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:	Cavan and Monaghan Hospital
Address of Healthcare Service:	Lisdarn Cavan Co Cavan H12N889
Type of Inspection:	Announced
Date of Inspection:	05 and 06 July 2022
Healthcare Service ID:	OSV-0001009
Fieldwork ID:	NS_0008

About the healthcare service

Cavan and Monaghan Hospital is a Model 3* public acute hospital comprising of both Cavan General Hospital and Monaghan Hospital and is part of the Royal College of Surgeons of Ireland Hospital Group. Cavan Monaghan Hospital provides services to the population of both counties and its catchment area extends to counties Meath, Longford and Leitrim.

All acute inpatient services are based on the Cavan General Hospital site. These include acute medical, surgical, paediatric, obstetrics and gynaecology services. The primary role of the Monaghan Hospital site includes the continuing care for medically discharged patients requiring inpatient stepdown and rehabilitation care. Both hospital sites provide extensive outpatient, theatre and day services with a Monaghan Injuries Unit located at the Monaghan Hospital site and an emergency department at the Cavan Hospital site.

The following information outlines some additional data on this healthcare service.

Model of Hospital:	3
Number of beds:	302 beds at Cavan site (254 inpatient beds and 48 day patient beds).

* The National Acute Medicine Programme model of hospitals describes four levels of hospitals as follows:
Model 1 hospitals: are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
Model 2 hospitals: can provide the majority of hospital activity including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.
Model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care.
Model 4 hospitals: are tertiary hospitals and are similar to Model-3 hospitals but also provide tertiary care and in certain locations, supra-regional care.

How we inspect

This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part of the role of the Health Information and Quality Authority (HIQA) to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, authorised persons (hereafter referred to as inspectors) reviewed relevant information about this healthcare service. This included any previous inspection findings, information submitted by the healthcare service provider, publicly available information and other unsolicited information received by HIQA since the last inspection.

As part of our inspection, where possible, we

- speak with people who use the service and the people who visit them to find out about their experience of the service
- speak with staff and management to find out how they plan, deliver and monitor the care and support that is provided to people who use the service
- observe care being delivered, interactions with people who use the service and other activities to see if it reflects what people tell us
- review documents to see if appropriate records are kept and that they reflect what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on two dimensions:

Capacity and capability of the service:

This section describes the governance, leadership and management arrangements in place in the healthcare service. It considers how effective they are in ensuring that a good quality and safe service is being sustainably provided. It outlines how people who work in the service are managed and supported through education and training, and whether there is appropriate oversight and assurance arrangements in place to ensure high quality and safe delivery of care.

Quality and safety of the service:

This section describes the experiences, care and support people 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 includes information about the environment where people receive care.

The full list of standards reviewed as part of this inspection by themes and dimension and the associated compliance judgments are listed in Appendix 1.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance has been made under each standard monitored on how the service performed. We include our monitoring judgments in the inspection report and where we identify partial or non-compliance with the standards, we will issue a compliance plan. It is the healthcare service provider's responsibility to ensure that it implements the actions in the compliance plan within the set time frames.

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.

This inspection was carried out during the following times:

Dates	Times of Inspection	Inspectors	Roles
05 July 2022 06 July 2022	09:00hrs to 17:00hrs 09:00hrs to 16:00hrs	Nora O' Mahony	Lead Inspector
		Patricia Hughes	Inspector
		Danielle Bracken	Inspector

Background to this inspection

An announced inspection of Cavan and Monaghan Hospital was conducted on 5 and 6 July 2022. This inspection was confined to the Cavan Hospital site and involved an assessment of compliance of the effectiveness of governance and three other national standards in the Emergency Department (ED). The findings of this are described in the first part of this report. The effectiveness of governance was also assessed in a sample of wards in addition to a core set of standards drawn from five themes.

The inspection focused, on four known key areas of risk:

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

The inspection team visited the following clinical areas on the Cavan hospital site:

- emergency department
- medical 2
- surgical 1

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

- representatives of the Hospital's Executive Management Team including the General Manager, the Director of Nursing, a Consultant Physician (deputised for the Clinical Director) and the Operations Manager/Deputy General Manager
- the Quality and Patient Safety Manager and the Quality and Standards Manager
- the Complaints Manager
- two non-consultant hospital doctors (NCHDs)
- the Human Resource Manager and the Medical Manpower Manager
- representatives leads for: infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Acknowledgements

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

[†] Transitions of care refers to the various points where a patient moves to, or returns from, a particular physical location or makes contact with a healthcare professional for the purposes of receiving healthcare. This includes transitions between home, hospital, residential care settings and consultations with different health care providers in out-patient facilities. Transitions of Care: Technical Series on Safer Primary Care ISBN 978-92-4-151159-9 © World Health Organization 2016.

Capacity and Capability

The following section of this report provides a description of findings and an overall judgment for the inspection across all areas inspected against Standard 5.5 of the *National Standards for Safer Better Healthcare*.

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

Emergency Department

During the inspection, HIQA observed that Cavan and Monaghan Hospital had management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare in the emergency department (ED). The hospital had put systems in place to enhance patient flow both through the emergency department and from the emergency department to the inpatient beds. However, despite these systems in place, challenges still remain and the hospital had further medium and long-term plans to improve patient flow, which are outlined later.

The hospital was challenged with the design and layout of the emergency department which only had capacity for 11 patients within two, three and four space bays, a one space resuscitation room and a single room. There were no toilet or shower facilities within the emergency department and patients had to go to the adjacent corridor to access toilets. At 11 am on the second day of inspection there were 23 patients registered in the emergency department. Eleven patients were accommodated in designated bays within the emergency department, five of these were admitted patients awaiting an inpatient bed. The other patients were awaiting for medical assessment.

Of the 23 patients in the ED:

- nine patients (39%) were waiting more than six hours from registration for a decision to admit or discharge
- two (9%) patients were waiting more than nine hours from registration for a decision to admit or discharge
- no patient was waiting more than 24 hours from registration for a decision to admit or discharge.

The hospital management sought to support patient flow on a daily basis through the following actions:

- The hospital held twice daily operational patient flow meetings at 12pm and 3pm to review hospital activity and identify opportunities to expedite the patient's journey.
- The on-site assistant director of nursing (ADON) visited the department at regular intervals throughout the day and night to review the emergency department activity and manage or escalate issues of concern.

- A bed status text message was distributed four times a day to the Executive Management Team.
- The emergency department held a formal team meeting each day at 4pm to review and discuss the patients within the department, their plans of care and any issues of concern.
- Monthly performance reports were circulated and reviewed at each Clinical Governance Committee to support ownership and involvement at clinical level. The performance reports included the following information:
  - number of admissions and discharges
  - each consultant's average length of stay
  - readmission rates
  - the average patient experience time in the emergency department.

The hospital management had identified additional medium-to-long-term measures to improve the physical environment and the patient experience time where emergency care was provided, as outlined below:

- Inspectors were informed that building plans were well advanced for an upgrade to the emergency department. This new build will include provision of a unit with 18 single rooms and a new endoscopy unit.
- Inspectors were informed that plans were advanced within the hospital to open a surgical assessment unit and a clinical decisions unit to further stream people into surgical and short-stay pathways. These services would help provide prompt access to an appropriate senior clinical decision maker, with access to diagnostics to improve the quality of the patient's journey and reduce the patient experience time.

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

- Acute medical assessment unit (AMAU). The hospital had recently re-established the AMAU which had capacity for 10 patients. Patients with medical conditions were streamed to the AMAU based on their Manchester triage category and AMAU criteria. The AMAU operated Monday to Friday from 8.00am to 18.00pm. It was staffed by a medical consultant, a registrar, a senior house officer and nursing staff. The positive impact of this unit was observed through the conversion rate which has reduced from 25% pre-AMAU to 18-20% in March-April 2022.
- Frailty intervention team (FIT). The FIT reviewed patients over the age of 65 years in the emergency department. The health and social care team undertook patient assessments and provided advice, education and equipment to support safe discharge to home. The team would also facilitate admission to an 'enable bed[‡]' in the associated Lisdarn unit for short-term physiotherapy or other required allied health professional or nursing services to enable the patient's safe return home. Staff who spoke with inspectors were very

[‡] Enable beds were used to enable people who use the service to return safety to their homes following a period of rehabilitation.

positive about the impact of this service for patients over the age of 65 years attending the emergency department.

- Rapid access treatment (RAT) minor injuries. To support patient flow and further stream patients appropriately, the emergency department had two areas run by advanced nurse practitioners (ANPs). The aim of the RAT service was early assessment and diagnosis with the use of protected slots for diagnostics such as echocardiograms, stress tests and computerised tomography (CT). This had resulted in earlier patient assessment, diagnosis and referral to appropriate teams for treatment and interventions or discharge.
- Deep vein thrombosis and renal colic pathway. The emergency department had developed pathways of care for patients with suspected deep vein thrombosis and renal colic. Through these pathways, patients had prompt access to assessments and diagnostics to improve timelines to diagnosis and treatment. These patients could also return the following day for further assessment, diagnostics and treatment if required.
- Workforce. The hospital had addressed longstanding workforce issues and now had a full complement of nursing and medical staff for the emergency department. This is discussed further in section 6.1. Inspectors were informed that the hospital responded, when possible, to requirements for additional staff due to increases in demand or decrease in resources due to staff absences.

Overall, HIQA was assured that this site of the hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare in the emergency department. The emergency department had a full complement of staff and resources. Inspectors noted the challenges presented by the environment in which care was provided, for example, the lack of space, toilet and shower facilities. The lack of effective flow for admitted patients to an inpatient bed was an issue, resulting in boarded patients in the emergency department. The hospital had put systems in place to enhance patient flow both through the emergency department and from the emergency department to the inpatient beds. Challenges still remain and the hospital had further medium and long-term plans in place to improve patient flow, such as the development of a surgical assessment unit and provision of the new build.

Wards

The hospital had management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services.

