Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	St James's Hospital
Address of healthcare service:	James Street Dublin 8 D08 NHY1
Type of inspection:	Unannounced
Date(s) of inspection:	29 March 2023
Healthcare Service ID:	OSV-0001102
Fieldwork ID:	NS_0035

The following information describes the services the hospital provides.

About the healthcare service

Model of Hospital and Profile

St James's Hospital (SJH) is a Model 4* hospital managed by a Board of Directors. It is a member of the Dublin Midlands Hospital Group (DMHG)† providing healthcare services on behalf of the Health Service Executive (HSE). The hospital provides acute, emergency, specialist services and residential care, across a vast range of medical and surgical specialties. Services provided by the hospital include:

- acute medical in-patient services
- elective surgery
- emergency care
- intensive and high-dependency care
- diagnostic services
- outpatient care.

SJH is one of eight adult designated national cancer centres in the country. The hospital is the largest acute academic teaching affiliated with Trinity College Dublin.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	1,068 inpatient and day beds

* A Model-4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24 hours, every day of the year) and an Emergency Department.

† The Dublin Midlands Hospital Group comprises seven hospitals – St James's Hospital, Tallaght University Hospital, Naas General Midland Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, the Coombe Hospital and St Luke's Radiation Oncology Network. The hospital group's academic partner is Trinity College Dublin.

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare. HIQA carried out a one-day unannounced inspection of the emergency department at SJH to assess compliance with four national standards from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information[§] and other publically available information.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in SJH's emergency department. It outlines whether there is appropriate oversight and assurance arrangements in place

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

[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

at SJH and how people who work in the emergency department are managed and supported to ensure the safe delivery of high-quality care.

2. Quality and safety of the service

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

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
29 March 2023	09:00hrs – 16:30hrs	Denise Lawler	Lead
		Nora O' Mahony	Support
		Aoife O' Brien	Support

Information about this inspection

This inspection of SJH's emergency department and the Acute Medical Unit (AMU) focused on compliance with four national standards from four of the eight themes of the *National Standards for Safer Better Healthcare* and on:

- the effective management to support the delivery of high-quality care in the emergency department
- patient flow and inpatient bed capacity in the emergency department and at wider SJH level
- respect, dignity and privacy for people receiving care in the emergency department
- staffing levels in the emergency department.

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

- Representatives of the Executive Management Group
  - Interim Chief Executive Officer
  - Director of Nursing
  - Interim Chief Operations Officer
  - Medical Director
- Deputy Director of Quality and Patient Safety
- Person Centred Care Manager
- Bed Manager Leads
  - Assistant Director of Nursing for Patient Flow
  - Medicine for Elderly (MedEI) Directorate Operations Manager
  - Medicine and Emergency Department (MED) Directorate Operations Manager.

Inspectors also spoke with medical staff and nursing management and people receiving care in the hospital's emergency department. Inspectors reviewed a range of documentation, data and information received during and after the on-site inspection.

Acknowledgements

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

What people who use the emergency department told inspectors and what inspectors observed in the department

On the days of inspection, inspectors visited the emergency department and the Acute Medical Unit (AMU). The emergency department provides undifferentiated care for adults with acute and or an urgent illness or injury. Attendees to the department presented by ambulance, were referred directly by their general practitioner (GP) or were self-referred.

The total planned capacity of SJH's emergency department was 35 treatment areas separated into the following areas:

- a waiting area with 45 seats
- a triage area with two treatment assessment rooms
- a resuscitation area: comprising five treatment bays for patients categorised as major. Four of the six bays were single, self-contained cubicles and the fifth bay was located in the main open resuscitation area
- a Senior Intervention Following Triage (SIFT) area: comprising three treatment bays where patients were assessed following triage by a senior clinical decision-maker usually at consultant in emergency medicine and or Clinical Nurse Manger (CNM) level, with timely access to diagnostics
- Zone 2: an open planned multi-occupancy area with seven single occupancy treatment bays
- Zone 3: seven single self-contained cubicles for the treatment of patients requiring isolation facilities
- Zone 4: two rooms, each with four treatment bays where ambulatory patients were treated.

On the day of inspection, the emergency department was busy relative to its intended capacity. At 11.00am there was a total of 56 patients registered in the department. Half of these patients were admitted and boarding in the department while awaiting an inpatient bed in the main hospital. Eleven (39%) of the 28 admitted patients were accommodated on trolleys and five (18%) patients were on chairs on the corridor in Zone 2. The AMU operates 08.00am to 08.00pm Monday to Friday, with a planned capacity of five trolleys. On the day of inspection, at 11.00am there were five patients in the unit.

During this inspection, inspectors spoke with a number of patients about their experience of care in the emergency department. Patients' experiences were generally positive. Patients were complimentary about staff describing them as '*lovely, very nice, pleasant, courteous'*, '*doing the best they can'* and as '*absolutely the best'*. Staff took '*time to listen'* and the patients who spoke with inspectors appreciated this.

Some patients commented on the lengthy waiting times, waiting for diagnostic tests and for an inpatient bed. Others commented on the lack of space between trolleys located on

the corridor. Patients commented on how trolleys on the corridor restricted the amount of space available for the safe passage of supplies and equipment to the emergency department, which had the potential to cause physical harm. Patients accommodated in the multi-occupancy rooms and on trolleys on the corridor confirmed that privacy screens were used to afford some privacy when care was being delivered. However, despite this, patients, especially those on trolleys on the corridor were concerned about the lack of privacy and confidentiality that arose as a result of their location. The experiences recounted by patients was similar to the findings from the 2022 National Inpatient Experience Survey (NIES),** where SJH scored the same or better than the national scores in the questions related to communication and interactions with staff, and waiting times in the emergency department.

Patients in the emergency department who spoke with inspectors said they would speak with a member of staff if they wanted to make a complaint. Patients confirmed they were not provided with information about the HSE's complaints process 'Your Service, Your Say' and or independent advocacy services. Inspectors did not see information on the HSE's 'Your Service, Your Say' and or independent advocacy services displayed in the emergency department on the day of inspection. This is something hospital management should address following this inspection.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. The hospital was found to be partially compliant with the two national standards assessed. Key inspection findings leading to the judgment of partial compliance with these national standards are described in the following sections.

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

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.
Inspectors found SJH had defined lines of responsibility and accountability for the governance and management of unscheduled and emergency care. Organisational charts submitted to HIQA detailed the direct reporting arrangements of the hospital's governance and oversight committees to the hospital group's Executive Management Group (EMG) and onwards to the DMHG and SJH's Board of Directors. These arrangements aligned with inspector's findings on inspection. Nonetheless, HIQA found that there was some scope to improve the overall operational functioning of the hospital's governance structures for unscheduled and emergency care. The hospital's interim Chief Executive Officer (CEO) had overall responsibility and accountability for the governance of SJH. The interim CEO had a dual reporting arrangement to the chair of SJH's Board of Directors and the CEO of the DMHG. HIQA found there were clear lines of accountability with devolved autonomy and decision-making for unscheduled and emergency care at SJH, which was governed and overseen by the Unscheduled Care Governance Group (USCGG). Chaired by the interim CEO, the USCGG met six weekly in line with their terms of reference and had oversight of the unscheduled and emergency care activity and SJH's performance against defined quality indicators. The USCGG reported and was accountable to the EMG and SJH's Board of Directors. The EMG was the senior executive decision-making group with responsibility for the executive governance and oversight of the quality and safety of the healthcare services provided at SJH. The group had oversight of SJH's emergency department's activity, compliance with established quality indicators, risk management processes and patient safety issues every month. Chaired by the interim CEO, membership of the group comprised executive and clinical managers from across the different health professions and departments in SJH. The group had defined dual reporting and accountability arrangements to the DMHG and SJH's Board of Directors. SJH's unscheduled and emergency care activity and compliance with relevant quality indicators were also reviewed at meetings of SJH's Hospital Board every two months and monthly at performance meetings with DMHG as part of the HSE's performance accountability framework. The Safety and Quality Assurance Governance Committee (SQAGC) provided the EMG and SJH's Board of Directors with assurance that the clinical governance structures and processes at SJH were appropriate and robust. Chaired by the interim CEO, the committee's membership comprised executive and clinical representation from all departments and directorates in SJH. The SQAGC met six times a year and reported to the Quality, Safety and Risk Board Committee. Minutes of meetings reviewed by inspectors showed that the committee had oversight of the risks, patient experiences, auditing activity and patient-safety incidents that occurred in SJH's emergency department. The minutes submitted to HIQA indicated that the SQAGC's terms of reference were due to be reviewed. In addition, time-bound actions with an assigned person to implement the actions were not recorded on the minutes of meetings reviewed by inspectors. This practice would facilitate

the oversight of agreed actions from oversight and governance committees, and is something that should be addressed following this inspection.

