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:	The Royal Hospital Donnybrook
Address of healthcare service:	Morehampton Rd. Dublin 4 D04HX40
Type of inspection:	Announced Inspection
Date of inspection:	14 and 15 August 2024
Healthcare Service ID:	OSV-0007267
Fieldwork ID:	NS_0090

About the healthcare service

Model of hospital and profile

The Royal Hospital Donnybrook is a Section 38* voluntary hospital. It is a rehabilitation and community inpatient healthcare service which operates in partnership with the Health Service Executive (HSE). At the time of inspection, the hospital was funded through Community Health Organisation† (CHO) 6. The hospital had 96 beds provided inpatient and outpatient rehabilitation and comprised of the following areas:

- The Short-term Post-Acute Rehabilitation Centre (SPARC) provided up to 6 weeks of rehabilitation for people aged 65 years of age and over.
- The general rehabilitation unit provided longer rehabilitation programmes for people aged 65 years of age and over.
- Stroke and Neuro-rehabilitation accepted patients both under and over 65 years of age.
- The hospital had five inpatient respite care beds which were used to provide care for people whose families and carers in the community setting would benefit from respite. Respite admissions were managed by The Royal Hospital Donnybrook, in liaison with a public health nurse where required.
- A day hospital provided services for adults in the community. It provided a nurse-led therapeutic rehabilitation programme for older persons with input from a range of health and social care professionals.
- Residential care – There were three separate ward areas that operated as designated centers for residential care within the same hospital building. These areas did not form part of the inspection.

* Section 38 relates to agencies provided with funding under Section 38 of the Health Act 2004. It is limited to 23 non-acute agencies and 16 voluntary acute hospitals currently within the HSE Employment Control Framework.

† CHO 6 is a Community Health Organisation of the HSE for Wicklow Local Health Organisation (LHO), Dún Laoghaire LHO and Dublin South East LHO. The area has a population of approximately 364,464 (HSE website 2022).

How we inspect

Among other functions, the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility to set and monitor standards in relation to the quality and safety of healthcare services. This inspection was carried out, as part of HIQA's role to assess compliance with the *National Standards for Safer Better Healthcare.*

To prepare for this inspection, the inspectors[‡] reviewed relevant information, which included information submitted by the hospital, unsolicited information[§] and other publicly available information.

During the inspection, the inspectors:

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

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

[§] 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.

About the inspection report

A summary of the findings and a description of how the hospital performed in relation to the 11 national standards assessed during the inspection are presented in the following sections, under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time — before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare services in the hospital 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 included information about the healthcare environment where people receive care.

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report. Appendix 2 outlines the hospital's plan to come into compliance with any standards of partial or non compliance.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
14 and 15 August 2024	9:00hrs–17:00hrs Day 1 9.00hrs–15:00hrs Day 2	Aedeen Burns	Lead
		Nora O' Mahony	Support
		Sara McAvoy	Support

Information on this inspection

During this two day announced inspection, the inspection team visited the following clinical areas:

- General Rehabilitation Unit (GRU)
- Short-term Post-Acute Rehabilitation Care (SPARC) unit.

- This inspection focused on four key areas of known harm, these were:

- infection prevention and control
- medication safety
- the deteriorating patient**
- transitions of care.††

The inspection team also spoke with the following staff:

- Representatives of the higher management team (HMT)
- Director of Nursing
- Human Resource Manager
- Clinical Director
- Operations Manager
- Representative for the non-consultant hospital doctors (NCHDs).
- Representatives from each of the following hospital groups:

- Hygiene and Infection Prevention and Control Committee
- Deteriorating Patient Group
- Medication Management

Inspectors also spoke with a number of staff from different professions and disciplines, and people receiving care in the clinical areas visited.

Acknowledgements

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

** The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

†† Transitions of care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

Over the course of the inspection, the inspectors observed staff interacting with patients. Interactions seen were kind, based on individualised care and promoted independence, privacy and dignity of the patient.

Inspectors spoke with a number of patients in each area visited. Patients the inspectors spoke with were happy with the care being delivered. They reported that staff attended to their needs in a way that promoted their independence and were "helping me to get back on my feet" "giving me the best treatment here" and "very respectful-marvellous." Although a number of patients did report delays when waiting for call bells to be answered. Most patients were aware of their plan of care. Patients were asked about the food they were given and described it using adjectives such as "excellent" "great" and "edible." Food was served in a spacious bright dining room. Posters in the ward notified patients to the availability of snacks outside of mealtimes. Patients on the SPARC unit had access to an outdoor courtyard area.

Information on the HSE 'Your Service Your Say' complaints process were displayed on the wards and suggestion boxes for concerns and compliments were available on the wards. Patients were not aware of the complaints procedure but voiced no concern about approaching staff if they had a complaint.

