



HospiceFriendly  
**HOSPITALS**

Putting Hospice Principles into Hospital Practice.

# National Audit of End-of-Life Care in Hospitals in Ireland

2008/9

## Resources and Facilities For End-of-Life Care in Hospitals in Ireland

### National Audit Report 1

May 2010

  
Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

 THE IRISH  
**HOSPICE**  
FOUNDATION

## Research Team

Kieran McKeown	Social & Economic Research Consultant, 16 Hollybank Rd., Drumcondra, Dublin 9, Ireland. Email: <a href="mailto:kmckeown@iol.ie">kmckeown@iol.ie</a>
Trutz Haase	Social & Economic Consultant, 17 Templeogue Rd., Terenure, Dublin 6W, Ireland. Email: <a href="mailto:thaase@iol.ie">thaase@iol.ie</a>
Shelagh Twomey	National Audit Manager of HFH Programme Irish Hospice Foundation, Morrison Chambers, 32 Nassau St., Dublin 2, Ireland. Email: <a href="mailto:shelagh.twomey@hospice-foundation.ie">shelagh.twomey@hospice-foundation.ie</a>

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## Ownership & Confidentiality

This report is the joint property of the hospitals who contributed to the national audit of end-of-life care in 2008/9, and the Irish Hospice Foundation. Information about any individual hospital is confidential to that hospital.

## List of National Audit Reports

Report One	Resources and Facilities for End-of-Life Care in Hospitals in Ireland
Report Two	Dying in Hospital in Ireland: Nurse and Doctor Perspectives
Report Three	Dying in Hospital in Ireland: Family Perspectives
Report Four	The Culture of End-of-Life Care in Hospitals in Ireland
Report Five	Dying in Hospital in Ireland: An Assessment of the Quality of Care in the Last Week of Life

## **The Time Before Death by Kabir <sup>1</sup>**

Friend, hope for the Guest while you are alive.  
Jump into experience while you are alive!  
Think... and think... while you are alive.  
What you call "salvation" belongs to the time  
before death.

If you don't break your ropes while you're alive,  
do you think  
ghosts will do it after?

The idea that the soul will rejoin with the ecstatic  
just because the body is rotten -  
that is all fantasy.  
What is found now is found then.

So plunge into the truth, find out who the Teacher is,  
Believe in the Great Sound!

Kabir says this: When the Guest is being searched for,  
it is the intensity of the longing for the Guest that  
does all the work.

Look at me, and you will see a slave of that intensity.

---

<sup>1</sup> Kabir (15th century ). He was born in India and his work is revered by Muslims, Hindus, and Sikhs. His poetry became popular in the West through the translations of Rabindranath Tagore and, more recently, Robert Bly.

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Mid-Western Regional Hospital Limerick  
Cavan General Hospital  
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Louth County Hospital, Dundalk  
Kerry General Hospital, Tralee  
Wexford General Hospital  
St. James's Hospital, Dublin 8  
Sligo General Hospital, Sligo  
Mater Misericordiae University Hospital  
Connolly Hospital  
Letterkenny General Hospital  
St. Luke's Hospital, Rathgar  
Portlaoise, Midland Regional Hospital  
Beaumont Hospital  
Waterford Regional Hospital  
South Tipperary General Hospital  
St. Luke's Hospital, Kilkenny  
Tallaght Hospital  
Nenagh, Mid-Western Regional Hospital  
Naas General Hospital  
Tullamore, Midlands Regional Hospital

### Community Hospitals

St. Joseph's Hospital, Trim  
Royal Hospital Donnybrook  
Bru Chaoimhin  
Bellvilla  
Meath Community Unit  
St. Mary's Hospital, Phoenix Park  
St John's Hospital, Sligo  
St. Mary's Castleblayney  
Oriel House  
Leopardstown Park Hospital  
Peamount Hospital, Newcastle  
Breffni  
Virginia

### Hospital Audit Managers

Fionuala O'Gorman  
Catherine Hand  
Bridget Clarke  
Josephine O'Hagan  
Mary McCrane  
Concepta Tallon  
Kathriona Campbell  
Richard Walsh  
Bernard Finnegan  
Paul Gallagher & Lucy KIELTY  
Kate Bree  
Breda Doyle  
Catriona Higgins  
Pauline McManus  
Wendy Fair  
Emer McEvoy & Ann Sheerin  
Mary Baggot  
Cliona Rafter  
Maria Barry  
Debbie Kavanagh  
Kathleen Flynn  
Mary Clifford  
Breda Murphy  
Claire O'Dea & Lorna Griffith

### Hospital Audit Managers

Frances Flynn  
Anne Dooley  
Muthu Saba  
Niamh Curran  
Karen Rowlett  
Michelle Russell  
Fran Butler  
Susan McGoldrick  
Geraldine Smyth  
Elaine Flanagan  
Elaine Keane  
Ann Gaffney  
Bernardine Lynch

Lisdaran  
Sullivan Centre, Cavan  
Boyne View Drogheda

Cottage Hospital, Drogheda

St. Mary's Hospital, Drogheda

St. Joseph's Hospital, Ardee

Bernie McManus  
Martha Adams  
Lena Varghese  
Ciara Cullen  
Karen McElaine (Unit 1)  
Mary Gallagher (Unit 2)  
Myrna Guay (Unit 1)  
Ann Keane (Unit 2)  
Eileen Dullaghan  
Bernie Murphy & Patricia Barry

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Cork University Hospital  
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**RCSI Pilot Study**

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St. John's Hospital, Sligo  
St. Columba's, Co. Kilkenny

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Mervyn Taylor

Programme Manager

Shelagh Twomey	Deputy Programme Manager
Helen Donovan	Standards Development Coordinator
Mary Bowen	Operations Manager
Denise Connor	Project Development Coordinator
Róisín Clarke	Programme Administrator
Grace O'Sullivan	Programme Administrator & Development Support
Lorna Peelo-Kilroe	National Practice Development Coordinator End-of-Life Care
Paul Murray	Development Coordinator - Forum on End-of-Life Care
Joanne Carr	Development Coordinator
Amanda Manning	Development Coordinator
Fran McGovern	Development Coordinator
Bryan Nolan	Development Coordinator
Aoife O'Neil	Development Coordinator
Ruth Agar	Development Coordinator
Colette Cunningham	Development Coordinator
Mary Friel	Development Coordinator
Nuala Harmey	Development Support

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Prof. David Clark	Chair, Visiting Professor of Hospice Studies, TCD & UCD
Orla Keegan	Head of Education, Research & Bereavement Services, The Irish Hospice Foundation
Mervyn Taylor	Programme Manager, Hospice Friendly Hospitals Programme
Shelagh Twomey	Deputy Programme Manager, Hospice Friendly Hospitals Programme
Max Watson	Consultant in Palliative Medicine, Northern Ireland Hospice
Gail Birkbeck	The Atlantic Philanthropies (in attendance)

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Prof. Cillian Twomey	Chair, Consultant Physician in geriatric medicine at Cork University Hospital and St. Finbarr's Hospital, Cork
Prof. David Clark	Visiting Professor of Hospice Studies, TCD & UCD
Denis Doherty	Chairman, The Irish Hospice Foundation Chairman, and Chairman, Nursing Homes Ireland
Eugene Murray	Chief Executive Officer, The Irish Hospice Foundation
Prof. Brendan McCormack	Director of Nursing Research & Practice Development, Royal Group of Hospitals, Belfast and University of Ulster at Jordanstown

Orla Keegan	Head of Education, Research & Bereavement Services, Irish Hospice Foundation
Richard Dooley	Network Manager, South Eastern Hospitals Group, HSE
Ann Ryan	Inspector Manager, Health Information & Quality Authority
Brenda Power	Broadcaster and journalist
Geraldine Fitzpatrick	Principal Officer, Services for Older People & Palliative Care, Department of Health & Children
Sheila Dickson,	First Vice-President, Irish Nurses Organisation
Margaret Murphy	Patient Representative on the Council of the Irish Society for Quality and Safety in Healthcare
Dr. Doiminic Ó Brannagáin	Consultant in Palliative Medicine, Health Services Executive, North East
Barbara Fitzgerald	Director of Nursing, Naas General Hospital
Dr. Peter Lawlor	Consultant in Palliative Medicine, St. James's Hospital and Our Lady's Hospice
Dr. Emer Longley	General Practitioner, Inchicore Medical Centre, D8.
Noel Mulvihill,	Health Service Executive, Local Health Manager, LHO - Dublin North Central (HSE)

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Dr. Kieran McKeown, on behalf of the Research Team.  
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## Executive Summary

This report describes the resources and facilities for end-of-life care in the 24 acute and 19 community hospitals. All data pertains to 2008.

### Coverage of Audit

Most people die in a hospital or similar setting, outside the home. In Ireland, at least half of all deaths occur in acute hospitals (48%) or hospices (4%); deaths at home still constitute a quarter of the total (25%), and a fifth die in long-stay facilities (20%); the remainder are deaths from suicide and traffic accidents (3%). The main focus of the audit is on patients who die in acute hospitals<sup>2</sup> but patients in one type of long-stay facility – community hospitals<sup>3</sup> – are also included. The 24 acute hospitals in the audit represent a major part of that sector in Ireland in terms of bed-capacity (74%), number of patients (72%), deaths (71%), and staff (73%). Coverage of the community hospital sector is less extensive, covering just 20% of bed-capacity although the average size of these hospitals in the audit (110 beds) is considerably higher than the average for all community hospitals (68 beds). In geographical terms, the audit has strongest coverage in the eastern part of the country. Weakest coverage is in the west with no participation from hospitals in Galway, Mayo or Roscommon - the former Western Health Board Region.

### Data Limitations

The audit data supplied by many hospitals is limited because: (i) some data is missing; (ii) some data is inconsistent with published HSE data; and (iii) some data is at variance with the experience of HFH staff who work with individual hospitals. For example, there is missing data on: deaths (such as whether the death was referred to a coroner, whether a post-mortem was held, whether it was a hospital or coroner's post-mortem, and number of 'brought-in-dead'), patients (such as number of in-patients and day-patients with a Medical Card), staff (such as actual and WTE number of staff, turnover and absenteeism), specialist palliative care staff, and complaints especially complaints about end-of-life issues. Similarly, there are inconsistencies with published HSE data in areas such as: the proportion of deaths followed by a post-mortem, absenteeism, and number of complaints. Finally, there are significant variances between hospital returns and the independent observations of healthcare experts in rating the quality of hospital and mortuary facilities<sup>4</sup>.

### Single rooms

Single rooms are increasingly seen as the standard of accommodation required in hospitals in order to control the spread of infection and cater for the preferences of patients and their families. In the audit, the proportion of single rooms in acute and community hospitals is 15%, similar to that in English hospitals<sup>5</sup>. However, this is far short of any of the standards – 100%<sup>6</sup>, 80%<sup>7</sup>, 50%<sup>8</sup> - that have been proposed for the proportion of single rooms in hospitals.

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2 In this report, the acute sector is defined as the 38 hospitals in the HIPE system which have A&E departments but excluding children's hospitals, orthopaedic hospitals, and eye & ear hospitals.

3 There is no official definition of a 'community hospital' in Ireland but the convention is to differentiate it from an 'acute hospital' if it does not have an accident and emergency department. Community hospitals are effectively long-stay facilities but offer a higher level of medical support compared to the average nursing home.

4 Tribal, 2007.

5 In 155 English hospitals which use the Liverpool Care Pathway, the median number of beds was 478 and the median number of side-rooms was 74, which implies that 15% of beds are in single rooms (Marie Curie Palliative Care Institute Liverpool, 2009:23).

6 Facility Guidelines Institute and the AIA Academy of Architecture for Health, 2006. Available at: <http://www.fgiguilines.org/guidelines.html>. Accessed 20 March 2009. In Ireland, a draft of the infection control

### **Bed occupancy rate**

The average bed occupancy rate of hospitals in the audit is 93% for both the acute and community hospitals, and even higher for the larger hospitals. This rate is well above the OECD average of 75%<sup>9</sup>, and is generally regarded as too high because it has the effect of causing overcrowding, reducing access for new patients, increasing the risk of infection, and threatening the quality of care of patients.

### **Place of death**

The audit established that most deaths in acute hospitals take place in wards (68%), the remainder occurring in intensive care (20%) and A&E (12%). In the community sector, most deaths (85%) occurred in the community hospital where the patient lived, but 15% took place in acute hospitals.

### **Coroners and post-mortems**

Over the past century, an increasing proportion of deaths have become the subject of post-mortems and inquests. In 1885, for example, only 2% of deaths in Ireland involved a post-mortem / inquiry but, 120 years later in 2005, nearly a fifth (18%) of all deaths were investigated by a coroner. The results of the audit reveal that 12% of all acute hospital deaths are referred to the coroner while over a fifth (21%) are followed by a post-mortem.

### **Brought in dead**

The concept of 'brought in dead' refers to patients who are pronounced dead outside the hospital. In the audit, as in the HIPE system, these deaths are additional to deaths which take place within the hospital. In acute hospitals, these deaths are equal to nearly a quarter (23%) of all deaths in the hospital. The majority of these were brought directly to the mortuary (71%), with the remainder brought to A&E (17%) and for preparation by funeral directors (12%).

### **Staffing**

In acute hospitals, nurses are by far the largest category of staff (40%) with a nurse-to-doctor ratio of 3.4 compared to an OECD average of 2.9<sup>10</sup>. Nurses are also the largest staff category in community hospitals (41%) but 'other patient care', mainly comprising health care assistants, is also a large staff category (37%). Staff turnover is 15% in acute hospitals and 14% in community hospitals, higher than the national average of 10%. The rate of absenteeism is 6% in the acute sector and 5% in the community sector and is regarded as a significant problem by the management in both sectors. This rate of absenteeism is well above the national average – and the HSE target - of 3.5% although there are large variations across staff grades.