On the day of inspection, there was evidence of strong clinical and nursing leadership in the emergency department. The clinical governance and oversight of the emergency department lay with the medical directorate, led by a clinical director, who reported to SJH's medical director. The clinical lead for the medical directorate also presented an update on the directorate's activity and performance with set quality indicators at meetings of the Medical Board. The Medical Board comprised medical consultant staff permanently appointed at SJH. The Board was an advisory Board for SJH's Board of Directors. The Medical Board met eleven times a year and had a defined dual reporting and accountability arrangement to SJH's CEO and SJH'S Board of Directors.

During core working hours operational governance and oversight of the day-to-day workings of the emergency department was the responsibility of the onsite consultant in emergency medicine supported by non-consultant hospital doctors (NCHDs). The department had a clinical lead, appointed on a rotational basis from SJH's complement of consultants in emergency medicine, who reported and was accountable to the clinical director for the medical directorate. Outside core working hours, clinical oversight of the emergency department was provided by the on call consultant in emergency medicine.

SJH did not have a formal bed management or discharge committee. However, it was evident that bed management and patient flow was monitored and managed through the following structures and processes:

- status update from site manager each morning
- flow huddles on 12 acute wards each morning
- daily bed management briefing group. This group also met in the afternoon when the hospital was in escalation
- weekly unscheduled care meetings
- engagement with hospital group and community services to improve patient care pathways.

Multidisciplinary operational meetings were held in the emergency department two weekly with a focus on reviewing the department's activity levels, compliance with established quality indicators, patient flow through the department, risk management processes and the management of patient-safety incidents. Operational meetings were held between the emergency department's CNM3, clinical lead and members of the EMG every week to review the department's overall performance.

In 2022, the attendance rate to SJH's emergency department was 52,840, which was one of the lowest attendances of all the emergency departments in the country (second to Tallaght University Hospital). When compared to 2020 and 2019 (before the COVID-19 pandemic), the attendance rates to SJH's emergency department have increased by 18%

and 4% respectively. The average monthly attendance rate to the emergency department in 2022 was 4,403 people, with a daily average attendance rate of 145 people. The majority of attendees were referred by a GP or self-referred. On the day of inspection, at 11.00am, the emergency department was busy relative to its intended capacity and function, with 56 patients registered in the department. Half of the patients in the department were admitted awaiting an inpatient bed in the main hospital. Eight patients (14%) were aged 75 years or older. The 50% of patients boarding in the emergency department was one of the highest of all the emergency departments inspected by HIQA to date and was indicative of issues with the flow of patients through the department and wider SJH level.

On the day of inspection, SJH were in escalation at black escalation level.[††] There was evidence that the majority of measures outlined in SJH's escalation plan for that level of escalation were implemented on the day of inspection. These included the cancelling or restricting of non-time sensitive or urgent scheduled care and the holding of a number of action-oriented meetings throughout the day to review activity and patient flow in the emergency department and wider hospital. Hospital management and clinical staff who spoke with inspectors discussed how the sheer volume of attendees to the emergency department has resulted in SJH being in a constant state of escalation, with the highest level escalation now being the norm. This continual use of the hospital's escalation processes to manage the demand for unscheduled and emergency care demonstrated how the mismatch between demand and inpatient bed capacity in SJH continues to be a challenge. At the time of inspection, hospital management at SJH were exploring a number of capital initiatives with the HSE to increase bed capacity in SJH. These included providing a regional surgical hub for surgical day-case services off-site and developing sub-acute bed capacity for patients that may not need hospital-level treatment and care. Progression and the full implementation of these initiatives has the potential to support and increase inpatient bed capacity at SJH, and improve the flow of patients through the emergency department and wider hospital level.

Continuous and effective flow of patients within and out of SJH was essential to optimal patient flow within and outside the emergency department and wider hospital. Hospital management described the measures in place to improve bed capacity and patient flow through the emergency department including holding daily huddles and weekly meetings with primary care services and the Community Healthcare Organisation 7 (CHO7). SJH discharged an average of 40 patients per month to step-down and convalescence care in community and rehabilitation inpatient services, and nursing homes in counties Kildare and Dublin. Notwithstanding this, inspectors were informed that the hospital's average length of stay (ALOS) of medical and surgical patients and number of patients with delayed transfers of care (DTOC) [‡‡] were factors that contributed to the inefficiencies in patient flow found on

[††] A hospital's escalation policy, sets out (within the parameters of the national framework) the key stages of steady state, escalation, full capacity protocol, de-escalation and review.
[‡‡] Delayed transfers in care: A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred.

inspection. SJH's DTOC and ALOS rates were higher than other Model 4 hospitals, which may be associated with SJH being a national referral centre for a number of specialities, but nevertheless are important factors in need of continued active management by hospital management.

In 2022, SJH's ALOS for medical patients was 10 (HSE's target ≤7.0) and the ALOS for surgical patients was 8.5 (HSE's target ≤5.6), both were significantly above the HSE's targets for that year. Year to date in 2023, the hospital's ALOS for medical patients was 8.5 (HSE's target ≤7.0) and the ALOS for elective surgical patients was 7.75 (HSE's target ≤5.0). At the time of inspection, there were approximately 66 patients in SJH who had completed their acute episode of care and who experienced a DTOC. The majority of these 66 patients were awaiting residential care. The DTOC and ALOS rates were reported monthly to the EMG and medical directorate, and every six weeks to the USCGG, with oversight from SJH's Board of Directors. Inspectors discussed the reported DTOC and ALOS rates with hospital management and were informed that rates were mainly due to the level of acuity and complexity of the patients accessing care at SJH, the hospital being a national referral centre for a number of specialities and or difficulty in sourcing suitable community supports to meet specific patient needs.

Collectively, the mismatch between availability and demand for inpatient beds at SJH, as evident on the day of inspection, impacted the flow of patients through the emergency department. This in turn impacted on patient experience times (PETs).[§§] At 11.00am on day of inspection, all patients registered in the department were triaged. The waiting time from:

- triage to medical review ranged from 0 minutes to 1 hour 27 minutes. The average waiting time was 52 minutes
- medical assessment to decision to admit ranged from 23 minutes to 8 hours 36 minutes. The average waiting time was 2 hours 30 minutes
- decision to admit to actual admission to an inpatient bed ranged from 5 hours 20 minutes to 32 hours. The average waiting time was 17 hours 40 minutes.

All patients were triaged and prioritised in line with the Manchester Triage System.[***] Following triage and categorisation, patients were referred to the most appropriate care pathway, which included: cardiac, epilepsy, falls and syncope,[†††] minor injury and AMU. Staff could view the status of all patients in the department — their prioritisation category levels and waiting times on the emergency department's electronic information system.

[§§] Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

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

[†††] The Falls and Syncope Unit (FASU) in St James's Hospital provides rapid, expert assessment and treatment for patients of all ages who suffer from dizziness, faints, falls and syncope (loss of consciousness).