On the clinical areas visited patients were accommodated in multi-occupancy single-gender rooms, each of these rooms had a toilet and shower room. Each ward had three single rooms with ensuite shower and toilet facilities.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. The Royal Hospital Donnybrook was found to be compliant with one national standard 5.2 and substantially compliant with three national standards (5.5, 5.8. and 6.1) Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

The Royal Hospital Donnybrook is a voluntary hospital, and is governed by a board of management. The chief executive officer (CEO) was the person with overall responsibility for quality and safety of services provided to patients in the hospital. The CEO reported to and was accountable to the board of management. This information was reflected in organisational charts supplied to inspectors and reported by members of HMT. Information on the governance structures of the hospital was also available on the hospital's website and in published annual reports. The most recent annual report available was for 2022. The hospital also operated in partnership with the Health Service Executive and met with the management team of CHO 6 on a two monthly basis.

The hospital's CEO, was supported by the hospital management team (HMT) which had multidisciplinary representation and comprised senior managers from across departments of the organisation. The HMT led and provided governance and oversight for the overall quality and safety of the healthcare services provided in the hospital including management of risk. The HMT had up-to-date terms of reference and was meeting regularly in accordance with these.

Clinical governance for the hospital was supported by the clinical governance committee (CGC) and the clinical governance steering committee (CGSC). The function of the CGC was to advise the board of management regarding clinical management and leadership to ensure that the hospital was prepared to provide patient care that met appropriate quality and safety standards. The CGSC supported the CEO and the clinical leadership of the hospital in fulfilling their roles in relation to quality, patient safety and clinical outcomes. This committee reviewed the systems for clinical governance at the hospital and made recommendations for the effective delivery of quality and safe patient care. Both of these committees had up-to-date terms of reference and were meeting in accordance with these. Evidence was seen

of reports of the clinical governance steering committee (CGSC) to the CGC and onwards to the HMT and board.

The hospital had established groups which had oversight of the effectiveness and quality of care related to three of the four areas of known harm which were the focus of this inspection – infection prevention and control, medication safety and management of the deteriorating patient. These groups had formalised reporting arrangements to the CGSC. The CGSC provided the board with a combined report on performance and compliance, standards and quality metrics annually. The committee relating to infection prevention and control, and the groups relating to medication management and the deteriorating patient are discussed further under national standard 5.5.

Staff spoken to on the day of inspection had a good understanding of reporting arrangements between staff, clinical management and senior management.

The CEO had responsibility for executive leadership at the hospital and reported to the board of management. Oversight and governance of clinical care was the responsibility of the clinical director who reported to the CEO. The director of nursing was responsible for the organisation and management of nursing services at the hospital and reported to the CEO. Health and social care professionals had upward reporting professional structures to members of the HMT.

Overall inspectors found that corporate and clinical governance arrangements were in place which were integrated and appropriate for the size, scope and complexity of the service provided. These governance arrangements had mechanisms for communicating issues raised from clinical areas to the board and vice versa. These governance arrangements defined roles, accountability and responsibilities for assuring the quality and safety of the service and were made publicly available on the hospital website.

Judgment: Compliant

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 that there were effective management arrangements in place to achieve planned objectives that involved all levels of the service. Organisational charts shared with inspectors demonstrated appropriate lines of management and accountability within the organisation and onward to the HSE. These were also described by staff on the days of inspection. The hospital had established the hygiene and infection prevention and control committee, the deteriorating patient group and the medication management group, to oversee and manage hospital activity in these areas. The deteriorating patient group was established to ensure the hospital had procedures in place for the early identification, escalation and management of the deteriorating patient. This group was chaired by the medical officer with representation from nursing and medical staff across the hospital. The group reported to the CGSG. The deteriorating patient group had adapted the Irish National Early Warning System (INEWS)[‡‡] for use in the hospital and supported the rollout of this adapted INEWS through training and audit within the organisation. This document and associated policies and procedures supported staff in the safe management and escalation of care of patients who experience a deterioration in their medical condition while in The Royal Hospital Donnybrook. This is further discussed under standard 3.1. The hygiene and infection prevention and control committee met quarterly as per their terms of reference (TOR), and their purpose was to ensure that systems and processes were in place to prevent and control the risk of infection to patients, residents, and staff. The committee was chaired by the operations manager of the hospital and the infection prevention and control nurse manager was vice chair. Membership also included assistant directors of nursing (ADON) clinical nurse managers (CNM) and the risk manager. hygiene and infection prevention and control committee provided written reports to the CGSC. Outbreaks were managed using

[‡‡] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient. The EWS focuses on categorization of patients' severity of illness, early detection of patient deterioration, use of a structured communication tool (ISBAR) promotion of an early medical review, prompted by specific trigger points use of a definitive escalation plan.

guidelines for acute hospitals with input from public health specialists. An infection prevention and control risk register was maintained and reviewed quarterly by the hygiene and infection prevention and control committee.

