennis



**This is an administrative and not a clinical reporting relationship*

While the administrative reporting relationships between the consultants and Network Manager were clear to the Investigation Team, the clinical accountability reporting framework was ambiguous.

This arrangement of multiple reporting relationships from within a single hospital to a network manager is not unique in the NHO. In the course of the investigation the Investigation Team identified there is a clear management line in place at network level and interviewees were able to describe these regional relationships. However, it was less clear to some what their reporting relationships were within MWRH Ennis.

MWRH Ennis has a Hospital Executive Committee which includes two consultants, one of whom is Chairperson, the Hospital Administrator and DoN. This Committee reviews and oversees service provision, operational matters and strategic issues which are then forwarded to the Network Manager for consideration. Some members of the Executive Committee reported that they do not feel they have executive power or authority within MWRH Ennis and little input into service development.

While many people interviewed reported there was clear managerial leadership within MWRH Ennis, the Investigation Team found that this was grounded in longstanding relationships with colleagues rather than formal management arrangements. The Hospital Administrator, as the budget holder, has responsibility for monitoring the budget but does not have management responsibility for all activity within MWRH Ennis and is not in a

position to make key decisions relating to use of resources, many of which are referred up to network level.

The Investigation Team concluded that, in reality, the various reporting lines and absence of clear local authority and devolved decision making meant no single person at Hospital level was fully accountable for the quality and safety of services and this system is unacceptable. The Investigation Team was of the opinion that this did not represent an accountable, reliable environment for patients and this principle is also endorsed by the Commission on Patient Safety and Quality Assurance.[2]

The system of management at MWRH Ennis is typical of many areas within the HSE operating as part of a network management structure. In the opinion of the Investigation Team the weakness of this model is that the locus of decision making and lines of accountability can be unclear. This is more of a challenge in times of change and transition. Many of these reporting arrangements are historic in nature and represent a potential barrier to effective governance and transition. The Investigation Team believes that an active programme to address these historical anomalies needs to be implemented.

The investigation Team developed a clear impression that within the HSE management, at a local, network and national level, there exists a commitment and desire to improve services for patients. The need for change had been acknowledged, however, the processes through which changes are implemented remain a challenge.

Staff reported, in a number of interviews, that they felt unsupported and under-resourced. Arising from the negative publicity in the recent past in some sections of the media and some sections of the public, a number of staff have been left feeling demoralised and disenchanted with the service that they work in. However, they still reported strong support for MWRH Ennis itself, from their families and from service users and their families.

The Investigation Team believes this strong community ethos is an important source of social and professional capital that will be a vital factor in implementing any future plans for MWRH Ennis. Furthermore, the Investigation Team believes it is vital that Hospital staff are closely involved in planning and shaping the future role of MWRH Ennis.

9.3 Communication

Good communication is core to safe, high quality health service delivery and is the cornerstone of the trust and respect between the patient-clinician relationship. Without this, person-centred care ceases to take place. It is essential for safe and accurate patient diagnosis and for the development of successful treatment plans and is associated with improved patient health outcomes and patient experience and satisfaction.

Good and effective communication between healthcare teams is also important as inadequate communication can potentially result in serious patient safety consequences for patients.[30-34]

The importance of communication is clearly stated through a number of national reports and guidance documents.

9.3.1 Communication with patients and or their relatives

A recurrent perception emerging from interviews with families of patients, and or patients, was that they had experiences where the HSE at a local, regional and national level had communicated poorly with them. The patients, and or their relatives, believed there was poor communication in relation to their care and in relation to the management of their concerns and complaints. The Investigation Team found examples of Hospital staff making efforts to communicate the outcome of complaints investigations including offering meetings.

The Investigation Team recognises that all of the patients and relatives of patients that it spoke to had believed that adverse incidents had occurred or had made complaints about their care, and their perceptions may differ from patients who may not have any concerns. However, this is the very group of patients who require empathetic, supportive and closely managed communication. The Investigation Team believes the mismatch they found between staff efforts to communicate effectively, and the patients' and or relatives' perception of what communication was appropriate and timely is at the centre of many of the concerns brought to its attention.

9.3.2 Communication with staff

Within MWRH Ennis, interviews with staff indicated that although they reported good informal communication based on personal relationships, there were few formal multidisciplinary forums for exchange of information. The Investigation Team also heard examples of poor inter-disciplinary communications, for example in relation to decision making about whether to admit patients or not. Inevitably, individual behaviour will influence inter-professional behaviour in the absence of clear codes of conduct and systems. The Investigation Team concluded that there was a need for a much more structured and managed approach to internal communication within MWRH Ennis.

In relation to the longer term development of services, the Investigation Team was concerned at the apparent absence of communication with staff in relation to proposed regional development plans. The reconfiguration

proposals were published in January 2009 and since then staff briefings have commenced. However, the Investigation Team is of the opinion that this delayed approach has made the management of any significant future change much more difficult to achieve as successfully as would otherwise have been the case.

9.3.3 Communication with other hospitals

Interviews with MWRH Ennis staff highlighted perceived issues in relation to communication with the network hospitals regarding operational matters such as patient transfers. Interviewees described mostly informal communication with little formalised regional networking occurring and no routine audit or monitoring of inter-hospital interaction. In previous investigations, the Authority has highlighted the importance of the active management and monitoring of inter-hospital relationships – especially clinical relationships – to ensure patient care is not potentially compromised by ineffective or inefficient transitions within patient care pathways.[25; 35] Whilst some protocols for transfers of care were in place, the Investigation Team is concerned that there did not appear to be formal mechanisms for the governance, audit or monitoring of inter-hospital transfers of care.

It is also imperative that effective and proactive communications take place for the benefit of patients who present to MWRH Ennis and who have, or are, being cared for at another hospital elsewhere in the country. Exchanging information in relation to a patient's care in these circumstances may be imperative in identifying, with the patient, their ongoing care and treatment and is a fundamental component to ensuring safe care in such circumstances.

9.3.4 Communication with primary and community care

It was reported through interviews with families of patients, and or patients, that there were some incidences of poor communication around discharge planning, as previously discussed in section 8.6, between MWRH Ennis and families and primary care givers. Clearly good communication between MWRH Ennis and primary and community care is a fundamental requirement of this important phase in patient care.

9.4 Clinical governance

9.4.1 Introduction

The term "clinical governance" refers to the behaviours, and systems and processes which promote accountability and encompass:

- audit
- policies and procedures
- risk management incorporating complaints and incident management
- reporting and monitoring of the quality and safety of services
- behaviours including relationships and communication
- leadership of the staff managing and providing care.

In common with many hospitals in Ireland, under the previous consultant contract there was no mechanism for supervision or appraisal of consultant practice to ensure that it was of an acceptable standard and the Investigation Team expected that the implementation of the new consultant contract along with commencement of competence assurance under the Medical Practitioners Act 2007[36] would begin to address this.

However, in the ED, the Investigation Team interviewed non-consultant emergency care physicians working autonomously with no formal mechanism for supervision, reporting or clinical accountability. Although there was an emergency medicine consultant from MWRH Limerick with a sessional commitment of four sessions a week to MWRH Ennis, the emergency care physicians did not have a formal reporting relationship to the consultant and therefore there appeared to the Investigation Team to be limited ongoing clinical accountability or support.

The Investigation Team found no evidence of any specific concern in respect of clinicians working in the ED. However, it does regard as very unsatisfactory the fact that non-consultant doctors were operating in this unaccountable and relatively unsupported environment which was not conducive to effective teamwork, learning or development of the doctors concerned. Such an environment could pose risks for patients.

Regarding clinical relationships between MWRH Ennis and other hospital teams, especially MWRH Limerick, the Investigation Team had these described to them as good at a personal level. Clinicians met informally and had built up good relationships with colleagues in other network hospitals over the years. Services and consultants with joint appointments between the hospitals described good professional relationships and functioning transfer of patients. However, there are no regular formalised clinical meetings between specialties or regular multidisciplinary meetings

to discuss cases, or issues in relation to operational matters, for example transfer arrangements within the Network.

The Investigation Team understands that any regular meeting or discussion takes time out of already busy schedules. However, it considers that ensuring a consistent and safe service depends on timely and appropriate decision making about the best care setting for patients. Whilst all professionals involved in a single given case will do their best to ensure it is managed optimally, it is important to review a series of cases on a regular basis to ensure the service as a whole is operating effectively and consistently. This service overview was lacking in the relationship between MWRH Ennis and MWRH Limerick. Important as this is under current arrangements, this will be vital in the context of any transition towards a new service model and therefore greater integration between clinical teams is needed to avoid the "negotiation" between centres to ensure that patients are cared for in the most appropriate settings.

9.4.2 Clinical audit

Clinical audit is the principal method used to highlight excellence in clinical practice and monitor clinical quality and validate care. When integrated into a wider set of processes it provides a powerful mechanism for ongoing quality improvement, highlighting incidents when standards are not met and identifying opportunities for improvement. MWRH Ennis had a part-time Clinical Audit Officer who chaired the multidisciplinary Audit Steering Committee. The Investigation Team was informed that the selection of clinical audit topics was prioritised according to risk and volume of activity.

The Investigation Team was provided with examples of clinical audit including monthly medical audit meetings where audit topics included for example chronic obstructive pulmonary disease (COPD), national stroke audit, pressure ulcers, medical record and infection control including hand-washing techniques and antibiotic usage. There were also monthly mortality and morbidity meetings where patient deaths were reviewed by the clinicians and certain individual cases, in particular if they were unexpected deaths, were discussed in greater depth by the whole group.

The presence of an audit programme was welcomed by the Investigation Team. Audits carried out are generally multidisciplinary with involvement from the clinicians, nursing and management. However, the involvement in audit and the attendance at audit meetings was variable within the different disciplines. Audit was part of the mandatory induction programme for new non-consultant hospital doctors. The audit nurse has undertaken an education programme on audit for all disciplines although there had been no recent programme.