The hospital had implemented the Home First[‡‡‡] care pathway and used the Community Intervention Team (CIT)[§§§] as a hospital admission avoidance measure. However, when compared to other Model 4 hospitals, the range of community based hospital admission avoidance measures used by SJH were limited. Further integration and collaboration with community services and the National Ambulance Service (NAS) could increase access and availability to other hospital admission avoidance options implemented by other hospitals, such as:

- Outpatient Parenteral Antibiotic Therapy (OPAT)[****]
- Pathfinder programme[††††]
- Hospital Ambulance Liaison Person (HALP).[‡‡‡‡]

In 2022, 27.3% of attendees to SJH's emergency department were admitted to the main hospital (conversion rate) for further care and treatment, which is comparable to conversion rates in Beaumount Hospital and St Vincent's University Hospital. Hospital managers and medical staff who spoke with inspectors attributed the high conversion rate to the acuteness and severity of illness of people presenting to SJH's emergency department. The percentage of patients who left SJH's emergency department before completion of care was 14%, which is significantly higher than the HSE's target of <6.5%. This rate is one of the highest of all emergency departments inspected to date by HIQA. SJH had a process in place to ensure that patients who had registered for care in the emergency department and had tests carried out, but left before completing care were followed up by medical staff, when required.

Other systems and processes in place at SJH to manage the demand in activity and to support continuous patient flow through the emergency department were not functioning as they should be on the day of inspection. The AMU was not functioning as an alternate flow pathway for patients in order to take pressure from the emergency department. It was a care pathway from the emergency department for patients who met the inclusion criteria for the unit, as opposed to being an alternative pathway for patients and GPs to use. Findings from this inspection suggest that the AMU in SJH could be used more effectively and efficiently to relieve the pressure and improve patient flow through the hospital's emergency department.

[‡‡‡] Home First is a hospital admission avoidance service comprising a multidisciplinary team that are dedicated to caring older patients that attend for emergency care with follow-up by community services.
[§§§] Community Intervention Team is a nurse-led measure supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.
[****] Outpatient parenteral antibiotic therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.
[††††] Pathfinder programme is a collaborative service staffed by health and social care professionals and the HSE's National Ambulance Service, with the aim to change conveyance to the emergency department following a 999 call for over 65 year olds with low acuity.
[‡‡‡‡] The Hospital Ambulance Liaison Person is responsible for managing the ambulances that arrive at the hospital, liaising between the ambulance service and the hospital's emergency department team.

Overall, it was evident that SJH had defined management arrangements in place to manage and oversee the delivery of care in the emergency department. Notwithstanding this, operationally, on the day of inspection SJH's emergency department was not functioning as effectively as it should be. There was scope for improvement in the monitoring of implementation of agreed actions from governance committee meetings. This is essential to providing assurances that the actions identified by governance committees to improve the quality and safety of unscheduled and emergency care at SJH are implemented.

The increased attendances to SJH's emergency department, the level of DTOC and ALOS rates, and the AMU not functioning as intended, collectively resulted in the mismatch between the number of inpatient beds required and actual bed capacity. This contributed to inefficient patient flow through SJH's emergency department and increased waiting times for patients. Measures in place to support patient flow through the emergency department and wider hospital, were not fully effective in managing the potential patient safety risks arising from long waiting times in the emergency department. The routine and normalised use of SJH's escalation plan demonstrates how SJH continues to be challenged by the mismatch between service demand and inpatient bed capacity. Furthermore, when compared to other Model 4 hospitals, the range of community based hospital admission avoidance measures used by SJH were limited. Further integration and collaboration with community services and the NAS could increase access and availability to additional hospital admission avoidance options implemented by other hospitals.

Judgment: Partially compliant

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

SJH had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare in the emergency department. Medical staffing levels in the department were maintained at levels to support the provision of 24/7 emergency care. The hospital was approved and funded for eight whole time equivalent (WTE)[§§§§] consultants in emergency medicine. At the time of inspection, seven consultants in emergency medicine positions were filled — six WTE on a permanent basis and one WTE on a locum basis — and one WTE position was unfilled. All permanent appointed consultants in emergency medicine were on the specialist register with the Irish Medical Council. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a consultant and boarded in the emergency department while awaiting an inpatient bed.

[§§§§] Whole-time equivalent - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

The hospital was an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. Consultants in emergency medicine were supported by 33 WTE NCHDs at registrar, senior house officer (SHO) and intern grades — 15 registrars, 15 SHOs and three intern. At the time of inspection, all NCHD positions except one at registrar grade were filled. A senior clinical decision-maker[*****] at consultant or registrar grade was on-site in SJH's emergency department during core working hours. Outside of core working hours, a consultant in emergency medicine was available off-site and staff confirmed that they were available and could be on-site within 30 minutes, if needed.

A CNM3, had responsibility for the nursing service within the emergency department. The CNM3 reported to the Assistant Director of Nursing (ADON) for the emergency department. A CNM2 was on duty each shift and had responsibility for nursing services during core working hours, out-of-hours and at weekends. The emergency department's approved and funded nursing staff complement was 84.5 WTE (inclusive of management grades). This number included the increase in WTE nursing staff approved as part of the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland.*[†††††] At the time of inspection, the department's actual complement of nursing staff was 73.5 WTE, with 13% (11 WTE) of staff nurse positions unfilled. Hospital management were managing the deficit in nursing staff levels through an ongoing recruitment campaign and the use of agency staff.

The emergency department had 16 nurses (inclusive of CNMs) rostered on day shift and 12 nurses (inclusive of CNMs) rostered on night shift. On the day of inspection, the department were short five (31%) nurses on the daytime rostered complement of nurses. One nurse was deployed to the department, which resulted in a shortfall of 25% on the rostered complement of nurses. It was difficult to fully quantify the specific impact that shortfall in nursing staff had on the care delivered in the emergency department on the day of inspection because the proportion of care delayed, unfinished or omitted was not being quantified. Nursing staff in the emergency department were supported by 16 WTE healthcare assistants. All of these positions were filled at the time of this inspection. Other members of the multidisciplinary team in the emergency department included six WTE Advanced Nurse Practitioners (ANPs)[‡‡‡‡‡] and one WTE clinical skills facilitator.

The AMU had an assigned complement of medical and nursing staff. Medical staffing to the unit comprised a medical consultant supported by six NCHDs at registrar and SHO grades — three registrars and three SHOs. The daily rostered complement of nursing staff was one

[*****] Senior decision-makers in St James's Hospital are defined here as a doctor at registrar grade or a consultant who has undergone appropriate training to make independent decisions around patient admission, treatment and discharge.

[†††††] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

[‡‡‡‡‡] Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

CNM and one staff nurse supported by one healthcare assistant. At the time of inspection, the unit was fully staffed by the full complement of medical and nursing staff. There were five patients in the unit at 11.00am. Inspectors found that there was potential for the AMU to be used more effectively and efficiently to relieve the pressure caused by increased attendance rates to the hospital's emergency department. This was discussed with hospital management on the day inspection.

Staff training records provided to inspectors outlined that nursing and medical staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice. HIQA found that compliance with nursing staff attendance and uptake at mandatory training was generally good in the areas of basic life support, Manchester Triage System and hand hygiene. However, there were opportunities for improvement in relation to the nursing staff attendance and uptake of training in transmission-based precautions sepsis management and the Irish National Early Warning System (version 2).§§§§§ Inspectors found that significant improvement was required in relation to medical staff attendance and uptake at mandatory and essential training.

Staff absenteeism rates at SJH were monitored and reported monthly as per the HSE's requirements. CNMs had oversight of the department's absenteeism rates for nursing staff. Reported staff absenteeism rates in the emergency department for last year (2022) was 5.46%, which included COVID-19 related absenteeism. This rate was slightly above the HSE's target of 4% for 2022.