If patients needed isolation, and single rooms were unavailable, the HSE antimicrobial resistance and infection control guidelines (AMRIC)[§§] were used to prioritise single-room usage. The infection prevention and control nurse lead collated and submitted a report on surveillance of healthcare associated infections (HCAIs) and infection outbreaks to the CGSG every three months including any instances of hospital acquired multi-drug resistant organisms, flu and COVID-19.

The medication management group was the group with primary responsibility for medication safety within the hospital. This group was led by a non-consultant hospital doctor (NCHD) at registrar grade who performed this role as part of their role as medical officer for the hospital. The Royal Hospital Donnybrook had no in-house pharmacy service. The group had medical and nursing representation. The external pharmacy service providers were members of this group. This group had established terms of reference, met regularly, and provided reports regularly to HMT via the CGSG regarding medication safety incidents and issues. The hospital did not have a clinical pharmacy service this is discussed further under standard 3.1. Medications were supplied to the hospital from an external pharmacy who also provided and electronic-prescribing product to the hospital. The medication management group maintained a risk register and had escalated the absence of a Royal Hospital Donnybrook pharmacist to HMT and this risk had been added to the corporate risk register. While a lot of work was being done to manage patient safety relating to medication management, this work was being done in house by medical and nursing staff. The only pharmacist input was from the pharmacy on contract for supply of medications to the hospital and vendor of the e-prescribing product in use in the hospital.

Overall inspectors found that management structure, controls and processes were in place, support and promote the delivery of high quality, safe and reliable healthcare services at the hospital but there was an identified risk in the absence of clinical pharmacy input.

Judgment: Substantially Compliant

[§§] HSE Guide to prioritisation of patients for single room isolation when there are not sufficient single rooms for all patients that require isolation priority guide for isolation.pdf

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.
There was evidence that there were monitoring arrangements in place in the hospital to identify and act on opportunities to improve the quality, safety and reliability of healthcare services provided. However, the hospital had not yet established a set of key performance indicators (KPIs),*** specific to their service, against which to measure their performance. The Royal Hospital Donnybrook had risk management structures and processes in place to proactively identify, manage and minimise risk. The CGSC and had oversight of risks in the hospital and reported to the HMT. The CEO and HMT managed the risks recorded on the hospital's corporate risk registers. A report on risk and health and safety management was delivered to the HMT and there was evidence of oversight at CHO 6. Local risk policies and procedures were aligned with HSE enterprise risk management strategy 2023. Evidence was seen that risk registers were kept locally in all areas, these were reviewed quarterly by the CNM with input from the risk manager. CNMs had access to live information on tracking and trending of incidents. CNMs, supported by ADONs, implemented measures locally to mitigate risks by taking actions appropriate to the risk presented. Significant risks were escalated via managers from local to corporate risk registers if appropriate. Evidence was seen that escalation of risks to the CHO 6 risk register was among the items on the standing agenda for the integrated risk management (IRM) meeting with the CHO 6 and that two monthly reports were provided to the CHO 6 regarding incidents and complaints in the hospital. Staff who spoke with inspectors understood how and when to report patient safety incidents and reported that learning from incidents was shared at staff handovers or through formal learning if necessary to improve service quality. Evidence was seen that action plans and actions taken after incidents were recorded at ward level with the support of the risk manager The hospital was regularly auditing a number of parameters relating to the four areas of harm such as nursing documentation, medication administration, hand hygiene compliance, cleanliness of the environment and personal protective equipment

*** Key performance indicators (KPIs) are an essential tool as they enable the public, service users and healthcare providers alike to have reliable information on current and desired standards in healthcare services. KPIs are used to identify where performance is good and meeting desired standards, and where performance requires improvement. Guidance on Developing Key Performance Indicators and Minimum Data Sets to Monitor Healthcare Quality HIQA 2013

compliance. The CGSC had oversight of these. Evidence was seen of action plans and re audit when compliance was below target.

Link nurse roles were established to share expertise from CHO 6 and improve care in the areas of continence promotion, infection prevention, tissue viability and falls. However, staff reported that it was not always possible to be released from clinical duties to attend meetings related to this role.

Information boards and suggestion boxes were on display in clinical areas and available to people who use the service on providing feedback, compliments and complaints. The hospital's department of nursing quality and risk had performed a patient survey for two weeks in quarter one 2024 and planned to repeat this annually.

Overall, the hospital was collecting data relating to its performance, although the hospital had not developed specific KPIs to measure service performance which was a missed opportunities to improve the quality, safety and reliability of healthcare services.