9.4.3 Policies, procedures and guidelines

The Investigation Team was informed and there was evidence that best practice in relation to policies, procedures and guidelines (PPGs) was not being comprehensively adhered to in MWRH Ennis. While it was reported that there were several PPGs developed and implemented, they had been developed in an ad hoc, non-standardised way; were not always widely disseminated, implemented and audited; and there was no central policy bank. Recognising this issue, a multidisciplinary PPGs Committee was established in early 2008 chaired by the Clinical Audit Officer. It was reported that a high number of new PPGs had been developed or reviewed and implemented in 2008 in response to concerns highlighted by patients and their relatives. However, these had not been audited for compliance. The Investigation Team was informed that there were planned education sessions for staff on PPGs.

It was reported in interview to the Investigation Team that, while new and revised PPGs had been disseminated, there was not comprehensive knowledge of these PPGs among front-line staff.

Recommendation cluster 11: leadership and governance

Local

11.1 All the acute hospitals contributing to the midwest region acute care system should form a hospital group under an integrated operational governance and management structure, based at the Mid-Western Regional Hospital Limerick. The group should be led by a management board with executive accountability and the appropriate skills and experience to discharge these responsibilities and to manage the changes required in the transition of patient services across the areas. Satellite centres should have clear and appropriate day-to-day on-site operational management arrangements.

11.2 This hospital group should be led by a chief executive, who is ultimately accountable for the provision and management of the services provided by the group, and who is accountable to the Network Manager. The chief executive should lead an executive management board consisting of directors, who have the appropriate skills and experience to discharge their responsibilities and who are accountable to the chief executive. This board will be responsible for the provision of all services and implementation and management of the transition of patient services across the area. The smaller hospitals in the group should have clear and appropriate day to day operational management arrangements reporting to the group management board.

11.3 A code of governance should be established that sets out the management board's roles and responsibilities including an oversight role in respect of safety and quality of health services provided. This must include clear lines of accountability and devolved decision making.

11.4 The regional management tier at Network level in conjunction with the executive management board of the hospital group should focus on strategic governance of the region, stakeholder engagement and performance management and monitoring of the hospitals.

11.5 The HSE should establish an active programme to address historical anomalies in reporting arrangements, in order to achieve clearer lines of accountability for clinicians and managers at hospital level. This should include all clinical consulting teams being appointed to, and organised from, the Mid-Western Regional Acute Hospital Group as part of a regional service.

11.6 Clinical teams in the Mid-Western Regional Acute Hospital Group should come under a unified clinical governance system led by regional clinical specialty groupings based in the regional centre in Limerick. This should incorporate the development of agreed patient pathways owned by the regional clinical departments each under the leadership of a clinical director.

11.7 For as long as an emergency service continues to be provided at the Mid-Western Regional Hospital Ennis, formal clinical accountability and reporting arrangements must be established immediately for emergency care physicians working in the emergency department.

9.4.4 Risk management

The Mid-Western Health Board Risk Management Strategy, 2005, established a risk management structure in the region with a risk manager and four risk advisors. Following the establishment of the HSE in 2005 and restructuring, the Risk Advisor covering MWRH Ennis was realigned with and reported within the Primary, Community and Continuing Care Directorate (PCCC) of the HSE, and advised both acute and non-acute services in County Clare. It was reported that the risk advisors within the network met informally on a two-monthly basis.

Since the final meeting of the Regional Strategic Healthcare Risk Management Group in February 2007 there had been developments at a national level with the development and roll out of the NHO's quality and risk framework. The role out of this national plan includes a regional wide structure with a network steering committee on quality risk and patient safety established in January 2009.

It is too early to say whether the new regional risk management structures will be effective. However, the Investigation Team believes it is important that there are clear lines of responsibility and accountability within the region and nationally and that these arrangements are effectively integrated with hospital-level risk management and that the processes are transparent, patient-focused, and with clear learning pathways.

At Hospital level there had been a merger of committees to form the Quality, Risk and Patient Safety Steering Committee (inaugural meeting in October 2008). It was reported in interview that the Risk Advisor (approximately 0.5 WTE), DoN and Hospital Administrator liaised regularly.

Interviews indicated that risk management in MWRH Ennis was a reactive process primarily through the incident reporting system. MWRH Ennis used the HSE incident reporting form and all incident reports were forwarded to the Risk Advisor who then risk-rated the incident. Incidents were entered on to the STARSweb system (see Glossary) and these reports were sent on a quarterly basis to the Hospital Administrator, the DoN, and the clinical nurse managers within MWRH Ennis. It was also reported that incident reports were audited and monitored by the Risk Advisor and the Hospital Administrator and were reviewed at the Quality Risk and Patient Safety Steering Committee.

Through documentation review, the most frequent incidents recorded on STARSweb for MWRH Ennis were slips, trips and falls – which would be comparable to the national picture.

It was also reported that the Risk Advisor carried out risk assessments and undertook regular tours of the wards to receive and give informal feedback in relation to risk and incident reporting. However, the Investigation Team is of the opinion that there was not a comprehensive proactive risk management system in place within MWRH Ennis.

The Investigation Team identified that, among the patient safety concerns brought to its attention, were examples of serious adverse incidents that had not been captured and escalated through MWRH Ennis's incident reporting system. It was indicated through interview to the Investigation Team that the incident reporting system was not fully embedded in practice and staff reported difficulty in attending education sessions. This indicated that there was a need for more structured, focused training and education for all staff members.

Interviews also described that within MWRH Ennis linkages between adverse events, complaints, claims and Freedom of Information requests were informal with no systematic integrated approach to their management. The Investigation Team was of the opinion that the integration of these systems would facilitate a more patient-focused approach and outcomes, more efficient and effective management of these systems, and would enable shared learning.

In response to a patient and their relatives concern, brought to the attention of the Authority, the Investigation Team reviewed risk management processes and two internal HSE reports carried out in response to a patient safety event: the first an incident review and the second a system analysis review. In the Investigation Team's opinion, while these reports made recommendations which began to address the issues highlighted by the incident, in particular the development of a number of new policies and procedures, they were limited in scope. More importantly the review process had failed to communicate adequately with the patient and their relative either before, during or after the initial review process to ensure all their questions had been addressed. This led to the view that the process was not transparent and undermined further trust, respect and communication with the patient and the relatives concerned, although apologies were made. The Investigation Team concluded the processes lacked sufficient engagement with the patient and relatives so as to build their confidence in the relevance, thoroughness and openness of the review. This issue was also identified by the Investigation Team in relation to complaints handling and is discussed further below.

9.4.5 Complaints management

A robust, active and responsive system for managing complaints and concerns is a vital attribute of a well performing health service. This is because it provides an important opportunity for patients and their relatives to better understand what has happened to them and why their experience was as it was. It also allows those responsible for services to learn how they might be improved. It also promotes accountability, not to attribute blame, but rather to encourage staff to take responsibility and make decisions to implement change where needed.

The national HSE comments, compliments and complaints policy, *Your Service Your Say*, was introduced with the concept of ensuring that people using services provided and or funded by the HSE had every opportunity to comment on their experiences, both positive and negative.[37] This national approach to manage complaints was reported to be in development. However, it was highlighted to the Investigation Team that there was not a comprehensive integrated approach between risk management, complaints and Freedom of Information. The Investigation Team is of the opinion that at this stage of the development (which was reported to the Investigation Team as year-two of a five-year programme) there is a focus in the MWRH Ennis on process and process outcomes, for example meeting correspondence deadlines, rather than engaging with patients to understand their desired outcomes which is the main element of a good complaints process.

The complaints officer in MWRH Ennis is the Hospital Administrator. The Investigation Team was informed that there was no local complaints policy. The methodology of how a complaint was dealt with depended on the type of complaint and was guided by the national policy. Copies of this policy and suggestion boxes were available throughout MWRH Ennis. [38] It was reported through staff interview that verbal complaints were dealt with locally and if necessary the complainant was asked to put the complaint in writing which was dealt with by the Hospital Administrator. Whereas MWRH Ennis had a system for recording its written complaints there was no reported system for logging verbal complaints.

The Investigation Team is of the opinion that the absence of a mechanism of recording verbal complaints is a significant weakness as serious complaints may be only reported verbally and may be missed. Verbal complaints are also an important source of learning for improvement.

The system as described to the Investigation Team, which complied with the national policy, involved all written complaints being acknowledged within five working days, and logged manually in a complaints log book, given an identification number and a file being created. A copy of the complaint was forwarded to relevant staff members for comment/feedback and on receipt of feedback the complainant received a follow-up letter of response within 30 working days. If there was a delay in receiving feedback from a staff member due to for example, annual leave, the complainant was written to seeking an extension. It was reported to the Investigation Team that occasionally relevant staff members and the complaints officer met with the complainant and their family. It was reported to the Investigation Team that the numbers and types of complaints are forwarded on a quarterly basis to the Consumer Affairs office in the HSE. However, MWRH Ennis reported that it did not receive any feedback.

In MWRH Ennis there was no systematic approach demonstrated to the Investigation Team for the dissemination of lessons learned from complaints or actions taken to avoid reoccurrence. There were also limited linkages with the Risk Advisor regarding clinical and non-clinical incidents and Freedom of Information requests. Complaints were not presented at the Quality, Safety and Risk Steering Committee meetings or at the Executive Committee meetings. There was no evidence that senior management received regular reports summarising the MWRH Ennis's monitoring and performance in relation to complaints.

Having reviewed the complaints handling process, it was clear that the staff concerned were seeking to address complaints raised and were using the national guideline. These guidelines rightly highlight the importance of meeting stated quality deadlines for providing responses. However, the comments received from patients suggest meeting arbitrary deadlines matters less than addressing openly the concerns and anxieties raised by people making complaints.

As recommended by the Authority in a previous investigation report[25], the MWRH Ennis should ensure that an effective independent advocacy service is in place in the hospital. These advocacy services should facilitate patients coming forward to raise concerns and have them addressed.

In order to make the process much more patient focused and more likely to successfully address the concerns raised, the Investigation Team makes the following recommendations.

Recommendation cluster 12: responding to concerns and learning from adverse incidents

Local

12.1 The Mid-Western Regional Hospital Ennis should ensure that a proactive patient-centred approach to risk management is taken and implemented throughout the Hospital according to national policies. This should include improving integration between its risk management, complaints, and freedom of information systems to facilitate timely, patient-focused responses and to enable shared learning.

12.2 The Mid-Western Regional Hospital Ennis should undertake a regular audit of the views of complainants to ascertain how the Hospitals approach to complaints and concerns can be improved and the necessary changes identified in such audits should be implemented.