The hospital had an operational plan for 2022 which outlined the hospital's key strategic objectives for the year and which was aligned to the RCSI Hospital Group Operational Plan 2019. The Executive Management Team had oversight of the implementation of the objectives of Cavan and Monaghan Hospital Operational Plan. From evidence provided during the inspection, the hospital was progressing with meeting the key objectives outlined in the operational plan. For example, key objectives such as improving access and emergency care pathways were being implemented through the establishment of a frailty intervention team,

reopening the acute medical assessment unit and planning to establish both a surgical assessment unit and a clinical decisions unit.

Human resources and medical manpower departments were responsible for workforce management in the hospital. Staffing levels and absenteeism rates were tracked and trended by the departments and reviewed fortnightly and reported at Executive Management Committee meetings and at monthly performance meetings with the RCSI Hospital Group.

The hospital's total approved whole time equivalent (WTE) posts in May 2022 were 1378.39 WTE with 1351.81 WTE posts filled leaving a shortfall of 109 WTE posts vacant. The vacant posts in May 2022 included:

- nursing 16 WTE
- medical/dental 12 WTE
- health and social care professionals 15 WTE
- general support 8 WTE
- midwives 11.1 WTE.

On the day of inspection, the areas visited by inspectors had full staff complements in place. Inspectors were informed that short notice nursing shortages were covered by redeployment of staff from other areas or additional shifts worked by nurses when possible.

Risks related to difficulties in recruiting nurses for specialist areas, midwives, consultant radiologists and consultant anaesthetists were all recorded on the hospital corporate risk register and monitored and reviewed at Executive Management Committee meetings.

The hospital had run recruitment posts to fill vacant positions, and reported that 21 new nurses were advancing through the recruitment process at the time of the inspection. The hospital had run two recruitment competitions for vacant consultant posts, but to date no successful candidate had been identified.

Currently the hospital had 4.2 WTE pharmacist posts unfilled due to planned leave. The impact of these vacancies was apparent to inspectors through lack of clinical pharmacy and medication reconciliation services in some clinical areas of the hospital. Inspectors were informed that this planned leave would also have an impact on elements of the antimicrobial services provided by the hospital. such as completion of audits and associated quality improvements programmes and education. This risk had been escalated by the Antimicrobial Stewardship Team to hospital management. Inspectors were informed that the IPC Committee now plan to review the AMS programme to identify priority areas for focus.

The lack of clinical pharmacists had also been escalated to the corporate risk register. Inspectors were informed by management of challenges filling short-term pharmacy posts.

The RCSI Hospital Group had a workforce plan 2021-2023 in place with a focus to maintain the current workforce and services provided by each hospital. Inspectors were informed that workforce management for Cavan and Monaghan Hospital was supported at RCSI Group level

through the overseas recruitment process and coordination of careers days and the employment controls process.

Inspectors were informed by management that some consultants employed in the hospital were not on the relevant Specialist Division of the Register of the Irish Medical Council. Senior hospital management had discussed the requirements to register on the Specialist Register with the consultants in question, and supports were in place to progress registration with appropriate support and oversight in place, in line with HSE guidance.

Training records relating to infection prevention and control, medication safety, the deteriorating patient and transitions of care were reviewed by inspectors, with a focus on the clinical areas visited by inspectors. Staff training records were available and managed at local ward level with oversight at management level. Compliance with mandatory training in areas such as use of early warning systems, identification and management of sepsis, standard precautions, hand hygiene and administration of prescribed medications were reviewed at monthly executive management committee meetings and performance meetings with the RCSI group. Reduced compliance against set targets was noted, areas for improvement and actions required were outlined and assigned to a named individual with set time frames. For example in May 2022, sepsis training for doctors was below target and an action for focused training in this area was assigned to the General Manager.

Training records management was currently under the remit of the operations management department. Inspectors were informed that training records management is currently under the remit of the operations services management department. Implementation of a Learning Management System will commence in quarter 3 of 2022 and mandatory training records will be processed through this system.

NCHD training records were captured as part of the National Employment Record System and monitored by the human resource department and reported at Executive Management Committee meetings. All new NCHDs had completed their mandatory training prior to commencing employment with the hospital.

The status of specialist training for nurses in specialist areas such as emergency department, ICU and CCU, was monitored and reviewed at the Quality and Safety Executive Committee. Clinical facilitators had been established to support staff in these areas. Nursing staff were supported to complete postgraduate courses with approximately 35 nurses undertaking, or planning to undertake, post graduate education courses.

In summary, notwithstanding that support and oversight in place were in line with HSE guidance for consultants, management should continue to advance arrangements to ensure that consultants are appropriately registered on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in the relevant speciality.

The pharmacy department should consider reviewing the workload among existing resources with prioritisation of work. Where there is a critical shortfall, exceptional contingency arrangements should be explored as patient safety remains a priority throughout.

The practice of boarding admitted patients in the emergency department impacts on the service's ability to maintain, promote and protect the patients' dignity, privacy and confidentiality, and a human-rights based approach to care. Although the boarding of patients in the ED at Cavan and Monaghan Hospital during this inspection was not as significant as seen in other model 3 hospitals, every effort should be made to reach a situation whereby it does not occur. Overall, inspectors found that Cavan and Monaghan Hospital had management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services with some areas for improvement identified.
Judgement: Substantially compliant

Emergency Department

The following section outlines findings from the inspection as they related to the Emergency Department. Findings and judgments are presented under three of the National Standards for Safer Better Healthcare relating to the themes of Workforce; Person-Centred Care; and Safe Care.

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

On the second day of the inspection, inspectors visited the hospital's emergency department and acute medical assessment unit (AMAU). The emergency department provided care for patients with acute and urgent illness or injuries and was the entry point for all patients presenting to the hospital. The emergency department entrance, waiting areas and triage areas were all housed within temporary prefabricated building structures.

Patients presenting to the emergency department at Cavan and Monaghan Hospital, were assessed for evidence of COVID-19. The emergency department had a local pathway in place with parallel streaming: 'Red pathway' for the COVID-19 stream and 'Yellow pathway' for the non-COVID-19 stream. These pathways separated patients with COVID-19, symptoms of COVID-19 or risk factors for COVID-19 from patients without, as soon as possible.

On arrival at the department, people with suspected or confirmed COVID-19 were directed to a separate entrance where they were met by the triage nurse in full personal protective equipment (PPE) and guided through the red pathway to the COVID-19 emergency department. Patients brought in by ambulance with suspected or confirmed COVID-19 were brought directly through the red pathway, having first alerted the triage nurse of their arrival.

The COVID–19 area of the emergency department had capacity for seven patients with three isolation rooms for suspected cases and four bays for confirmed cases. There was also a waiting area that could be secured off to accommodate additional patients progressing through the red pathway if required.

Patients presenting to the emergency department with no symptoms of COVID-19 were streamed through the yellow pathway. These patients were triaged, first by means of a telephone call with the triage nurse followed by an in-person triage.

There were three separate waiting areas with over 25 pairs of socially distanced seats as they waited further assessment by nurses and doctors. Signage was visible in the waiting areas to guide patients and a member of the security team was on hand to direct patients.

Patients with medical conditions initially streamed through the yellow patient pathway were then streamed to the acute medical assessment unit (AMAU) or emergency department based on their Manchester triage category[§] and AMAU admission criteria.

[§] The Manchester Triage System (MTS) is a validated five point scale use for the initial assessment of patients presenting in emergency departments. Triage Category 1: immediately/life threatening. Triage category 2: very

The emergency department had capacity for 11 patients within two, three and four bay areas, a one space resuscitation room and a single room. There were no toilet or shower facilities within the emergency department, and patients had to return to the adjacent corridor to access toilets. Areas for staff to complete patient notes and review diagnostic results was limited with many staff competing for access to a small area.

All patients within the emergency department at 11.00am on the day of inspection were on trolleys within designated bays of the department. There were additional patients waiting on chairs in the waiting areas.

Inspectors observed that staff working in the emergency department were wearing appropriate personal protective equipment (PPE) in line with the public health guidelines in place at the time.

Inspectors spoke with a number of patients in the emergency department to learn about their experiences of the care received. Patients who spoke with inspectors were waiting from one to 10 hours in the department. Overall, patients were happy with the care they received. Feedback received by inspectors included that '*all was good so far'* and '*happy enough' 'good to be here when you need it'*. One patient did outline that they had to wait to receive required assistance. Not all patients who spoke with inspectors knew how to make a complaint if required.

Inspectors also spoke with patients on inpatient wards who had received their initial care in the emergency department. When asked what had been good about the care they had received in the hospital so far, patients talked positively about their experience in the emergency department (ED). Patients told inspectors: '*no delay, was seen quickly and isolated' 'was very ill, seen very quickly'*, '*I was surprised at how quickly I got to the ward', 'privacy provided in ED'*. One patient however, outlined that they had to wait 12 hours for an inpatient bed.

urgent/urgent. Triage Category 3: urgent /semi urgent. Triage category 4: standard/routine. Triage category 5: non-urgent.

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

For a service to achieve high-quality, safe and reliable healthcare it needs to have sufficient staff with the required skill-mix and competencies to respond to the needs of the population it serves. Cavan and Monaghan Hospital had addressed long-standing workforce issues and now had a full complement of nursing and medical staff for the emergency department.

A consultant in emergency medicine was the overall clinical lead in the emergency department. The clinical lead escalated issues of concern to the General Manager and or the Clinical Director as appropriate. There were four consultants in emergency medicine in the emergency department supported by non-consultant hospital doctors at registrar and senior house officer grades. A senior clinical decision-maker,** consultant or registrar, was available on site in the emergency department 24/7. Consultants were on site during core hours Monday to Friday, with one consultant providing on-call cover during evenings, nights and weekends. The on-call consultant routinely visited the emergency department on Saturday and Sunday mornings and provided cover for emergencies outside of these times. The registrars and senior house officer grades provided medical cover in the department 24/7.