Judgment: Substantially Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.
The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. At the time of inspection the hospital had low numbers of vacancies The role of risk manager had been vacant for a short time but a replacement was due to start imminently. There were no vacancies in nursing or health and social care professionals. The allocation of doctors comprised one WTE consultant in gerontology and one medical officer 0.28 WTE. The consultant was operationally accountable and reported to the CEO. Other consultants who held admitting rights to the hospital and who provided cover on stroke and neurological rehabilitation units had contracts with St. Vincent's University Hospital. These consultants were supported on site by senior house officers (SHOs) who were allocated to the hospital on rotation from St. Vincent's Hospital and St Michaels Hospital. Medical cover was provided onsite Monday to Friday during core hours. On-call cover was provided outside of these hours by the SHOs. In the absence of a report from the Framework for Safe Nurse Staffing and Skill Mix: Phase 3iii [†††]the hospital had benchmarked staffing levels against similar organisations and at the time of inspection the hospital employed 95.3 Nurses (at all grades) and 75.42 HCAs. There were no vacant nursing positions. However, activity and acuity levels in the hospital at the time of inspection were supported by the use of seven WTE agency staff nurses. The human resource manager had oversight of training records for mandatory training within the hospital. While uptake of some training such as safeguarding and open disclosure was good across most grades, other areas required attention. For example, the levels of attendance at basic cardiac life support (BCLS) and hand hygiene were low with an overall 59% of staff having hand-hygiene training and 57% of relevant staff having up-to-date BCLS training. Absenteeism was tracked by the human resource manager and reported to HMT and to the HSE. For the year to date until inspection the hospital had an absence rate of 4.7% which was just above the HSE target of 4%. Occupational health, back to work

[†††] Phase 3 of the Framework is focused on safe nurse staffing and skill mix in general non-acute care settings. Phase 3 will include 3 different stages. Phase 3(i) applies to long-term residential care settings (LTRCs) for older persons. Phase 3(ii) applies to general community care settings and Phase 3(iii) applies to step down and rehabilitation care settings.

interviews and employee assistance programmes were available to support staff wellbeing.

The hospital had Daisy[‡‡‡] and Bee awards to recognise exceptional performance by nurses and healthcare assistants. Staff were nominated for these awards by patients or colleagues.

While there were effective arrangements in place and minimal vacancies, inspectors found room for improvement with regard to compliance with mandatory training, particularly BCLS and hand hygiene.

Judgment: Substantially Compliant

[‡‡‡] The Daisy Award® is a recognition program to celebrate and recognize nurses by collecting nominations from patients, families, and co-workers. It is funded by a charitable foundation. Bee awards are given to support workers.

Quality and Safety Dimension

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

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

Throughout their observations, it was evident to inspectors that the staff consistently demonstrated a strong commitment to treating patients with respect and promoting their dignity. Staff members were observed engaging with patients in a compassionate and considerate manner, ensuring that each individual's preferences and personal boundaries were respected. There was evidence that in one instance where a patient complained that they felt their dignity or autonomy had not been promoted, this was taken seriously and dealt with by management. Patient information was handled in line with GDPR guidelines and patient records were stored in a locked room.

Staff were observed asking for consent before care procedures, thus fostering a culture of respect for patient autonomy. Additionally, patients reported that they were encouraged to participate actively in decisions about their care, reinforcing a sense of empowerment and self-determination. Patient's care relating to elimination was delivered in a way that promoted continence and dignity.

The majority of patients were cared for in multi-occupancy rooms. While curtains were used to afford privacy when personal care was being attended to, conversations were still audible to others in the room. Although there was nobody receiving end-of-life care while inspectors were on the wards, staff reported that these patients were prioritised for single rooms.

In summary, it was evident that within the constraints of the physical environment the hospital promoted and respected users' dignity, privacy and autonomy.

Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
There was evidence of a strong commitment to promoting kindness, consideration, and respect in patient care. This commitment was evident during the inspection process, through observations, staff interviews, and patient feedback. Care was individualised using recognised assessment tools. During the inspection, patients consistently reported that they were treated with kindness and respect by staff. They expressed satisfaction with the level of courtesy and attention they received. Staff were observed communicating clearly and with empathy, ensuring that patients understood their care. Staff interviewed during the inspection demonstrated awareness of the principles of a human rights based approach to care and provided examples of how they integrate kindness and respect into their daily practices. Patients were made aware of how to provide feedback regarding their care and feedback boxes were available on the wards. Overall, it was evident that the organisation had a strong culture of kindness, consideration and respect.
Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.
The director of nursing in Royal Hospital Donnybrook was the senior accountable person with responsibility for managing complaints in the hospital. The hospital had a local complaints management policy which aligned with the HSE complaints management policy 'Your Service Your Say'. Inspectors observed information signs explaining how to submit complaints and compliments and this was also contained in the information booklet given to patients on admission. Advocacy services were available to patients via the medical social work department, however inspectors did not see evidence that this service was advertised to patients. Evidence was seen that patient's complaints and concerns were responded to quickly, openly and effectively. Staff reported having received training on complaints management and explained to inspectors that initially, point of contact resolution of complaints was attempted in accordance with national policy, and evidence was seen that verbal complaints were recorded. Staff reported that feedback on complaints was provided to staff on the clinical areas via ward managers, and learning was shared through CNM meetings and at ward huddles.