### **Standard of hospital facilities**

Using the Design and Dignity Guidelines<sup>11</sup> as a standard, hospitals self-rated their facilities at 5.8 out of 10.0, with almost no difference between acute and community sectors. Facilities with a specific focus on end-of-life care received the same rating. This result is at variance with an independent observation of 15 acute and 5 community hospitals carried out for the HFH programme in 2007<sup>12</sup>, which awarded

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building guidelines recommends that all 'new-builds' should have 100% single rooms (Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278-9)

7 Health Information and Quality Authority, 2008:45

8 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278

9 OECD, 2007.

10 OECD, 2007.

11 Hospice Friendly Hospitals Programme, 2008:18.

12 Tribal, 2007.

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the hospitals an average score of 3.6 out of 10.0. Despite their relatively high self-assessed scores, only one acute hospital and no community hospital, merits a 'green light' (equivalent to a score of 8.5 or higher).

### **Distribution of specialist palliative care services**

A majority of acute hospitals in Ireland do not meet the government-approved standard of having a full specialist palliative care team. This result is in line with a more comprehensive analysis of specialist palliative care teams in 38 acute hospitals carried out by the Irish Hospice Foundation (IHF)<sup>13</sup>. Similarly, a majority of community hospitals do not have access to a specialist palliative care service. The audit was unable to discover any rationale behind the distribution of specialist care services in hospitals since it seems to bear no relationship to the number of deaths in each hospital.

### **Complaints**

All acute hospitals received complaints but more than half the community hospitals (10, 53%) reported no complaints. Complaints about end-of-life care seem to represent a relatively small proportion of total complaints in acute hospitals (2.7%), and this appears low by comparison with experience elsewhere<sup>14</sup>.

### **Policies and procedures on end-of-life care**

A third of acute hospitals (33%) - compared to less than two out of ten community hospitals (16%) - do not have written policies, procedures, objectives or targets on end-of-life care. This compares unfavourably with the infrastructure of written policies, procedures and guidelines for end-of-life care in hospitals in Northern Ireland<sup>15</sup>.

### **Training for end-of-life care**

End-of-life care rarely features in the induction of staff, unlike the practice in Northern Ireland where all staff are normally informed about the hospital's policies, procedures and guidelines for end-of-life care during their ward induction<sup>16</sup>. Despite this, hospitals provide a substantial amount of in-service training in end-of-life care, both acute (19, 79%) and community (10, 51%), broadly similar to that in English hospitals<sup>17</sup>. Significantly, the provision of end-of-life training in acute hospitals is not related to either the number of deaths – a proxy indicator of need for specialist palliative care services – or the existence of a full, partial, or no specialist palliative care team.

### **Supports for end-of-life care**

Over half the acute hospitals (58%), but less than a fifth of community hospitals (16%), have a document outlining the supports that are available for staff involved in end-of-life care.

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13 Murray, Sweeney, Smyth and Connolly, 2006. See also Murray, 2008.

14 For example, the Healthcare Commission for England & Wales (replaced by the Care Quality Commission in March 2009) received over 16,000 complaints for independent review between 2004 and 2006. Of these, 54% were complaints about hospitals involving the care received at the time death, compared with only 22% being about patient safety. Most families complained about quality of communication; for example receiving contradictory information from different staff members and not being prepared by staff for the patient's death (Cited in Mayor, 2007).

15 Northern Ireland Health and Social Care Bereavement Network, 2009:13-14.

16 Northern Ireland Health and Social Care Bereavement Network, 2009:14.

17 In 155 English hospitals which use the Liverpool Care Pathway, continuing education and training for care of the dying is provided for medical staff (74%), nursing staff (84%) and non-qualified clinical staff (58%) (Marie Curie Palliative Care Institute Liverpool, 2009:28).



### **Standard of mortuary facilities**

Using the Design and Dignity Guidelines<sup>18</sup> as the standard, the audit found that acute hospitals had 45% of the recommended facilities for mortuaries compared to 40% in community hospitals. These findings are consistent with two previous assessments of mortuaries in Ireland<sup>19</sup>.

### **Bereavement services and facilities**

The majority of acute (14, 58%) and community (16, 84%) hospitals do not have a bereavement service. However, hospitals which have a bereavement service also tend to have reasonably good facilities to deliver that service.

### **Conclusions and issues for consideration**

These findings raise a number of issues which merit further consideration by each individual hospital and their staff, and the HSE generally. In the final section of the report, we outline these issues in detail in order to facilitate discussion, reflection and a considered response.

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18 Hospice Friendly Hospitals Programme, 2008:18.

19 Tribal, 2007:20; Willis, 2009:114.

# 1 Introduction

Most people die in a hospital or similar setting, outside the home. In Ireland, at least half of all deaths occur in acute hospitals (48%) or hospices (4%); deaths at home still constitute a quarter of the total (25%), and a fifth die in long-stay facilities (20%); the remainder are deaths from suicide and traffic accidents (3%) (see Tables 1.1a-b). This is significant because dying, death and bereavement are important events for patients, families and friends and, for that reason, it is appropriate to inquire how, and how well, hospitals provide care for people at this stage of life. The purpose of the audit therefore is to open the door, and turn the light, on this previously unexplored aspect of hospitals in Ireland.

The importance of hospitals and long-stay institutions as places where people die has grown in significance over the past century. In 1885, for example, the vast majority of people in Ireland (85%) died at home but, 120 years later in 2005, this pattern is reversed with only 25% of people dying at home (see Table 1.1 and Figure 1.1). Those who die outside the home are almost evenly divided between acute hospitals (40%) and over long-stay facilities (35%)<sup>20</sup>. In this respect, Ireland holds a mid-way position between those countries which have proportionately fewer deaths at home such as England & Wales (19%) and the USA (21%), and those which have a higher proportion of deaths at home such as France (28%), Switzerland (28%), Germany (30%) and the Netherlands (30%)<sup>21</sup>.

The trend towards what might be called ‘the hospitalisation of dying’ looks set to continue for a variety of reasons. There are demographic factors such as longer life-expectancy<sup>22</sup> accompanied by rising illness rates (sometimes referred to as morbidity), particularly among older age groups, which is resulting in a high rates of hospitalisation for older people<sup>23</sup>. There are cultural reasons, sometimes referred to as the ‘medicalization of everyday life’<sup>24</sup>, which predisposes individuals to think of life’s difficulties – including dying<sup>25</sup> – as abnormal or pathological, and leads institutions such as hospitals to offer ‘treatments’ for these difficulties; this process can both over-value and over-burden hospitals and, in the case of dying, can create a disposition to see dying as ‘something to be resisted, postponed, or avoided’<sup>26</sup>. There may also be social reasons such as the decline in family size and other

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20 Based on 2007 data from the Central Statistics Office (Vital Statistics) and the HIPE. The HIPE system (Hospital In-Patient Enquiry), established in 1971, is a computer-based health information system designed to collect clinical and administrative data on discharges from, and deaths in, acute hospitals in Ireland. In 2006, 57 acute public hospitals in Ireland reported to HIPE. The ESRI has been responsible for managing, and reporting on the HIPE Scheme on behalf of the Department of Health and Children and the Health Service Executive since 1990. In 2006, HIPE captured 96.7% of activity in public hospitals.

21 Data cited in report by National Audit Office (2008:49).

22 Walsh, 2008; Whelan, 2008.

23 Armstrong, 2008

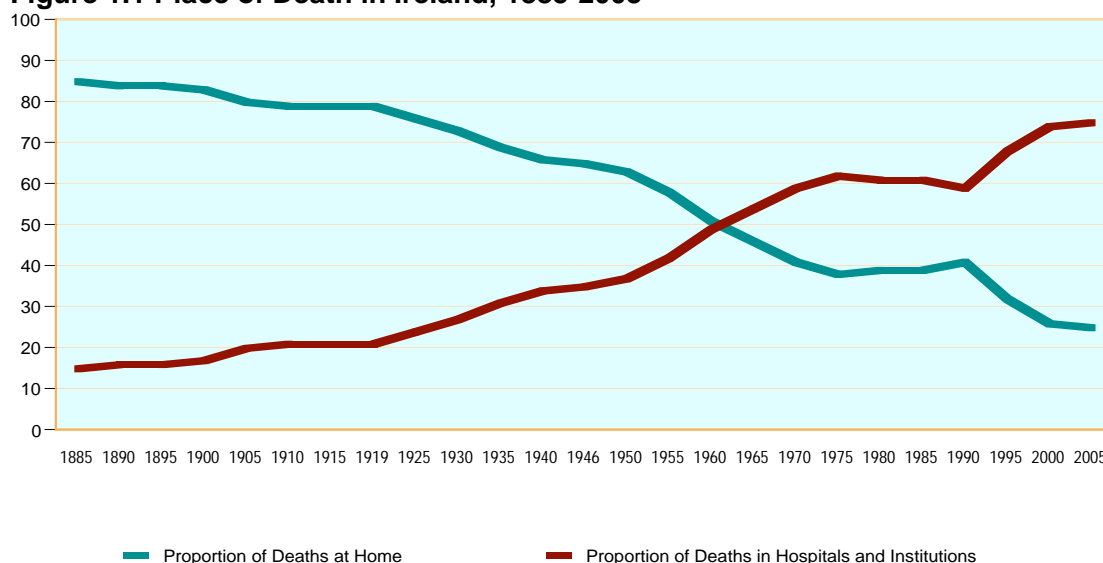
24 Szasz, 2007; one of the earliest and most influential commentaries on the ‘medicalisation of dying’ was by Ivan Illich (1976).

25 The concept of ‘medicalisation’ has been used to throw light on the inappropriate use medical concepts – such as patient, disease and treatment – to explain ‘normal’ life processes such as birth and death as well as ‘normal’ life difficulties such as mental health problems, deviant behaviours, sexual functioning and orientation, drug dependency, etc. It is true that these situations may have a medical aspect – involving symptoms of physical dysfunction – but clearly there is no ‘medical solution’ to situations such as dying, death and bereavement. These are inescapable parts of the human condition and, as the evolution of palliative medicine testifies, they call for a human response to ensure that unnecessary suffering – including physical pain, fear and loneliness – is relieved. It is clear that having a ‘good death’ – as defined in the UK end-of-life strategy – requires much more than medical treatment; the UK end-of-life strategy defines a good death as comprising: (i) being treated as an individual with dignity and respect (ii) being without pain and other symptoms (iii) being in familiar surroundings and (iv) being in the company of close family and / or friends (Department of Health, 2008:9).

26 Clark, 2002

community supports although the evidence suggests that families still care for older people as in previous generations<sup>27</sup>.

**Figure 1.1 Place of Death in Ireland, 1885-2005**



At the same time, there are also countervailing forces to the hospitalisation of dying such as the expressed preferences of the majority of Irish people to die at home<sup>28</sup>. Indeed the preference for dying at home would appear to be stronger among doctors and nurses than among patients<sup>29</sup>. In addition, there is a growing realisation by hospitals and health services that a substantial proportion of patients who die in hospital could be cared for more appropriately at home, in a hospice, or in a nursing home<sup>30</sup>. However, the overall balance of forces affecting the hospitalisation of dying suggests that most people may not die at home because the majority of deaths tend to follow a period of chronic illness related to conditions such as heart disease, liver disease, renal disease, diabetes, cancer, stroke, chronic respiratory disease, neurological disease and dementia. Long-term projections in England<sup>31</sup> - which already has a lower proportion of deaths at home (19%) compared to Ireland (25%) -

27 See Fahey and Field (2008:57) for a summary of the evidence.

28 In a survey of 1,000 adults aged 15+ in the Republic of Ireland, carried out in 2004, 67% indicated that they would like to be cared for at home if they were dying (Weafer and Associates, 2004:10-11).

29 This is based on a survey of 1,899 ICU doctors, nurses and patients in six European countries, who were asked where they would rather be if they had a terminal illness with only a short time to live; the results showed that more doctors and nurses would prefer to be at home or in a hospice and more patients and families preferred to be in an ICU (Sprung, Carmel, Sjøkvist, et al., 2007). The same study also revealed that physicians provide more extensive treatment to seriously ill patients than they would choose for themselves, possibly indicating a public demand for life-prolonging interventions that may have little prospect of success.

30 In Ireland, a random sample of 3,035 medical and surgical in-patients across 37 acute hospitals were reviewed between November 2006 and February 2007 by PA Consulting Group and Balance of Care Group (2007) for the HSE. The results of this study, though not focused on end-of-life, showed that 13% could have been treated outside an acute setting, 75% of elective survey patients were admitted earlier than necessary, 39% of day patients could have been treated in an alternative setting, and discharge planning was in evidence from the notes of 40% of patients. In response to this, the HSE introduced a Code of Practice for Integrated Discharge Planning in December 2008 with the overall purpose of reducing the average length of stay in hospitals to the OECD average. This code of practice provides a framework for care and case management and comprises a suite of national standards, recommended practices, forms, toolkits, key metrics and audit tools. In the UK, a recent study on end-of-life care by the National Audit Office (2008:7) reported: 'Our detailed examination of patient records in one PCT [Primary Care Trust] found that 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month. Alternative places of care for these patients identified by our work were equally split between home based alternatives (in the patient's own home or a care home) and bed based care in a hospice. Local data suggest there was sufficient inpatient palliative care capacity to take many of the patients who died in hospital'.

31 Gomes and Higginson, 2008.

suggest that only 10% of people will die at home in 2030, and this is part of the scenario on which the end-of-life strategy for England is based<sup>32</sup>.

The fact that this study is an audit – and not just a piece of research – means that it is intended to be part of a quality improvement cycle which allows each hospital to assess its performance against established standards and to make improvements in light of the gaps identified. In other words, the audit is a means to an end, not an end in itself: the means involve assessing each hospital's end-of-life care and the end is to assist the hospital in drawing up and implementing a quality improvement plan.

The rationale and importance of audit as an instrument of quality improvement was clearly articulated in 2008 by the Commission on Patient Safety and Quality Assurance as follows: “Clinical audit needs to be at the heart of clinical practice, and is something that all health practitioners should be engaged in. Clinical audit is about continuing evaluation and improvement by health professionals working towards delivery of safe, high quality care for patients. Clinical audit arguably constitutes the single most important method which any health care organisation can use to understand and ensure the quality of the service it provides. It is one of the principal methods used to monitor clinical quality and the results provided by clinical audit are a source of indispensable information to patients, the public, clinicians, and healthcare managers. It also provides a powerful mechanism for ongoing quality improvement highlighting incidences where standards are not met and identifying opportunities for improvement”<sup>33</sup>.