Overall, hospital management were organising and managing their workforce to enable the delivery of high-quality care in the emergency department. However, on the day of inspection, the department were short five (31%) nurses on the rostered complement of 16 nurses. One nurse was deployed to the department, which resulted in a shortfall of 25% on the rostered complement of nurses. It was difficult to fully quantify the specific impact the nursing staff shortfall was having on the care delivered because the proportion of care delayed, unfinished or omitted was not being assessed. Hospital management must ensure that there is sufficient capacity and contingency arrangements in place across all staff disciplines, but especially nursing to ensure staff resourcing can meet the demand for unscheduled and emergency care at SJH. Furthermore, attendance at and uptake of mandatory and essential training for nursing staff and especially medical staff in the emergency department requires significant improvement. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement following HIQA's inspection.

Judgment: Partially compliant

§§§§§ Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under two national standards (1.6 and 3.1) from the two themes of person centred care and support and safe care and support. The hospital was found to be partially compliant with the two national standards assessed. Key inspection findings leading to the judgment of partial compliance with these national standards are described in the following sections.

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

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

Privacy and dignity in the emergency department was supported for patients accommodated in individual cubicles. Privacy curtains were used in multi-occupancy areas. Inspectors observed how the close proximity of patients on trolleys in the corridor compromised patient's confidentiality. Privacy screens were used when administering care and treatment to these patients, but it was difficult to maintain patient confidentiality as others could overhear patient-clinician conversations. This was not in line with the human-rights based approach to healthcare promoted and supported by HIQA.

Patients accommodated on trolleys on the corridor who spoke with inspectors commented on how they felt that their level of privacy was compromised because of their location. The experiences recounted by these patients were not fully aligned with the 2022 NIES findings relating to respect and dignity in the emergency department. Furthermore, in 2022, nearly a quarter (23%) of the complaints received by hospital management about the emergency department related to dignity and respect.

The number of toilets and showers in the emergency department was not adequate to meet the needs of the number of patients in the department at the time of inspection, especially when compared to the department's intended capacity. Inspectors also observed the challenges to maintain adequate physical distancing between trolleys and or chairs located on the corridor, which posed an infection risk.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. However, inspectors observed the difficulty in preserving patient's privacy, dignity and confidentiality when accommodated on a trolley on the corridor. Notwithstanding the efforts of staff, patients on trolleys outside of defined cubicle spaces had little to no privacy or dignity and it was clear that the confidentiality of patients

accommodated in that location was compromised. The measures used to promote and respect the dignity, privacy and autonomy of patients receiving care in the emergency department was not fully effective in meaningfully promoting the patient's human rights at the time of inspection.

Judgment: Partially compliant

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

There were systems and processes in place in SJH to identify, evaluate and manage immediate and potential risks to people attending the emergency department. However, HIQA found that not all measures to protect patients in the department from the risk of harm were being effectively implemented.

Performance data was collected on a range of different quality indicators related to SJH's emergency department, in line with the HSE's reporting requirements. This included the number of presentations to and admissions from the emergency department, DTOC, ALOS and ambulance turnaround times. SJH's compliance with defined quality indicators was reviewed at monthly meetings of the EMG, monthly meetings between SJH and DMHG, and six weekly meetings of the USCGG.

Data on PETs collected on the first day of inspection, showed that at 11.00am, the hospital was not aligned with four of the five HSE targets for the emergency department. At that time, of the 56 patients registered in the department:

- 57% of attendees to the emergency department were in the department for more than six hours after registration — not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 54% of attendees to the emergency department were in the department for more than nine hours after registration — not in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.
- 7% of attendees to the emergency department were in the department for more than 24 hours after registration — not in line with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.
- Eight (14%) attendees to the emergency department were aged 75 years and over. 12% of these patients were admitted or discharged within nine hours of registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration.

- All attendees to the emergency department aged 75 years and over were discharged or admitted within 24 hours of registration.

Risk management

HIQA was satisfied that risks related to the emergency department and controls and corrective actions to mitigate the risks were formally reviewed in line with SJH's risk management policy and processes as outlined to inspectors during this inspection. Identified risks were regularly reviewed at meetings of relevant executive governance committees. Emergency department-related risks were managed in line with the HSE's risk management processes at department level with oversight of the process assigned to the CNM3. There was sufficient evidence that risks, mitigating controls and corrective actions were regularly reviewed at department level and the risk register was updated to reflect review dates. High-rated risks that could not be managed at emergency department level were escalated to and recorded on SJH's corporate risk register. The SQAGC, EMG and Senior Incident Management Team (SIMT) had oversight of the risks, mitigating controls and corrective actions recorded on SJH's corporate risk register.

At the time of inspection, there were six high-rated risks related to the emergency department recorded on SJH's corporate risk register. These included:

- medical staffing shortage
- nursing staff shortage
- rates of patients who leave the emergency department before completion of treatment
- patients boarding in the emergency department
- overcrowding
- physical infrastructure.

The key findings from this inspection aligned with the high-rated risks related to the emergency department recorded on SJH's corporate risk register. The corporate risk register was updated to reflect review dates.

Infection prevention and control

At the time of inspection, a COVID-19 management pathway was in operation in SJH's emergency department. Attendees were screened for signs and symptoms of COVID-19 on arrival to the emergency department and assigned to the most appropriate care pathway. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the emergency department's electronic information system. A nurse from the infection prevention and control team visited the emergency department daily during core working hours. Staff in the department had access to a microbiologist 24/7.

Inspectors were informed that all patients were screened for *Carbapenemase-producing Enterobacterales* (CPE)[******] and *Methicillin Resistance Staphylococcus Aureus* (MRSA)[††††††] on admission to the main hospital, in line with national guidance at the time of inspection. Patients requiring transmission-based precautions were accommodated in single cubicles in the emergency department. However, the accommodation of patients on trolleys on the corridor did not facilitate adequate physical distancing to minimise infection prevention and control risks. There were two negative pressure isolation rooms in the emergency department.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available to staff. Hand hygiene signage was also observed to be clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment (PPE), in line with public health guidelines at the time of inspection. Hand hygiene audits were carried out in the emergency department with oversight by the infection prevention and control team, but the documentary evidence reviewed by inspectors suggest that auditing was not carried out at regular intervals. Findings from a hand hygiene audit carried out in August 2021 and reviewed by inspectors showed that SJH's emergency department was compliant with the HSE's target of 90%. HIQA was not provided with findings from more recent hand hygiene audits for the emergency department. There was evidence that quality improvement plans were developed to improve the hand hygiene practices and standards in the department. Hand hygiene audits should be carried out monthly to assure hospital management and patients using the healthcare services that required standards of hand hygiene are being achieved.

SJH's emergency department was generally observed to be clean and well maintained on the day of inspection. Staff confirmed that terminal cleaning[‡‡‡‡‡‡] was carried out following suspected or confirmed cases of COVID-19. There was evidence that monthly environmental and equipment hygiene audits were carried out in the emergency department using a standard approach. There was evidence that quality improvement plans were implemented when necessary to improve the standard of environmental hygiene in the department.

Medication safety

A clinical pharmacist was available to staff in the emergency department, but the department did not have a comprehensive pharmacy service. Pharmacy-led medication reconciliation was carried out on admitted patients and this was underpinned by a formalised policy. The department had a list of high-risk medicines. Staff who spoke with inspectors were knowledgeable about high-risk medicines and associated risk reduction

[******] Carbapenemase Producing Enterobacterales (CPE) are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are, therefore, much more difficult to treat.
[††††††] Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a strain of bacteria that has become resistant to the antibiotics commonly used to treat ordinary staphylococcal infections.
[‡‡‡‡‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

strategies in place in SJH. The use of high risk medications was underpinned by a formalised policy. The emergency department had a list of sound alike look alike drugs (SALADs) and staff were aware of this list. Staff in the emergency department had access to an antimicrobial pharmacist, when needed.