Written and verbal complaints were reported every two months to CHO6 via the IRM meeting, and to the Clinical Governance Steering Committee in Royal Hospital Donnybrook quarterly. Complaints were monitored by the complaints officer to identify any trends, however complaints were small in number and outnumbered by compliments received by the hospital.

Overall, there was evidence that the hospital had systems and processes in place to respond to complaints and concerns promptly, openly and effectively with clear communication and support provided throughout this process.

Judgment: Compliant

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

On the days of inspection, inspectors visited the General Rehabilitation Unit (GRU) and Short-term Post-Acute Rehabilitative Care (SPARC) clinical areas. Inspectors observed that overall the physical environment was clean, spacious, bright and well-maintained. Patients were complimentary about the physical environment on the ward, outlining that they liked that the ward was 'quiet'. There were 11 single rooms available for the 96 beds. None of these rooms had an anteroom or controlled ventilation. The single rooms on the wards visited did not have handwashing sinks. The sinks observed in clinical areas on inspection were not compliant with HSE standard for clinical sinks[§§§].

The wards visited each had five 6-bedded rooms and three single rooms with ensuite shower and toilet. Single rooms were prioritised for patients requiring transmission-based precautions or patients receiving end-of-life care. No patients on the wards visited required transmission-based precautions on the day of inspection, but staff described the process to ensure appropriate placement of these patients when needed and this was supported by national policy. Alcohol-based hand sanitiser dispensers were available and accessible for staff and visitors on the wards.

Ward staff who spoke with inspectors were satisfied with the level of cleaning resources in place, and the CNM for the wards had oversight of cleaning schedules for their areas and these were up to date on the day of inspection. Cleaning staff had responsibility for flushing of sinks and showers for reduction of risk from Legionella, oversight for this was provided by the cleaning supervisor. However, records of flushing were not available on

[§§§] Infection Control Guiding Principles for Buildings Acute Hospitals and Community Healthcare Settings AMRIC Implementation Team 2023

all wards visited - this was brought to the attention of staff on the day of inspection. After 5.30pm there were no cleaning staff on duty.

Cleaning of patient equipment was assigned to the staff who had used the equipment, and staff described to inspectors that equipment would be cleaned after each use. However, there was no system in place to indicate when equipment had been cleaned after use. Healthcare assistants had responsibility for additional weekly cleaning of equipment, this was monitored by the CNM of the ward. Patient equipment observed on inspection appeared clean. Environmental audits reviewed by inspectors demonstrated high levels of compliance, this was consistent with inspectors' observations on the day of inspection. Hazardous material and waste was safely and securely stored in each clinical area visited and appropriate storage and segregation of linen was observed.

In summary, while there was evidence that the physical environment was spacious and clean. Hand hygiene sinks did not conform to national requirements, single rooms did not have hand hygiene sinks. Flushing records were not maintained on all wards visited on the day of inspection.

Judgment: Partially Compliant

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

The hospital had effective systems and processes in place to monitor, evaluate and respond to information to ensuring continuous improvement of services. Information sources which informed continuous improvement efforts included patient-safety incident reviews, complaints, risk assessments and patient experience surveys. This systems of monitoring and evaluation provided assurances to both hospital management and CHO 6 management regarding the quality and safety of services. There was some relevant data that was not being collected.

Wards had an agreed audit schedule for 2024 and there was evidence that audits measuring quality and safety of care were being performed as per this schedule. CNMs had access to results which were shared with staff via notice boards in public areas. Audits were performed regularly for quality of nursing documentation, hand hygiene compliance, medication storage and documentation, and environmental cleanliness. Results seen by inspectors showed compliance levels were generally good for the areas visited on inspection. There was also evidence that patient feedback was sought in an effort to improve their experience of care. This was done in the form of suggestion boxes and a formal survey. While most of the feedback was positive, evidence of action plans for areas of improvement were not supplied to inspectors.

Hospital management tracked performance indicators related to the prevention and control of healthcare-associated infections relating to mandatory training in PPE, hand hygiene, standard and transmission-based precautions. The Infection Prevention and Control Committee produced a report every three months, and their findings were shared with the CGSC. Outbreaks were monitored and reports produced on closure to identify any possible learning. The hospital performed monthly environmental audits, both wards visited on the day of inspection showed high levels compliance with environmental audits. Hand-hygiene compliance for the first quarter of 2024 did not reach the 90% target for either of the wards visited on inspection. There was evidence that action plans put in place for areas on non-compliance. Overall compliance with hand-hygiene training for all grades year to date was 70.25%, with only household staff achieving the target of 90%.

An audit of antimicrobial prescribing compliance undertaken by the medical officer showed a high level of compliance with antimicrobial prescribing. Medication storage and custody was audited monthly as part of the nursing and midwifery quality care metrics with good levels of compliance across the hospital. The hospital had carried out an audit investigating the link between the two highest patient safety incidents in the hospital - falls and medications. The audit found a link between polypharmacy and falls in the hospital and results were disseminated both in the hospital and at professional conferences. The action plan suggested that a clinical pharmacist input into patient care in the hospital could potentially reduce polypharmacy and falls and this information was shared with the HMT.