Attendees to the emergency department were assigned to the emergency medicine consultant-on call until admitted or discharged. If admitted, the patient was assigned under the care of a specialist consultant and boarded in the emergency department while awaiting an inpatient bed. However, if the patient's clinical condition deteriorated, staff in the emergency department provided the necessary emergency response. A clinical nurse manager 3 (CNM3), had responsibility for the nursing service within the emergency department. The CNM3 reported to the Assistant Director of Nursing (ADON) for Urgent Ambulatory Care. Urgent issues such as staffing shortages occurring out of hours were escalated to the on-site ADON. A CNM2 was on duty each shift, and had responsibility for nursing services out of hours and at weekends. The CNM2 escalated issues to the on-site ADON out of hours. An additional CNM2, working core hours four days per week, was responsible for admitted patients boarded in the emergency department.

Five staff nurses, a CNM1 and CNM2 were rostered on duty each day and night shift. A nursing roster, for a four week period, had a full complement of nursing staff rostered for each shift. Short-term sick leave resulted in absences which were replaced by redeployment or agency when possible. Overall, HIQA was assured that Cavan and Monaghan Hospital planned, organised and managed the workforce in the emergency department to achieve the service objectives for safe and reliable healthcare.

Judgement: Compliant

** Senior decision-makers are defined here as those who have undergone appropriate training to make independent decisions around patient admission and discharge.

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

People who use healthcare services have a right to expect that their dignity, privacy and confidentiality are respected and promoted. People should be communicated to and cared for in a manner that respects their dignity, privacy and autonomy. The environment in which care is delivered should also promote and protect the patient's dignity and privacy, and protect the personal information of people who use the service.

Staff in the emergency department were observed by inspectors to treat patients with dignity and respect in the emergency department. Communications observed between staff and patients were respectful. Inspectors observed staff familiarising patients with their surroundings and attending to patient's individual needs in a dignified and respectful manner. Curtains were secured around patients to provide privacy and protect their dignity when providing personal care.

This correlated with the results of the National Inpatient Experience Survey (NIES) for Cavan and Monaghan Hospital carried out in 2021. When people who had used the service were asked, if they felt they were treated with dignity and respect while in the emergency department the hospital scored 8.9, higher than the national average of 8.8. Also, when asked if they were given enough privacy while in the emergency department the hospital scored 8.6, higher than the national average of 8.2.

The hospital had introduced initiatives to improve the patient experience times for attendees to the emergency department as previously described under national standard 5.5 such as, the frailty intervention team, the rapid access treatment service and the deep vein thrombosis and renal colic pathways. Inspectors were informed that these initiatives impacted positively on patient experience times and admission rates. This correlated with the hospital's metrics for May 2022, which outlined that the average time spent in ED for non-admitted patients was 5 hours.

Inspectors were also informed of a 'Purple Card' initiative in place in the hospital to promote dignity and respect for pregnant women at risk of or experiencing a miscarriage. This purple card, when shown by a pregnant women immediately alerted staff to the possibility of miscarriage and therefore staff would bring the women directly to the gynaecology service in a respectful and dignified manner.

The emergency department also had a separate room adjacent to the emergency department, where bereaved people could spend time with their deceased relative or friend in a quiet and respectful space.

The emergency department had a capacity for 11 patients accommodated within two, three and four bay areas, a resuscitation room which accommodated one patient and a single room. On the day of inspection, all patients were accommodated in designated bays with privacy curtains provided around each individual space.

However, inspectors were informed that on many occasions patients were accommodated on extra trolleys in the emergency department and on the adjacent corridors. On these occasions, the acute medical assessment unit (AMAU) area was opened overnight to accommodate patients awaiting inpatients beds, with a priority to have the unit cleared by morning to facilitate AMAU activity. This clearance was achieved through early discharges, transfer to the transit lounge if suitable for discharge later or admission to an inpatient bed.

Inspectors found that there was no toilet or shower facilities located within the emergency department which potentially affected the dignity and respect afforded to people using the service. Toilets for patients use were located on the adjacent corridor which did not facilitate easy access for patients. Inspectors observed a patient being provided with a commode in the absence of accessible toilets.

Although capacity was not an issue on the day of inspection, considering the lack of space available within the department inspectors were informed that the area would become more challenging once demand increased. The hospital was planning to manage the environment and improve patient flow through a new build incorporating an emergency department, endoscopy and 18 single rooms and the opening of a surgical assessment unit and clinical decisions unit. This is due to commence in quarter 3 of this year.

Overall, on the day of inspection, the staff in the emergency department promoted dignity, privacy and confidentiality for the people who used the service. However, HIQA was not fully assured that the environment in which care was delivered always promoted and protected the dignity and privacy for the patients. The deficit of toilet and shower facilities and lack of available space during periods of overcrowding should be addressed by hospital management.

Judgement: Substantially compliant

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

To protect people who use the service from the risk of harm associated with the design and delivery of healthcare, services must proactively monitor, analyse and respond to information relevant to the provision of care.

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks identified by the emergency department were entered on the Emergency Medicine Clinical Governance Committee's risk register and by the committee. Risks beyond the control of this committee were escalated to the corporate risk register.

Services must also proactively identify, evaluate and manage risks and identify aspects of care associated with possible increased risk of harm. Four such risk areas, which were the focus of

this inspection: infection prevention and control, medication safety, deteriorating patient and transitions of care are discussed below.

Infection prevention and control

The waiting, triage and emergency department room areas were observed to be clean and well maintained on the day of inspection, with some minor exceptions which were outlined to staff on the day. A cleaner who spoke with inspectors outlined the routine for cleaning the waiting areas. Inspectors observed this cleaning routine in practice.

On arrival at the emergency department, patients were assessed for the risk of COVID-19 and multidrug-resistant organisms which were managed as per national guidance. The hospital's patient administration system flagged patients who had previously attended the hospital with communicable infectious diseases.

Staff in the emergency department had access to infection control nurses and microbiologists for advice and guidance. Emergency staff had attended infection prevention and control education. Training records reviewed by inspectors outlined full staff attendance at education sessions for outbreak management, hand hygiene and donning and doffing of personal protective equipment (PPE). On the day of inspection, inspectors were provided with training records from the emergency department which outlined compliance with standard and transmission-based precaution education at only 73% for nurses and 81% for healthcare assistants. Staff informed inspectors that this training was ongoing.

Medication safety

A clinical pharmacist service was provided in the emergency department, with a pharmacist also assigned to the Frailty Intervention Team (FIT). Emergency department consultants liaised with the hospital's microbiology consultant and the antimicrobial pharmacist for antimicrobial stewardship advice and support. The antimicrobial pharmacist also attended the Emergency Medicine Clinical Governance Committee meetings to provide feedback on audits of use of antimicrobial therapy.

Deteriorating Patient

The hospital used the National Early Warning System to support the recognition and response to the clinical deterioration of patients in the emergency department. Staff could describe the escalation process enacted and followed when the early warning system was triggered. Inspectors were informed that the hospital planned to implement the Emergency Medicine Early Warning System, but this had not commenced at the time of inspection.

There was a clinical facilitator within the emergency department who was assigned responsibility for implementation of the Early Warning System within the department. This role was currently vacant due to planned leave, and although advertised for replacement no applicants had applied. This role was currently being supplemented by the hospitals' nurse practice development unit. The majority of staff in the emergency department were up to date

with training in Early Warning Systems with compliance ranging from 73-100% for nurses and doctors.

Transitions of care

The Frailty Intervention Team in the emergency department played an important role in supporting safe transition of care through assessment of the frail elderly patient over 65 years of age and provision of advice, education and equipment to facilitate safe discharge. The team also facilitated patient transfers to 'enable beds' in the nearby Lisdarn unit for patients assessed as requiring additional support to facilitate safe return to the home environment.

The medical doctors held clinical handovers at 8:00am, .00pm and 10.00pm to review activity levels and to plan care and improve the patient experience times and experience of care. An audit of the handover was undertaken in March 2022, which outlined that handover or handover sheets were not completed for 58% of the handovers. Recommendations and learning was shared following the audit, however no re-audit was completed to check for improvements in practice.

Inspectors were informed that the ISBAR[††] communication tool was used when transferring patients to the ward areas to ensure standardised effective communication.

Staff in the emergency department outlined that a major cause of patient's complaints was related to lack of a timely clinical discharge summary sent to the patient's general practitioner (GP) following discharge from the hospital. The emergency department had focused on improving the provision of discharge summaries to patients on discharge, the impact of which had resulted in reduced complaints from patients and families related to discharge summaries.

Overall, on the day of inspection HIQA, notwithstanding areas for attention as outlined above, HIQA inspectors were assured that the design and delivery of healthcare services in the emergency department protected people who use the service from the risk of harm.

Judgement: Substantially Compliant

[††] ISBAR =**I**dentify, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation), a technique used to facilitate prompt and appropriate communication in relation to patient care and safety is used for clinical handover.

Ward areas

This section describes findings and judgments against selected National Standards from the themes of Leadership, Governance and Management (5.2 and 5.8), Workforce (6.4), Person–centred Care (1.6, 1.7 and 1.8), Effective Care (2.7 and 2.8) and Safe Care (3.1 and 3.2) from the inspection of clinical areas other than the hospital's Emergency Department.

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

During the inspection, inspectors visited two wards, medical 2 and surgical 1 and spoke with people using the service about their experience of care during their stay at the hospital. Medical 2 was a 32-bedded medical ward, which catered for the needs of patients with a variety of medical conditions. It was at full capacity on the day of inspection. Surgical 1 was a 31 -bedded ward, which had 27 patients at the time of inspection. It catered for the needs of patients receiving surgical, gynaecology and medical care.

Inspectors observed that staff interactions with people using the service were kind, caring and respectful. Staff were observed to sit at the patient's level for conversations and speak in lowered tones to maintain confidentiality. Curtains were drawn around patients for privacy. However, inspectors observed patient names being visible on whiteboards on ward corridors and healthcare records in an unlocked trolley on the ward corridor which was not fully supervised.