The standards used in the audit to assess the quality of end-of-life care are the Draft Quality Standards for End of Life Care in Hospitals<sup>34</sup>. These standards were prepared and published by The Hospice Friendly Hospitals (HFH) Programme, and are based on a comprehensive review of international research and practice on end-of-life care. The Draft Quality Standards for End of Life Care in Hospitals, which incorporates previously published Design and Dignity Guidelines<sup>35</sup>, were prepared with the support of the Health Information and Quality Authority, the statutory body with responsibility for setting standards in health and social services and monitoring healthcare quality.

This audit is based on the understanding that end-of-life care in a hospital setting is infused by a hospice philosophy<sup>36</sup> which vitalises both: (i) the individualised palliative care<sup>37</sup> of patients whose illness is beyond cure and (ii) the system of supports within

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32 Department of Health, 2008:26.

33 Commission on Patient Safety and Quality Assurance, 2008:151. In February 2009, the Minister for Health and Children announced a Government decision to prepare legislation to implement the recommendations in the report of the Commission on Patient Safety and Quality Assurance. Of particular relevance in this context is the Commission's recommendation that 'There should be a mandatory licensing system in Ireland to cover both public and private healthcare providers. It must be an equitable and transparent system, with a review of the licences every three years. It will apply to existing and new bodies, with time being given for compliance' (p.25). A further recommendation states: 'As part of the licensing process recommended in this Report, all licensed healthcare facilities must demonstrate active participation in local and national clinical audit as appropriate to their services (p.30).

34 Hospice Friendly Hospitals Programme, 2009.

35 Hospice Friendly Hospitals Programme, 2008.

36 A hospice philosophy is defined in the Draft Quality Standards for End of Life Care in Hospitals as follows: 'a philosophy of care which includes but is not solely reflected in a medical speciality. The philosophy goes beyond palliation and is characterised by a holistic (physical, psychosocial and spiritual) attention to illness. The focus of a hospice philosophy should not be exclusively on dying and death but rather should be based on providing holistic care and symptom control as soon as possible in the disease trajectory'. (Hospice Friendly Hospitals Programme, 2009:57). This definition, in turn, is taken from O'Shea, Keegan, McGee, 2002:11-12.

37 Palliative care has been described as an 'interdisciplinary speciality that focuses on improving quality of life for patients with advanced illness and for their families through pain and symptom management, communication and support for medical decisions concordant with goals of care, and assurance of safe transitions between care settings' (Morrison, et al, 2008). According to the World Health Organisation, 'palliative care has the following characteristics: provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends

a hospital which enable that care to be provided to the highest standard. In this sense, end-of-life care is firstly an individual-level reality that is directly experienced by the patient, and by those involved with the patient's care such as doctors, nurses, and relatives. Secondly, end-of-life care is a system-level reality that is experienced through the resources and facilities which are available to the hospital as well as a set of staff perceptions and practices that are culturally embedded within each ward and the hospital<sup>38</sup>.

Based on this understanding, we have devised an audit system to reflect the multi-level nature of end-of-life care (Figure 1.2). At the individual-level, we have devised three questionnaires to measure how, during the last week of life, the patient's quality of care and quality of life is perceived by nurses (Questionnaire 1), doctors (Questionnaire 2) and relatives (Questionnaire 3) At the system-level, we have also devised three questionnaires to measure end-of-life care perceptions and practices in each ward (Questionnaires 4), in the hospital overall (Questionnaire 5), as well as the hospital's resources and facilities (Questionnaire 6). This multi-level understanding of end-of-life care (EOLC) is visualised in Figure 1 as a set of concentric circles which depict the individual-level and system-level aspects of the audit.

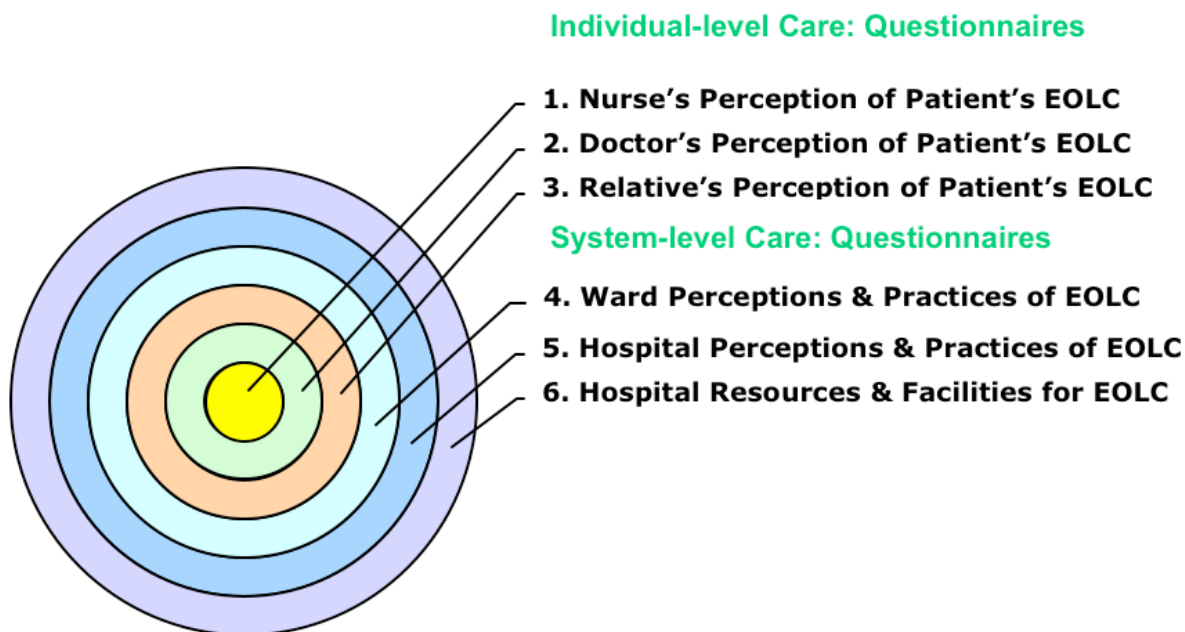
The data in this report is based on returns from 43 hospitals to Questionnaire 6 which covers the hospital's resources and facilities for end-of-life care. All data refer to 2008. The collection of this data posed a challenge for many hospitals because they do not appear to have up-to-date information systems to produce data readily. This resulted in gaps and inconsistencies in the returns from individual hospitals and this, in turn, required us to cross-check each individual return with centralised HSE data in FactFile, HealthStat, Health Intelligence, National Employment Monitoring Unit, Consultant Appointments Unit, Office of Consumer Affairs, HIPE, etc. This in turn posed its own set of problems because there is no standardised name or ID number for each hospital across the different HSE databases. In cases where individual hospital returns were at variance with centralised HSE data, we adopted the latter as the authoritative source.

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neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications'. Available at <http://www.who.int/cancer/palliative/en/>. Accessed 18 March 2009.

<sup>38</sup> This approach is not unique to end-of-life care, and is generic to understanding how patients experience hospital care generally. A recent review pointed out that: 'Every detail [of the patient's experience] is shaped by the actions, attitudes and behaviours of individual members of staff, that are in turn shaped by their personal experience and values (including professional values) and attitudes, and by their colleagues. They are also shaped, in ways that are more difficult to discern, by the practices, opportunities and limitations of the organisation in which they work; the wider health care system and the wider political and social context in which it operates' (Goodrich and Cornwell, 2008:31).

**Figure 1.2: Audit Framework for End-of-Life Care (EOLC)**



In view of these difficulties, it is important to acknowledge that the audit data supplied by many hospitals is limited because: (i) some data is missing; (ii) some data is inconsistent with published HSE data; and (iii) some data is at variance with the experience of HFH staff who work with individual hospitals. For example, there is missing data on: deaths (such as whether the death was referred to a coroner, whether a post-mortem was held, whether it was a hospital or coroner's post-mortem, and number of 'brought-in-dead'), patients (such as number of in-patients and day-patients with a Medical Card), staff (such as actual and WTE number of staff, turnover and absenteeism), specialist palliative care staff, and complaints especially complaints about end-of-life issues. Similarly, there are inconsistencies with published HSE data in areas such as: the proportion of deaths followed by a post-mortem, absenteeism, and number of complaints. Finally, there are significant variances between hospital returns and the experiences of HFH staff in terms of: the proportion of beds in single rooms, the rating of hospital and mortuary facilities; the existence of documented policies, procedures, objectives and targets for end-of-life care; and the extent of induction and in-service training.

The analysis of data in each section involves two main components. First, there is a national-level analysis of the data for the acute and community sectors and, where relevant, an assessment of these sectors relative to national standards. Second, there is a hospital-level analysis of each individual hospital, based on a comparison of the hospital with national-level data for the acute and community sectors and, where relevant, an assessment relative to national standards.

In order to illustrate the data graphically, we adopt the performance-rating system used in HSE's HealthStat system<sup>39</sup>. This system rates the performance of a hospital

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<sup>39</sup> HealthStat is HSE's information system for measuring and managing the performance of hospitals. The system contains 38 indicators or 'metrics' to measure the three themes of access (such as waiting times), integration (such as length of stay), and resources (such as staff absenteeism). Performance on each individual indicator and on each overall theme is visually displayed on a 'dashboard' using the three colours of the traffic light: (i) green means very good performance if within 15% of the target (ii) amber means average performance, room for improvement, if within 15%-35% of the target (iii) red means unsatisfactory, requiring urgent attention, if outside the target by 35% or more.

on a 'dashboard' comprising three categories which are colour-coded like traffic lights:

- (i) a green light to indicate a very 'good performance' if it is within 15% of the standard;
- (ii) an amber light to indicate an 'average performance' that is 15% to 35% short of the standard, outside the acceptable tolerance, and a cause for concern; and
- (iii) a red light to indicate an 'unsatisfactory performance' if it is 35% or more short of the standard, significantly outside the acceptable tolerance, and a cause of major concern.

However, the precise interpretation of these graphics should be done with care since the exact performance criteria for each standard – and therefore the precise meaning of 'green', 'amber', and 'red' - have not yet been worked out. In other words, the graphics should be read as illustrations rather than as a definitive assessment of the performance of each hospital.

The results presented in this report follow the same basic structure as Questionnaire 6: Section 2 Coverage of audit, Section 3 Accommodation, Section 4 Patients, Section 5 Deaths, Section 6 Staff, Section 7 Standard of hospital facilities, Section 8 Specialist palliative care services, Section 9 Complaints, Section 10 Policies and procedures, Section 11 Training and staff supports, Section 12 Standard of mortuary facilities, and Section 13 Bereavement services and facilities.

In the final section 14 of the report we present our conclusions and raise issues for further consideration. All of the statistical tables are in a Technical Appendix at the end of the report. Before reporting the results, we use the next section to place the audit in its national context by describing its geographical and sectoral coverage relative to all acute and community hospitals in Ireland.

## 2 Coverage of the Audit

Given that this is a national audit of end-of-life care, it is appropriate to state the extent of its coverage in the acute<sup>40</sup> and community<sup>41</sup> hospital sectors in Ireland. A total of 43 hospitals – 24 acute and 19 community - participated in the audit. These are listed in Tables 2.1 and 2.2.

All of the main acute hospitals in the country (39) were invited to participate in the audit<sup>42</sup>. In total, 24 acute hospitals agreed to participate in the audit, equivalent to nearly two thirds (62%) of those invited.

In geographical terms, as Figure 1.3 illustrates, the audit has strongest coverage in the eastern part of the country. Weakest coverage is in the west with no participation from hospitals in Galway, Mayo or Roscommon - the former Western Health Board Region.

Turning to community hospitals, Figure 1.3 shows a similar pattern with a much higher level of participation in the east compared to the west. This however is not a reflection of interest by community hospitals nationwide since the audit was offered only to community hospitals in Phase 1 of the HFH Programme, and all but one accepted. In total, 19 community hospitals participated in the audit, equivalent to 12% of the 156 community hospitals in Ireland. In geographical terms, these hospitals are exclusively in the eastern part of the country – especially Dublin and the North East – with the exception of St. John's Community Hospital in Sligo.

From a sectoral perspective, the national audit covers a major part of the acute hospital sector in Ireland in terms of the number of patients (72%), deaths (71%), staff (73%), and bed-capacity (74%) (Tables 2.3-2.5 and Section 3.1). In that sense, it is truly a national audit, and its findings are relevant to the entire acute hospital sector. Coverage of the community hospital sector is weaker because the audit represents just 20% of all community hospital beds in Ireland although these hospitals tend to be larger (averaging 110 beds each) compared to community hospitals generally (averaging 68 beds each). Nevertheless the findings of this audit are also likely to have direct relevance to end-of-life care in all community hospitals.