12.3 As recommended by the Authority in a previous investigation report[25], the MWRH Ennis should ensure that an effective independent advocacy service is in place in the hospital. These advocacy services should facilitate patients coming forward to raise concerns and have them addressed.

12.4 The Health Service Executive should ensure that the new regional risk management structures, in the midwest, have clearly defined lines of responsibility and levels of accountability. The processes must be transparent, patient-focused and have clear learning pathways.

12.5 At a regional level the risk management process should be regularly monitored and audited with the outcomes reported through the national risk management structure to the Chief Executive Officer of the Health Service Executive.

12.6 The Health Service Executive should identify a suitable independent person or organisation, agreed with individuals/persons that request it, to offer mediation with a view to discussing in detail and resolving any residual concerns in the way with which their complaint was dealt.

National

12.7 Risk management and complaints processes in the Health Service Executive and health services generally must include a stage in the process to establish, understand and document the outcomes desired by affected patients/relatives before any investigation or review is undertaken.

12.8 The Health Service Executive should ensure the planned implementation of their new Quality and Risk Framework takes account of the lessons from this investigation and that an appropriate training programme on risk management and feedback is delivered that emphasises the importance of communication and outcomes as well as process.

12.9 The role of the Office of the Ombudsman for public services should be publicised more effectively by the Health Service Executive in relation to the handling of complaints in the health service to ensure complainants understand they can have the handling of complaints reviewed and national learning can be applied throughout the health service.

9.5 Clinical staffing

Best practice indicates that to facilitate optimum patient care there should be sufficient numbers of appropriately trained staff to provide this care.

At the time of the investigation, senior clinical presence on the MWRH Ennis site was in a state of flux. There had been a number of consultants who had served in MWRH Ennis over decades who had recently retired or left and so there was a break in their leadership. At the time of the Investigation, a high proportion of consultants were either locum or temporary appointments. In a previous investigation carried out by the Authority there was a recommendation that the HSE should review workforce planning at national and local levels.[25] The majority of consultants who were providing services in MWRH Ennis held their substantive post in MWRH Ennis with a small number providing designated sessions in other healthcare settings. While MWRH Ennis has medical and surgical NCHDs there are no junior doctors in radiology or anaesthetic services.

It was reported through interview and in Hospital documentation that all the nursing staff within MWRH Ennis are employed as registered general nursing staff. There are no midwives, children's nurses or healthcare assistants employed by MWRH Ennis. It was also reported that the clinical nurse manager 2 (CNM2) roles have a substantial clinical commitment in addition to their managerial functions.

It was highlighted to the investigation Team, through senior nurse management and staff interviews, that nurse staffing levels were insufficient in certain departments of MWRH Ennis. In 2007 the HSE commissioned a review of the nursing staff levels in MWRH Ennis.[38] In response to this report an increased adjustment of two whole time equivalents (WTE) in the night nursing staff allocation was introduced in 2008.

Cognisant of the proposed changes recommended within this report, the Investigation Team is of the opinion that future staffing should be consistent with the skills and staffing levels required for the services that will be provided in MWRH Ennis in the future. The staff should be supported and involved in any training or development they may need related to the proposed changes.

9.6 Continuous professional development and training

Ultimately the quality of care the patient receives is the result of the continued growth and personal and professional development of the individual providing the care.

At MWRH Ennis, continuous professional development is not a formally identifiable, strategically planned process. There was no evidence to indicate that MWRH Ennis had conducted a staff training needs analysis nor reviewed current practices to direct the development of in-service, competency-based professional development programmes.

There was no system in place within MWRH Ennis to centrally record all training that staff had attended. Training records reviewed were not up to date and therefore the Investigation Team was unable to determine the numbers of staff who had attended mandatory training sessions and or education sessions and professional training programmes. From those records reviewed it was evident to the Investigation Team that ongoing training is more skills based than competency based. Some staff interviews report that although there are some education and training programmes available that attendance is not high and it was reported that there were difficulties for staff in being released to attend these sessions.

Specialty specific programmes have been developed and coordinated by clinical nurse specialists, for example infection control and haemovigilance, and it was reported through interview that specialty areas had devised ward-specific staff induction programmes, for example the emergency department, and there was a multidisciplinary programme for NCHDs. A generic nursing staff induction programme and workbook was completed in 2008.

It was reported that a regular programme of education and audit for consultants and NHCDs has been developed including a monthly medical audit meeting, mortality and morbidity meetings and weekly journal clubs and clinical presentation forums. It was reported that it is mandatory for medical staff to attend the monthly mortality and morbidity meetings, however, not all medical and surgical staff attend the weekly meetings. This programme of education and audit is not multidisciplinary.

MWRH Ennis is an approved An Bord Altranais site, consequently, bachelor of science nursing students are on clinical placement from University of Limerick. They also participate in surgical and medical training schemes for NCHDs.

9.7 Infection prevention and control

The MWRH Ennis infrastructure, as previously described, is small with limited space. Isolation facilities are absent in a number of areas including the "intensive care unit" and emergency department.

Following reports of increased incidences of *Clostridium Difficile (C. difficile)* in MWRH Ennis from March to April 2007 the HSE carried out an investigation and a report was published: *Review of Increased Identification of Clostridium difficile at Ennis General Hospital in 2007: Key findings and Recommendations,* April 2008.[28] The findings of this report identified an increase in *C. difficile* associated diarrhoea (CDAD) (46 patients) and it was noted that CDAD was a contributory factor to the cause of death in 13 of these cases. This report included recommendations, a number of which have been implemented including the appointment of a consultant microbiologist, as part of the infection control team, for two sessions

a week, upgrading work on wards, including upgrading hand hygiene facilities and replacement of floor coverings, increased hygiene awareness and training. The Infection Control team are now consulted in relation to all capital and service development initiatives. However, some of the issues highlighted in the report of the increased identification of *C. difficile,* including high occupancy and isolation facilities, have not been addressed.

The MWRH Ennis laboratory is linked to the regional laboratory system which has a surveillance system for Healthcare Associated Infections including Methicillin-Resistant *Staphyloccocus aureus* (MRSA) and *C. difficile*. The MWRH Ennis infection control team regularly reviews infection control information including data from the laboratory surveillance system and liaises with ward staff. The Investigation Team was informed that there were no regular formal meetings between the MWRH Ennis infection control team and the regional microbiology services. An Infection Control Committee has been re-established meeting quarterly with the part-time consultant microbiologist as chair.

The recent independent review of hygiene services by the Authority rated MWRH Ennis as "Poor" and identified a risk in relation to patient safety which was highlighted to MWRH Ennis and the NHO.[39-41] The Authority identified inadequate infection control and hygiene risk management procedures during a renovation project, during the hygiene inspection process in 2008.[41] MWRH Ennis responded with an implementation plan and described works that had been carried out. The Authority in line with its policy in relation to identified risk will carry out another on-site assessment in 2009.

9.8 Health information

High quality information should be at the core of decision making concerning the planning, management and provision of health services at all levels from individual to local and national levels. However, fit-for-purpose health information technology (HIT) systems are essential to underpin a modern health system and can lead to considerable benefits in improving patient safety and quality of care. These systems also support the provision and accessibility of accurate and meaningful health information and drive improvements and knowledge.[2]

The Commission on Patient Safety and Quality Assurance highlighted that nationally, although there were localised examples of good practice in health information and HIT, the available information tends to be limited more to financial and administration information rather than the impact of care on patients.

In MWRH Ennis, the main information system was a patient administration system (PAS) that did not collect clinical details, diagnostics or outcomes. The laboratory information system (the APEX system) provided access for clinical staff to the results of diagnostic tests performed on patients attending MWRH Ennis. This system was linked with the regional system in MWRH Limerick and therefore clinical staff could access results of tests undertaken in both MWRH Ennis and MWRH Limerick in real time. A radiology information system (RIS) was available within the radiology department which only recorded administration and appointment details. It was reported in interview that they were part of the national programme for the roll out of the picture archiving and communication systems (PACS). The HSE website provides information on services available within MWRH Ennis. The Risk Advisor utilises the Clinical Indemnity Scheme's STARSweb information system.

In certain departments patient information is maintained manually. Examples include the Nurses' Log in the emergency department which records attendances to the ED, an operating theatre register for all elective and emergency surgery, and a complaints log for all written complaints.

The Investigation Team concluded that there was limited integration between the different information systems being used within MWRH Ennis. This lack of integration means that important patient clinical information may not be shared efficiently between the different services and could result in ineffective and unsafe decision making about patient care.

Recommendation cluster 13: managing change and transition

Local

13.1 The local change programme should be led by an experienced senior manager and the implementation programme must incorporate significant engagement with service user and clinical stakeholders.

13.2 A comprehensive programme of change, that is effectively led and managed, needs to be undertaken. This will take time to implement, and the Health Service Executive needs to ensure that appropriate facilities, resources and staff are in place throughout the current Midwest Hospital Network in order that changes in the location of patient care can be safely accommodated.

13.3 The Health Service Executive should, as a priority, undertake a review of the clinical and non-clinical management, leadership and governance arrangements at Mid-Western Regional Hospital Limerick to ensure that the governance arrangements and organisational structure are fit for purpose, and that clinicians and managers in key positions have the capacity and capability to manage the new role of the Hospital.

National

13.4 The corporate HSE executive management team should nominate a specific Director accountable for ensuring the development of an implementation plan for these recommendations. This should include a clear timeframe with milestones. Progress against the implementation plan should be made public and reported to the Board of the Health Service Executive.

13.5 There should be regular progress reports to the Minister for Health and Children.

10 Conclusions

This section now sets out in more detail the conclusions drawn by the Investigation Team and goes on to make a series of local and national recommendations to improve quality and safety for patients in the future. In coming to these conclusions, the Investigation Team has taken into account the:

- essential factors that drive the need for services to be organised to prioritise quality and safety for patients
- challenges in the current healthcare environment
- resources available to the HSE
- current trends in healthcare internationally, and in Ireland, set out previously in the report.