Since the introduction of INEWS the compliance with the system was being monitored regularly results showed good adherence to the new protocols. Feedback from staff was sought during the pilot phase and both doctors and nurses spoke positively about its impact on patient safety.

Data on admissions, length of stay and issues such as compliance with completion of the referral form, although collected, were not tracked or trended. The hospital had not established KPIs for parameters relating to transitions of care which was a missed opportunity to measure effectiveness of the care provided.

Overall, quality and safety of care and its outcomes were measured using existing national performance indicators and benchmarks appropriate to the scale of the hospital, and the hospital actively engaged with patients for feedback. The hospital was not monitoring or evaluating performance relating to transitions of care.

Judgment: Substantially Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.
The Royal Hospital Donnybrook had systems in place to proactively identify, evaluate and manage some immediate and potential risks to people using the service. This included ensuring that actions were taken to eliminate or minimise risks. However, some risks persisted; the following describes the particular arrangements concerning the four areas of focus of the inspection - infection prevention and control, transitions of care, management of the deteriorating patient and medication management. Patients' status for MDROs was obtained from the admitting hospital prior to admission to the Royal Hospital Donnybrook, this facilitated correct isolation on arrival. Use of isolation rooms was prioritised based on national guidelines. The hospital had a number of COVID-19 outbreaks in the year to date. Evidence was seen that outbreaks were managed with the appropriate level of governance. Public health officials provided guidance on appropriate outbreak management. Outbreak committees were convened and reports were completed and disseminated following closure of the outbreak. Staff who spoke with inspectors confirmed that the enhanced cleaning reported in outbreak meetings did occur. Evidence was seen that risk assessments and mitigating actions were put in place for building works taking place, and that the water supply was being tested for Legionella. Staff had access to local and national policies to guide infection prevention and control practices. Some local policies for infection prevention and control were overdue for revision; such as those for equipment decontamination, and standard and transmission based precautions. All patients referred to the service are assessed by The Royal Hospital Donnybrook's rehabilitation coordinator with support from the consultant geriatricians prior to acceptance for admission. A transfer document had been designed to capture the information required from the referring hospital to facilitate a safe transition of care. On admission, an individualised plan of care was devised and standardised assessments were used to asses for risks such as malnutrition and pressure ulcers. On discharge, a multidisciplinary discharge summary was supplied to the patients' community services or care facility detailing their rehabilitation progress and current needs. There were protocols in place to avoid unnecessary readmission to the acute hospital for instances such as patients requiring non-urgent medical review or transfusion. These protocols allowed for the streaming of Royal Hospital Donnybrook patients to specific care pathways in the acute hospital, where they could be reviewed, treated, and if appropriate returned to The Royal Hospital Donnybrook. Staff were familiar with procedures for transfer to another hospital in an emergency situation. Staff had access

to lab results on the IT system of St. Vincent's hospital if necessary. An off-site on-call service was provided outside of core working hours by a senior house officer. Procedures were in place to identify delays in discharge, and a Delayed Transfers of Care Working Group had recently been established however, this group had not yet established terms of reference.

The hospital had adapted the Irish National Early Warning System for use within the organisation, and applied a system of escalation suitable for the context in which care was being delivered as recommended in National Clinical Guideline 1.[****] Basic life support equipment was available and there was evidence that it was checked regularly.

Inspectors were informed that the patients' call bell system was obsolete and required replacement. This risk was rated amber 12 on the corporate risk register, with a lack of funding for a replacement system sited as the main contributing cause of the risk. Inspectors were informed that the risk was escalated to the HSE. Due to the obsolete system broken patient call- bells could not be replaced. This resulted in a shortage of patient call-bells on wards visited. To mitigate this risk, patients were assessed and those in most need of assistance were provided with a call bell. This risk was discussed with management of the day of inspection- who planned to re-escalate the risk to the HSE.

There was no clinical pharmacy service[††††] available to patients or staff in the hospital. Medicine reconciliation was performed by the admitting doctor against the discharge prescription from the referring hospital. Medicines were dispensed using a digital prescription and administration record. This system differed to that in use in other hospitals through which doctors rotated and doctors underwent relatively brief training in its use. Safety measures were being incorporated into the digital system to facilitate safe administration of medications. Staff were encouraged to report medication safety incidents, and evidence was seen of changes made to the digital system as a result of such feedback. However, this function was reactive rather than proactive in some cases, with changes occurring in response to incidents rather than anticipating the potential for error. Staff had access to the Irish Medicines Formulary and antimicrobial prescribers' guidance was available via a digital application linked to St. Vincent's University Hospital (to which doctors had access). Outside of core working hours a senior nurse had access to a limited range of stocked medications and medications for emergency situations

[****] Early warning systems (EWS) are used to support the recognition of and response to a deteriorating patient. The EWS focuses on categorization of patients' severity of illness, early detection of patient deterioration use of a structured ISBAR) communication tool, early medical review, prompted by specific trigger points and use of a definitive escalation plan. National Early Warning System - HSE.ie

[††††] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

were available. The hospital had defined a list of medications which could not be administered in the hospital. Staff were aware of the risks associated with sound alike look alike drugs (SALADS) and high risk categories of medications. However, high-risk medications and SALADs relevant to this organisation were not defined in the hospital's medication management policy. The medication management policy available to staff and reviewed during the inspection did not accurately reflect current electronic prescribing procedures in practice in the hospital and referred to paper based procedures.