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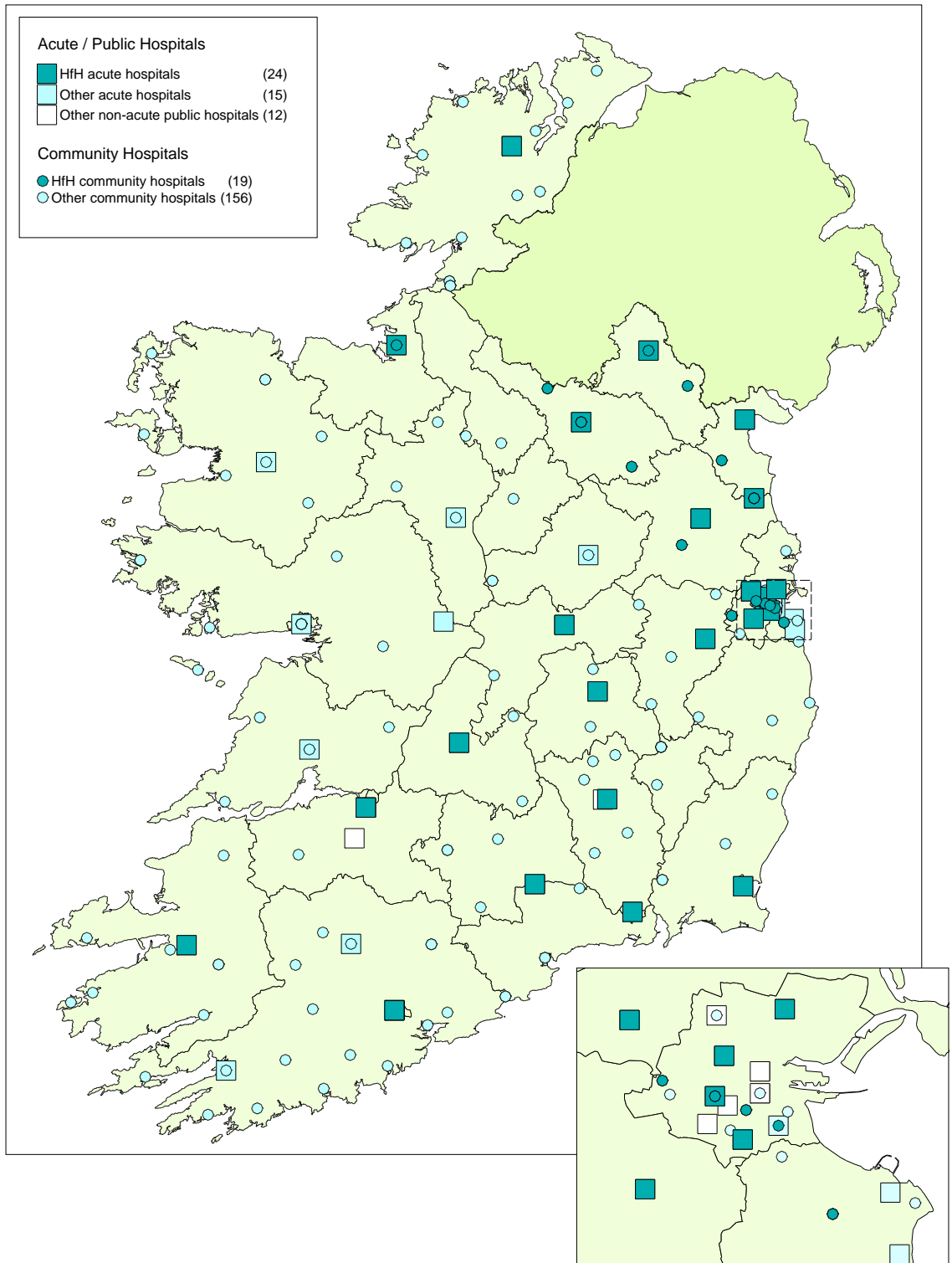
40 In this report, the acute sector is defined as the 38 hospitals in the HIPE system (Hospital In-Patient Enquiry) who have A&E departments but excluding children's hospitals, orthopaedic hospitals, and eye & ear hospitals. These 38 hospitals are listed in Table 2.1. The HIPE Scheme, established in 1971, is a computer-based health information system designed to collect clinical and administrative data on discharges from, and deaths in, acute hospitals in Ireland. In 2007, 57 acute public hospitals in Ireland reported to HIPE. Since 1990, the ESRI has been responsible for managing, and reporting on the HIPE Scheme on behalf of the Department of Health and Children and the Health Service Executive. In 2007, HIPE captured 96.7% of activity in public hospitals. In this report, all HIPE data refer to 2007.

41 Note that there is no official definition of a 'community hospital' in Ireland but the convention is to differentiate it from an 'acute hospital' if it does not have an accident and emergency department. Community hospitals are effectively long-stay institutions but offer a higher level of medical support compared to the average nursing home.

42 Children's hospitals were not included in the invitation because the audit system is not suitable for assessing end-of-life care for children. Orthopaedic hospitals and eye & ear hospitals were also excluded because end-of-life care is not a normal or expected feature of these hospitals.



**Figure 1.3: Hospitals in the HFH Audit**



### 3 Accommodation

Hospital accommodation is typically measured by bed-capacity. For this reason, the audit measured the total number of beds in each hospital broken down by: (i) in-patient and day-beds; (ii) beds in single and multi-occupancy rooms; and (iii) average bed-occupancy. It is worth noting that the number of beds reported by many hospitals in the audit varies significantly from the number of beds published in HSE's FactFile website (Table 3.1).

#### 3.1 In-patient and day-beds

The 24 acute hospitals who participated in the audit have a combined total of 9,027 hospital beds (Table 3.1). This means that the audit covers 74% of all beds in acute sector in Ireland, defined as the 38 hospitals in the HIPE system which have A&E facilities.

There are 10,532 beds in 156 community hospitals in Ireland, based on 2009 data<sup>43</sup>. The 19 community hospitals which participated in the audit have a combined total of 2,072 hospital beds. This means that the audit covers 20% of all beds in community hospitals in Ireland. On average, each of the 156 community hospitals in Ireland have 68 beds, which is substantially lower than the average of 110 beds in the 19 community hospitals who participated in the audit. This implies that the audit of community hospitals is more representative of larger community hospitals.

From a comparative perspective, Ireland has 2.9 acute beds per thousand population which is less than the OECD average of 4.1 per thousand<sup>44</sup>. The implications of this need to be interpreted with care since the number of acute beds required in a society depends on its health needs and on how services are configured, both within hospitals (for example, between in-patient and day services), as well as between hospital-based and community-based services. In view of this, it is significant that the vast majority of acute hospital beds in Ireland (88%) are inpatient<sup>45</sup>, identical to the proportion (88%) among acute hospitals in the audit (Table 3.1).

#### 3.2 Beds in single and multi-occupancy rooms

The vast majority of beds in participating hospitals are in multi-occupancy rooms, both acute (85%) and community (86%), (Table 3.2 and Figure 3.1). The proportion of single rooms in acute hospitals shows relatively modest variation around the average of 15%, with two hospitals having as low as 6% single rooms but one having 55% single rooms. This is identical to the proportion of 'side-rooms' in English hospitals (15%) which use the Liverpool Care Pathway<sup>46</sup>. In the community sector, the variation around the mean of 14% is much more pronounced with some having no single rooms and others having 55% and 78%.

No published data is available to compare this to the national picture although it is generally accepted that single rooms are scarce in the Irish hospital system. It has also been observed that 'a significant proportion of the existing single rooms in public hospitals are private patient beds'<sup>47</sup>. The fact that most hospital accommodation is in multi-occupancy rooms has come under increasing scrutiny in recent years for a

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43 Data supplied by the HSE to the Hospice Friendly Hospitals Programme.

44 OECD, 2007.

45 PA Consulting Group, 2007:47.

46 Marie Curie Palliative Care Institute Liverpool, 2009:23.

47 PA Consulting Group, 2007:71.

variety of reasons, and not just because it falls short of the standard of accommodation that would normally be available in even a low-cost hotel.

A key concern with hospital accommodation is that the control of infection is increasingly hindered by the absence of single rooms where infected patients can be isolated<sup>48</sup>. A further concern, of particular relevance in this context, is that many patients and their families prefer a single room, particularly at the end of life. This is based on the growing body of research which shows that patients and their families prefer single rooms for a variety of reasons including: visual and auditory confidentiality and privacy; reduced noise levels; control over personal information; opportunity to rest; and peacefulness of the dying process<sup>49</sup>.

These considerations indicate that single rooms are an important indicator of the quality of hospital accommodation. In the US, 100% single rooms have now been adopted as the standard for all new hospital accommodation<sup>50</sup>, while in the UK a minimum of 50% of single rooms is now the standard<sup>51</sup>. In Ireland, a draft of the infection control building guidelines recommends that 100% of in-patient accommodation in newly built acute care hospitals should be single-patient rooms<sup>52</sup>. Significantly, the HIQA standard for residential care facilities for older people in Ireland, requires that there must be 80% single rooms for 'the newly built residential care setting, new extension or first time registration'<sup>53</sup>.

In 2007, the HFH Programme commissioned a study of the physical environment in 20 acute and community hospitals in Ireland with particular reference to the adequacy of supports for dying, death and bereavement. This study found that the lack of single rooms 'does not provide flexibility or choice on the ward for staff to support a dying patient and their family in privacy, if required. Where single rooms were available they were predominantly used for isolation purposes in respect of infection control policies and MRSA management. At certain sites there was also the added demand for the use of single rooms for private patients'<sup>54</sup>.

It is clear that all of the hospitals in the audit fall far short of any of the standards – 100%, 80%, 50% - that have been proposed for the proportion of single rooms. In the language of HSE's HealthStat system, all hospitals in the audit – with the exception of one acute and two community hospitals - merit a red traffic light because they are more than 35% outside the target and therefore deemed unsatisfactory and a cause of major concern (Figures 3.1 and 3.2).

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48 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009; see also Dowdeswell, Erskine and Heasman, 2004.

49 For a review of the research, see Hugodot, 2007; Ulrich, 2008; see also Hugodot, A., and Normand, C., 2007.

50 Facility Guidelines Institute and the AIA Academy of Architecture for Health, 2006. Available at: <http://www.fgiguidelines.org/guidelines.html>. Accessed 20 March 2009.

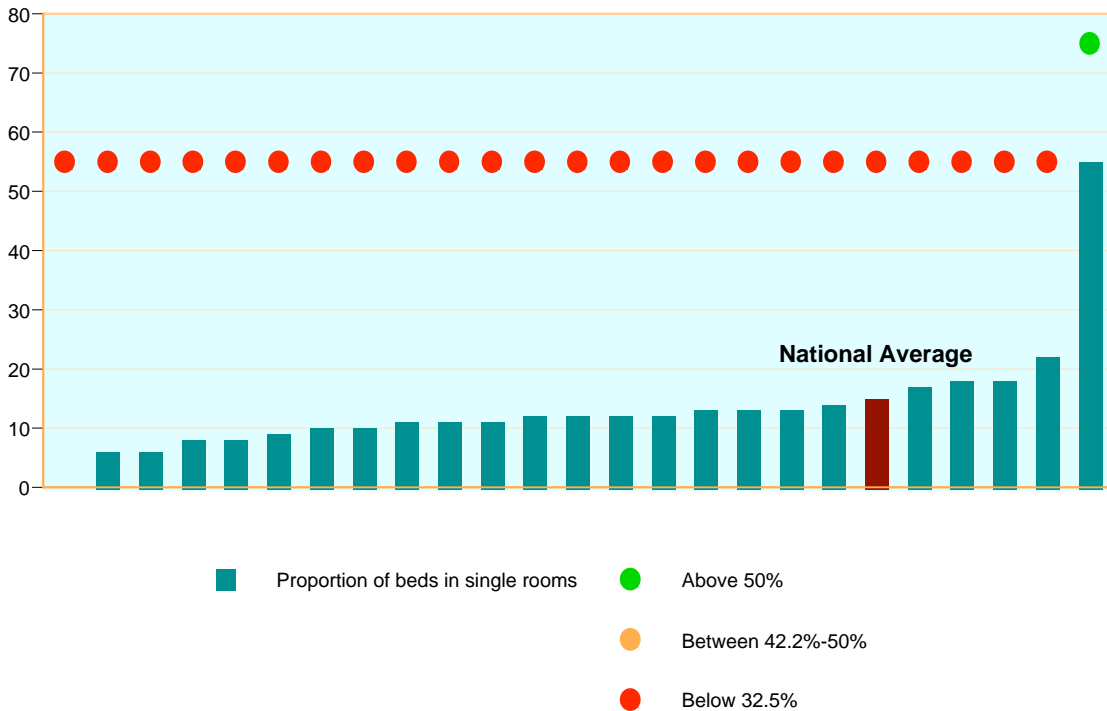
51 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278

52 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278-9

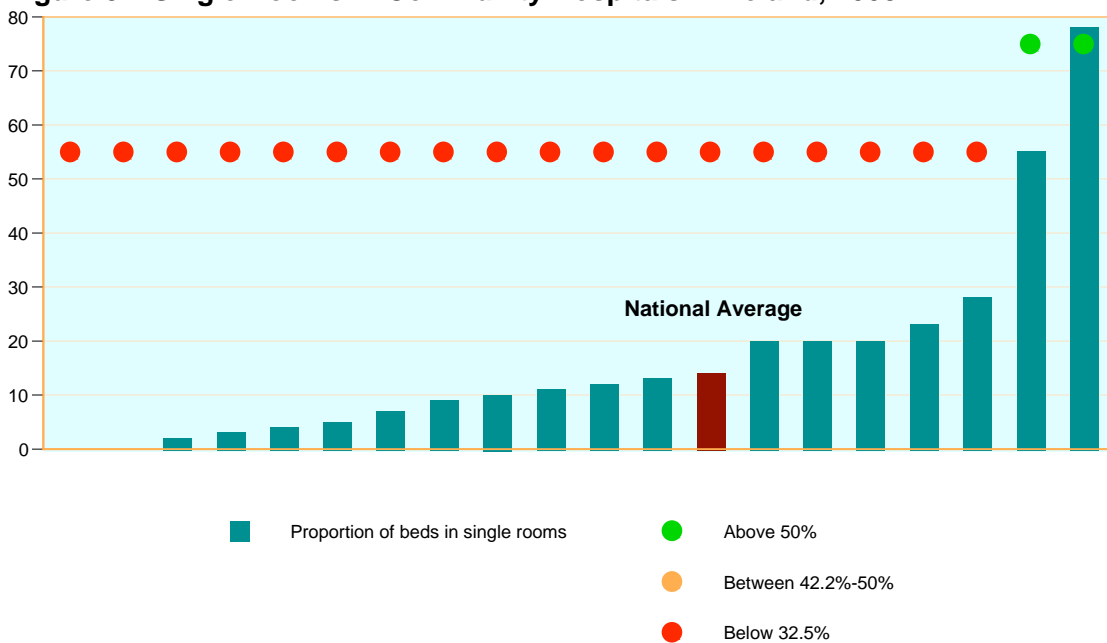
53 Health Information and Quality Authority, 2008:45

54 Tribal, 2007:11

**Figure 3.1 Single Rooms in Acute Hospitals in Ireland, 2008**



**Figure 3.2 Single Rooms in Community Hospitals in Ireland, 2008**



In Section 8 below, we assess how the availability of single rooms affects end-of-life care by reference to the following standard in the HFH Design and Dignity Guidelines: ‘Every hospital should be able to offer patients approaching end-of-life a choice of a single separate unit of accommodation (single room) with individual ensuite facilities. For patients who wish for privacy at the end of life, that option is very important’<sup>55</sup>.