In drawing these conclusions, the Investigation Team recognises the scale of the change process necessary in the midwest and that detailed planning, management and implementation of change has to be undertaken openly, transparently and through a process of engagement, which includes an active process with the public, local stakeholders and staff so that the difficult discussions that are required for the benefits of safe services take place. The responsibility for this effective implementation is that of the HSE.

Over many years the staff at MWRH Ennis have continued to provide a comprehensive range of healthcare services to the local population. These services have been maintained by the commitment of nursing, medical, paramedical and administrative staff and are greatly valued by the local community. However, the evolving knowledge of clinical practice shows that medical care in some illnesses is best provided in centres that deal with large volumes of those specific conditions.

The Investigation team recognises that HSE are currently developing some services in light of these concepts, for example cancer services.

What has driven this investigation is patient safety and quality and, one clear over-riding finding is arising from the investigation – change for safety must happen.

It is unsafe to keep the configuration of services at MWRH Ennis as they are and these changes must take place safely and effectively. There are also significant opportunities for appropriate, high quality services to be provided at MWRH Ennis in the future however, these must be in line with recognised standards.

Service model

The Investigation Team looked at how a range of services are delivered in MWRH Ennis, heard the experiences of some patients using those services and the experience of clinicians and other staff trying to deliver them. It looked at staffing numbers and analysed activity data as well as looking at current working relationships with other hospitals in the Mid-West Regional Hospital Network. Having considered all this information in the context of national and international trends in healthcare, the Investigation Team concluded the current acute service model is unsustainable in the long term. Whilst some staff described a lack of resources, the Investigation Team does not believe additional resources deployed in seeking to sustain acute services at MWRH Ennis would be appropriate, as it is ultimately unviable as an acute hospital in its current configuration. There simply are not sufficient numbers of patients with acute and major conditions to maintain safe clinical services at MWRH Ennis.

Furthermore, the Investigation Team believes some aspects of the current service present potential risks to the health and welfare of service users and should be discontinued as soon as practicable. These findings are serious issues of patient safety that are at the heart of safeguarding the public and therefore the implementation of these changes are a priority and should not be compromised in the current fiscal climate.

To promote patient safety and improved quality, the future role of MWRH Ennis should focus on providing diagnostics, outpatient, day surgery, appropriate medical care, minor injury and rehabilitation as part of the regional hospital network.

Specifically, the Hospital Network should begin a transition process that culminates in stopping acute surgical admissions to MWRH Ennis as soon as possible. The withdrawal of acute surgical beds will require the review of day surgery practice to ensure any intermediate procedures remain appropriate on a site with no resident anaesthetic cover and such patients requiring overnight stay are transferred to an appropriate facility.

In parallel to this process, the emergency department should transition into a day minor injury centre managed as a satellite of the MWRH Limerick Emergency Department.

The discontinuation of acute surgery and 24-hour emergency services will also require a review of which acute medicine cases can be safely treated at the hospital because a proportion of medical cases require surgical or anaesthetic assessment.

Importantly, a clear vision for the services in MWRH Ennis should be stated – the change process should not be solely about moving services to MWRH Limerick. This is important not just for the people and healthcare staff of Ennis, but because there will need to be a corresponding flow of non-acute services into the local centres to release capacity on the regional hospital site. This will mean for example, building on and expanding the range of day surgery and diagnostics services provided in MWRH Ennis.

In addition, the potential for development of a dynamic multidisciplinary rehabilitation service for older people incorporating outpatient, day hospital, diagnostics and inpatient beds integrated with community rehabilitation teams presents a significant opportunity to enhance services aimed at promoting health and independence for older people.

To facilitate all these changes within the hospital system, further developments in associated services including the ambulance service, community services and primary care will be necessary to ensure effective, safe implementation of new patient care pathways.

In the course of the Investigation, the Investigation Team was made aware of proposed changes to the configuration of services in the midwest, recommended by an external consultant report commissioned by the HSE.[10] Having concluded this investigation, the Investigation Team broadly supports the direction of travel proposed in the report with services built around maximising local access to non-acute and community care whilst consolidating complex and acute care onto a single regional site in MWRH Limerick. However, it will be essential that MWRH Limerick has the leadership and managerial resources and the technical and communication skills to support the infrastructural changes necessary for the new configuration of services in this region.

In parallel to the organisational re-shaping that will be necessary to deliver safer services, it is vital that clinical teams are engaged from the outset in developing and implementing the clinical pathways for patients to ensure the right patients are treated safely in the right setting. This should include making the most of existing resources by ensuring patients are not admitted into inpatient beds unless absolutely necessary. This means ensuring that as many patients as possible who require surgical procedures that can be safely carried out as day cases are treated in this way. It also means ensuring patients with those medical conditions that can be treated safely and appropriately without admission to hospital beds are not admitted – so-called ambulatory care.

The Investigation Team suggests that it would be beneficial to identify a selection of surgical procedures ("baskets") that are monitored in order to benchmark day case rates. Similarly a selection of medical conditions should be identified to benchmark how many are admitted for treatment rather than treated without admission. This should be implemented alongside the reconfiguration in the midwest and consideration given to its introduction nationally.

Governance and management arrangements

The system of management at MWRH Ennis is typical of many areas within the HSE operating as part of a network management structure. This model — with a "hospital administrator" at site level who does not have overall management responsibility for all activity on the site and certain clinical staff reporting directly to

the Network Manager — has grown from historical practice. With the right governance and management in place, this model could work in a stable environment but not in a situation such as at MWRH Ennis where services have undergone change, key clinical staff have retired and public expectations are growing. The weakness of this model is that clarity about the locus of decision making and lines of accountability can be elusive. This becomes more of a challenge in times of changes and transition and does not support a model of clear accountability and reliability for quality and safety. Certainly, to people outside of the system, identifying who is responsible for the totality of their care can be difficult and this was reflected in the experience of some of the patients and families that the Investigation Team spoke with.

Under the current arrangements the Network Manager is at the centre of all decision making for the Network and has a large number of personnel reporting directly to him. In addition, the Network Manager chairs and leads the regional risk and safety committee. The Investigation Team concluded there is a risk that these complex reporting lines could dilute the impact of the regional manager in a period when clear and accountable leadership are particularly important and also, as a result, the decision making is distant from the provision of patient care and this can pose risks to patient safety.

Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance endorsed by the Government in February 2009 recommends the formation of management boards at local level. In the context of the significant change programme planned in the midwest, and the fact that the licensing of healthcare providers, also recommended by the Commission, will be introduced during the lifetime of that project, the Investigation Team believes that the current governance arrangements will not provide the clarity and focus needed to drive the change towards safer services at MWRH Ennis, or prepare for licensing. The Investigation Team concluded the HSE should identify clearer, more direct management responsibility for leading the service. It recommends the establishment of a management board centred on the regional hospital in Limerick to oversee the entire acute hospital network of the region. This management board must be led by an experienced and effective senior manager and should include managers and clinicians. This arrangement should also include effective involvement of service users.

Clinical groupings

Leading on from the points above, the medical cover in MWRH Ennis has been historically built on the work of a small number of clinicians who, over many decades, established practices and ways of working that maintained services through their personal involvement and commitment. Many of these longstanding clinicians have left or retired and at the time of the investigation five out of the 11.5 consultant posts were held by temporary appointments. The working practices that sustained the service in the past are no longer appropriate and the size of the consultant body is too small to be viable in the longer term.

Taking account of international best practice and the increasing drive and need for clinical services to be organised and delivered regionally, the Investigation Team concluded that there needs to be a transition towards all clinical consultant teams being appointed to, and organised from, MWRH Limerick as part of a regional service. This will allow more viable clinical groupings, enhance recruitment and rotation options and allow enhanced training opportunities as well as promoting ownership at the regional hospital for ensuring key clinical services at MWRH Ennis are maintained and developed appropriately. This process should happen in parallel to implementing the recommendations of the Commission in respect of creating clinical directorates as the basis for clinical governance.

Workforce and skill mix

There is no diversity of skill mix in the nursing staff working in MWRH Ennis. This means that fully qualified nurses are providing all aspects of patient care that in other organisations are provided by healthcare assistants under the supervision of the nursing staff and this is not a good use of this valuable resource. This skill mix does not represent value for money as resources could be better used by providing the appropriate numbers of appropriately skilled staff to provide the required service and should be reviewed as the services provided at MWRH Ennis transition into a new model.

Clinical pathways

Having spoken to many hospital staff, patients and relatives, as well as reviewing case notes and formal complaints, the Investigation Team developed a picture of how patients are admitted into MWRH Ennis, treated and cared for whilst there, and how they are discharged or transferred to another care setting. The Investigation Team encountered many hard-working staff, dedicated to doing their best for patients, sometimes in challenging circumstances. There were some good examples of patient services that were well planned, organised and delivered around the needs of patients. However, it also found examples of poorly coordinated care with key decisions or information about patients faltering in the gaps between systems, teams and departments. There was an absence of planning in some of the cases reviewed and "hand-over" between teams or institutions was dependent on personal relationships to make them work. This absence of predetermined steps in care for patients with similar conditions – known as care pathways – makes it more difficult to plan the care of individuals including for transfer or discharge. Without a clear concept of what should be happening to a given patient, key decisions about care or preparation for discharge can be delayed meaning patients stay in hospital for longer than necessary. Care pathways are a vital tool in ensuring the right patients are cared for in the right way in the right setting.

With the focus moving towards transition into the new configuration, it is absolutely crucial that key care pathways are agreed between the clinical professionals and institutions responsible for patient care. It is important to describe the end-point pathways that will underpin the new configuration. However, it is as important that interim pathways are developed and implemented. This means work on this aspect of planning for the future service must commence as soon as possible.

Managing and planning for change

In the context of the HSE's proposed midwest reconfiguration, local level implementation plans have already been developed, to varying degrees. These changes, along with those arising from the recommendations within this report, present significant challenges that cannot be underestimated. Successful implementation will require experienced leadership and management skills, detailed planning, communication and coordination to ensure changes in patient care locations are matched by changes in resources and infrastructure and these are not fully in place at this time.

A key factor in the success of this programme will be gaining commitment from patients, the public and their representatives as well as professionals in the local area and wider community. A process such as this will inevitably entail difficult choices and possibly challenging discussions in order to drive safer, more appropriate services for the people of Ennis and the surrounding area. Without engagement from all concerned in the process, sustainable change will become more difficult. This aspect of the planning and programming must be given a high priority.