When patients were asked to describe what had been good about their stay in the hospital patients were complimentary about the staff who cared for them and the experience of care they had received. Patients told inspectors, *'they really look after me'*, *'everyone gave me a lot of attention*,' *'ward care is excellent'*, *'staff very attentive'*.

When asked what could be improved about service or care they received, patients responded saying: *'can't think of anything, 'happy with care', 'everything grand', 'no I have no concerns'*. One patient said that staff *'come in and out, but they are busy'*.

Most patients who spoke with inspectors knew how to raise a complaint, if required. However, patients told inspectors they had no reason to complain. 'Your Service Your Say' leaflets were observed by inspectors to be available on wards.

The corridor of one ward visited was observed by an inspector to be congested with equipment being stored on both sides of the corridor. This will be discussed further in 2.7. Overall, inspectors observed that the wards visited were clean and well maintained. This was reiterated by people using the service, who complimented the cleanliness of the wards.

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

To deliver high-quality, safe and reliable healthcare, service providers need to have integrated corporate and clinical governance arrangements in place with clearly defined roles and responsibilities focused on quality and safety outcomes for people who use the service.

During this inspection, HIQA was assured that Cavan and Monaghan Hospital had formalised corporate and clinical governance arrangements in place to provide quality, safe and reliable healthcare. The hospital had updated its Corporate Governance Structures, approved in 2022, which outlined the reporting structures within the hospital and to the RCSI Hospital Group. These reporting structures were evident to inspectors during the inspection.

At corporate level, the hospital had defined lines of responsibility and accountability for the governance and management of services. The General Manager had overall responsibility for governance and management of the hospital and reported to the Chief Executive Officer of the Royal College of Surgeons of Ireland (RCSI) Hospital Group.

The hospital's Quality and Patient Safety structures were under review and reform was in progress, although not finalised or formalised at the time of inspection. The Quality Safety and Executive Committee (QSEC) had only met three times since January 2020, which was not in line with its terms of reference (TOR). Therefore, the governance arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services were not fully functioning. This will be discussed further below.

Executive Management Committee

Cavan and Monaghan Hospital's Executive Management Committee (EMC) was accountable for leading and directing the performance of the hospital and ensuring that safe, effective services were delivered. The committee met as per its terms of reference with good attendance at meetings. The committee had a standing agenda, based on themes of the *National Standards for Safer Better Healthcare*. Minutes reviewed by inspectors reflected the agenda items and required actions were assigned to an individual with set timeframes.

The Executive Management Committee reported to the RCSI Hospital Group's Chief Executive officer (CEO) through the monthly Hospital Performance Meeting attended by the hospital's senior management. The hospital's performance metrics were reviewed and discussed under seven dimensions: access and patient flow, infection prevention control, medication management, maternity services, patient care and treatment, patient and family experience, staffing absenteeism and training.

The following reports were also presented to the RCSI Hospital Group for review and monitoring:

- hospital activity and waiting list rates
- corporate risk register updates
- Quality and Patient Safety Performance report which included: serious reportable events, serious incidents, incident trends, complaints trends and metrics, incident reviews, training compliance, progress on implementing recommendations from reviews and updates on coroner and legal cases.
- finance reports
- human resource report.

Time-bound actions, assigned to an individual, were outlined where the hospital's performance fell below the acceptable levels or target. For example, the hospital's metric for assessing if the clinical discharge summary was issued to the patient's primary healthcare provider within 1 week of discharge fell well below the expected target and a time-bound action was put in place. This will be discussed further in section 3.1.

The hospital had Clinical Governance Committees for medicine, surgery, emergency medicine, anaesthetics, pathology, radiology, obstetrics and gynaecology and paediatrics, each with an identified clinical lead. The committees met four times a year with representatives from medical and nursing and midwifery staff, middle and senior management, quality and patient safety and pharmacy. The committees reported to the Quality Safety Executive Committee (QSEC) and the chairperson escalated issues of concern to the General Manager.

These committees monitored and reviewed the service's incidents, complaints, key performance indicators and audits. The committees reported to the Quality Safety Executive Committee through their chairpersons and they presented biannual update reports to the QSEC. Each Clinical Governance Committee maintained a risk register for risks identified within its services. Risks outside the control of the service were escalated to the corporate risk register. For example, the lack of isolation facilities was on the Medical Clinical Governance Committee risk register and this risk had been escalated to the corporate risk register.

The hospital's Quality Safety and Risk Committee (QSEC) had only met twice in 2021 and once in 2022 – in the year to date. This was not in line with the committee's terms of reference. The terms of reference were currently under review. The aim of the QSEC, as per the 2016 terms of reference, was to provide assurances to the EMC that there was a clear accountability framework within the hospital for quality and patient safety and to provide direction and support to the committees which reported to QSEC.

Considering the role and responsibilities of this committee, it was noted that it was not meeting as required. For example, through minutes reviewed no evidence was found that the Drugs and Therapeutics Committee had formally reported to this committee in 2021 or 2022. The hospital outlined that oversight was transferred to the hospital's Strategic COVID committee which met frequently during this time to support the functioning of QSEC.

In the absence of the QSEC, inspectors were informed that issues of concerns were dealt with by the relevant Clinical Governance Committee. Monitoring and evaluation of services and risks identified were escalated and reported to the Executive Management Committee and in turn were reported at the monthly performance meeting.

Inspectors were informed and review of documentation confirmed that the hospital was currently reviewing the governance structure and hospital committees to streamline and enhance the reporting process. The hospital's new Corporate Governance Structures approved in 2022 clearly outlined reporting structures within the hospital and to the RCSI Hospital Group.

The hospital planned to use performance metrics and data to monitor each committee and service. This would provide measurable assurance to the hospital management of the quality and safety of services and identify areas for improvement. A pilot of the new structure was in place for the Quality Safety and Risk Committee (QSEC) which had updated its meeting agenda items to reflect the themes of the *National Standards for Safer Better Healthcare.* Inspectors were provided with a schedule of meetings outlining the reporting plan for each sub-committee for 2022.

The formalised governance arrangements in place for assuring the delivery of care for the four key areas of risk which are the focus of this inspection are outlined below.

Infection prevention and control (IPC)

The hospital had effective management arrangements in place to support the delivery of the infection prevention and control (IPC) programme. The Infection Prevention and Control Steering Committee (IPCSC) was responsible for the governance of IPC in the hospital. The committee reported to the QSEC and presented bi-annual reports to it. The hospital had both an Infection Control Programme and an Antimicrobial Stewardship Programme in place. The IPCSC provided oversight, direction and support to its subgroups including hygiene and decontamination, environmental monitoring and the IPC operational group**.**

The Infection Prevention and Control Steering Committee met as per its terms of reference, with good attendance at meetings. It had a standing agenda, based on the themes of the *National Standards for Safer Better Healthcare*. Minutes reviewed by inspectors were comprehensive and reflected agenda items. Actions were assigned to individuals with timelines outlined.

Medication safety

The hospital had a Drugs and Therapeutics Committee (DTC) which was responsible for governance of medication safety within the hospital. However, minutes from the last three meetings of this committee reviewed by inspectors identified that there had been a gap in formal meetings between October 2021 and March 2022, which was not in line with the hospitals terms of reference.

The committee reported to the Quality and Patient Safety Committee (QSEC). However, no evidence of formal reporting by the DTC to this committee was seen in the QSEC minutes reviewed by inspectors. To ensure that governance, accountability and oversight arrangements for medication management and safety are effective, the Drugs and Therapeutics Committee

needs to function and report in line with its terms of reference to provide assurance for medication safety.

Inspectors were informed that in the absence of formal meetings, oversight of medication safety was maintained by the chair and co-chair of the committee and risk or issues were escalated directly to the Clinical Director or General Manager. An example of such an issue was described to inspectors, discussed with the Clinical Director and learning shared with colleagues at multidisciplinary meetings and at the daily consultant handover meeting. Medication safety incidents were reviewed, tracked and trended and monitored at both the Executive Management Committee meetings and the hospital's monthly performance meetings. Medication safety risks were reported on Clinical Governance Committee risk registers and escalated to the corporate risk register when the required controls were outside the scope of the committee. For example, the lack of a clinical pharmacist had been escalated to the corporate risk register. The hospital had a full complement of pharmacists but the current complement was reduced due to 4.2 WTE pharmacists being on planned leave and where there was no replacement cover in place. Management told inspectors that it is very difficult to get pharmacists for short-term replacement posts. The impact of these vacancies is discussed in section 3.1.

The deteriorating patient

The hospital had just established a Deteriorating Patient Committee to oversee the deteriorating patient improvement programme. The committee will advise on the implementation, evaluation and monitoring of the hospital's early warning systems, sepsis management and resuscitation throughout the organisation. It will advise on training requirements and resources required and support the associated education programmes.

The first meeting of the committee was held in June 2022 where draft terms of reference were reviewed. The existing Resuscitation, Sepsis and End of Life Committees will report to this committee. The hospital had a designated lead for the early warning systems and clinical facilitators supporting staff at ward level.

Transitions of Care

The hospital did not have an overarching committee responsible for transitions of care. Inspectors were informed that the responsibility for transitions of care was under the governance of each Clinical Governance Committee. The bed manager, liaison nurses and discharge coordinator reported to the patient flow manager and had responsibility for coordinating hospital admissions, transfers and discharges. This team reported to the hospital deputy manager and liaised daily with the Director of Nursing for Integrated Care to support safe transitions of care.

Overall, while the hospital had defined corporate and clinical governance arrangements in place, at the time of inspection, governance arrangements were being restructured to streamline and improve the effectiveness of reporting structure. The QSEC had not met in line with its terms of reference which were under review. As a consequence this committee was not maintaining its oversight role and function in line with its terms of reference. It had revised its meeting

structure and was piloting the revised performance driven approach to streamline and improve its effectiveness.