<sup>55</sup> Hospice Friendly Hospitals Programme, 2008:18.

### 3.3 Bed-occupancy rates

Ireland's bed-occupancy rate<sup>56</sup> in March 2009 was 89%<sup>57</sup>. This is higher than the HSE bed-occupancy target for 2009 of 86%<sup>58</sup>. However returns from the audit indicate an overall bed occupancy rate of 93% for both the acute and community hospitals, ranging from 75% to 100.5%. Larger hospitals tended to have higher occupancy rates, at 95% and upwards. Ireland has the fourth highest bed-occupancy rate in the OECD where the average is 75%<sup>59</sup>.

It is true that there is no single desirable level of bed-occupancy but the rate in Ireland is generally regarded as too high because, in conjunction with existing admission and discharge policies<sup>60</sup>, it has the effect of causing overcrowding, reducing access for new patients, increasing the risk of infection, and threatening the quality of care of patients. A recent survey on the control of infection in 49 acute hospitals in Ireland found that 'a high rate of bed occupancy compromised their ability to implement the [MRSA] guidelines'<sup>61</sup>. In addition, high bed occupancy has been identified as a factor which can threaten the overall quality of care<sup>62</sup>.

### 3.4 Summary

Acute hospitals in the audit are broadly similar to the acute sector as a whole in terms of the proportion of in-patient beds (88%), the proportion of beds in single rooms (15%), and the average bed-occupancy rate (93%). Community hospitals in the audit also have a similar profile in terms of the proportion of beds in single rooms (14%), and the average bed-occupancy rate (93%). In comparative perspective, the acute sector in Ireland differs from the average pattern in the 30 OECD member countries in having fewer acute beds per thousand population, both in-patient and day-patient, a lower proportion of beds in single rooms, and a much higher bed-occupancy rate. From an end-of-life perspective, the most significant aspect of these findings is that many hospitals are likely to find it difficult to meet the standard of ensuring that every patient approaching the end of life is offered the choice of a single room with individual en-suite facilities. The difficulty in meeting this standard arises not just from the relative scarcity of single rooms within the hospital system but also from the direct competition for these rooms by infection control.

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56 Bed occupancy rates are calculated by dividing the total number of occupied bed-days by the total number of available bed-days, multiplied by 100.

57 HSE Supplementary PR Data, 2009:31.

58 HSE Supplementary PR Data March 2009, 2009:18; HSE National Service Plan 2009, 2008:71.

59 OECD, 2007.

60 A random sample of 3,035 medical and surgical in-patients across 37 acute hospitals were reviewed between November 2006 and February 2007 by PA Consulting Group and Balance of Care Group (2007). The results showed that 13% could have been treated outside an acute setting, 75% of elective survey patients were admitted earlier than necessary, 39% of day patients could have been treated in an alternative setting, and discharge planning was in evidence from the notes of 40% of patients. In response to this, the HSE introduced a Code of Practice for Integrated Discharge Planning in December 2008 with the overall purpose of reducing the average length of stay in hospitals to the OECD average. This code of practice provides a framework for care and case management and comprises a suite of national standards, recommended practices, forms, toolkits, key metrics and audit tools.

61 Cited in Fitzpatrick, Roche, Cunney and Humphreys, 2009:278

62 A recent study of the factors enabling compassionate care in acute hospital settings noted that: 'The factor that has arisen again and again in terms of producing stress and reducing compassion is the heightened bed occupancy within hospitals. As hospitals cope with increasing patient demand and higher levels of throughput, it becomes even more important to address humanity within the process, dealing compassionately with staff so that they in turn can do the same for patients. There is of course nothing wrong per se with technically focused, rapid treatment, high-turnover, and short lengths of hospital stay – only a minority of patients would willingly prolong their stay in hospital – but it is important for compassion to be seen and valued as essential to the delivery of care, not an option or add-on' (Firth-Cozens and Cornwell, 2009:12).

## 4 Patients

The audit collected information on three characteristics of patients within each hospital: (i) number of in-patients and day-patients; (ii) number of public and private patients; and (iii) number of patients with a Medical Card.

### 4.1 In-patients and day-patients

The 24 acute hospitals which participated in the audit account for 72% of all patients, both in-patient and day patients, in the acute sector in 2008 (Tables 4.1 and 4.2). Patients discharged from acute hospitals in Ireland are divided between day-patients (54%) and in-patients (46%)<sup>63</sup>. This is similar to the breakdown in the 24 acute hospitals who participated in the audit with 55% day-patients and 45% in-patients. However there is huge variation between hospitals in the proportion of day cases (from a low of 25% to a high of 80%). In comparative perspective, the proportion of day cases in the Irish hospital system in 2006 (53%) was substantially higher than the OECD average (34%) in that year<sup>64</sup>.

### 4.2 Public and private patients

Public patients receive hospital services free of charge<sup>65</sup> while private patients pay through either private health insurance or out-of-pocket payment. In the 24 acute hospitals in the audit, the proportion of public patients (80%) is identical to the proportion in the acute sector generally<sup>66</sup> (Table 4.2). Given that more than half (54%) of all discharges from acute hospitals in Ireland in 2007 were also patients with a Medical Card (see the next sub-section), this implies that a substantial proportion of patients who do not have a Medical Card are nevertheless public patients.

In the HSE National Service Plan<sup>67</sup>, and in HealthStat<sup>68</sup>, the target is that 80% of patients will be public patients. Using this performance rating system, all but one of the acute hospitals in the audit system receive the 'green light' because they are within an acceptable tolerance of the target (68% to 80%); by the same reasoning, all community hospitals receive a green light.

### 4.3 Patients with Medical Card

The Medical Card is an entitlement to receive certain health services free of charge, with eligibility predominantly determined by income or age<sup>69</sup>. Due to the uneven returns from hospitals on this issue, we use 2007 HIPE data to estimate the proportion of patients with a Medical Card (Table 4.3). This reveals that more than

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63 Department of Health & Children, 2008:19. This is a reversal of the pattern in previous years where the number of in-patient cases exceeded the number of day cases. The reason for the significant increase in day cases is due to mainly to 'the inclusion of particular/specific activity within the HIPE scheme – such as day patient radiotherapy, day patient dialysis encounters - from 2006 onwards (Department of Health & Children, 2008:20).

64 OECD, 2007.

65 According to the HSE website on 12 June 2009: 'Everyone living in Ireland and certain visitors to Ireland are entitled to a range of health services either free of charge or at reduced cost. If you need to attend a public hospital or stay overnight in hospital as a public patient, you may be liable for Hospital Charges. Medical card holders and certain other groups do not have to pay hospital charges'. See [http://www.hse.ie/eng/Find\\_a\\_Service/Older\\_People\\_Services/Benefits\\_and\\_Entitlements/Hospital\\_charges.html](http://www.hse.ie/eng/Find_a_Service/Older_People_Services/Benefits_and_Entitlements/Hospital_charges.html)

66 Public patients tend to spend slightly longer in hospital (6.7 days) compared to private patients (5.8 days). See Department of Health & Children, 2008: Table 3.9.

67 HSE National Service Plan 2009, 2008:54

68 HSE HealthStat for Hospitals Guide, 2009:55

69 In 2001, the Medical Card was made available to all persons aged 70 years and over, irrespective of means. In 2009, this was restricted to those persons aged 70 years and over whose self-assessed income met the eligibility criteria.

half of all patients (53%) had a Medical Card, similar to the proportion in the acute sector (54%). However there is huge variation in the proportion of patients with a Medical Card from a low of 28% in one hospital to a high of 94% in another.

It is noteworthy that the proportion of hospital patients with a Medical Card is much higher than the proportion of the population of Ireland (28%) who have a Medical Card<sup>70</sup>, indicating the higher usage of hospital services by this group. Medical Card patients also tend to stay considerably longer in hospital (8.6 days) compared non-Medical Card patients (4.6 days)<sup>71</sup>.

#### **4.4 Summary**

Acute hospitals in the audit represent approximately 72% of all patients in the acute sector. The majority of these are day-patients (55%), which is similar to the acute sector as a whole, and indicates a much higher day-case rate compared to the OECD average of 34%<sup>72</sup>. The proportion of public patients in the audited hospitals (80%) is also identical to the proportion in the acute sector. Equally, the proportion of patients with a Medical Card is broadly similar at 53%. Community hospitals are essentially long-stay facilities, the permanent home of patients, and the vast majority of these are public patients with a Medical Card.

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70 Department of Health & Children, 2008:66.

71 Department of Health & Children, 2008: Table 3.7.

72 OECD, 2007.

## 5 Deaths

The acute hospitals in the audit account for 71% of deaths in the acute sector. It is noteworthy that the number of deaths reported by acute hospitals is higher than the corresponding figures in HIPE, possibly because deaths in A&E are not included in HIPE since they are not in-patients. There were 444 deaths in community hospitals but there is no data, comparable to the HIPE, for the community hospital sector and, for that reason, it is not possible to estimate the proportion of deaths represented by the audit for that sector.

In order to facilitate comparison between hospitals, we estimated the death rate in each hospital as the number of deaths divided by the number of in-patients multiplied by 100. This reveals that the annual death rate in the acute sector is 2.8% of all in-patients (ranging from 1.3% to 4.7%) compared to a death rate of 8.4% in the community sector (ranging from 0.0% to 24.0%) (Table 5.1). The higher death rate in community hospitals is due to the much smaller number of inpatients in these hospitals relative to their number of deaths, and relative to the number of inpatients in acute hospitals.

### 5.1 Place of death in hospital

The audit classified deaths in acute hospitals according to whether they occurred in A&E, intensive care, or wards. The results show that most deaths (68%) occur in wards, but a third take place in either intensive care (20%) or A&E (12%) (Table 5.2).

In the community sector, most deaths (85%) occurred in the community hospital where the patient has lived but 15% took place in acute hospitals (Table 5.2). Of particular note is the wide variation in the proportion of community hospital residents who die in an acute hospital. Among those five community hospitals which had over 30 deaths in 2008, the proportion of these deaths which occurred in acute hospitals ranged from 4% to 5% to 17% to 19% to 25% to 32%. It is not possible to draw any direct inferences from this although it may serve to reinforce concerns which have been raised, both within the HFH Programme and elsewhere<sup>73</sup>, about the appropriateness of transferring some patients from community to acute hospitals at the end of life.

### 5.2 Deaths referred to coroner

The role of the coroner is to enquire into the circumstances of sudden, unexplained, violent or unnatural deaths<sup>74</sup>. The coroner's purpose is simply to establish the facts and this may require a post-mortem examination which is carried out by a pathologist, who acts as the coroner's agent for this purpose. This may be followed by an inquest. The coroner is not permitted to consider civil or criminal liability. In a hospital setting, deaths are reported to the coroner in circumstances such as: an accident, suicide or homicide; negligence or misadventure; deaths occurring before a

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73 In its review of end-of-life care in the UK, the National Audit Office (2008:5) observed that: 'The proportion of care home residents who die in hospital could be reduced. Our survey found that a quarter of care home resident deaths occur in a hospital. There were also wide variations between care homes in the number of residents who die in hospital, ranging from none to all residents. In one PCT [Primary Care Trust], the proportion of residents dying in care homes could have been increased from 61 per cent to 80 per cent, if greater support and advice had been provided to those care homes'. In another study, based in the south west of England, a majority of patients who were admitted from a nursing home and who died in hospital 'could have stayed in the nursing home to die' (Abel, Rich, Griffin and Purdy, 2009:4).

74 A detailed flow chart of how deaths are registered in Ireland, and the role of coroners in that context, is presented in National Suicide Research Foundation, 2007: Figure 1, page 44.



diagnosis is made; whilst a patient was undergoing an operation or was under the effect of an anaesthetic; neglect or lack of care, including self-neglect; and where the death resulted from any industrial disease.

Over the past century, an increasing proportion of deaths have become the subject of post-mortems and inquests. In 1885, for example, only 2% of deaths in Ireland involved a post-mortem / inquiry but, 120 years later in 2005, nearly a fifth (18%) of all deaths were investigated by a coroner (see Table 1.1). It seems likely that some of the forces driving 'the hospitalisation of dying' discussed above (see Section 1), may also be driving the long-term rise in post-mortems.

Only acute hospitals were asked about the number of deaths referred to a coroner two thirds of these (15, 63%) made a return; this suggests that, in a third of hospitals, this information may not systematically recorded or easily retrievable. The results from these hospitals indicate that only 12% of deaths are referred to the coroner (Tables 5.5 and 5.6<sup>75</sup>). The rate of referral to coroners varies from a low of 2% of all deaths in one hospital to a high of 44% of deaths in another. A&E is the main source of referrals (41%) but the rate of A&E referrals ranges from 48% in one hospital to 100% in a number of hospitals. Similarly, although intensive care accounts for over a third of referrals (36%), these range from 3% to 100% across hospitals.

### 5.3 Post-mortems

A post-mortem is an examination of the body to determine the exact cause of death and is usually carried out by the hospital's pathologist. A post-mortem may be carried out at the request of either the hospital or the coroner although the audit returns indicated that these two sources of post-mortems are not clearly distinguished by many hospitals in their recording systems. In addition, the unevenness of the returns to this item suggests that this type of information is not recorded in a way which is easily retrievable (Tables 5.7 to 5.8<sup>76</sup>).

Based on the returns, the audit revealed that about a fifth (21%) of all deaths in both acute and community hospitals result in a post-mortem. In acute hospitals, the rate of post-mortems varies from a low of 2% to a high of 44%, while the numbers in community hospitals are too small to offer any generalisation. About half of all A&E deaths in acute hospitals (51%) are followed by a post-mortem, but this varies from 37% to 90% across hospitals. Similarly, nearly three in ten deaths in intensive care (28%) are followed by a post-mortem with a range of 3% to 35% across hospitals.