The Investigation Team recognises the significance of the midwest reconfiguration plan for the wider Irish healthcare system. In the interest of patient safety and quality of care, this needs to be successfully implemented. It will provide a template for similar healthcare communities and represent a defining outcome in the transformation programme. For this reason, the Investigation Team believes the programme should be owned and managed at the highest level of the HSE and the political system, with a HSE Director accountable for the successful implementation. Progress against the Implementation Plan should be monitored by the Board of the HSE with regular reports to the Minister for Health and Children.

Concluding remarks

This investigation was established at the Minster for Health and Children's request to assess the quality and safety of clinical services at MWRH Ennis. A number of specific concerns about patient care were raised in the period running up to and since the instigation of the investigation. In each of these cases, subsequently shared with the Investigation Team, is a story of personal trauma, loss or unanswered questions. From the outset, the Investigation Team was, and is, acutely aware of the balance it had to achieve between answering the overall question it had been posed about the safety of the current healthcare systems and addressing individual concerns of families of patients and or patients.

These concerns have shaped the investigation to a significant degree – and it was important to the Investigation Team that these stories were heard first in its deliberations and that the voices of these patients echo in the findings of this investigation.

However, although this report has sought to show how the experiences of patients, and or families of patients, who contributed to the investigation were a consequence of aspects of the service model at MWRH Ennis, it was not the remit of this investigation to explore the detail of individual cases except to the extent that they informed the wider inquiry into the quality and safety of services for current and future patients. Inevitably for some individuals there may remain questions unanswered under the Terms of Reference of this investigation and potentially outstanding concerns about the way in which their complaints had been dealt with by the HSE. In the Investigation Team's opinion, the best way for these residual concerns to be addressed is through face-to-face communication between the HSE and those individuals. Recognising the break-down of trust that has occurred in some cases, the Investigation Team recommends that the Health Service Executive should identify a suitable independent person or organisation, agreed with individuals/ persons that request it, to offer mediation with a view to discussing in detail and resolving any residual concerns in the way with which their complaint was dealt.

As in any service sector, the role of addressing individual concerns about service quality should as a matter of principle rest with those charged with providing services – in this case, the HSE. In order to demonstrate its ability to investigate and learn from serious concerns and other adverse events, it is essential that the HSE develops and implements credible systems for internal review that promote internal learning and command public confidence in their transparency by focusing on patients' interests at the heart of such reviews. The Investigation Team recognises that this confidence is not always present and this has led some patients, and their relatives, to feel they had no other recourse than to try to obtain answers to their concerns through legal channels, or by bringing their stories into the public domain through the media, or both.

This report contains specific recommendations for improvements in the management and handling of concerns which the Investigation Team believes will begin to build confidence. These must include the principles of open disclosure recommended by the Commission on Patient Safety and Quality Assurance. It also suggests that current arrangements for escalation to independent review, for complainants unsatisfied with the handling of their concerns, should be made clearer and more accessible.

In addition, and as part of its programme of service development in preparation for healthcare licensing, the Health Information and Quality Authority will prioritise working with the HSE and other important stakeholders to develop national standards for managing adverse events, concerns and complaints.

Although the genesis of this investigation, and some of its work, centred on patients or families of patients with serious concerns regarding the service they had received, the Investigation Team was struck by the strong ethos of community service embodied in many of the MWRH Ennis staff interviewed as part of the investigation. The Investigation Team believes that, in the past, this ethos of community service has been translated into seeking, for the best reasons, to provide a range of services out of step with modern models of practice for a hospital of its size and occasionally at the boundaries of appropriate care. It is vitally important this grounding in its community is used as a foundation on which to build a thriving, appropriate and safer future for MWRH Ennis.

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12 Glossary of terms and abbreviations

Acute lower respiratory tract infection (LRTI): Rapid onset or short duration of an infection of the lower passage through which air enters and leaves the body.

Acute hospital: is a short-term hospital that has facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions including injuries.

Anastomosis: the connection of two structures. It refers to connections between blood vessels or between other tubular structures such as loops of intestine.

Apex laboratory system: an information technology system used to automate the management and reporting of laboratory results generated by lab equipment. Also called ILab system.

Appendicectomy: surgical procedure to remove the appendix.

Appendicitis: inflammation of the appendix.

Atrial fibrillation: rapid and irregular heartbeat causing palpitations and shortness of breath.

Bi-PAP: Bi-level Positive Airway, which is a breathing apparatus that helps people get more air into their lungs.

Bypass protocol: is an agreed patient management plan so that a patient is brought directly to the most appropriate healthcare setting bypassing a service which may be more local but does not have the appropriate clinical expertise.

Cardioversion: drug or electrical shock treatment to return an irregular heartbeat (atrial fibrillation) to normal rhythm.

Chronic obstructive pulmonary disease (COPD): long-term (chronic) lung condition where the airways and air sacs are obstructed making it difficult to exhale and breathe normally.

Circumcision: is a surgical procedure to remove the skin at the tip of the penis.

Clinical governance: the framework through which all the components of quality including patient and public involvement are brought together and placed high on the agenda of each health organisation.

Clinical nurse manager (CNM): a nurse more senior than a staff nurse but more junior than an assistant director of nursing. A CNM 2 is more senior than a CNM 1.

Colectomy (sub-total colectomy): this is a surgical procedure to remove all (total) or part of (sub-total) the large intestine (colon).

College of Anaesthetists of Ireland: is responsible for the continued guidance, training and examination of anaesthetists in training.

Colostomy: a surgical procedure that involves connecting a part of the colon (bowel) on to the anterior abdominal wall, leaving the patient with an opening on to the abdomen called a stoma. This opening serves as a substitute anus through which the intestine can eliminate waste products. It can be permanent or temporary.

Computerised tomography (CT): the practice of taking images of the body in a number of selected planes using radiography, and thereby building a three-dimensional image of an area.

Consultant: senior hospital doctors, including physicians, surgeons, anaesthetists, pathologists and others.

Coronary care unit (CCU): facilities, observation and monitoring for patients following a cardiac episode, insertion of a pacemaker or other heart-related incident.

Critical care – level 0/1: no organ monitoring/ support or gastrointestinal support only. This level of care is not typically defined as part of the remit of critical care, and is care that should be available on a general ward.

Critical care – level 2: monitoring/ support of one organ system (excluding gastrointestinal support) or the combination of basic respiratory support/ mechanical ventilation and basic cardiovascular support.

Critical care - level 3: advanced respiratory support/ mechanical ventilation or monitoring/ support of two or more organ systems (excluding gastrointestinal support and the combination of basic respiratory support and basic cardiovascular support).

Dilation and curettage (D&C): surgical procedure to remove tissue from the lining of the womb (uterus).

Director of nursing (DoN): the senior nurse in a hospital.

Echocardiogram (ECHO): A diagnostic visual record of a test that utilises ultrasound waves to create a visual image of the heart muscle.

ED (emergency department): the department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care.

Endoscopy: examination of the upper digestive tract (oesophagus and stomach) including the first portion of the small intestine (duodenum) using a very narrow flexible tube with a tiny camera attached (endoscope).

Excision of lesion of testicle: surgical removal of an area of abnormal skin tissue from the testicle.

Exploration of scrotal contents with fixation of testis: surgical procedure to examine the inside of the scrotum and using a stitch (suture) to fix the testicle to the inside of the scrotum to stop it from twisting around.

FAEM: Faculty of Accident and Emergency Medicine (UK).

Fibreoptic colonscopy of caecum +/- biopsy: an examination of first part (caecum) of the large intestine (colon) using a narrow flexible tube with a tiny camera attached (colonoscope). The doctor can examine the intestine for abnormal tissue and take a sample (biopsy) for testing.

Fine needle biopsy: use of a thin needle to take cells from a body organ or tissue for diagnosis.

Gastrectomy: a partial or full surgical removal of the stomach.

Gastritis: inflammation of the stomach lining.

GP: general practitioner.

Hemicolectomy: a procedure (also referred to as right- or left-hemicolectomy) to remove part of the large bowel (colon).

Hospital In-Patient Enquiry (HIPE): an information technology system used to collect information on inpatients at Irish acute hospitals. Information is provided by the hospitals to the central system administered by the Economic and Social Research Institute.

HSE: the Health Service Executive.

Integrated care pathways: structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem.

Intensive care unit (ICU): a unit providing complex support for multi-organ failure and or advanced respiratory support.

Intensivist: a physician who specialises in the care of critically ill patients, usually in an intensive care unit.

Intern: a doctor in training more junior than a senior house officer.

Invasive ventilation: pushing air into a patient's lungs through a tube that has been inserted into the airway.

Laceration of kidney: tear in the kidney.

Laparoscope: a narrow tube with a tiny camera which is inserted into the abdomen allowing the surgeon to view an internal organ on a television screen and carry out surgery using tools inserted through small incisions.

Laparoscopic appendicectomy: surgical removal of the appendix using a laparoscope which is inserted into the abdomen through small incisions.

Laparoscopic cholecystectomy: surgical removal of the gall bladder using a laparoscope which is inserted into the abdomen through small incisions.

Lingual fraenectomy: is a procedure to remove some tissue under the tongue which is restricting tongue movements.

Mastectomy: a mastectomy is the medical term for the surgical removal of one or both breasts.

Medical assessment unit (MAU): the role of the MAU is to facilitate patients who require a more urgent medical assessment as opposed to waiting for an outpatient appointment. The MAU acts as a "gateway" to the hospital. Often linked to the emergency department, patients can be assessed in this unit for discharge or admission.

Mesenteric lymphadenitis: inflammation of the lymph nodes in the area where the intestine attaches to the abdominal wall (mesentery). Lymph nodes help the body to fight off infection.

MRSA: Methicillin-Resistant *Staphyloccocus aureus*.

MWRH: Mid-Western Regional Hospital.

National Hospitals Office (NHO): a directorate of the Health Service Executive responsible for acute hospitals and the ambulance service.

NHS: National Health Service (UK).

Non-consultant hospital doctor (NCHD): includes registrars, SHOs and interns.

Outreach services: whereby health professionals from a hospital travel to another hospital or to the local community to provide specialty services, for example, antenatal services.