Deteriorating patient

The appropriate national early warning system — INEWS version 2, was being implemented at the time of inspection for use with admitted patients boarding in the emergency department. There was a plan in place to implement the Emergency Medicine Early Warning System (EMEWS) in SJH, with staff training on the system to be provided by the clinical skills facilitator. Inspectors were informed that formal handover forms were used for the safe transfer of care within and between hospital departments.

The process of clinical handover was underpinned by a formalised policy. The Identify, Situation, Background, Assessment and Recommendation ($ISBAR_3$)[§§§§§§] communication tool was used for clinical handover and when transferring patients from the emergency department. The ISBAR tool was integrated into the electronic patient record used in SJH. There was limited evidence from the documentation reviewed by inspectors that the use of the ISBAR tool in SJH's emergency department was being audited.

Management of patient-safety incidents

There was a system in place at SJH to report, review and manage patient-safety incidents that occur in the emergency department. Staff who spoke with inspectors were aware of the process, which was underpinned by a formalised policy that was in line with the HSE's incident management framework. Incidents related to the department were reported on the hospital's quality management system. Patient-safety incidents were tracked and trended by the quality and safety improvement directorate and were reviewed at meetings of the SQAGC. Serious patient-safety incidents were reported to the hospital's SIMT for review and escalated to the hospital group and SJH's Board of Directors. Documentation reviewed by inspectors showed that in 2022, there were 146 patient-safety incidents reported in the emergency department, with the most common reported incidents being falls, delay in treatment and absconding. Staff told inspectors that there was good culture of reporting patient-safety incidents in the emergency department and that findings in relation to patient-safety incidents were discussed with staff at the daily huddles and operational meetings every two weeks.

Management of complaints

[§§§§§§] Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

Inspectors found there was a coordinated response to complaints related to the emergency department that was in line with the HSE's 'Your Service You Say'. Hospital management supported and encouraged point of contact complaint resolution, with complaints managed at department level by the CNM with oversight by the complaints officer. Staff in the emergency department were knowledgeable about the complaints management process. Hospital management received 138 complaints related to the emergency department in 2022. Complaints were tracked and trended by the quality and safety improvement directorate, with feedback shared with the CNM who in turn shared the information on complaints resolution with staff. The most common complaints, received in 2022 about the emergency department, were about safe and effective care, and dignity and respect. There was evidence that initiatives were introduced in SJH's emergency department to improve the delivery of care following the receipt of a complaint. SJH was compliant with the HSE's target of 75% complaints resolution within 30 working days. Information relating to SJH's complaints process, the HSE's 'Your Service, Your Say' and independent advocacy services could be displayed in the emergency department following this inspection.

In summary, there were arrangements in place to monitor, analyse and respond to information relevant to the delivery of safe care in SJH's emergency department. Risks related to the emergency department were identified and managed at department level, and escalated to executive management when needed. However, HIQA found that not all measures to protect people attending SJH's emergency department from the risk of harm were used. Admitted patients accommodated in the emergency department was symptomatic of the ineffective patient flow and insufficient bed capacity, which impacted on PETs and exposed patients to risks of harm on the day of inspection. There was inadequate physical distancing between trolleys located on the corridor, which was an infection risk. Auditing of environmental, equipment and hand hygiene practices in the emergency department was also an area that could be strengthened and improved. A comprehensive clinical pharmacy service, inclusive of pharmacy-led medication reconciliation should be developed and implemented to support safe medication practices in the emergency department.

Judgment: Partially compliant

Conclusion

HIQA carried out a one-day unannounced inspection of SJH's emergency department and AMU to assess compliance with four national standards from the *National Standards for Safer Better Healthcare*.

Capacity and Capability

SJH had defined corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare in the emergency department. Hospital management had implemented a range of measures to improve the flow of patients through the emergency department and increase inpatient capacity at SJH. However, it was evident from findings on the day of inspection that the department was not functioning as effectively as it should be. There was an issue with patient flow in the department and this compromised the privacy, dignity and confidentiality of patients accommodated on trolleys located on the corridor.

It was clear that hospital management were working to optimise capacity within and outside of the hospital. However, the hospital was challenged by the number of DTOC and the ALOS of medical and surgical patients, which was high when compared with other Model 4 hospitals. The mismatch between availability and demand for inpatient beds, as evident on the day of inspection impacted on patient flow through the emergency department, on PETs and contributed to the boarding of admitted patients in the department. The continual use of SJH's escalation plan demonstrates how the hospital continues to be challenged by the mismatch between demand for unscheduled and emergency care, ineffective patient flow and inpatient bed capacity. Hospital management should review the effectiveness of the escalation measures to adequately address patient flow issues in the emergency department and at wider hospital level. Further integration and collaboration with community services and the NAS should occur to increase access and availability to a range of hospital admission avoidance options. The progression and full implementation of capital initiatives, being explored with the HSE at the time of this inspection, has the potential to increase inpatient bed capacity at SJH and improve the flow of patients through the hospital's emergency department.

Hospital management were working to actively recruit medical and nursing staff to fill vacant positions in the emergency department. Notwithstanding this, there were notable shortfalls between the department's approved and actual rostered complement of nursing staff. Hospital management should continue to progress with recruitment to fill these positions permanently and must, as a priority, ensure that there is sufficient capacity and contingency in resourcing the emergency department to reduce the potential risk to patient safety.

Quality and Safety

Inspectors observed staff being kind and caring towards people receiving care in the emergency department. The majority of patients who spoke to inspectors were complimentary of staff. However, the privacy, dignity and confidentiality of patients in the emergency department, especially for patients accommodated on trolleys and chairs on the corridor was compromised.

There were effective arrangements in place in SJH to monitor, analyse and respond to information relevant to the delivery of unscheduled and emergency care. However, HIQA found that not all measures were acted on to protect patients in the emergency department from the risk of harm. The physical environment in the department did not support the delivery of high-quality, safe, reliable care. For example, there was insufficient physical distancing between trolleys located on the corridor, which was an infection risk. There was also scope for improvement in the auditing of environmental, equipment and hand hygiene practices in the emergency department. Auditing is essential to ensure that care and services provided in the department are in line with best practice standards and guidance, and that areas for improvement are identified and acted on.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management, as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions being employed to bring the hospital into full compliance with the four national standards assessed during inspection.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection at SJH was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

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

Compliance Plan for St James's Hospital OSV-0001102

Inspection ID: NS_0035

Date of inspection: 29 March 2023

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

This compliance plan only relates to:

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

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

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

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Instructions for use

The service provider must complete this plan by;

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

The service provider's compliance plan should be SMART in nature;

- Specific to the standard
- Measurable so that it can monitor progress

- Achievable
- Realistic
- Time bound.

Service Provider's responsibilities

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

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate measures to address the areas of risk previously identified by HIQA inspectors may result in escalation to the relevant accountable person in line with HIQA policy and continued monitoring.

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

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

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

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

Compliance descriptors

The compliance descriptors used for judgments against standards are as follows:

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

Compliance Plan

Compliance Plan Service Provider's Response

National Standard Judgments relating to the Emergency Department	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Response:

SJH Compliance Plan

Introduction:

SJH is committed and acknowledges its responsibility to optimise capacity within and outside of the Hospital in order to address the challenges caused to patients and staff by the high and growing demand for unscheduled and emergency care. As acknowledged in HIQA's stage 1 report, the Hospital has defined corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare in the emergency department; these governance structures and processes have enabled the Hospital with the full backing of the Hospital Board to initiate plans and implement a range of measures to increase inpatient capacity and improve the flow and experience of patients through the emergency department. In addition the Hospital actively engages with the relevant bodies e.g. Department of Health and the Health Service Executive (HSE) and community services, i.e. CHO 7, to seek support for and collaboratively develop facilities, services and pathways of care that are effective, efficient and high-value in order to best serve the healthcare needs of persons who might otherwise have no option but to attend the Hospital's Emergency Department, to be admitted for in-patient care or experience avoidably prolonged hospital admissions. This compliance plan summarises and briefly describes the current and planned activities to which the Hospital has committed in order to increase capacity, develop and / or optimise existing Admission Avoidance and Early Discharge Pathways, assure and where possible improve the effectiveness of the Hospital's escalation processes. While SJH has endeavoured to provide timelines for the realisation of all of the projects and work-streams included, many are dependent on support and input

from bodies and / or services external to the Hospital and are therefore outside the control of SJH.