In the interim, management of the hospital had good oversight and assurances mechanisms in place to provide assurance to HIQA of the delivery of high-quality, safe and reliable healthcare. However, the hospital, as a priority, needs to finalise and formalise the proposed governance restructuring arrangements.

Judgement: 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.

At the time of inspection, Cavan and Monaghan Hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided.

There were risk management structures in place to proactively identify and manage risk. Each Clinical Governance Committee (CGC) maintained a risk register for risks identified within their service. Risks outside the control of the services were escalated to the corporate risk register. The corporate risk register was reviewed monthly by the Executive Management Committee (EMC), with updates provided at the monthly performance meetings with the RCSI Hospital Group.

The hospital proactively identified, documented and monitored patient safety incidents. These incidents were tracked and trended monthly in the hospital's Quality and Patient Safety reports presented at meeting of the EMC, QSEC, CGCs and monthly performance meetings with the hospital Group. There were processes in place to share learning from patient safety incidents through daily safety huddles, daily consultant handovers, newsletters, and the distribution of the hospital's Quality and Safety Performance Reports through committees, such as the Clinical Governance Committees (CGC) and through line managers.

The hospital's performance and activity was monitored through review of performance metrics at quarterly CGC meetings, at QSEC meetings, at monthly EMC meetings and performance meetings with the hospital Group. Recommendations from audits, reports and coroners cases were compiled by the quality and patient safety department and monitored at EMC and at performance meetings.

HIQA was assured that information from monitoring was used to improve the quality and safety of services within the hospital. In June 2022, the hospital held an information day and presented the hospital's current quality improvement projects (QIP) to share learning and identify quality and safety priorities for the hospital. For example, one QIP presented on the day

and discussed with inspectors during the inspection, was related to 'Safer Discharge' which incorporated a number of elements to improve the patient's journey through the service. This initiative was outlined in the hospital's Operational Plan 2022. The first element of this initiative was commenced in the hospital related to SAFER[‡‡] patient flow. As part of the QIP, staff endeavoured to ensure that the following were in place:

- senior review before midday
- all patients have expected date of discharge
- flow of patients commenced at earliest opportunity
- early discharge before midday and
- review systematic multidisciplinary review of patients with extended length of stay.

This QIP was still a work in progress, and had not to date been evaluated to measure compliance or impact.

Other elements of this QIP, yet to be implemented, related to the 'Golden Patient' and 'Red and Green Bed Day'. A red day constitutes a day of no added value for the patient, for example, if a diagnostic test was cancelled or not completed. A green day refers to a day of added value which supported and progressed the patient's pathway of care. A 'Golden Patient' referred to a patient who a consultant would focus on with an aim of early discharge or transfer to discharge lounge between 8 am and 10 am the next day.

Information from feedback and complaints from people who use the services was shared within the service to promote learning. For example, tracking and trending of complaints had highlighted a trend in complaints from patient's families related to poor communication. To address this issue, the hospital had developed a QIP to improve communication between hospital staff and families. This was currently being piloted on one hospital ward.

With regard to the four areas which were a focus of this inspection, infection prevention and control, medication safety, the deteriorating patient and transition of care; inspectors were satisfied that there was evidence of monitoring arrangements in place with governance by the relevant governance committees to identify and act on opportunities to improve quality and safety. This will be discussed further under standard 2.8.

Results from the National Inpatient Experience Survey (NIES) and associated quality improvements plans was an agenda items at QSEC and EMC Committees. The hospital had developed a QIP related to discharges and communications and an awareness day was held in May 2022.

Overall, HIQA was assured that the hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided.

[‡‡] SAFER: **S**enior review before midday **all** patients have expected date of discharge, **F**low of patients will commence at earliest opportunity, Early Discharge before midday, **R**eview systematic multidisciplinary review of patients with extended length of stay.

Judgement: Compliant

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

Supporting the workforce involves supporting and promoting a culture that values, respects and actively listens to and responds to the views and feedback from all members of the workforce.

Staff who spoke with inspectors reported that they felt supported by their colleagues and line managers, and that Cavan and Monaghan Hospital was a good place to work. Staff reported that they felt supported to provide feedback and raise concerns at forums such as the daily safety huddle and ward meetings. An example of an issue raised by staff members at a ward meeting was outlined to inspectors whereby a solution was identified and implemented.

There were systems in place for staff to access the occupational health services and the employee assistance programme. Staff who spoke with inspectors were aware of how to access these services. Posters to promote awareness of the employee assistance programme were clearly visible on notice boards in areas frequently visited by staff. Staff informed inspectors that counselling and debriefing services were available and accessible to staff following a serious incident or traumatic event.

Inspectors were informed that the hospital held 'staff appreciation events' such as free tea and cakes in the staff canteen or free ice creams to demonstrate appreciation for staff commitment and hard work.

The hospitals had recommenced Schwartz rounds[§§] in May 2022. This provided an opportunity for all staff to reflect on their work through conversations facilitated by a local clinical lead and facilitator. Inspectors were informed that 69 staff attended the session and that good feedback was received. The hospital plan to continue the Schwartz rounds two to three monthly.

The hospital facilitated leadership development days for clinical nurse managers and clerical staff to enhance leadership and management skills.

Staff health and wellbeing was a standing agenda item on the Executive Management Committee meeting and the Quality Safety Executive Committee. Minutes of meetings viewed by inspectors indicated that Schwartz rounds, staff vaccinations and staffing levels were discussed at these meetings. Inspectors were informed that quality and safety walkarounds were undertaken by management. However, to date no record of the quality and safety walkarounds was documented. This should be addressed and formalised by the hospital to ensure issues raised through this forum are documented and actioned.

Overall, through evidence gathered during this inspection, HIQA were assured that the hospital supported their workforce in delivering high-quality, safe and reliable healthcare.

[§§] Schwartz rounds are conversations with staff about the emotional impact of their work.

Judgement: Compliant

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

People who use healthcare services have a right to expect that their dignity, privacy, autonomy and confidentiality are respected and promoted. People should be communicated with and cared for in a manner that respects their dignity, privacy and autonomy. The environment in which care is provided should promote and protect the patient's dignity and privacy, and protect the personal information of people who use the service.

In the most recent National Inpatient Experience Survey (NIES) for the hospital held in 2021, when people who had used the service were asked, if overall they were felt treated with dignity and respect while in the hospital, the hospital scored 8.9 marginally lower than the national average of 9.0. When asked if they were given enough privacy while in the hospital, they scored 8.6, which was marginally lower than the national average of 8.7.

On the day of inspection, inspectors were assured that the staff of the hospital promoted and respected the dignity and privacy of the people who use the service. Staff promoted a person-centred approach to care by communicating with patients in a respectful manner. Staff ensured that the environment in which people using the service received their personal care provided privacy through the use of privacy curtains and moving patients to the clinical room for gynaecology examinations. Inspectors observed staff familiarising patients with their surroundings and attending to individual needs in a dignified and respectful manner. To support dignity and respect, single rooms were used for people who were receiving end-of-life care and news was shared with families in a private area.

Inspectors observed patients personal information being visible on whiteboards and healthcare records in unlocked charts trolleys being unattended on ward corridors. The hospital needs to have systems in place to ensure the patient's personal information is protected at all times to maintain privacy.

Judgement: Substantially compliant

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

Inspectors found that staff working in the clinical areas inspected were committed to promoting a person-centred approach to care. Inspectors witnessed examples of kindness during interactions between patients and staff. Staff were regularly checking on patients and attending to their needs.

Patients spoke favourably about their interactions with staff. Inspectors observed, and a patient reported, a calm and quiet atmosphere on the ward.

The hospital promoted a culture of kindness, consideration and respect through the development of quality improvements which enhanced consideration and respect for patients and their families. For example, there were 'protected meal times' on wards to enable patients eat their meals uninterrupted. The hospital was piloting a QIP whereby families were contacted 12 hours following admission to improve communication between hospital staff and families.

The hospital promoted a culture of kindness, consideration and respect through their interactions with each other. All management and clinical staff interactions observed during the two day inspection were respectful and considerate.

The service proactively identified and recognised stages of care and treatment where people using the service may be more vulnerable. For example, inspectors were informed that:

- women arriving at the hospital who were at risk of miscarriage displayed a 'purple card' thereby alerting staff to the situation, so they were brought directly to the gynaecology ward
- patients at end of life were cared for in a single room to promote privacy and dignity, with the use of the Hospice Friendly Hospital symbol.[***]
- patients for intimate gynaecology examinations were transferred to the clinical room for additional privacy
- there was 'protected mealtimes' on wards to enable patients to eat their meals uninterrupted.

Overall, HIQA was assured that the hospital promoted a culture of kindness, consideration and respect.

Judgement: Compliant

[***] The Hospice Friendly Hospitals end of life symbol is displayed when a person has died, or in some instance when a person is imminently dying. On seeing the symbol, staff create an atmosphere of quiet, avoid mobile phone use and are prepared to meet people who are grieving.

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

The hospital had systems in place to respond to complaints and concerns in an effective manner in line with national guidance. The hospital's patient advocate liaison service and risk manager was the designated complaints officer for the hospital.

There was oversight and monitoring of the timeliness of responses and management of complaints. Complaints for each service were reported and reviewed at the Clinical Governance Committee meetings. Completed reports were provided to the clinical lead for the service to oversee the implementation of recommendations within 28 days. The quality and patient safety department maintained and monitored a database of all recommendations, and sought evidence from service leads that recommendations had been implemented. The implementation of recommendations was also reported to QSEC, EMC and at monthly performance meetings.

The hospital supported and encouraged point of contact complaint resolution in line with national guidance. An example of a resolution of a recent verbal complaint was outlined to inspectors. Complaints which could not be resolved at the point of contact were escalated to the quality and patient safety department to be managed at that level by means of a Point of Contact Complaint Resolution form to be completed for level 1 complaints. There was tracking and trending of all complaints, and level 2 complaints were reported to the QSEC, EMC and at monthly performance meetings with the Hospital Group.