Panendoscopy to duodenum with biopsy: examination of the upper digestive tract including the first portion of the small intestine (oesophagus, stomach and duodenum) using a very narrow flexible tube (panendoscope). The doctor can view the tissue lining and take a tissue sample (biopsy).

Paramedic: a person who is trained to give emergency medical treatment.

PAS: patient administration system.

Patient advocacy: the practice of an individual acting independently of the service provider, on behalf of, and in the interests of the patient/service user, who may feel unable to represent themselves in their contact with staff.

Percutaneous endoscopic gastrostomy (PEG): an endoscopic procedure for placing a tube into the stomach. It involves placing a tube into the stomach through the abdominal wall. The procedure can be performed in order to place a feeding tube as a long-term means of providing nutrition to patients who cannot swallow or take food their mouths.

Peritoneum: is the lining inside the abdominal wall covering the internal organs in the abdomen.

Picture archive and communication system (PACS): is a comprehensive management system for diagnostic imaging studies. It enables digital communication, archiving, processing and viewing of images and image-related information. The ability for care providers to have faster access to diagnostic imaging information allows care to be delivered more expediently.

Policies, procedures and guidelines (PPGs): a set of statements or commitments to pursue courses of action aimed at achieving defined goals.

Protocol: a detailed plan of a medical treatment or procedure.

Rapid assessment unit: this service is for patients who need urgent assessment and diagnostics, but who may not need formal hospital admission.

Repair of inguinal hernia: a surgical procedure to repair an inguinal hernia which is a protrusion of soft tissue through a weak area on one side (unilateral) of the groin (lower abdomen).

Risk management: the systematic identification, evaluation and treatment of risk. A continuous process with the aim of reducing risk to organisations and individuals.

Semi-structured interviews: is a technique used to collect qualitative data by setting up an interview that allows a respondent the time and scope to talk about their opinions on a particular subject.

Senior house officer (SHO): a medical or surgical doctor more senior than an intern but more junior than a registrar. Senior house officers may be in training.

Specialist centre: where care is delivered by consultants and other specialist healthcare professionals.

STARSweb: is a national database established and maintained by the Clinical Indemnity Scheme to record adverse clinical incidents and "near misses" reported by hospitals.

Subcutaneous tissue: Subcutaneous tissue is the third layer of the three layers of the skin.

Syncope and collapse: fainting with loss of consciousness.

Terms of reference: describe the purpose and structure of a project, committee or meeting.

The Authority: the Health Information and Quality Authority.

UTI: urinary tract infection.

Wedge resection of ingrown toenail: is a surgical procedure to remove a small wedge of nail which is ingrowing.

Appendices

Appendix 1: Terms of Reference

The investigation was carried out under the following Terms of Reference:

In accordance with a request made by the Minister for Health and Children under Section 9(2) of the Health Act 2007 (the Act), the Health Information and Quality Authority (the Authority) will undertake an investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive (HSE) at the Mid-Western Regional Hospital Ennis (the Hospital).

Terms

The investigation will seek to ascertain whether safe, quality services and practices are in place and, if this is not the case, to ensure that where there may be a serious risk to the health or welfare of a person(s) receiving such services from HSE, these risks shall be identified and recommendations made with a view to eliminating or ameliorating the risks for patients. The investigation shall be carried out within the following terms:

1. To investigate the planning, management and provision of clinical services in the Hospital (including services provided in the emergency department) to include, but not be limited to, the referral, diagnosis, treatment and follow-up of patients.

2. In undertaking term 1, the Investigation Team will review the arrangements for providing safe, quality clinical care to include, but not be limited to:

- how the needs of patients to access safe, quality clinical care in the appropriate setting are being met within the Hospital's geographical region, including issues relating to service design, staff skills and teamwork
- the governance, management and leadership of the Hospital including the management and use of information, communication between staff and between patients and staff, the management of complaints and patient safety incidents and the related communications with patients and relatives/carers
- the resources available to HSE and the requirement that it uses its available resources in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.

3. The Investigation Team will take into account the experiences of patients and family members from recent cases as part of the investigation.

4. The Investigation Team will also take into account the findings and recommendations of previous investigations undertaken by the Authority and the recently published *Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance*.

5. The investigation shall be carried out in whatever manner and with whatever methodology the Investigation Team believes is the most appropriate. The scope of the investigation will be limited to those aspects of safety and quality that the Investigation Team considers are most relevant and material to the investigation.

6. If, in the course of the investigation, it becomes apparent that there are further reasonable grounds to believe that there is a serious risk to the health or welfare of any person and that further investigation is necessary beyond the scope of these terms of reference, the Investigation Team may in the interests of investigating all relevant matters, and with the formal approval of the Authority, extend these terms to include such further investigation within their scope or recommend to the Authority, and the Minister for Health and Children, that a new investigation should be commenced as appropriate.

7. The Investigation Team shall undertake the work of the investigation in three months. Following this, the Investigation Team shall prepare a report which, once ready for publication by the Authority, will be submitted to the Board of the Authority for approval. This report shall outline the Investigation, its findings, conclusions and any recommendations that the Investigation Team sees fit to make. In the interests of wider service improvement, national recommendations may also be made where the Investigation Team considers appropriate.

8. The investigation will be conducted by a Team appointed and authorised by the Authority in accordance with Section 70 of the Health Act 2007. The Team will carry out the investigation pursuant to powers contained in Part 9 of the Act.

Appendix 2: The Investigation Team

Diane Whittingham is Chief Executive of the Calderdale and Huddersfield Foundation Trust in West Yorkshire. She was previously Chief Executive of the Huddersfield NHS Trust, a post she held since 1997. In 2003, for a 12-month period, she took on the role of interim Chief Executive of the West Yorkshire Ambulance service which had governance and performance challenges. She has more than 30 years experience of health service management working in a range of organisations (acute, mental health, primary and community care) across the Midlands, Yorkshire, Manchester and the northwest of England. Her areas of professional interest are organisational development, leadership, action learning and patient safety. She holds an MA in Health Management from Manchester University and the Diploma of the Institute of Health Service Management, England.

Mary Dunnion is a qualified Registered General Nurse with post registration clinical qualifications in midwifery and critical care nursing. Since qualifying, she has attained additional qualifications in health, safety and welfare at work from University College Cork; personnel management and industrial relations from National College of Ireland; clinical risk management from University College Dublin and an MSc In Health Services Management from Trinity College Dublin. She is currently completing her second year in a two-year Masters Programme in Healthcare Ethics and Law at the Royal College of Surgeons in Ireland. She has worked in senior positions in clinical nursing practice development and more recently in general and nursing management. Since June 2003, she is Director of Nursing and member of the Executive Management Board at Mercy University Hospital, Cork.

Alan McKinney is consultant in emergency medicine in Northern Ireland's Western Health and Social Care Trust based in Derry where he has worked since 1991. The Western Trust was formed two years ago by the merging of two acute and a community health trust and incorporates three hospitals providing services to a mixed urban and rural community. Prior to the merger Mr McKinney championed and was chairman and lead clinician of an emergency care managed clinical network. He is currently lead clinician in emergency medicine and clinical director of medicine in the Western Trust. He provides personal experience of clinical management in accident and emergency medicine and in the establishment of training and governance arrangements and an understanding of the inter-relationships necessary to provide pathways to specialist care for those entering healthcare via the emergency department.

Henry Osborne is a consultant surgeon at Beaumont Hospital, Dublin, with a particular interest in breast and gastrointestinal surgery. He is a former member of the Board of Beaumont Hospital, and Medical Administrator at the Hospital. He is a graduate of Trinity College Dublin (1970) and his MD was awarded by Trinity College in 1982. Has been a Fellow of the Royal College of Surgeons in Ireland (RCSI) since 1974. He is a clinical lecturer in surgery in RCSI and contributes extensively to the postgraduate surgical teaching of the College.

Christine Murphy-Whyte holds a Masters in Social Science from University College Dublin. She has over 33 years full-time employment experience mainly in state sponsored agencies including 20 years management experience, mostly at senior management level. She has worked with and on behalf of people with disabilities in the fields of education/training and employment, disability services, advocacy, and national policy development and has extensive experience at both practitioner and management levels in the fields of research, training and development, standards, certification and quality assurance.

Formerly Head of Policy and Public Affairs with the National Disability Authority, she took early retirement in 2005, following diagnosis and treatment for breast cancer. She is currently Chairperson of EUROPA DONNA Ireland – the Irish Breast Cancer Campaign, a volunteer-based patient advocacy organisation which is affiliated to EUROPA DONNA, the European Breast Cancer Coalition of 41 countries campaigning for evidence-based best practice in the diagnosis and treatment of breast cancer. She was elected as a member of the Board of EUROPA DONNA in 2006 and is currently Vice President.

Dr Dermot Power is a consultant in geriatric medicine at the Mater Misericordiae and St Mary's Hospitals, Dublin, and is Medical Director of St Mary's Hospital. A graduate of medicine in University College Dublin, his Membership of the RCPI was awarded in 1995 and a MD was awarded by UCD in 2001. He attained his Fellowship of the Royal College of Physicians of Ireland in 2006. Among his qualifications, he also has a Diploma in Management for Medical Doctors jointly awarded by the RCSI and Irish Management Institute. Dr Power is a member of the British Geriatrics Society, Irish Gerontological Society, Irish Medical Organisation, and Royal Society of Medicine. He is a member of the Board of the Health Information and Quality Authority.

Internal Team

Jon Billings, Director of Healthcare Quality and Safety

Maureen Burns-Rees, Programme Coordinator

Hilary Coates, Head of Learning and Safety

Peter Culhane, Programme Coordinator

Ann Delany, Quality Assurance Manager

Gillian Hastings, Programme Coordinator

Joan Heffernan, Programme Manager

Lisa Kiely, Clerical Officer

Deirdre Mulholland, Head of Standards and Methodology

Anne O'Connell, Business Coordinator

Appendix 3: Data requested from Mid-Western Regional Hospital Ennis

Please provide the following information, or equivalent, and highlight where such documentation/data does not exist. (Further information may be requested throughout the investigation)

1 Governance and leadership

- Governance structure
    - Organogram
    - Network and Hospital organisational structure
    - Reporting Structures
        - Network
        - Local
- Network and Hospital Strategic plan
- Network and Hospital Corporate plan
- Annual Report
- Hospital Business Plan (Work Plan) 2007 and 2008
- Committee Structures
    - Committee types
    - Membership
    - Frequency of Meetings
    - Minutes of Meeting since January 2007
    - Minutes of senior management meetings since January 2007
    - Minutes of mortality and morbidity meetings since January 2007
- Budget allocation for Ennis Hospital — 2006, 2007, 2008
- Capital development plan
- Services provided to other organisations and any corresponding service level agreements, quality assurance and financial arrangements
- Services contracted from other organisations and any corresponding service level agreements, quality assurance and financial arrangements (for example, laboratory services)
- Copies of any reports on the configuration and or quality and safety of services in the hospital or the midwestern region.