1.0 Continue to work on optimising capacity within and outside the Hospital

1.1 New Critical Care, Burns and ED Capital Project: Long-Term Plan

St. James's Hospital has a well-advanced major capital development plan underway for the re-construction of a new Critical Care and Burns facility which includes a new Emergency Department. This project is included in the Hospital's Campus Development Plan. Although the design is not yet finalised, the proposed development will significantly increase the size of the ED with triage, assessment and treatment areas that meet all relevant national standards and best-practice including Infection Prevention and Control requirements. An extended AMU facility will be accommodated within this development. This plan is progressing through the relevant internal and external approval processes. In SJH, the execution of the Project including the mitigation of risks and measures required to safeguard patient safety, access and privacy is overseen by the Directors of Capital Projects & Estates and Facilities Management. It is monitored through the Hospital's Strategic Programme and is routinely reported to the Hospital's Executive Management Group and the Hospital Board.

1.2 Expansion and reconfiguration of the ED's registration, waiting and triage areas Capital Project: Medium-Term Plans

SJH recognises that the current ED facility does not meet with the standards required and quality of infrastructure the Hospital aspires to provide in terms of optimising the safety and experience of persons (patients) attending and the staff working there. The existing ED building is restricted from expansion because of its proximity to the new Childrens' Hospital Ireland (CHI) construction site. Furthermore, the current ED facility was negatively impacted by an immediate reconfiguration that had to be undertaken in March 2020 in response to the onset of the COVID 19 pandemic. In order to provide optimum protection for patients and staff the access areas to the ED were divided to facilitate patient screening and this reduced the capacity in the registration and patient assessment (triage) areas.

Currently SJH is progressing a significant capital development plan for the expansion and reconfiguration of the ED's registration, waiting and patient triage areas. This project is designed to improve the safety and experience of patients as it includes increased and enhanced areas for waiting, patient assessment and privacy booths for registration to optimise protecting patent's dignity and privacy.

The execution of this project including the mitigation of risks and measures required to safeguard patient safety, access and privacy is overseen by the Directors of Capital Projects and Estates and Facilities Management. It is also

monitored through the Hospital's Strategic Programme and reported through the Hospital's Executive Management Group to the Hospital Board.

1.3 Increased Bed Capacity on-site Project – Long Term Plan (3-5 years).

SJH is currently engaged with Phase 1 of the Department of Health & HSE's Accelerated Acute Bed- Building plan. The timelines for elements of this project will be outside the control of SJH.

1.4 Sub-acute bed capacity for patients who have completed hospital-level treatment and care – Short Term Plan (August 2023)

SJH has tendered for the acquisition of sub-acute beds in an off-site facility, on receipt of HSE approval to progress to tender. The timeline for access to these beds will be dependent on factors beyond the control of SJH.

1.5 Regional Surgical Hub for surgical day-case service off site: Short Term Plan (Q1 2023 - January 2024)

SJH is seeking access to off-site surgical facilities. If realised, the Hospital aims to open such facilities incrementally and as soon as is practicable, pending HSE approval procedures, successful staff recruitment and the necessary operational management and governance arrangements being in place.

1.6 SJH Chronic Disease Management Facility 162-165 James Street: Long Term Plan (3-5 years)

SJH's Initial Project Initiation Document (PID) and Preliminary Business Case (PCB) were approved by the HSE Board in 2022 and subsequently the derelict site at 162-165 James Street was purchased on behalf of SJH in January 2023. SJH plans to develop facilities on this site to provide a range of services for Chronic Disease Management through collaboration between community and hospital teams. This project represents a key element of the Hospital's Strategic Programme. Timelines for the development are dependent on factors outside the control of SJH.

2.0 <u>Review the effectiveness of the hospital's escalation measures to adequately address patient flow issues in the ED and wider Hospital</u>

As described in the Hospital's ED Escalation Policy (copy provided to HIQA) and acknowledged in the report, SJH has a number of processes that are implemented at the time of ED escalation. These include specific communications to Ward Managers and Medical Teams to inform and request engagement with the timely discharge of patients, increased frequency of Daily Bed Management Briefing group i.e. 0930 and 1500, use of day-only facilities to accommodate patients waiting admission etc. In addition to these the Hospital has the following plans underway to improve patient flow and the effectiveness of the hospital's escalation measures.

2.1 Operational Ward Huddles (Current – Short Term; Year End 2023)

In 2023 SJH introduced daily Operational Ward Huddles on the wards. These huddles are facilitated by the Hospital's Lean Transformation Team and are attended by Nursing, Medical and Health and Social Care Professionals. The Huddles are designed to enable staff to focus on those patients' suitable for discharge, identify and act on any barriers to flow and / or discharge at ward, hospital service and community service level e.g. radiology, cardiology (echocardiograms) support care consultations etc.

The Huddles are now standard practice on 12 wards and the Hospital plan to have Operational Huddles taking place on all wards by the end of 2023.

2.2 The Visual Hospital Project (Current - Medium Term; Year End 2024)

SJH commenced the roll-out of the Visual Hospital Project in July 2020. This involved providing the Hospital's Senior Management and Bed Management Team with timely access to current (two-hourly updates) accurate information on the status of all the Hospital's in-patient beds i.e. occupancy, discharge plan, pending tests etc. This information is updated and used throughout the day but specifically at the time of the Daily Bed Management Briefing group meetings, i.e. 0930 and 1500, where along with the update information on the status of ED, i.e. numbers waiting, Patient Experience Times, numbers awaiting admission, safety and / or staffing concerns etc. the Visual Hospital Information enables prompt, effective and more efficient decision making.

In May 2023 the Digital Visual Hospital phase of the project commenced in SHJ. Digital White Boards currently used by the Bed Management Department and 5 inpatient wards enable the Hospital and all the stakeholders involved in Tier 2 and 3 escalations to have more efficient and timely access to comprehensive information on in-patient occupancy, potential discharge opportunities and barriers to discharge (coded). Again this enable more effective escalation practices e.g. Bed Management briefings and decisions e.g. opening access to day-beds, cancellation of admissions etc. In addition, access to this information will support the Hospital in the identification and analysis of delays in patient pathways which can be used to identify and support the Hospital's continuous improvement priorities in this aspect of care such as the Hospital's Specialist Core Ward Designation Project.

The Digital Visual Hospital Project will be rolled out to 12 identified wards by the end of 2023 with full roll-out to all wards planned for 2024.

3.0 <u>Undertake further integration and collaboration with community services and / or the National Ambulance Service (NAS) to increase access and availability to hospital admission avoidance options</u>

3.1 CHO 7 Chronic Disease Management (CDM) Hubs – Medium Term (1-3

years)

SJH Management and Emergency Department Teams will continue to participate in the Steering Groups established by CHO 7 to develop Chronic Disease Management (CDM) hubs in the Meath Community Health Centre and on the Cherry Orchard site.

3.2 Admission Avoidance / Early Discharge Pathways

SJH's ED and AMU Teams will continue to develop additional admission-avoidance and early-discharge pathways in collaboration with the Hospital's clinical services including the SJH OPAT service. This includes the following work that is currently underway and / or planned

- OPAT: ED / Infectious Diseases Pathway for patients who attend the ED with infections such as cellulitis and / or pyelonephritis that are clinically suitable to receive intravenous antibiotics treatment and follow-up care as outpatients. This pathway is in development and expected implementation date is Q3 2023;
- Diagnostic Imaging ambulatory care pathway;
- Headache Management;
- Heart Failure;
- Endoscopy Access;
- Frailty.