The rate of complaints investigated and responses sent to the complainant within 30 days was monitored monthly by the hospital and hospital group. Data reviewed for 2021 indicated that the hospital was in full compliance for seven months of the year. However, the rate for the remaining five months ranged from 53%-66%, below the RCSI Hospital Group set target of 75%. The hospital explained, that in order to provide a coordinated response to complaints there was, on occasions, a delay in completing the clinical judgement element of the investigation due to clinical staff workload.

Information related to 'Your Service Your Say'[†††] was observed on clinical areas and was also included in the patient information folder viewed by inspectors. The majority of patients who spoke with inspectors were satisfied that they could make a complaint if required, and

[†††] The Health Service Executive system for management of service user feedback for comments, compliments and complaints

inspectors were informed that advocacy services, such as SAGE and medical social workers, were available to assist patients to make a complaint if required.

Staff who spoke with inspectors reported that they had access to feedback on tracking and trending of complaints for their services and that learning was shared at the clinical nurse manager's forums and ward meetings. Feedback was also provided through the Clinical Governance Committees with a breakdown of complaints for each service. This feedback was seen displayed on wards visited by inspectors.

Overall, inspectors were assured that Cavan and Monaghan Hospital had processes in place to respond openly and effectively to complaints and concerns raised by people using the service. However, management at the hospital need to review mechanisms to ensure that responses to complaints are sent to complainants within 30 days in line with HSE guidance.

Judgement: Substantially compliant

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

During the inspection, inspectors visited two clinical areas at the Cavan Hospital site; Surgical 1 and Medical 2. Surgical 1 was a 31-bedded ward which catered for the needs of patients receiving surgical, gynaecology and medical care. The ward had multi-occupancy rooms comprising of four six-bedded rooms, one three-bedded room, and four single rooms with en-suite facilities. The ward had 27 patients at the time of inspection. One bed was reserved for early pregnancy review until 11:00am and three beds were closed to admissions as patients who were identified as contacts of confirmed COVID-19 cases were cohorted together, with contact and droplet precautions as per national guidance.

Medical 2 was a 32-bedded medical ward which catered for the needs of patients with a variety of medical conditions. The ward had multi-occupancy rooms comprising of four six-bedded rooms, one four-bedded room and four single rooms with en-suite facilities. The ward was at full capacity at the time of inspection. In both areas inspected, the multi-occupancy rooms had shower and toilet facilities, and physical distance of one metre was maintained between beds, in line with national guidance.

Overall, the areas visited by inspectors were clean and well maintained with a few exceptions. Inspectors observed cleaning schedules and checklists in place for cleaning the environment and patient equipment, with oversight at local and supervisor level. The hospital had a tagging system to identify clean equipment. The wards visited had adequate cleaning staff and resources.

There were adequate supplies of personal protective equipment (PPE). Alcohol-based hand sanitiser dispensers and hand-hygiene sinks were strategically based throughout the ward. Hand hygiene sinks observed by inspectors were compliant with international best evidence, and hand hygiene signs[‡‡‡] were clearly displayed.

On Surgical 1, inspectors observed adequate and appropriate storage of supplies and equipment. However, a corridor on Surgical 1 ward was observed to be congested with equipment stored on both sides of the corridor. Medical 2 corridor was also congested with chart trolleys and medical monitoring equipment. Some office space on Medical 2 ward was assigned to personnel with hospital-wide duties. Congestion on corridors could pose a risk to patient safety in an emergency. Hospital environments should be safe and secure for the people who use the services. Areas should be planned and managed with ongoing assessment of risk, to maintain the quality and safety of care for patients.

Overall, on the day of inspection HIQA was assured that the physical environment on the areas inspected supported the delivery of quality care for the patients who used the services. However, the hospital must ensure that there is safe access and egress along all hospital corridors to ensure safety for patients and staff.

Judgement: Substantially compliant

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

The hospital had systems in place to monitor, evaluate and continuously improve the effectiveness of healthcare services. A variety of measures were used to evaluate the effectiveness of healthcare including experience of care from the perspective of people who used the services, their clinical outcomes, and the governance and oversight arrangements in place to ensure that findings were reported and monitored. Information from monitoring and evaluation was used to improve care and share information, examples of which are provided below.

Measures used by the hospital to evaluate the effectiveness of healthcare included; performance metrics, activity data, audit, quality nursing metrics, surveillance data, national inpatient experience data and self-assessments against the *National Standards for Safer Better Healthcare.*

Performance metrics

[‡‡‡] World Health Organisation (WHO) 5 moments of hand hygiene.

The hospital used national performance indicators and benchmarks to monitor the quality and safety of care and its outcomes. The hospital also monitored additional key performance indicators as part of the RCSI Hospital Group. These metrics were monitored and reviewed monthly and up-to-date performance data was published by the RCSI Hospital Group. Performance data was reported and discussed at Clinical Governance Committee meetings, Quality and Safety Executive Committee, Executive Management Committee meetings and at monthly performance meetings with the RCSI Hospital Group. Areas for improvement and actions required were outlined and assigned to named individuals with timeframes.

The performance metrics were outlined as key performance indicators under the following seven core dimensions:

- access and patient flow
- infection control and management
- medication management
- maternity services
- patient care and treatment
- patient and family experience - National Inpatient Experience Survey results
- staff – absence rates, Garda vetting and training.

Audits were undertaken, with oversight by an audit facilitator with recommendations centrally collated by the quality and patient safety department and monitored at EMC meetings and reported and discussed at monthly performance meetings.

Medication safety

Medication metrics and nursing quality metrics were collected monthly with some evidence provided of quality improvements developed when standards fell below acceptable targets with actions assigned to an individual with time frames. Medication safety metrics were reviewed by the Drugs and Therapeutics Committee and reported at the monthly EMC and performance meetings.

Information from medication monitoring had been used to develop QIPs. For example, the hospitals medication record was revised to include an antimicrobial review section after three days and an automatic stop unless rewritten after seven days to improve compliance with antimicrobial stewardship. A medication management QIP was also initiated in February 2022 and updated in June 2022, with recommendations, timeframes and assigned person. However, there was opportunities for monitoring data to be used to implement improvements in other areas of medication safety practice for example, compliance with the recording of patient weight on medication records was low on many wards and required improvement.

An antimicrobial pharmacist attended the Clinical Governance Committee meetings to provide feedback on results and a monthly antimicrobial newsletter was developed to share learning with staff.

Medication safety audits were planned with oversight by the various Clinical Governance Committees. Audits were coordinated centrally by the clinical audit facilitator. The list of medication safety audits in progress and completed by the various services was viewed by

inspector. Some evidence of re-audit to ensure improvement in practice was provided to inspectors for example, the emergency department was re-auditing the deep vein thrombosis proforma.

Infection prevention and control

The hospital monitored and publically reported monthly IPC metrics for the following items (results for April 2022):

- hospital-acquired staphylococcus aureus bloodstream infection- 0 cases (<1 per 10,000 BDU)
- hospital acquired Clostridium Difficile – I case (<2 per 10,000 BDU)
- carbapenemase-producing enterobacteriaceae (CPE) surveillance testing - Compliance 100% (target 100%)
- healthcare workers compliance with hand hygiene protocols compliance- Compliance 100 % (target 90%)
- healthcare workers vaccinated seasonal flu – Compliance 64% in March 2022 (RCSI hospital group (HG) target 95%)
- front line staff fully vaccinated for COVID-19- Compliance 80% (RCSI HG target 100%).

Monthly environment, equipment and hand hygiene audits were undertaken by the hospital. Inspectors reviewed results for the clinical areas visited during the inspection with overall good compliance achieved.

Quality improvement plans (QIPS) were developed by the hospital when standards fell below acceptable levels. For example, a QIP for CPE surveillance was developed when compliance fell to 89% in May 2022 (RCSI HG target 90%). However, there was an opportunity for information gathered through monitoring to be used to implement improvements in other areas of infection prevention and control to improve practice.

Deteriorating patient

The early warning systems were monitored through monthly metrics. These metrics included the measurement of baseline observations, increased escalation of care, monitoring the use of the ISBAR tool, documentation of care of the deteriorating patient and escalation of care using the sepsis form. Compliance with the metric varied across departments with high compliance noted on most wards. However, there was room for improvement for early warning systems monitoring data to be used to implement improvements in practice in areas such as: the use of ISBAR, increased frequency of observations and escalating care in cases of the deteriorating patient.

Transitions of care

The hospital tracked the average length of stay and the rate of delayed transfer or discharge. On the day of inspection the average length of stay for medical patients was 11 days (HSE target day≤7) and for surgical patients was 5 days (HSE target day≤5.2). At the time of inspection, the hospital reported having six patients whose transfer of care was delayed. Audits

of clinical handover were in progress by department in the hospital and examples from the emergency department and the women and children's directorate were viewed by inspectors.

Staff in all three clinical areas visited were aware of the National Inpatient Experience Survey results and could provide examples of QIPs in place to address these findings. One improvement identified was to improve staff knowledge of the Frailty Intervention Team and ensure that FIT assessment was included in patient handovers to improve information at transfer of care to an inpatient bed. The FIT team had undertaken a QIP to improve frailty awareness among staff in the hospital.

On the day of inspection, HIQA was assured that the hospital had systems in place to monitor and evaluate the effectiveness of healthcare services. However, the hospital should ensure that all information gathered from monitoring, in particular in respect of IPC and management of the deteriorating patient is used to implement required changes and then re-audited to ensure the required changes in practice have occurred.

Judgement: 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 hospital had arrangements in place to ensure proactive monitoring, analysis and response to information significant to the delivery of care. This was achieved through the hospital's incident and complaint management processes, the undertaking of risk assessments and review of the hospital's corporate risk register. The hospital also reported and tracked serious reportable events and serious incidents and monitored ongoing coroner and legal cases.