### 5.4 Brought in dead

The concept of 'brought in dead' refers to patients who are pronounced dead outside the hospital. As with deaths in A&E, these deaths are not included in the HIPE recording system because, strictly speaking, the patients have not been admitted to the hospital. Similarly in this audit, they are additional to the deaths which take place within the hospital. The results of the audit show that these deaths are equal to nearly a quarter (23%) of all deaths in acute hospitals (Table 5.9). The majority of cases were brought directly to the mortuary (71%) with the remainder brought to A&E (17%) and for preparation by funeral directors (12%). However there is huge variation between hospitals in what happens to BIDs when they arrive at the hospital: in some

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<sup>75</sup> Note that the percentages in this table do not sum to 100% because of inconsistencies in data returns from hospitals.

<sup>76</sup> Note that the percentages in this table do not sum to 100% because of inconsistencies in data returns from hospitals.

cases, they are almost invariably brought to A&E, in others they are almost invariably brought to the mortuary, while in others they are brought for preparation by the funeral director.

## **5.5 Summary**

The number of deaths in acute hospitals which participated in the audit represents about 71% of all deaths in the acute sector. As a result, one can have some confidence that the audit gives a broadly representative picture of dying and death in an acute hospital in Ireland. The annual death rate in the acute sector – defined as deaths relative to in-patients in 2008 - is 2.8% compared to 8.4% in the community sector. Significantly, a substantial minority (15%) of residents in community hospitals die in an acute hospital. Most deaths in acute hospitals occur in wards (68%), with the remainder in intensive care (20%) and A&E (12%). Just over a tenth of all deaths in acute hospital deaths (12%) – and more than four in ten of those in A&E (42%) - are referred to the coroner and most of these result in a post-mortem. However there is substantial variation between hospitals in the proportion of deaths referred to a coroner and in the proportion of deaths that result in a post-mortem. This, in turn, may be due to the differing profiles of deceased patients in each hospital, and there may also be some variation in the referral practices from A&E and intensive care departments. In addition to deaths which occur within the hospital, a substantial number – equivalent to nearly a quarter (23%) of all deaths in acute hospitals - are 'brought in dead'. Most of these are brought directly to the mortuary (71%) with the remainder brought to A&E (17%) and for preparation by funeral directors (12%).

## 6 Staff

The audit collected information on the total number of staff in 2008, both actual and whole-time-equivalent (WTE), broken down by specific staff categories. Due to difficulties in the returns from a number of hospitals, data on WTE staff in each hospital was sourced from HSE's National Employment Monitoring Unit. In addition, information was collected on staff turnover and absenteeism, essentially because previous studies have identified these indicators – notably the ratio of staff to patients and the rate of staff turnover - as predictors of quality of care<sup>77</sup>.

### 6.1 Number of staff

Acute hospitals in the audit employ nearly three quarters (73%) of all staff in that sector (Table 6.1). The number of staff employed in these hospitals ranges from a low of 254 to a high of 3,725. By contrast, community hospitals in the audit employ just over a quarter (28%) of all staff in that sector and the range of staff employed varies from 9 to 507.

There are significant differences in the staffing profile of acute and community hospitals in the audit. The main difference is the much higher nurse-to-doctor ratio in community hospitals (26.6) compared to acute hospitals (3.4), bearing in mind that both sectors have a higher nurse-to-doctor ratio compared to the OECD average of 2.9<sup>78</sup>. The community sector is also distinctive in having a much higher proportion of staff in the 'other patient care' category (37% compared to 7% in the acute sector), mainly comprising health care assistants. The audit reveals that there are 10% more actual than WTE staff, due to part-time working and job-sharing.

### 6.2 Staff turnover

Staff turnover was measured by the proportion of staff employed for less than one year. However not all staff returned information on this item (Table 6.2). The results show a staff turnover of 15% in acute hospitals and 14% in community hospitals, with considerable variation around this average in both sectors. In Ireland, a recent study of turnover rates – sometimes referred to as job mobility - found that 'each year approximately 10 per cent of workers change jobs'<sup>79</sup>, with lower turnover rates among workers who are older, more skilled, and employed in the public sector.

### 6.3 Absenteeism

Absenteeism is the number of days that staff are unable to work because of sickness and other reasons not including annual leave, expressed as a percent of the total number of work days available. This definition is used in HSE's HealthStat system, described in Section 1 above, which collects monthly data from hospitals on lost time: 'lost time is any time lost through absences due to certified and uncertified sick leave and unexplained absences'<sup>80</sup>. From this information, HealthStat calculates an absence rate by dividing the total time absent by the total time available, and then multiplied by 100.

Absenteeism is a key performance indicator in the HealthStat system, and in 2008 the HSE set a target of 3.5% absenteeism or less for each hospital. This target is

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<sup>77</sup> For a recent review of the research evidence, see Bostick, Rantz, Flesner, and Riggs, 2006.

<sup>78</sup> OECD, 2007.

<sup>79</sup> Bergin, 2009:24

<sup>80</sup> HSE HR Circular 08/2008; see also HSE HealthStat, 2009:44.

close to the national average rate of absenteeism in the private sector as measured in two recent studies: one by the Small Firms Association (which estimated the national rate of absenteeism at 3.5%)<sup>81</sup>, the other by the Irish Business and Employers Federation (which estimated the national rate of absenteeism at 3.4%)<sup>82</sup>. The average rate of absenteeism in the civil service in 2007 was 5%<sup>83</sup>.

There are some inconsistencies between the audit returns on absenteeism and the HealthStat statistics; since the latter is published on HSE's website, it seems preferable to rely on this source. The results show an overall absenteeism rate of 6.0% in the acute sector (ranging from 4% to 12%); the rate in the community sector is 5% (ranging from 0% to 12%) (Table 6.3). These rates vary significantly across staff grades with medical staff having the lowest rates (0.9% in acute, 3.2% in community). The two staff categories which have the highest rates of absenteeism are 'other patient care' which includes health care assistants (8.5% in both acute and community), and general support staff which includes porters, catering, household, mortuary and security staff (8.4% in acute, 8.1% in community) (Table 6.4c).

No acute hospital in the HealthStat system has been awarded a 'green light' for its absenteeism rate. In its HR Circular 08/2008, the HSE recommended annual improvements of 10% in absenteeism rates in order to achieve the overall target of 3.5%. With this scale of improvement, the average acute and community hospital would take 4 years to achieve the target of 3.5% absenteeism.

The management in each hospital was also asked to express a view on whether the number of days lost was a problem for the hospital, based on a rating scale from 1 (not a problem) to 10 (major problem). The results indicate that the average problem score is quite high at 7 in the acute sector (ranging between hospitals from 1 to 10), and even higher in the community sector at 8 (ranging between hospitals from 3 to 10).

## 6.4 Summary

The audit represents nearly three quarters (73%) of all staff in the acute sector but a much smaller proportion (28%) of staff in the community sector. Acute hospitals have a higher nurse-to-doctor ratio compared to the OECD average of 2.9, but significantly below the ratio in community hospitals (26.6). Community hospitals also have a much higher proportion of health care assistants compared to acute hospitals. Staff turnover is 15% in acute hospitals and 14% in community hospitals, higher than the national average of 10%. The rate of absenteeism is 6% in the acute sector and 5% in the community sector, both significantly above the national average and the HSE target of 3.5%, but there are very large variations in absenteeism across staff grades.

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81 Small Firms Association, 2008. This study calculated that an absenteeism rate of 3.5% is equivalent to a loss of 8 working days, assuming 20 days annual leave and 10 days of public holidays. National data on the number of days lost through injury and illness is collected by the CSO through the Quarterly National Household Survey, 2003-2007, and reported by the Health and Safety Authority, 2008. The latest data for 2007 reveals that the total number of days lost in Ireland as a result of injury and illness was 1,745,300 in a total workforce of 2,081,300. This is equivalent to an average of 1.19 days for each member of the workforce<sup>81</sup>, which is understandably less than the estimate of the Small Firms Association because it is based on survey data of employees who have experienced injury or illness rather than the management data on employee absences. Nevertheless the data is significant in showing that health and social work sectors recorded the second highest rate of injury (after construction) and illness (after agriculture, hunting and forestry / fishing) in 2006 (Health and Safety Authority, 2008: Figures 2.8 and 2.9.). The two main forms of injury are manual handling and slips, trips and falls, while the two main types of illness are bone, joint or muscle, followed by stress, depression and anxiety.

82 Irish Business and Employers Federation, 2004. Workplace Absence Survey – 2004. Dublin: Irish Business and Employers Federation.

83 Comptroller and Auditor General, 2009.

## 7 Standard of Hospital Facilities

In June 2008, the HFH programme published a set of guidelines for improving the physical environment of hospitals for end-of-life care. These guidelines, referred to as Design and Dignity Guidelines<sup>84</sup>, are informed by the findings of evidence-based design and research on end-of-life care<sup>85</sup>. The guidelines are not statutory but have the support of Health Information and Quality Authority (HIQA) and are being adopted as a means of guiding improvement in the physical facilities of hospitals. The introduction to the Design and Dignity Guidelines<sup>86</sup> states: 'It is anticipated that the Guidelines will primarily be used in the development of project briefs for new hospital buildings. They are also relevant for refurbishment projects, and should be used to assess existing facilities and guide improvements'.

In the audit these guidelines are used by each hospital to self-assess the quality of its physical facilities. This is done by asking management to rate 22 statements about the physical facilities of the hospital – all taken from the guidelines - on a scale from 1 (untrue) to 10 (true). These statements refer to recommended aspects of the physical facilities which affect all patients, relatives and staff – and not just end-of-life care – but three statements have particular pertinence to end-of-life care: (i) all patients at the end of the life are offered a choice of a single room (ii) each ward has a meeting room for sensitive private conversations between staff and patients or relatives (iii) each ward has enough storage for the personal belongings of deceased patients.

### 7.1 Year hospital originally built

The audit collected data on the year in which the hospital was originally built. This may be an indicator of the quality of physical facilities, although many hospitals will have undergone improvements over the years. What is significant is that the majority of hospitals in the audit (63%) were built well before the modern era beginning in the 1960s (Table 7.1). This, in turn, may influence the standard of its facilities as discussed in the next section, as well as the standard of the mortuary (Section 12 below).

### 7.2 Standard of facilities

The audit reveals that the overall standard of facilities – based on all hospitals and all facilities – is 5.8 on a scale from 1-10, with almost no difference between acute and community sectors (Tables 7.2 to 7.4). Most of the scores, in both acute and community hospitals, are close to, or above, the mid-point score of 5. In the acute sector, only three items received a low score: child-friendly TV lounge on each ward (2.3), access to room suitable for therapies (2.2) and relative's room close to each ward (2.3). In the community sector, only one item received a low score: child-friendly TV lounge on each ward (3.1).

More than a third of hospital managers (38%) rated their hospital facilities as good or excellent (defined as 6.5 to 10). This is lower than the results of an audit of hospital and hospice facilities for end-of-life care in Northern Ireland where 54% of managers rated facilities as good or excellent, although only 32% of staff rated the same

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84 Hospice Friendly Hospitals Programme, 2008:18.

85 The most recent reviews of research on evidence-based design are: Ulrich, Zimring, Zhu, et al, 2008; and Keller and Kronick, 2008. The practical implications of this research for improving the design of existing and new hospital facilities are spelt out in Sadler, Keller and Rostenberg, 2009.

86 Hospice Friendly Hospitals Programme, 2008:18.

facilities as good or excellent<sup>87</sup>. This suggests that some caution is needed in the interpretation of these findings given that every rating reflects of both the objective condition of facilities but also the subjective appraisal of those facilities.

Another source of comparison is an independent study of the physical environment in 15 acute and 5 community hospitals - all included in this audit – which was carried out for the HFH programme in 2007 by Tribal healthcare consultants<sup>88</sup>. That study was based on an assessment framework which rated 11 key dimensions of the hospital's physical environment, each on a 10-point scoring scale, from which was derived an overall average score of 3.6<sup>89</sup>. Separate scores were given for three categories of hospital: old estate unrefurbished (2.3), old estate refurbished (3.5), and new build (5.3). It is clear that the overall score provided by the managers in each hospital (5.8) is well above that of independent healthcare experts (3.6)

There are three possible explanations why these two sets of results are so at variance. First, a substantial minority of responses to the audit tended to score each item as either 1 or 10 rather than points in-between thereby turning the 10-point scale into a 2–point scale; maybe this is a design flaw in the questionnaire. Second, those who completed the audit in each hospital seem to view its physical environment through a much more positive lens compared to the independent healthcare consultants who completed the Tribal assessment. This, in turn, suggests that the pattern of response to this aspect of the audit may reflect their level of awareness and attentiveness to evidence-based design in hospitals – or the lack of it - rather than a truly objective appraisal of the hospital's physical environment. Third, the lack of consistency between results highlights the absence of a robust methodology for auditing the physical environment of hospitals in a way that yields reliable results. This was also acknowledged by the authors of the Tribal study who pointed out that there is 'no recognised structured approach which can be used to assess these conditions [the physical conditions of hospitals] and to compare one hospital with another'<sup>90</sup>.

We expressed the scores for each hospital using HSE's HealthStat 'traffic light' system (Figures 7.1 and 7.2). The results reveal that, despite the relatively high self-assessed scores, only one acute hospital and no community hospital merits a 'green light' (involving a score of 8.5 or above).