- Clinical audit activity on a hospital and or departmental basis since January 2007
- Patient and public involvement in policies or activities
    - Results of patient perception surveys or focus groups since January 2007
- Safety, quality and risk management
    - Regional and organisational strategies, policies and procedures
    - Minutes of safety, quality and risk management meetings at Hospital and or Network level since January 2007
        - Number of clinical adverse events reported since January 2007
        - Number of clinical adverse events reported to CIS since January 2007
        - Number of patient safety incidents reported since January 2007
        - Number of patient safety incidents reported to CIS since January 2007
        - Number of clinical related complaints and claims since January 2007
- Healthcare Associated Infections (HCAIs)
    - Minutes of the Infection Prevention and Control Committee since January 2007
    - Details of HCAI Surveillance Programme-
        - Number of infections by type including Clostridium Difficile, MRSA and E Coli since January 2007
        - Number of infections by type including Clostridium Difficile, MRSA and E Coli notified to corporate HSE or Health Protection Surveillance Centre (HPSC) since January 2007

2 Service design and environment

Please provide a list of **all** services provided by the Hospital, to include agreements with Network and national hospitals to provide services for patients under the care of the MWRH Ennis where applicable. For each department, service, unit or specialty including outpatients and emergency departments (called a "service" hereunder for brevity) please provide the following information:

- Description and structure of the services
- Staffing structure (total number of staff, WTE and contract basis i.e. permanent, locum, agency) and respective roles for each clinical service
- Numbers and type of staff covering the emergency department (ED) over a 24-hour period throughout the week (including level and grade of medical cover assigned solely to the ED)
- Volume of activity for each service since January 2007 (numbers of new and follow-up patients or other appropriate measure)
- Specific information regarding the ED since January 2007:
    - New patient presentations by presenting complaint, triage category, number, age, gender, time of presentation
    - Follow-up (including wound-care) patient presentations by presenting complaint, triage category, number, age, gender, time of presentation
    - Re-attendance presentations (seen in ED with same complaint) by presenting complaint, triage category, number, age, gender, time of presentation
    - number of admissions to the hospital from the ED
    - percentage of transfers from the ED to other hospitals
    - waiting times in the ED
    - patient protocols/procedures for triage, admission, transfer and 'bypass'
    - with the ambulance service
    - 24-hour cover arrangements

- Specific information regarding the surgical services since January 2007 including:
    - activity by type and number of surgery, e.g. paediatric, gynaecological type and number of each procedure
    - breakdown of elective and emergency surgical work since 2007
    - average length of stay
    - waiting times by condition and surgeon
    - 24-hour cover arrangements
- Specific information regarding the symptomatic breast disease service at Ennis before it closed to include:
    - volume of activity for the last three years
    - key performance indicators
    - number of adverse events, patient safety incidents including misdiagnosis, reported and known
    - number of patients who have come forward through the recent helpline for further investigations
- Current arrangements for referral and access to the symptomatic breast disease service
- Specific information regarding the intensive/critical care unit since January 2007 to include:
    - activity by condition and reason for admission
    - average length of stay
    - annual mortality rate in the unit
    - number of ventilated patient per month
    - number of patients transferred to further care from the
    - intensive/critical unit
    - anaesthetic cover arrangements
    - 24-hour cover arrangements throughout a week
- Specific information regarding the paediatric services since January 2007:
    - activity by condition and age
    - time of day of admission
    - number of transfers to other hospitals
    - 24-hour cover arrangements

- Specific information regarding the medical services since January 2007 to include:
  - activity by condition, specialty, age and consultant
  - mode of referral
  - average length of stay
  - 24-hour cover arrangements
- Specific information regarding the outpatients services since January 2007 to include:
  - activity by specialty and consultant
  - waiting times for appointment by specialty and consultant
  - referral procedures between outpatients services and other Hospital
  - departments and between GP's
- Specific information regarding the radiology services since January 2007:
  - Activity by type and numbers
  - Activity by referral route i.e. ED, wards, outpatients, GP, community facility
  - Cover arrangements by grade over 24 hours throughout the week
  - Reporting time for results by referral type - procedures for managing backlogs
  - Backlog by type, referral and waiting time (if relevant)
  - Number of patients and type of procedures referred to external providers both network, national and international to include details of referral arrangements, any corresponding service level agreements, quality assurance and financial arrangements. This should include details of how these referrals are communicated with patients and their referring doctor.
- Specific information regarding the laboratory services:
  - Activity by department
  - Procedures for requesting investigations and communicating results both within and out of hours and normal and abnormal results
  - Number and type of specimens referred to external providers both network, national and international to include details of any corresponding service level agreements, quality assurance and financial arrangements

- Quality assurance activities
- Cover arrangements over 24 hours

3 Human resources

- Staffing of the hospital, including:
  - Number and names of consultants, their specialties, whether they are permanent, temporary or locum, their sessional commitments, whether they are joint-appointments with other hospitals (and if so where that hospital is), and whether there are any visiting consultants. You may wish to present this data in a table, as attached.
  - Number of non-consultant hospital doctors, their categories and specialties, and how many of these NCHDs are in training or non-training posts. You may wish to present this data in a table as attached
  - Number of nurses (including director of nursing) and categories. You may wish to present the data in a table as attached
  - Number of allied health professionals and categories. You may wish to present the data in a table as attached (the list is not intended to be exhaustive)
  - Number of managers and administrative staff and categories
- Details of policies and procedures for verifying registration status with professional regulatory bodies for permanent and temporary medical staff including consultants and nursing staff
  - Recruitment and appointment policies and procedures
  - Probationary arrangements for new staff
  - Staff induction policy
  - Clinical supervision policy
  - Education and training: policies, programmes and attendance records for:
    - Induction
    - Incident reporting training
    - Risk assessment training

  - Root cause analysis training
  - *Your Service Your Say* training
- Last two reports from the professional bodies (Medical Council and An Bord Altranais) and Colleges regarding the training of relevant specialties and professionals within the Hospital

4 Information Management

- Information management policies, procedures and structures
- Hospital In-Patient Enquiry Scheme (HIPE) data
- Blank patient record – hospital and emergency department
- Mortality and morbidity rates, waiting times, any performance monitoring reports for the hospital, any other performance indicators
- **See separate questionnaire to be completed**

Tables of consultants and staff numbers

CONSULTANTS AT MWRH, ENNIS			
Name	**Specialty**	**Session Commitments**	**Category**
Categories: Permanent; Temporary; Locum; Full Time; Part Time; Visiting; On Leave (period of leave); Joint Appointment (with which hospital)			

Number of non-consultant hospital doctors							
SPECIALTY	Lecturer	SpR	Registrar		SHO		Intern
			Training	Non-training	Training	Non-training	

Number of nurses and midwives		
	Personnel	Total WTE
Total no. of staff nurses/midwives		
Total no. of Clinical Nurse/Midwife Managers 1s		
Total no. of Clinical Nurse/Midwife Managers 2s		
Total no. of Clinical Nurse/Midwife Managers 3s		
Total no. of Clinical Nurse Specialists		
Total no. of Clinical Facilitators		
Total no. of Advanced Nurse Practitioners		
Total no. of Assistant Directors of Nursing		

Number of allied health professionals		
	Personnel	**Total WTE**
Total no. of Allied Health Professionals		
Total no. of Pharmacists		
Total no. of Physiotherapists		
Total no. of Radiographers		
Total no. of Occupational Therapists		
Total no. of Dieticians		
Total no. of Laboratory Scientists/Technicians		

Number of management and administrative staff		
Category	**Personnel**	**Total WTE**

Mid-Western Regional Hospital Ennis

Questionnaire to determine what information is collected and in what format it is collected in.

In all answers, please attach additional documentation if necessary

1. Patient administration system (PAS)

a) Do you have a PAS System? *(If you have a PAS please indicate the year it was implemented)*

b) What data items are collected on the PAS Patient Master Index (PMI) system? *(please attach a list)*

c) What activities are captured on your PAS, e.g. Outpatient clinics, Admissions, Chart tracking etc?

d) Are all patients registered on the PAS? *(If not, please identify which patients are and which patients are not registered on the PAS)*

e) Do you audit the quality of data held on the PAS? *(If yes/ please describe the audit types and frequency)*

2. Emergency department

a) Are there any IT systems used in the emergency department other than PAS? (*If yes, please provide the name of this system*)

b) If yes, what data items are collected on this system? (*please attach a list*)

c) If no, please attach what forms are used to collect data in the emergency department (*please send a blank form*)

d) How long has this form been in use?

e) What was used prior to this form? (*Please attach if available*)

f) What data items were collected using this prior method? (*please attach a list*)

g) Has there been any internal and external audit carried out on your emergency department data?

h) How often are these audits run?

3. HIPE

a) How is HIPE data collected?

b) What does HIPE cover (e.g. admissions, day cases)?

c) What is the usual time delay between activity occurring and the coding of this activity?

d) List the data items collected on HIPE database locally. (*please attach a list*)

e) Has a quality audit been done on your HIPE data? (*If yes, please describe the audit types and frequency*)

4. Other systems

a) Are there any other IT systems used in the hospital (e.g. CCU, ICU, operating theatres, surgical wards, bed management)? (*Please list and describe the general functions of any systems*)

b) Do you have any linked systems which pull data directly from another hospital system(s)? (*Please indicate any linkages and describe the flow of data between each system*)

c) If no, please enclose any forms that are used in the hospital to collect data

5. Laboratory results

a) How are laboratory results communicated to GPs?