Infection prevention and control

The hospital had systems and processes in place to protect services user from the risk of harm related to infection prevention and control. The hospital had an effective infection prevention and control programme and an antimicrobial stewardship programme in place. An outbreak management team was in place to manage outbreaks. Completed outbreak reports were reviewed by inspectors. However, inspectors were informed that recent COVID-19 outbreak reports had not been completed in line with national guidance due to workload. It is necessary that outbreak reports are completed so that lessons are learned and shared.

Infection prevention and control incidents were tracked and trended and reviewed at the Infection Prevention and Control Steering Committee (IPCSC) and monitored at senior level by the hospital's QSEC, EMC and at monthly performance meetings.

An infection prevention and control representative attended Clinical Governance Committees (CGC) to discuss IPC risks. IPC risks were included on the Clinical Governance Committee's risk register. IPC risks were escalated to the corporate risk register when the required controls were

beyond the scope of that service. An example of an IPC risk escalated to the corporate risk register was the risk of infection due to insufficient isolation facilities. IPC risks on the corporate risk register were discussed at the Infection Prevention and Control Steering Committee and at EMC Meetings.

Surveillance screening was undertaken for COVID-19, MRSA, VRE and CPE in line with national guideline. However, the hospital was not undertaking screening for ESBL in line with national guidance. This was a finding in the previous HIQA Infection Prevention and Control inspection in 2019. The hospital had developed a quality improvement plan (QIP) following this inspection. The multidrug resistance taskforce (the membership of which included the Infection Prevention and Control Team) was tasked with identifying and bridging the gap between local practice and national guidance.

Infection prevention and control education was provided to staff in the following; standards and transmission precautions, outbreak management, donning and doffing of personal protective equipment (PPE) and hand hygiene. Training records reviewed by inspectors for wards visited during the inspection identified full compliance with attendance at hand hygiene, outbreak and donning and doffing of PPE education. Compliance with staff attendance at standard and transmission based precautions education on Surgical 1 ward ranged from 90-100%, however the same training on Medical 2 ranged from only 71-77% compliance. Oversight of training records was monitored at ward level. On the day of inspection, the hospital was unable to verify overall hospital training records for IPC. The hospital informed inspectors that a new quality management software system was being introduced in the hospital, proposed for Quarter 4 2022. It is planned to track training records on this system.

The hospital reported an overall compliance rate of 90% for mandatory sepsis training. In June 2022, the hospital reported low compliance rates with the new 2021 eLearning sepsis training on HSELand, at 68% for nursing and midwifery, 26% for non-consultant hospital doctors and 35% for consultants. This low compliance was reported and monitored through QSEC, EMC and performance meetings and a quality improvement plan was put in place to improve compliance rates.

The hospital had a suite of up-to-date Infection Prevention and Control (IPC) policies and guidelines which were accessible to staff and provided guidance on IPC issues such as outbreak management, isolation prioritisation, environmental cleaning, and transmission- based precautions.

Medication safety

Medication safety incidents are tracked and trended and reviewed at the Drugs and Therapeutics Committee and monitored at senior level by the hospital's QSEC, EMC and at monthly performance meetings.

The hospital had systems in place to support the safe management of high-risk medicines, which are medicines which have an increased risk of harm if they are misused or used in error. Risk-reduction strategies in place for anticoagulants and insulins were reviewed by inspectors on wards visited and found to be in line with hospital guidance. The hospital had developed a

list of sound alike look alike drugs (SALADS) and was in the process of implementing same, with a strategy for full implementation by Q4 2022.

The absence of a SALAD list with associated risk-reduction strategies was outlined in the previous HIQA Medication Safety inspection in 2019. The hospital had developed a quality improvement plan following this inspection which included an action related to implementation of a SALAD. This action had a named responsible person but target timelines had been exceeded.

Clinical pharmacy service provision was limited at the hospital and was not standardised across wards. There were clinical pharmacists that were only allocated to the emergency department, medical 1, surgical 1, surgical 2 and the pre discharge lounge. Inspectors were told that when requested, pharmacists would undertake clinical reviews and medication reconciliation for patients with complex, high-risk or multiple medications in other clinical areas. Inspectors were informed that the services was currently short 4.2 WTE pharmacists due to planned leave. The impact of this reduced staffing level was reduced a clinical pharmacy service on wards and the lack of medication reconciliation for all patients on admission and discharge. The lack of a clinical pharmacy service for all patient areas incorporating a medication reconciliation service should be addressed.

The hospital had undertaken a pilot of clinical pharmacy services for 4 weeks to highlight the role and benefits of the services. During the four week period, 91 patient medication records were reviewed by a pharmacist. The pharmacist made 198 interventions with 125 (63%) accepted. The theme of pharmacy intervention included: omitted doses, incorrect doses, inappropriate medication, drug interactions and duplicate therapy. These interventions improved medication safety for patients and concurred with international evidence that outlines the benefits of clinical pharmacists[§§§] in hospital wards in preventing adverse drug events.

Medication safety training compliance recorded was between 98-100% overall for nurses, however, only 30% overall for doctors. Inspectors were informed that doctors were sent a virtual slide show of a safe and appropriate prescribing practice bundle in place at Cavan and Monaghan Hospital and education sessions were provided by the antimicrobial pharmacist.

The hospital had medication management polices to guide staff. These policies were accessible to staff. However, some medication safety policies reviewed by inspectors were overdue for review.

Deteriorating patient

The hospital had systems and process in place to anticipate, recognise escalate and respond to the clinically deteriorating patient. The Irish National Early Warning System (INEWS), Paediatric Early Warning System (PEWS) and the Irish Maternity Early Warning System (IMEWS) were all in place in the hospital. The hospital Group had set a target of 100% for medical, nursing and midwifery professionals to be trained in the early warning system and appropriate tool(s) depending on work speciality. Metrics monitored by the hospital identified that in May 2022,

[§§§] Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.

90% of nurses and 83% of medical staff were trained in the INEWS. 100% of midwives and 82% of doctors were trained in IMEWS. 100% of relevant staff were trained in PEWS.

The hospital had recently implemented an electronic Irish National Early Warning System which had provided many benefits to identify and respond to the deteriorating patient. For example:

- allows for real time data collection to occur at point of care
- automated capturing of vital signs and calculation of the early warning score
- clear digital representation of observation chart displayed at bedside and centrally at nurses station
- access to data for audit and evaluation of the system.

The hospital had identified a risk relating to the reliability of wireless internet which resulted in occasional delays in viewing digital observations charts. This was observed by inspectors on the day of inspection and reported by staff. The risk was recorded on the hospitals corporate risk register and escalated to hospital Group level with a proposal to enhance the hospital's connectivity. However, notwithstanding this issue, inspectors noted the considerable potential of the system to be a key support to managing real time patient data.

Transitions of care

The bed manager, liaison nurses and discharge coordinator reported to the patient flow manager and had responsibility for coordinating hospital admissions, transfers and discharges. This team reported to the hospital deputy manager and liaised daily with the Director of Nursing for Integrated Care to support safe transitions of care.

The hospital had systems in place for clinical handover to support safe transitions of care such as daily consultant handover meetings at 4 pm. On Friday, this included handover of all patients who required weekend reviews. An additional medical registrar was on duty during core hours at weekends with a specific remit for reviewing the deteriorating patient on the wards. The hospital held whiteboard meetings at ward level which tracked the patients to identify and action any issues related to patient flow.

The hospital had established a Frailty Intervention Team (FIT) which operated Monday to Friday comprising of a clinical nurse manager 2, a physiotherapist, an occupational therapist, a pharmacist, a speech and language therapist and a social worker. Staff who spoke with inspectors were very positive about the impact of this service for patients over the age of 65 years attending the emergency department.

Inspectors were informed that the FIT service had enhanced transitions of care for older patients through the provision of advice, education and equipment to support safe discharge home. These patients could also be admitted to an 'enable bed' in the associated Lisdarn unit for short-term physiotherapy or other required allied health professional or nursing services to enable the patient's safe return home.

The hospital monitored compliance with the HIQA *National Standards for a Clinical Summary (Patient Discharge)* using datasets contained within discharge correspondence and found that there was a 90% compliance as reported in its most recent published data May 2021. The

hospital also monitored the rate of compliance with the requirement to ensure that a clinical discharge summary was issued to the patient's primary healthcare provider within 1 week of discharge. Providing all patients with an electronic discharge summary on discharge was a focus of the hospital's Operational Plan 2022. Compliance with this metric was significantly below the hospital's target of 100% with only 27% compliance in January 2022 with a gradual rise to 53% compliance in June 2022.

This metric was reviewed as part of the hospital's performance metrics at monthly EMC and performance meetings and a quality improvement plan was initiated by the hospital and shared with hospital staff. Although it is commendable that the hospital are monitoring, reviewing and publishing this data, it is essential that accurate information regarding the patient's stay in hospital is sent to the primary care healthcare professional in a timely manner to support safe and continued care and management following discharge.

Overall, there are opportunities for improvement in the systems in place to protect service users from the risk of harm especially in the areas for focus of this inspection. The hospital need to ensure that discharge summaries reach the primary care healthcare professional in a timely manner to enable safe and continued care and management following discharge. To support medication safety, the hospital should provide a clinical pharmacy service for all patient areas and introduce risk-reduction strategies to promote safer management of SALADS. The IPC team also need to ensure that outbreak reports are completed for all outbreaks, in line with national guidance to support learning. The hospital needs to ensure that the electronic INEWS is accessible at all times to ensure recognition timely response and record of a potential deteriorating patient. The hospital also needs to ensure staff attendance at mandatory training.

Judgement: Partially compliant

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

The hospital had systems in place to effectively identify, report, manage and respond to patient safety incidents. Staff who spoke with inspectors were clear on the system in place to identify and report patient safety incidents and on their roles and responsibilities supported by the HSE National Incident Management Framework. Patient safety incidents were reported in a timely manner through the National Incident Management System in line with national guidance.