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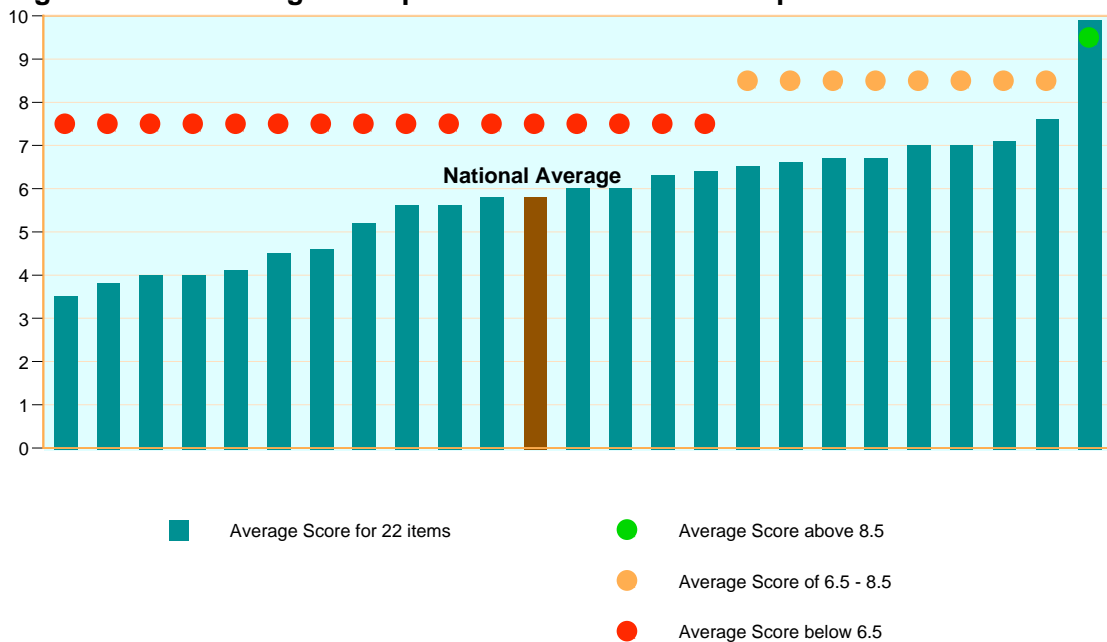
87 The audit involved a survey of 145 ward managers and 1,633 hospital staff (Northern Ireland Health and Social Care Bereavement Network, 2009: 50-53).

88 Tribal, 2007.

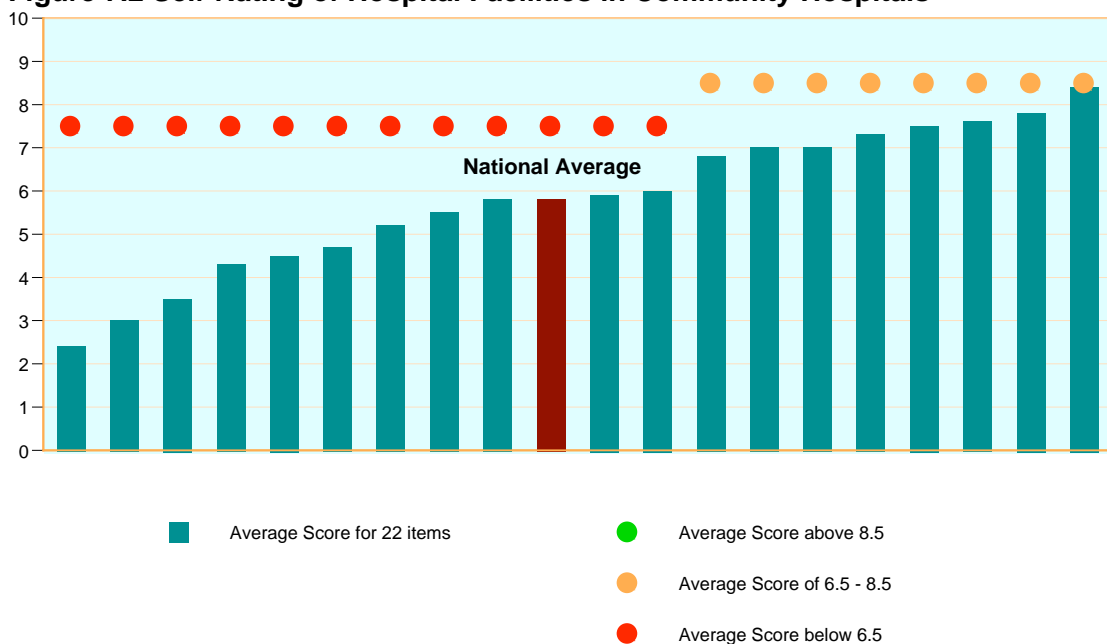
89 The authors explain that: 'The assessment framework was developed from the work carried out on the pilot project by Rodd Bond undertaken at Our Lady of Lourdes Hospital in Drogheda in partnership with the Health Services Executive (2004-2006) in order to provide some consistency of approach following the conclusion of the pilot project' (Tribal, 2007:5).

90 Tribal, 2007: iii.

**Figure 7.1 Self-Rating of Hospital Facilities in Acute Hospitals**



**Figure 7.2 Self-Rating of Hospital Facilities in Community Hospitals**



### 7.3 Summary

The audit assessed the overall quality of hospital facilities using, as a standard, the Design and Dignity Guidelines<sup>91</sup> published by the HFH programme in June 2008. This was done by asking management to rate 22 statements, taken from the Guidelines, on a scale from 1 (untrue) to 10 (true). The overall score to emerge from this exercise was 5.8, with almost no difference between acute and community sectors. Facilities with a specific focus on end-of-life care also received the same rating.

91 Hospice Friendly Hospitals Programme, 2008:18.

This result is a cause of some surprise because it is at variance with an independent observation of 15 acute and 5 community hospitals carried out for the HFH programme in 2007<sup>92</sup>. These hospitals are also included in the audit. That study also used a 10-point scoring scale to rate 11 dimensions of the physical environment of hospitals and derived an overall average score of 3.6, well below the self-rating of hospitals in this audit.

We offer two possible explanations for these different results. First, a substantial minority of responses to the audit tended to score each item as either 1 or 10 rather than points in-between thereby turning the 10-point scale into a 2-point scale, possibly indicating a design flaw in the questionnaire. Second, those who carried out the self-assessment in each hospital are likely to see its physical environment through very different eyes compared to independent observers who are attuned to evidence-based hospital design. This, in turn, suggests that the pattern of response to this aspect of the audit may have less to do with an objective appraisal of the hospital's physical environment and more to do with awareness and attentiveness to evidence-based design in hospitals. Both of these considerations, but especially the second one, draw attention to the inherent limitations of using a self-report instrument to assess the physical environment of hospitals.

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<sup>92</sup> Tribal, 2007.



## 8 Specialist Palliative Care Services

This section reports on the number of hospitals which have a specialist palliative care service and, where applicable, the number and categories of staff who make up that service. We also report on the number of hospitals which have a specialist care team, including the hours of a palliative medicine consultant, as well as those hospitals which use the Liverpool Care Pathway as part of its end-of-life care. These are important indicators of service provision for end-of-life care but may also be taken as indicative of a hospice philosophy within the hospital. A hospice philosophy is defined in the Draft Quality Standards for End of Life Care in Hospitals as follows: 'hospice refers to a philosophy of care which includes but is not solely reflected in a medical speciality. The philosophy goes beyond palliation and is characterised by a holistic (physical, psychosocial and spiritual) attention to illness. The focus of a hospice philosophy should not be exclusively on dying and death but rather should be based on providing holistic care and symptom control as soon as possible in the disease trajectory'.<sup>93</sup>

### 8.1 Specialist palliative care services in acute hospitals

The audit asked each hospital: 'Does the hospital have a specialist palliative care service?'. The results show that all but one acute hospital (23, 96%) have a specialist palliative care service (Table 8.1).

A specialist palliative care service, as defined in 2001 by the National Advisory Committee on Palliative Care<sup>94</sup>, involves the following disciplines: consultant in palliative medicine, non-consultant doctor, specialist palliative care nurse, physiotherapist, occupational therapist, social worker, pastoral care, speech & language therapist, clinical nutritionist, pharmacist, care attendants/assistants, volunteer coordinators, librarian/educational staff, and administration. The recommendation of the National Advisory Committee on Palliative Care, which has been adopted as government policy, is that 'each health board area should have a comprehensive specialist palliative care service to meet the needs of patients and families in the area'<sup>95</sup>, and 'all health care professionals should be able to access advice and support from specialist palliative care providers when required'<sup>96</sup>.

With this in mind, the audit asked each hospital to report on the number of WTE staff who make up a specialist palliative care service, so defined. We then used this information to estimate the number of WTE specialist palliative care staff per 100 deaths in each hospital since this could be regarded as an approximate indicator of need for specialist palliative care services (Table 8.1). The results show that acute hospitals have an average of 1.2 WTE specialist palliative care staff per 100 deaths, with only two hospitals having more than 2.0 WTE per 100 deaths. Nevertheless, it is clear that the distribution of WTE specialist palliative care staff is not systematically related to the number of deaths in each acute hospital; of particular note is the fact that the three acute hospitals with the largest number of deaths is below the average in terms of WTE per 100 deaths.

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93 Hospice Friendly Hospitals Programme, 2009:57. This definition, in turn, is taken from O'Shea, Keegan, McGee, 2002:11-12.

94 National Advisory Committee on Palliative Care, 2001: Chapter Five. This committee was set up by the Minister for Health and Children in 1999 and its report was published in 2001. This report, in turn, has been adopted as government policy. The committees recommendations on acute general hospitals are in Chapter Seven (pp.57-70) of the report while the recommendations on community hospitals are in Chapter Eight (pp.89-90).

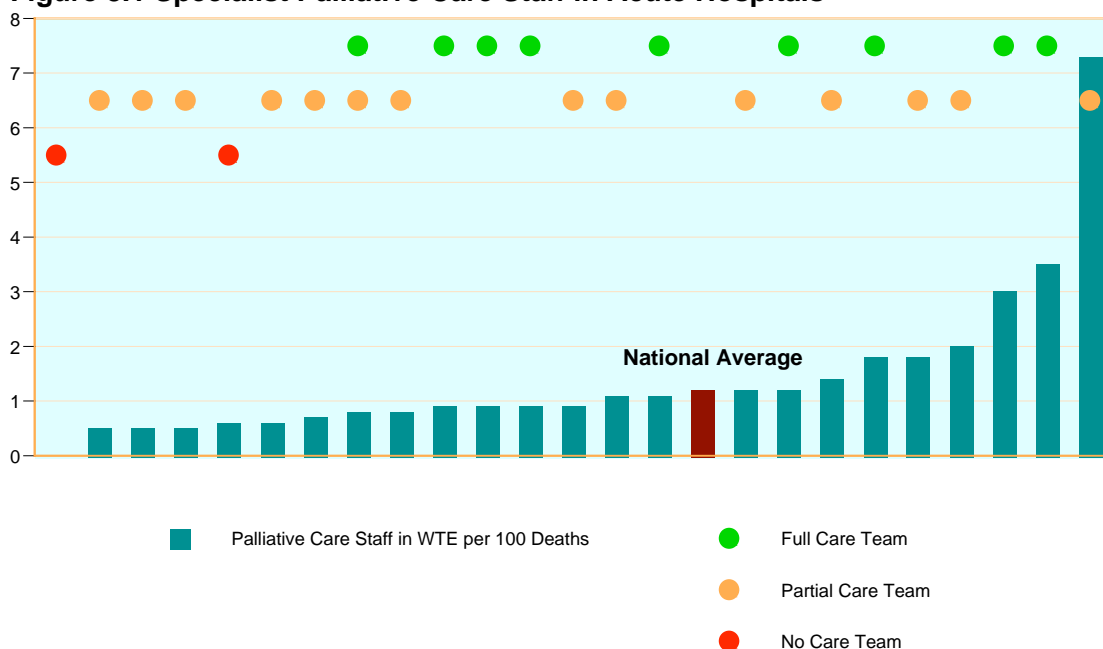
95 National Advisory Committee on Palliative Care, 2001:58.

96 National Advisory Committee on Palliative Care, 2001:58.

In tandem with this, we analysed the allocation of hours by palliative medicine consultants according to the number of deaths in each acute hospital<sup>97</sup>, bearing in mind that there is no allocation of consultant hours to community hospitals. This revealed an overall average of 2.7 hours of a palliative medicine consultant per death. Three hospitals have no palliative medicine consultant hours and most of the remainder (15, 71%) have under 4.0 hours per week per 100 deaths. It is striking that the three hospitals which have by far the largest number of deaths are among those with the fewest hours of a palliative medicine consultant per death. Again, it is clear that there is no relationship between the allocation of palliative medicine consultant hours and the number of deaths in each hospital.

The National Advisory Committee on Palliative Care<sup>98</sup>, cited above, made a specific recommendation that each acute hospital should have a specialist palliative care team comprising a consultant in palliative medicine, a non-consultant doctor, a specialist palliative care nurse, a social worker, and a medical secretary<sup>99</sup>. Using this as our definition of a 'full' team, we defined a 'partial' team as one where there is at least a doctor and a nurse, while 'no team' is where there are none of the specialisms present. The results of the audit show that, with two hospitals having no team, just over half (13, 54%) have a partial team and over a third (9, 38%) have a full team. In other words, a majority of acute hospitals in Ireland do not meet the government-approved standard of having a full specialist palliative care team. This result is in line with a more comprehensive analysis of specialist palliative care teams in 38 acute hospitals carried out by the Irish Hospice Foundation (IHF), and based on 2004 data<sup>100</sup>.