3.3 Pathfinder Programme

SJH ED Clinical Leads previously explored the potential effectiveness of implementing this initiative through SJH's ED. The SJH ED Leads have undertaken to again explore with the relevant bodies the potential to develop and adopt a Pathfinder Programme that is adaptable to the local context and that would not negatively impact the department's already challenged core staffing needs. (Timeline: Q3-4 2023)

4.0 <u>Improve the effectiveness of the Acute Medical Unit (AMU) in order to relieve the pressure and improve patient flow through the emergency department</u>

4.1 Expansion and reconfiguration of the ED's registration, waiting and triage areas Capital Project: Medium-Term Plans (July 2024).

Refer to SJH Compliance Plan Standard 5.5; Plan 1.2)

4.2 AMU Workforce (Medium – Long Term: Current to 5 years)

St. James's Hospital is currently actively working on recruiting and retaining staff across all services including the ED and AMU. The Hospital will continue to seek support from the HSE to fund the staffing positions required to enable the AMU to progress towards operating as a Level 4 Hospital AMU i.e. operating 24/7 including weekends, on a phased basis. This includes requests for funding to support the realisation of the following positions which will be made on an ongoing basis to enable the Hospital's AMU services to be extended accordingly.

- 6 WTE consultant equivalents;
- An increased NCHD;
- An increased Nursing workforce;
- An Advance Nurse Practitioner;
- Dedicated Health and Social Care Professional hours;
- Administration Support.

5.0 Improve the effectiveness of the Hospital's 'Unscheduled Care Governance Committee' in order to provide more effective monitoring and oversight of unscheduled and emergency care at SJH

5.1 The Hospital will revise the Terms of Reference and functions of the Hospital's Unscheduled Care Governance Committee to include a means whereby agreed actions are translated to, implemented, monitored and reported on in the ED and at the Committee meetings (Q3 2023).

6.0 Revise SJH's Safety and Quality Assurance Governance Committee (SQAGC) ToR and meeting record process.

6.1 The Hospital will update the Hospital's SQAGC Terms of Reference (August 2023)

6.2 The Hospital will introduce the inclusion of 'time-bound assigned actions' in the meeting records for monitoring and follow-up (August 2023).

Timescale: Timescales and estimated timescales for the initiatives and projects described herein are provided where possible alongside each plan / project.

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

Outline how you are going to improve compliance with this standard.

1. **Ensure there is sufficient capacity and effective contingency arrangements in place across all staff but especially nursing to ensure staff resources in ED can meet the demand for unscheduled and emergency care in SJH**

St. James's Hospital recognises the importance of planning, organising and managing their workforce effectively in order to achieve the delivery of care that is safe, effective and person-centred while also supporting and safeguarding the wellbeing of the Hospital's workforce. Currently the Hospital is actively working on recruiting and retaining staff across all services including the ED. However, in the context of the current national and global healthcare workforce shortages, the Hospital's established processes for sourcing supplementary staff through the Hospital's Nursing Bank, Nursing Agencies and the procedures use internally to reassign staff from one clinical area to another are not always able to meet the growing levels of demand being experienced in services such as ED. It is in this situation that the following long, medium and intermediate mitigation actions have been agreed.

ED Nurse Staffing Levels – Long, Medium and Immediate Plans and Actions

- SJH ED has been awarded 11 WTE Nursing Positions under the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland (DoH 2022)
- The Hospital has successfully recruited nurses into 5.5 of these positions; 4 of which are due to commence work in SJH ED on the 12th June 2023 and the other on the 27th July 2023. The appointment of identified and panelled nursing staff to the remaining 5.5 WTE positions is dependent on confirmation of funding at this time.
- SJH ED will engage with the next phase of the Framework for Safe Nurse Staffing in ED which is to include staff for patients boarding in ED while awaiting admission and will pursue the resources that are identified through that process.
- Currently, for every nursing vacancy that occurs in the ED on a daily basis (i.e. a vacant post or an unscheduled absence including illness etc.) a SJH Nurse Bank Request is submitted. The Nursing Bank Office allocate staff available to them based on relative staffing needs across the Hospital. SJH ED also submit requests to the Hospital's Nurse Bank Office when there is an escalation in the number presenting to ED or in the number of patients boarding awaiting admission.

- Nursing staff have been re-deployed from other clinical areas in the Hospital to the ED at times of relatively higher levels of boarding of in-patients. Relative need and dependency is monitored across the hospital using the Trendcare™ technology and a risk based staff allocation is undertaken on a shift basis under the oversight of the Nursing Executive.

2. ED Staff Attendance at Training (Mandatory and Essential)

2.1 Improve nursing staff uptake of and attendance at mandatory and essential appropriate to their scope of practice and at the required frequency with a focus on transmission-based-precautions, sepsis management and the Irish National Early Warning system (Version 2)

2.2 Significantly Improve medical staff uptake of and attendance at mandatory and essential appropriate to their scope of practice and at the required frequency

SJH recognises the importance of providing staff with access to the information and training they require to provide care that is safe, effective, person-centred and reliable. While the current staff shortages and prolonged periods of increased numbers of persons presenting to the Hospital's ED has created challenges for staff in both providing and attending training, the Hospital has also identified opportunities for improving how workforce training attendance data is captured, shared and reported in the Hospital and subsequently shared with external authorised agencies. Improving the capture, sharing, reporting and monitoring of workforce training is currently an area of focus for improvement within SJH. It is in this context that the following long, medium and more immediate mitigation and improvement actions have been agreed.

<u>Long / Medium Term Plans</u>

The Hospital's Learning and Development Leads in the Human Resources Directorate (i.e. i.e. SJH Centre for Learning and Development and Medical Manpower Leads) will work with the ED Medical and Nursing Leads to achieve the following outcomes:

- Ensure all ED medical and nursing staff are informed of and can access their Mandatory Training programmes on the Hospital Learning Systems, i.e. *LearnPath™.*
- Define the Essential Learning Programmes for ED Medical and Nursing staff, i.e. the specific names of the training programmes that the staff are required to attend and how they can access them including on-line, face-to-face etc. and how they can record their attendance and learning event completion.
- Optimise the opportunities for staff to access the Essential Training Programmes on-line where appropriate.
- Ensure all ED medical and nursing staff are informed of and can access the Essential Training programmes they are required to complete.

- Ensure that the mandatory training programmes completed by rotating medical staff (i.e. interns & NCHDs) that is captured on the National Educational Recording (NER) database is transferred in a timely and complete manner onto SJH *LearnPath*™.
- Provide training and support to assigned ED staff to enable them to access training records for ED Medical and Nursing Staff and provide monthly reports of training attendance to ED Clinical Leads.
- Enable Staff providing face-to-face Education and Training to capture attendance electronically that can be automatically uploaded to SJH *LearnPath*™.

Immediate Mitigation Plans

SJH CLD, Medical Manpower and ED Clinical and Operational Leads are currently undertaking the following actions:

- A review and update of the attendance records for current ED Medical Staff at Mandatory Training. The record, once updated, will be provided to ED Medical Lead for action. The records once updated will be provided to the ED Medical Lead for action with the relevant staff members.
- A review and update of the attendance records for current ED Medical and Nursing Staff at Essential Training including those programmes identified in the report (i.e. transmission-based-precautions, sepsis management and the Irish National Early Warning system [Version 2]). The updated records will be provided to the ED Medical and Nursing Leads for action with the relevant staff members.
- Identifying and providing opportunities for in-service in the Department for Medical and Nursing staff. The current schedule includes:
    - INEWS learning for ED that is in progress;
    - Transmission Based Precautions Workshops being provided by Infection Prevention and Control Service;
- Schedule monthly training meetings to monitor progress, identify and resolve attendance, data capture and reporting deficits.