Evidence of tracking and trending of incidents was provided to inspectors with governance and oversight arrangement in place to review and manage incidents. At local level, incidents related to each service were reviewed at the Clinical Governance Committee. Incidents were also

reviewed at the Executive Management Committee meeting and at monthly performance meetings.

Evidence of how the service used information arising from patient safety incidents to promote improvements in safety and quality was provided to inspectors. For example, clinical staff outlined the process involved in identifying, reporting and responding to a patient safety incident related to falls with learning shared at ward safety pauses. Hospital wide initiatives called 'Falls Friday' and 'Tissue Tuesday' were in place during which patient safety issues or concerns related to falls and pressure ulcers were discussed, metrics reviewed, proactive actions identified and learning shared with staff.

The hospital had a Serious Incident Management Forum (SIMF) whose role was to review Serious Reportable Events, Serious Incidents and reported incidents that may have a clinical care issue which contributed to an unexpected adverse clinical outcome. Category 1 incidents were reported to the Senior Accountable Officer in line with national guidance and a SIMF was convened to review and subsequently report on same to the QSEC.

The hospital tracked all serious reported events (SRE) and serious incidents (SI) and reported the number and categories at monthly EMC and performance meetings. The status and time frame for each review was monitored.

Recommendations from reviews were tracked and monitored by the quality and patient safety department until evidence of implementation was provided by the assigned responsible person. An update on the status of reports and recommendations was provided to governance committees.

The hospital's medication safety incidents were tracked and trended to identify areas for improvement and share learning. 293 medication safety incidents were reported January-May 2022. This equated to 9.3 medication incidents as reported to NIMS[****] per 1,000 bed days used (national target rate of 3.0). Higher incident reporting rates both demonstrate and promote an improved culture of safety.

Medication safety incidents were categorised using an evidence-based medication error index that classifies an error according to the severity of the outcome. The majority of errors did not reach the patient, or reached the patient but appropriate monitoring intervention prevented harm. Incidents were reviewed at the Drugs and Therapeutics Committee and at monthly EMC and performance meetings.

Overall, HIQA was assured that Cavan and Monaghan Hospital had systems in place to effectively identify, report, manage and respond to patient safety incidents from the information reviewed on inspection.

Judgement: Compliant

[****] The State Claims Agencies (SCA) National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the SCA (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

Conclusion:

This inspection, which was confined to the Cavan site of the Cavan and Monaghan Hospital was carried out against the *National Standards for Safer Better Healthcare* (HIQA 2012) under the revised monitoring programme using a core set of standards on 5 and 6 July 2022. The inspection involved an overall assessment of compliance of the effectiveness of governance (NS 5.5). Compliance with three other national standards were assessed in the emergency department: standard 6.1 from the dimension of Capacity and Capability and standards 1.6 and 3.1 from the dimension of Quality and Safety. Compliance with three national standards from the dimension of Capacity and Capability (5.2, 5.8 and 6.4) and seven national standards from the dimension of Quality and Safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) was assessed in the following ward areas, Medical 2 and Surgical 1.

Capacity and Capability

Overall, inspectors found that Cavan and Monaghan Hospital demonstrated substantial compliance in respect of management arrangements in place to support and promote the delivery of healthcare in the hospital. Management should continue to advance arrangements to ensure that consultants are appropriately registered on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council in the relevant speciality. Pharmacy resource arrangements should be reviewed against the workload to progress prioritisation of work and eliminate potential risk associated with the current reduced clinical pharmacy service.

The emergency department was challenged by the lack of space in the environment in which care was provided. The lack of effective flow for admitted patients to an inpatient bed resulted in boarded patients in the emergency department. This is a concern. The hospital had put a system in place to enhance patient flow both through the emergency department and from the emergency department to the inpatient beds. Challenges remained and inspectors acknowledge the further medium and long-term plans in place to improve patient flow, such as the use of the surgical assessment unit and a new build for the emergency department.

Inspectors found that the emergency department was compliant in relation to the national standard associated with organising and managing workforce (NS 6.1). The hospital had addressed long-standing workforce issues and now had a full complement of nursing and medical staff for the emergency department. HIQA were assured that Cavan and Monaghan Hospital planned, organised and managed the workforce in the emergency department to achieve the service objectives for safe and reliable healthcare.

In relation to the ward inspections, inspectors found that Cavan and Monaghan Hospital had formalised corporate and clinical governance arrangements in place to provide quality, safe and reliable healthcare (NS 5.2). The hospital had updated the hospital's Corporate Governance Structures, approved in 2022, which outlined the reporting structures within the hospital and to

the RCSI Hospital Group. These reporting structures were evident to inspectors during the inspection. The hospital was in the process of restructuring governance and reporting arrangements for quality and patient safety to streamline and improve the effectiveness of these reporting structures. The hospital should finalise and formalise the proposed restructuring arrangements. Management of the hospital had good oversight and assurances mechanisms in place which provided assurance to HIQA of the delivery of high-quality, safe and reliable healthcare.

At the time of inspection, HIQA was satisfied that Cavan and Monaghan Hospital had systematic monitoring arrangements in place, however, there were further opportunities to use information gathered to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services they provided (NS 5.8).

Inspectors found that the hospital supported their workforce in delivering high-quality, safe and reliable healthcare.

Quality and Safety

On the day of inspection, inspectors found that staff in the emergency department sought to promote dignity, privacy and confidentiality for the people who used the service (NS 1.6). However, inspectors were not fully assured that the environment in which care was provided always promoted and protected the dignity and privacy for the patients, for example, the lack of toilet and shower facilities in the ED and lack of space during instances of overcrowding. In the ward areas, inspectors found that staff at the hospital promoted and respected the dignity of the people who use the service. Staff were observed to be considerate and respectful to patients. However, inspectors observed patient's personal information visible on whiteboards and healthcare records in open trolleys unattended on ward corridors. The hospital needs to have systems in place to ensure the patient's personal information is protected at all times. The hospital staff promoted a culture of kindness, consideration and respects (NS 1.6 and 1.7)

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department with oversight from the Emergency Medicine Clinical Governance Committee (NS 3.1). Risks which were beyond the control of this committee were escalated to the corporate risk register and Executive Management Team. HIQA was assured that the design and delivery of healthcare services in the emergency department protected people who used the service from the risk of harm from infection prevention and control, medication safety, deteriorating patient and transitions of care. In the ward areas, inspectors identified some opportunities for improvement in the systems in place to protect services user from the risk of harm especially in the four areas of focus of this inspection. The hospital should ensure that discharge summaries reach the primary care healthcare professional in a timely manner, to allow for safe and continued care and management following discharge. The hospital also needs to ensure compliance with attendance at all mandatory training. To support medication safety the hospital should progress the clinical pharmacy service for all patient areas and introduce risk-reduction strategies to promote safer management of SALADS. The IPC team also need to ensure that outbreak reports are completed for all outbreaks, in line with national guidance to support learning. The hospital had

also recently implemented an electronic Irish National Early Warning System which had provided many considerable benefits to identify and respond to a potential deteriorating patient but additional work is needed locally to ensure that the electronic INEWS is accessible at all times to ensure timely anticipation, recognition and response to the deteriorating patient.

In the ward areas, the physical environment in the areas inspected, supported the delivery of quality care for the people using the services. However, the hospital must ensure that there is safe access and egress along all hospital corridors to ensure safety for patients and staff (NS 2.7).

The hospital had systems in place to respond to complaints and concerns in an effective manner in line with national guidance. The hospital monitored, evaluated and established QIPs to improve the healthcare services. The hospital identified, reported and managed patient-safety incidents. However, there was an opportunity to ensure that all monitored data was used to implement change and improve practice (NS 3.3).

Overall, while noting a number of areas for improvement across several standards, inspectors found that the hospital was compliant or substantially compliant in most areas.

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 national standards assessed during this inspection at the Cavan site of the Cavan and Monaghan Hospital was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management sets out the actions taken or planned in order for the healthcare service to come into compliance with the national standards judged to be non-compliant. It is the responsibility of the healthcare service provider to ensure that it implements the actions in the compliance plan within the set time frames to fully comply with the national standards.

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

Capacity and Capability Dimension	
Judgements relating to ward area findings only	
National Standard	**Judgement**
Theme 5: Leadership, Governance and Management	

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Judgments relating to Emergency Department findings only	
Theme 6: Workforce	
Standard 6.4: Service providers support their workforce in delivering high quality, safe and reliable healthcare	Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially 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: Cavan and Monaghan Hospital's response

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

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

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

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

	SMART Objective	Interim actions	Action Owner
1	100% of discharge charge summaries will be issued electronically to the primary healthcare provider within 1 week of the patients discharge by year end 2022.	New PCs in the clinical areas Enhanced focus This metric is reported and monitored locally at QSEC (two-monthly) and at RCSI HG Performance (monthly)	Director of Operations
2	A Clinical Pharmacy service business plan to be completed by Q4 2022.	Business Plan to be developed and submitted By C&MH (and approved by RCSI HG)	Chief Pharmacist General Manager
3	SALADS List has been developed and implementation has commenced. Full implementation across remaining areas to be completed by Q4 2022.	Implementation on-going.	Chief Pharmacist
4	Wave 4 and Wave 5 Outbreak Reports will be completed by year end 2022.	Complete outbreak reports	Infection Prevention & Control Team
5	Network coverage will be improved to reduce the	Phase 1 – Celullar coverage booster for wards installed.	Director of Operations

		risk of outage of the KEWS system.	Phase 2 – Cellular booster in planning stage for ED and OPD. Phase 3 – Cellular booster in planning stage for Maternity and administration areas. KEWS network coverage is a standing agenda on the monthly E-Health steering committee (RCSI HG & C&MH)		
	6	100% of staff will be advised to complete the required Mandatory Training and training will be captured on Q PULSE by Q1 2023	Notice will be issued to all staff groups regarding mandatory training requirements Training will be recorded on Q Pulse Assurance will be sought re Mandatory training attendance at QSEC	Operational Services Manager All relevant Leads	
Timescale: Q1 2023					