Overall, there were some structures and procedures in place to protect service users from the risk of harm associated with the design and delivery of healthcare services. The early warning system had been adapted and implemented to identify and manage the deteriorating patient in this setting. Patients requiring isolation for transmission based precautions and outbreaks were managed in accordance with national guidelines. Processes had been designed to facilitate safe transitions of care into and out of the hospital. However, medication management policy was poorly reflective of the electronic system in place and did not provide accurate guidance for current procedure and there was no clinical pharmacy service available. Some local policies provided to inspectors relating to infection prevention and control were in need of revision. The call-bell system was obsolete which impacted the availability of call bells for all patients.

Judgment: Partially Compliant

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

The Royal Hospital Donnybrook had systems in place to identify, manage, respond to and report on patient-safety incidents. These systems aligned with the HSE Enterprise Risk Management Policy and Procedure 2023. Data regarding the number and type of incidents was collated and reported to the HMT via the CGSC, and also reported to CHO 6 via the IRM. A serious incident management team (SIMT) was convened to review serious incidents and provide assurance to the board in relation to their management. In addition to SIMT the hospital had established an incident committee which performed a quarterly review of all incidents. The incident committee had multidisciplinary membership from across the organisation. All incidents in the previous four months were discussed by the incident committee and the effectiveness of actions taken after the incident were discussed, one of its aims as per the TOR was cross organisational learning from incidents.

The Serious Incident Management Team (SIMT) ensured that all serious reportable events and serious incidents were reported to the National Incident Management

System (NIMS)[‡‡‡‡] managed in line with the HSE's Incident Management Framework. The hospital had no open incidents which met the criteria for the commissioning of a review. Patient safety incidents were reported to the National Incident Management System (NIMS) and the hospital reported that compliance with the 30 day KPI for entry onto NIMS was 100%.

Staff who spoke with inspectors were knowledgeable about the processes for reporting patient-safety incidents. Incidents were tracked to identify trends in types of incidents a total of 781 incidents were reported in 2023 which indicated a good culture of reporting. The top incidents reported in 2023 were slips, trips and falls, medication incidents and clinical procedures. Falls, medication and other patient safety risks were captured on the hospital's risk register and mitigating measures were outlined. Some of these mitigating measures were in evidence on the day of inspection and in evidence supplied in documentation.

All medication incidents were reviewed by the medication management group. These incidents were categorised using the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP).[§§§§]Evidence was seen of changes in practice as a result of reviews of medication incidents and learning being shared in the areas in which the incident occurred. However, there were some missed opportunities to cascade learning hospital wide.

There was evidence that people impacted by patient-safety incidents were kept informed during the review process. Patient safety incidents were recorded locally and uploaded to NIMS promptly compliant with the KPI set by the HSE.

Overall, the hospital had systems in place to identify, manage, respond to and report on patient-safety incidents.

Judgment: Compliant

[§§§§] NCC MERP (USA) adopts a Medication Error Index that classifies an error according to the severity of the outcome.

Conclusion

Capacity and Capability

The hospital had established corporate and clinical governance structures that were ~~well~~ integrated and appropriate for its size, scope, and complexity of the services provided by the hospital. Mechanisms were in place to ensure two-way communication from frontline staff to senior management. Roles, accountability, and responsibilities within the governance arrangements were clearly defined and made publicly accessible on the hospital website.

The management structure, controls, and processes promoted the delivery of high-quality, safe, and reliable healthcare services. The hospital had monitoring arrangement in place, for the four areas that were the focus of this inspection, with appropriate oversight arrangements in place.

Effective staffing arrangements were in place, with minimal vacancies reported. However, there was an identified risk due to the absence of a clinical pharmacist.

The hospital had not established service specific key performance indicators (KPIs) for measuring service performance, which limited the ability to leverage data for continuous quality improvement.

Inspectors found deficiencies in mandatory training compliance, specifically in basic cardiac life support and hand hygiene.

Quality and Safety

Inspectors observed that staff consistently exhibited a commitment to treating patients with respect and safeguarding their dignity. Throughout the inspection process, it was clear that staff engaged with patients compassionately, considering each individual's preferences and boundaries. The hospital also maintained a system for handling patient complaints and feedback, providing feedback boxes on wards and ensuring patients were informed about how to share their experiences.