6. Referral to other hospitals

a) How are referrals made to other hospitals, what forms are used? (*please attach a copy of the form)*

7. Other sources of data

a) Please describe in detail any audits both external and internal (other than those mentioned above) which have taken place in your hospital in the past twelve months. (*Please provide the results and quality improvement plans arising out of any of these audits where available*)

b) Please describe any research projects undertaken in the hospital in the past twelve months. (*Please provide results where possible*)

Appendix 4: Theme codes for interviews

Interview transcripts were coded to structure the findings of the Investigation Team. This coding system enabled the interview transcripts to be categorised into structured themes.

Interview Themes	Theme Codes
Governance	**G**
Accountability arrangements within service/department	G1
Accountability arrangements within hospital	G2
Accountability arrangements within network/region/national	G3
Risk management systems , policies and procedures	G4
Incident reporting system	G5
Management of adverse events, near misses, complaints claims, including reporting procedures	G6
Feedback to staff following reporting of incidents	G7
Evidence of learning following adverse incidents, near misses, complaints and claims	G8
Quality assurance arrangements within a service/department	G9
Supervision of juniors at service/department level	G10
Quality and safety of the services at service/department level	G11
Quality and safety of the services and between services at Hospital level	G12
Quality and safety of the services and between services at network regional level including community	G13
Quality and safety of the services at national level	G14
Clinical Effectiveness Systems processes and policies and procedures	G15
Clinical audit activity – individuals, teams organization	G16
Evidence of learning from clinical audit	G17
Evidence of application of evidence based practice	G18
Patients involved in audit	G19

Leadership	**L**
Leadership at network level	L1
Leadership at senior management level	L2
Leadership at professional/clinical level	L3
Leadership at department level	L4

Communications	**C**
Communications – systems processes, policies and procedures	C1
Communication within disciplines	C2
Communication between disciplines	C3
Communication within network including primary and community care	C4
Communication with national level	C5
Communication with services users and public	C6

Skills and education	SE
Recruitment – appropriate training, experience, credentialing	SE1
Induction programme	SE2
Appraisal/performance reviews of staff	SE3
Grievance, disciplinary,sickness/absence procedures	SE4
Continuous professional development	SE5
Mandatory training	SE6

Teamwork	T
Multidisciplinary team working within services	T1
Multidisciplinary team working between services	T2
Multidisciplinary team working in regional network	T3
Multidisciplinary team involvement in audit	T4
Multi-team involvement in audit	T5

Information management	IM
Systems and processes, policies and procedures	IM1
Information from audit	IM2
Implementing research to inform practice	IM3
Access to library, Internet, journals	IM4

Patient focus	PF
Patient involvement in their individual case	PF1
Patient involvement in planning	PF2
Feedback on complaint/concern reporting	PF3
Evidence of monitoring of patient experience	PF4

Service design and environment	SDE
Service design based on evidence based practice	SDE1
Evidence of provision of services based on need	SDE2
Planned service delivery – bed management, escalation policy for ED	SDE3
Planning for future service developments	SDE4
Networked arrangements with other centres	SDE5
On call rotas for clinical staff – including locums	SDE6
Clinical lead – consultant-led/nurse led services	SDE7
Hospital transfer protocols – local, network	SDE8
Hospital bypass protocols – local, network	SDE9
Quality and safety of service environment	SDE10
Development and planning	SDE11

Appendix 5: Clinical staffing levels at Mid-Western Regional Hospital Ennis

A. Medical consultants (on 30 September 2008)

	Total whole time equivalent (WTE)	Permanent WTE	Temporary	Contract of indefinite duration
Consultant anaesthetists	3	2	1	
Consultant physician/ cardiologist	0.7	0.7		
Consultant physician	1		1	1
Consultant geriatrician	1	1		
Consultant surgeon	2		1	1
Consultant radiologist	1.2	0.2	1	
Consultant in emergency medicine	0.3			
Consultant microbiologist	0.2		0.2	
Total	**11.5**			

B. Non-consultant hospital doctors (on 30 September 2008)

	Total WTE	Training WTE	Non-training WTE
Emergency care physicians	4		4
Surgical registrars	3		3
Medical registrars	5	3	2
Surgical SHOs	4	1	3
Medical SHOs	6	6	
Surgical intern	1	1	
Total	**23**	**11**	**12**

C. Nurses (on 31 October 2008, including those on leave)

	WTE
Nurse managers	33.9
Permanent staff nurses	71.05
Temporary staff nurses	21.41
Healthcare assistants	0
Total	**126.36**

Appendix 6: Letter to Health Service Executive

Professor Brendan Drumm
Chief Executive
Health Service Executive
HSE Dublin
Parkgate Street
Parkgate Business Centre
Dublin 8

Ref: TC/RBG/BD/050109

5 January 2009

Dear Brendan,

Investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive (HSE) at the Mid Western Regional Hospital, Ennis

As you are aware, following a request from the Minister for Health and Children, the Health Information and Quality Authority is currently undertaking an investigation into the quality and safety of services at the Mid Western Regional Hospital (MWRH), Ennis in accordance with section 9(2) of the Health Act 2007 and this work is ongoing.

In the course of the Investigation, so far there are a number of issues that have been identified by the Investigation Team that the Authority believes have the potential to pose serious risks to the health and welfare of persons receiving services at the MWRH, Ennis. These issues have been identified from information provided by the MWRH, Ennis, and from the series of interviews conducted to date. While these issues and this correspondence will be referred to in the report of the investigation on its conclusion, the Authority believes it is important that they are brought to your attention now, in advance of its conclusion. This is being done so that the issues may be addressed and managed by the HSE as a matter of priority. These issues are specified below:

1 Patient Transfer Arrangements

The Authority has identified that, although clinicians in the MWRH, Ennis identify patients with complex problems across a range of specialities who require emergency or urgent transfer to either the Mid Western Regional Hospital, Limerick or to a Specialist Centre, there are no robust protocols in place to ensure the safe and timely referral, acceptance and transfer of these patients.

The Authority recommends that:

1.1 The HSE should develop robust protocols to ensure the safe and timely referral, acceptance and transfer of patients from MWRH, Ennis to the appropriate centres, where required. These protocols should be developed and implemented by appropriately trained personnel with immediate affect.

1.2 There should be an agreement between the Ambulance Service and the MWRH, Ennis, to ensure that a request by a clinician for an emergency inter-hospital ambulance patient transfer from the MWRH, Ennis, should receive a prioritised ambulance response comparable with that of a 999 call. The clinicians at the MWRH, Ennis will need to ensure that the patient is appropriately and optimally prepared and stabilised prior to the transfer.

1.3 In the case of patients who may require acute neurosurgical care, these patients should be transferred directly to the Mid Western Regional Hospital, Limerick. The Mid Western Regional Hospital, Limerick should take full responsibility and accountability for the care of the patient, including onward transfer to a Specialist Neurosurgical Centre if appropriate.

2 The Intensive Care Service

The current intensive care practice in the MWRH, Ennis, has been established by a small group of consultant anaesthetists, and the wider clinical team, with a concept that aims to provide the best level of patient care for the acutely ill patient within the level of resources and workforce available, constrained by access limitations to the regional tertiary centre and particularly the regional neurosurgical centre. There are difficulties in providing this service and these are recognised by the consultant anaesthetists. At this stage in the ongoing Investigation, the Investigation Team has not been provided with information regarding any specific negative patient outcome in relation to the service.

The Authority has specific concerns in relation to the out-of-hours ability of the MWRH, Ennis to provide an appropriate registered medical practitioner with an appropriate level of training and experience to provide immediate on-site treatment of acute respiratory, circulatory and airway emergencies in intensive care, including the immediate management of patients receiving invasive mechanical ventilation. It would be acceptable for such emergency care to be provided by emergency physicians, anaesthetists, internal medicine physicians or surgeons with the appropriate competencies for the purpose of stabilising such patients prior to their transfer to an appropriate critical care facility. It is unclear that such competencies are available for 24 hours a day, 7 days a week in the MWRH, Ennis intensive care service.

The Authority recommends that:

2.1 Patients requiring intensive care, including invasive mechanical ventilation, must be stabilised and safely transferred to the Mid Western Regional Hospital, Limerick, subject to availability (or other suitable hospital with Level 2/3 critical care resources) as a matter of priority. If in exceptional circumstances there is a delay in transfer, medical staff need to be available on-site with appropriate competencies to provide immediate on-site treatment of acute respiratory, circulatory, and airway emergencies, including the immediate management of patients receiving invasive mechanical ventilation in intensive care.

3 Obstetric and Paediatric Services

The Authority has identified that obstetric patients and children with acute conditions are being brought to the MWRH, Ennis, by the Ambulance Service. There is no acute specialised obstetric or paediatric service in the MWRH, Ennis. The Authority notes that obstetric and paediatric bypass protocols have been locally agreed and that plans for the establishment of these protocols are being developed with a plan to have these protocols in place in early 2009. However, the Authority believes that the current practice poses a potential serious risk for persons requiring such services.

The Authority recommends that:

3.1 Robust and safe ambulance protocols, delivered by appropriately trained personnel, for obstetric patients and children by-passing the MWRH, Ennis, should be implemented without delay. Ambulance personnel should be trained appropriately to manage obstetric and paediatric emergencies.

If in the course of the investigation, further potential serious issues relating to the health and welfare of persons receiving services at the MWRH, Ennis, are identified then these will be brought to your attention.

In view of the matters identified above, can you please outline the arrangements that will be put in place to address these risks and recommendations. I would appreciate if the Authority could receive an update on such progress within 14 days of the date of this letter.

If you require further information relating to any of the issues outlined above then please do not hesitate to contact me.

Yours sincerely,

Dr Tracey Cooper
Chief Executive

Copy: Ann Doherty, Acting National Director, National Hospitals Office, HSE
Jon Billings, Director of Heathcare Quality and Safety, HIQA
Michael Scanlan, Secretary General, DoHC

For further information please contact:

Healthcare Quality and Safety Directorate
Health Information and Quality Authority
George's Court
George's Lane
Dublin 7

Phone: +353 (0)1 814 7400
Email: qualityandsafety@hiqa.ie
URL: www.hiqa.ie