Timescales:

- **ED Staff Essential training**: Progress on implementation of the immediate risk-mitigation measures will be reported at end August 2023, following the July NCHD intake, to the CEO through Executive Management Group (EMG) reporting. Implementation of longer-term improvements will be reported on a monthly basis through EMG. Staff training and education is likely to be included in monitoring of implementation of the Hospital's overarching People Strategy that is in development with direct oversight by members of the Hospital Board.

National Standard Judgments relating to the Emergency Department	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard

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

Response:

St James's Hospital (SJH) recognises the importance of protecting patient safety and respecting the rights of patients' and staff to dignity and privacy and is committed to improving structures, processes and procedures within the Hospital including the Emergency Department (ED) as resources made available to the Hospital allow.

The infrastructure and practice improvements that the Hospital anticipates will improve the safety and experience of service users and the staff working in the ED are summarised below.

1.0 Long-Term Plans

St. James's Hospital has a well-advanced major capital development plan underway for the re-construction of a new Critical Care and Burns facility which includes a new Emergency Department. This project is included in the Hospital's Campus Development Plan. Although the design is not yet finalised, the proposed development will significantly increase the size of the ED with triage, assessment and treatment areas that meet all relevant national standards and best-practice including Infection Prevention and Control requirements. This plan is progressing through relevant internal and external approval processes. In SJH, the execution of the Project including the mitigation of risks and measures required to safeguard patient safety, access and privacy is overseen by the Directors of Capital Projects & Estates and Facilities Management. It is monitored through the Hospital's Strategic Programme and is routinely reported to the Hospital's Executive Management Group and the Hospital Board.

2.0 Medium-Term Plans

SJH recognises that the current ED facility does not meet with the standards required and that the quality of infrastructure Hospital aspires to in terms of optimising the safety and experience of persons (patients) attending and the staff working there. The existing ED

building is restricted from expansion because of its proximity to the new Childrens' Hospital Ireland (CHI) construction site. Furthermore, the current ED facility was negatively impacted by an immediate reconfiguration that had to be undertaken in March 2020 in response to the onset of the COVID 19 pandemic. In order to provide optimum protection for patients and staff the access areas to the ED were divided to facilitate patient screening and this reduced the capacity in the registration and patient assessment (triage) areas.

Currently SJH is progressing a significant capital development plan for the expansion and reconfiguration of the ED's registration, waiting and patient triage areas. This project is designed to improve the safety and experience of patients as it includes increased and enhanced areas for waiting, patient assessment and privacy booths for registration to optimise protecting patent's dignity and privacy.

The execution of this project including the mitigation of risks and measures required to safeguard patient safety, access and privacy is overseen by the Directors of Capital Projects and Estates and Facilities Management. It is also monitored through the Hospital's Strategic Programme and reported through the Hospital's Executive Management Group to the Hospital Board.

3.0 Interim Actions and Measures to Mitigate Risks

3.1 Display of Patient Feedback / Complaint Information

The Hospital's ED Team have displayed additional SJH Patient Experience Information Material i.e. Posters and Leaflets, in the Department. These materials were developed by the Hospital's Patient Experience Team and are in keeping with the HSE's 'Your Service, Your Say' principles and practices. The material include information on accessing independent advocacy services.

3.2 Close proximity of patients on trolleys compromising Patient Safety (Infection Risk) and patient's right to privacy and dignity

The Hospital is committed to the following actions to mitigate risks to patients' safety from infection and their right to privacy and dignity.

- SJH will continue to work actively on identifying and addressing opportunities both inside and outside the Hospital to optimise its bed capacity and improve the effectiveness and efficiency of care and experience for patients attending the ED. Specific measures are being implemented to improve patient flow and reduce ED congestion as outlined in the Hospital's response to the Leadership, Governance and Management standard judgement.
- The ED Team wish to provide assurance that they recognise the need to respect the privacy and dignity of patients and do their utmost to optimise staff awareness in this regard. Their ability to assure the privacy of patients is

regrettably constrained at times by infrastructural deficits and the number of patients needing to be accommodated in the ED.

- Work is ongoing, in collaboration with the Security team managers, to improve control access and strengthen the security presence in the ED as a risk-mitigation measure.

Timescale:

- Access to Patient Feedback materials has been improved and will be monitored on an ongoing basis.
- The timescales for longer-term plans are as outlined above.

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

Response:

SJH acknowledges the impact of the physical environment on the delivery of high-quality, safe and reliable care. The measures planned and to be implemented in response to this inspection are outlined below.

1. <u>Long-Term Plan for Improved Infrastructure</u>

The major capital development plan underway for the re-construction of a new Critical Care and Burns facility including a new Emergency Department, as previously described in relation to Standard 1.6, aims to address the risks to patient safety in relation to patient isolation and physical distancing between patients.

2. <u>Hand Hygiene Auditing in ED - Immediate and Medium-term Actions</u>

2.1 In response to HIQA's inspection report, the SJH Infection Prevention and Control Team have completed a Hand Hygiene Audit in the ED. The audit findings are being shared with the Department and an action plan is being co-developed with the ED team. ED hand hygiene will be reaudited in six weeks' time as per usual practice. This audit cycle will be managed within the Hospital's IPC programme overseen by the PCHCAI Steering Committee within the Hospital's Quality and Safety Governance Framework.

2.2 The SJH Infection Prevention and Control Team will recommence undertaking Hand Hygiene Auditing in the ED Department in accordance with National Hand Hygiene Audit requirements and the Hospital's Annual Infection Prevention and Control Plan for 2023 (approved by the Hospital's Prevention and Control of Hospital Associated Infections – PCHCAI Steering Committee in March 2023). This will include the following:

- Bi-annual Audits as part of the National Hand Hygiene Programme
- Audits in response to outbreaks, concerns and / or incidents

2.3 The SJH Infection Prevention and Control Team will review their IPC Hand Hygiene Audit Plan and seek direction from the Hospital's PCHCAI Quality and Safety Programme Committee in relation to the frequency of Hand Hygiene Audits required by SJH for assurance (August 2023). The IPC Team will support the implementation of the PCHCAI decision in relation to the frequency and methodology of Hand Hygiene auditing in SJH going forward.

3 ISBAR for Clinical Handover - Compliance Audit

3.1 Medium-term plans: The SJH ED team aspires to reliably deliver and assure high-quality, safe and person-centred clinical handover practices, including the effective use of communication tools. The ED team is engaging in a human factors research study that seeks to understand and support human factors in healthcare, including clinical handover.

3.2 Interim actions and measures to mitigate risks: The ED team will include within its clinical audit programme an audit of clinical communication including the use of the ISBAR3 communication tool in the transfer of patients from the Emergency Department. The audit will be led by the ED Nurse Clinical Facilitator and the first cycle of this audit will be completed by the end of Q3 2023, to provide interim assurance and contribute to a Quality Improvement Plan regarding the effectiveness of clinical communication for patient transfers. The audit will be reported and any identified risks and improvements managed through the Hospital's Quality & Safety Governance Framework.

4 ED Clinical Pharmacy Service

Medium- to Long-Term Plan

The Hospital's Director of Pharmacy (DOP) will undertake the following actions in response to HIQA's inspection:

- Review international best practice for clinical pharmacy and Pharmacy-led Medicines Reconciliations services in Emergency Departments;
- Consult with clinical and operational leadership within the Hospital & ED to review identified models of best practice;
- Identify gaps in service and compile a gap analysis;
- Identify resources required to address the identified service gaps;
- Compile a business case, informed by the evidence and consultation process outlined above, for the required resources and submit to the Hospital CEO and EMG for review and consideration for onward submission to the Health Service Executive seeing support for improvement.

  Timescale: 3 months to submission of a Business Case to the CEO & EMG.

Timescales:

- ISBAR audit – end Q3 2023
- ED Clinical Pharmacy Service – 3 months to submission of a business case.

Service Provider Use	
Service Provider	St James's Hospital
CEO/General Manager/Master Signature	
Date	**26/07/2023**

HIQA Official Use	
Date Reviewed	31/07/2023
Authorised Person(s)	Denise Lawler
Signature