A commitment to quality and safety was evident, with the hospital using national performance indicators and benchmarks to measure outcomes. The hospital had a system in place to identify and respond to patient deterioration which mapped onto the INEWS and was supported by local policy. The hospital had processes to ensure safe transitions of care and systems for reporting patient safety incidents, which were promptly uploaded to the National Incident Management System (NIMS), meeting HSE key performance indicators. Serious incidents were reviewed, and individuals impacted by these incidents were kept informed throughout the process.

While the physical environment was spacious and clean, inspectors noted limited availability of single rooms relative to the overall number of beds, which could affect patient comfort and infection control. Additionally, hand hygiene sinks seen on inspection did not meet national requirements, and single rooms lacked dedicated sinks, potentially impacting adherence to hygiene standards.

The hospital missed some opportunities to monitor and improve performance, as service specific KPIs had not been developed. Some policies were not fully aligned with current practices. Specifically, the medication management policies required updates to reflect hospital practices accurately and local policies regarding infection prevention and control also needed revision. The call-bell system was obsolete which impacted the availability of call bells for all patients posing a risk to prompt response to patient need.

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

Compliance classifications

An assessment of compliance with the 11 national standards assessed during this inspection was made following a review of the evidence gathered 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 national standards was identified, HIQA issued a compliance plan to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

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

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Substantially Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant

Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Appendix 2

Compliance Plan for The Royal Hospital Donnybrook

OSV-0007267

Inspection ID: NS_0090

Date of inspection: 14 and 15 August 2024

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

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

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

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

We acknowledge that we are non complaint with IPC standards in regard to there being no sinks in our single rooms.

1. Our current sinks are not IPC compliant / best practice

Specific issue: Our sinks across the site not IPC compliant and no sinks in single rooms.

Measurable: Please see report attached. According to our maintenance manager there will be a requirement of a total of 43 Handwashing Basins and Taps. On a material and labour quote, the costs for these works will exceed €75k we and will therefore have to tender for this project. These works will be industrial and will involve ground works, noise pollution, pipe freezing, fire sealing works and disruption to rooms while works are in progress. We will also need to look at redecoration cost post project.

Achievable: We need to secure funding from the HSE and/or the Board for the full

Ward 2	SPARC	All Singles Rooms, Bays, Sluice Room, Clinical Room and Nurses Station	Handwashing Sinks and Taps	13
Ward 3	GRU	All Singles Rooms, Bays, Sluice Room, Clinical Room, In front of Physio Gym and Nurses Station	Handwashing Sinks and Taps	13
Ward 6	Stroke Neuro	All Single Rooms, All Bays, Sluice Rooms, Clinical Room and Nurses Station	Handwashing Sinks and Taps	17

cost, shown in the attached document.

Time scale: It will take 2 to 3 months to complete works, once funding approved, start in one ward and working our way through the wards.

2. Recording of toilet flushing process

Specific: Flushing role and recording.

Measurable: New control system and process in place.

Achievable: Immediate, please see below.

Time: Already implemented.

Post meeting with cleaning manager and our IPC CNS, please see logbook excerpt above, to include a column for weekly flushing activity.

Post meeting with staff, Mondays will be the day for flushing.

Timescale: Complete

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

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

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

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

1. Call bell system not functioning

Specific: Calls Bells to be replaced in all three wards.

Measurable: Costing of €48k ro replace call bells across three wards.

Achievable: Funding sought from the HSE and Board. Quotes received.

Timescale: Six week lead time and four weeks for instalment, once funding approved. Funding approval expected Q1 2025.

2. Two outstanding policies on Infection Control

Specific: Two policies, one on Decontamination of Equipment, and second on Standard Precautions.

Measurable: Yes, one completed and going to HMT for approval and time line for completion on second policy.

Achievable: Yes by end Q4 2024, already in progress.

Timescale: End Q4 2024.

3. Medication management policy

Specific: Policy does not match our current process.

Measurable: Revised and updated, ready for approval. By end Q4 2024.

Achievable: Yes completed going to HMT for approval.

Amendments to policy include sections on the following:

- Use of Digicare electronic medication management system
- A section on Salads
- The safe handling, prescribing, dispensing, administration, and monitoring of high-alert medications in the hospital to reduce the risk of medication error and patients.

Timescale: Will be in share point for access by all staff in December 2024.

4. No full time pharmacist on site

Specific: we need to find a budget to employ a pharmacist on site

Measurable: Costing of the post we predict we will a 2.5 WTE for holiday relief etc.to have an efficient department and service for patients and staff education

Achievable: Funding sought from the HSE and Board. We know that we have primary notification about funding for 0.5 WTE of a pharmacist under the neuro rehabilitation project This will be the beginning of building up the service to 2.5WTE

Timescale: we are currently doing job description and plan to place advert before year-end. Funding approval expected Q1 2025.