**Figure 8.1 Specialist Palliative Care Staff in Acute Hospitals**



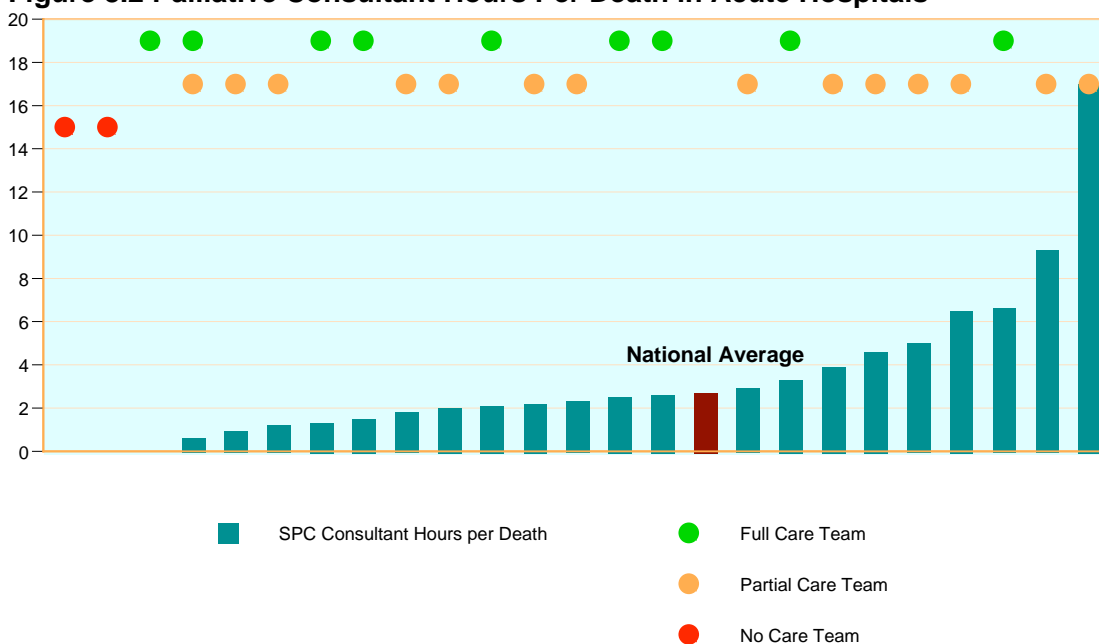
97 This indicator of need for specialist palliative medicine consultants differs from the current approach which is based on: 'At least one WTE (whole time equivalent) Consultant in Palliative Medicine per 160,000 of the population with a minimum of two consultants in each Health Board Area' (National Advisory Committee on Palliative Care, 2001:61).

98 National Advisory Committee on Palliative Care, 2001: Chapter Five. This committee was set up by the Minister for Health and Children in 1999 and its report was published in 2001. This report, in turn, has been adopted as government policy. The committees recommendations on acute general hospitals are in Chapter Seven (pp.57-70) of the report while the recommendations on community hospitals are in Chapter Eight (pp.89-90).

99 National Advisory Committee on Palliative Care, 2001:80.

100 Murray, Sweeney, Smyth and Connolly, 2006. See also Murray, 2008.

**Figure 8.2 Palliative Consultant Hours Per Death in Acute Hospitals**



This audit confirms that the distribution of specialist palliative care resources is uneven between hospitals but also suggests that little improvement has been made between 2004 and 2008. More generally, the results, as summarised in Figures 8.1 and 8.2, suggest that supply-led considerations – probably reflecting the way some hospitals seek specialist palliative care resources while others do not – may be the driving force in determining the allocation of specialist palliative care resources rather than more objective measures of need such as the number of deaths requiring specialist palliative care, which would include cancer, heart failure, dementia, and chronic obstructive pulmonary disease<sup>101</sup>.

## 8.2 Specialist palliative care services in community hospitals

The three main elements of government policy for specialist palliative care in community hospitals are: (i) the provision of designated palliative care beds; (ii) core medical care provided by general practitioners; and (iii) support and advice provided by the community-based specialist palliative care team.

As regards the latter, the audit found that one community hospital has a specialist palliative care service and a further five have access to one, but the majority (13, 68%) have neither (Table 8.1). However none of the community hospitals reported having any palliative care specialisms among its staff. The reasons for the poor access of community hospitals merits further investigation to determine if this arises from the lack of specialist palliative care services in the community, or the fact that these services have not been properly linked into the community hospitals.

The IHF appraisal, referred to in the previous section, identified 167 palliative care beds in community hospitals throughout the country but noted that ‘in many cases’<sup>102</sup> they are not exclusively designated for that purpose. The IHF team also observed that ‘there is variation on policy relating to who has access to these beds (in terms of healthcare professionals and patients), how access is granted, how the individual

101 A recent report estimated that, when the needs of patients with heart failure, dementia and chronic obstructive pulmonary disease are added to those with cancer, the estimated number of patients requiring specialist palliative care ‘would increase by at least 50%’ (Health Service Executive and Irish Hospice Foundation, 2008:2).

102 Murray, Sweeney, Smyth and Connolly, 2006:72.

hospitals define palliative care patients, how the beds are used, e.g. short-stay respite versus long-stay for someone who happens to have a malignancy that is not currently life limiting but who has need of a long-stay bed, etc<sup>103</sup>.

### 8.3 Use of Liverpool Care Pathway

The Liverpool Care Pathway (LCP) is a multi-professional framework of care which is used during the dying phase and is based on standards of care found in the hospice environment<sup>104</sup>. The goals of care are to ensure the physical comfort of the patient, psychosocial insight, spiritual care for patients and carers, as well as communication including information giving and receiving. This framework is one of three – the other two are Gold Standards Framework and Preferred Priorities for Care – that have been recommended by the UK Department of Health<sup>105</sup> and by the UK National Institute for Health and Clinical Excellence (NICE)<sup>106</sup>. The results of the audit reveal that only one community hospital, and no acute hospital, uses the LCP; however it is known that some acute hospitals outside the audit use the LCP. This contrasts with an earlier study, sponsored by the HFH Programme and the National Council on Ageing and Older People, which found that nearly 20% of the 327 long-stay care settings surveyed used an ‘integrated care pathway’, although the report does not specify if this included the Liverpool Care Pathway<sup>107</sup>.

### 8.4 Summary

The audit revealed that a majority of acute hospitals in Ireland do not meet the government-approved standard of having a full specialist palliative care team. This result is in line with a more comprehensive analysis of specialist palliative care teams in 38 acute hospitals carried out by the Irish Hospice Foundation (IHF), and based on 2004 data<sup>108</sup>. Similarly, a majority of community hospitals do not have access to a specialist palliative care service.

We analysed how different aspects of specialist palliative care are distributed between acute hospitals according to the number of deaths in each hospital, assuming the latter to be a proximate indicator of need. This revealed that a number of aspects of specialist palliative care - notably the number of WTE specialist palliative care specialisms, the hours of palliative medicine consultants, and the existence of a full, partial, or no specialist palliative care team - bear no relationship to the number of deaths in each hospital. This finding suggests that supply-led considerations may be driving the allocation of specialist palliative care resources rather than more objective demand-led measures of need such as the number of deaths which require specialist palliative care. It is hard to avoid the conclusion that the absence of a clear resource allocation model for specialist palliative care services is creating inequities in access to these services.

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103 Murray, Sweeney, Smyth and Connolly, 2006:72-73.

104 Marie Curie Palliative Care Institute Liverpool, 2007:10; see also 2009.

105 Department of Health, 2006.

106 National Institute for Health and Clinical Excellence, 2004.

107 O'Shea, Murphy, Larkin, Payne, Froggatt, Casey, Ní Léime, and Keys, 2008:119.

108 Murray, Sweeney, Smyth and Connolly, 2006. See also Murray, 2008.

## 9 Complaints

Since January 2007, the HSE has operated a statutory complaints procedure in accordance with the provisions of the Health Act 2004. This procedure, which is staffed by nearly 900 designated complaints officers<sup>109</sup>, applies to all HSE actions, as well as service providers who have contracts with the HSE, such as acute and community hospitals. In 2008, there were over 9,000 complaints to the HSE of which less than two thirds (5697, 62%) related to hospitals<sup>110</sup>, and six out of ten (61%) of these related to voluntary hospitals. The vast majority of these complaints were resolved following a local investigation but 2% (83) of complainants requested an internal HSE review.

Complaints which remain unresolved through the HSE's complaints procedure can be referred to the Ombudsman's Office and 84 complaints about hospitals were received in 2007<sup>111</sup>, rising to 94 in 2008<sup>112</sup>, these being a relatively small fraction (15%) of all health service complaints to the Ombudsman in these years. The complaints covered issues such as 'an unexpected death in hospital, lack of courtesy in the care and treatment of patients, communication difficulties in respect of the transmission of urgent medical reports between hospitals, lack of dignity and respect surrounding the death of patients in hospitals, inadequate record keeping and failure to apologise for poor service provided'<sup>113</sup>.

The audit asked each hospital to report on the number of official complaints made to the hospital in 2008, and the proportion of these which were about end-of-life issues. All acute hospitals received complaints but more than half the community hospitals (10, 53%) reported no complaints (Tables 9.1 and 9.2). It is noteworthy that the number of complaints reported by over a third of acute hospitals is at variance with the corresponding data held by HSE's Office of Consumer Affairs, indicating some difficulties in recording or retrieving this information (Table 9.2).

In order to facilitate comparison between acute hospitals, we calculated the rate of complaints relative to in-patients and day-patients; for community hospitals, the rate was calculated relative to the number of beds. This revealed that acute hospitals received an average of 6 complaints per 1,000 patients, ranging from 1 to 13. In community hospitals, the average number of complaints per 1,000 beds was 8, ranging from 6 to 28.

Two significant aspects of these rates are noteworthy. First, in the acute sector, some of the largest hospitals generate not only a higher number of complaints but also a higher rate of complaints. Second, in the community sector, hospitals generate a higher rate of complaints compared to the acute sector despite a high proportion of community hospitals reporting no complaints.

At present, the HSE classification of complaints to hospitals does not include the category 'end-of-life issues'. The audit requested hospitals to estimate the number of complaints which were about end-of-life issues. The results show that no complaints about end-of-life issues are known to have been received by community hospitals

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109 HSE Annual Report 2007, 2009:44

110 HSE Annual Report 2008, 2009:44

111 Ombudsman, 2008.

112 Ombudsman, 2009.

113 Ombudsman, 2008:34.

while half of the acute hospitals received some complaints, equivalent to 2% of the total. This appears low relative to the experience elsewhere<sup>114</sup>.

Complaints provide a valuable learning opportunity for a hospital, although it needs to be recognised that they are not an unambiguous indicator of quality, or lack of it. This is because complaints usually cover only a small proportion of patients and treatments within a given year, about 6%. In addition, it is possible for patients to be satisfied with some aspects of a service and dissatisfied with others. This was highlighted in a recent study of complaints to the National Health Service in Scotland which found that over 80% of those surveyed were satisfied with most aspects of the hospital care received but half of these (44%) were also dissatisfied with certain aspects of the service, especially waiting times<sup>115</sup>. Significantly, only 6% of those who expressed dissatisfaction proceeded to make a complaint and, for these, staff attitudes and behaviour were the single biggest source of complaint<sup>116</sup>. This illustrates why, in assessing the quality of a service, it is important to view complaints in conjunction with other measures of consumer satisfaction<sup>117</sup>. Even when all the relevant data sources are considered simultaneously, the results are not always unambiguous<sup>118</sup>.

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114 For example, the Healthcare Commission for England & Wales (replaced by the Care Quality Commission in March 2009) received over 16,000 complaints for independent review between 2004 and 2006. Of these, 54% were complaints about hospitals involving the care received at the time death, compared with only 22% being about patient safety. Most families complained about quality of communication; for example receiving contradictory information from different staff members and not being prepared by staff for the patient's death (Cited in Mayor, 2007).

115 Craigforth, 2006: 19-21. This is not dissimilar to results of a survey, commissioned by the HSE's Office of Consumer Affairs, involving a random sample of 3,517 Irish people on their experience of public health and social care services in Ireland in 2007. A sub-sample of these (344, 10%) had experience of hospital services in the last year and reported high overall levels of satisfaction on dimensions such as: effective treatment by a trusted professional (78%), involvement in decisions and respect for own preferences (75%), clear and comprehensive information (80%), emotional support, empathy and respect (83%), easy to get around the hospital (74%). However there was a marked dip in satisfaction on dimensions such as cleanliness of hospital toilets (62%), contact with the hospital by phone (69%), and car-parking facilities (46%) (UCD and Lansdowne Market Research, 2007).

116 Craigforth, 2006:42-44.

117 In order to get a more rounded view of patient satisfaction, the Department of Health in the UK has mandated the NHS, from April 2009, to collect Patient Reported Outcome Measures (PROMs) for four elective procedures. These procedures are hip replacement and knee replacement operations, varicose vein surgeries and groin hernia surgeries. Information is collected at both pre-operative and post-operative stages and is designed to measure clinical outcomes from the perspective of patients and how they perceive their health and the impact of treatments on their quality of life. See <http://www.glasgows.co.uk/proms/>

118 A review of the evidence on patients in English hospitals produced the following conclusions: 'Returning to the opening question, how does it feel to be a patient in hospital in England in the 21st century? It is apparent that we have found it difficult to answer. We do not have much data on trends, and it is difficult to know how most aspects of English hospitals compare with those in hospitals in other countries. The information we have is contradictory: broadly, the picture from the survey data is positive, the picture from patients' and families' stories is more mixed, and the complaints data suggest serious grounds for concern' (Goodrich and Cornwell, 2008:16).

## 10 Policies and Procedures

We have seen that most people die in a hospital or similar setting, outside the home (see Figure 1.1 and Tables 1.1a-b). This means that hospitals play a key role for society in terms of dying, death and bereavement. Despite this, it has been observed that 'end-of-life care is frequently not yet seen as a core activity of hospitals and is not normally included in service plans. Neither is its importance adequately reflected in hospital cultures, systems and structures'<sup>119</sup>. Against this background, the audit asked each hospital if it had documents or business plans which set out its policies, procedures, objectives and targets for end-of-life care.

The results of the audit show that, in the acute sector, about six out of ten hospitals (14, 58%) have a document outlining policies and procedures for end-of-life care; the corresponding proportion in community hospitals is two thirds (13, 68%) (Table 10.1). A significant minority of acute (9, 38%) and community (6, 32%) hospitals have specific objectives and targets for improving end-of-life care in their business plan, and some do not even have a business plan. Despite this, a majority of both acute (17, 71%) and community (15, 79%) hospitals have a standing committee on dying, death and bereavement, or its equivalent.

These results are at variance with the experience of HFH staff who find that the quality and range of documents on end-of-life care in most hospitals is quite limited. However a contrasting view is presented in a study of 327 long-stay care settings in Ireland which found that 'written policies on end-of-life care are available in the majority of facilities (80 per cent)'<sup>120</sup>. In Northern Ireland, an audit of end-of-life care in hospitals and hospices reveals that the infrastructure of policies, procedures and guidelines for end-of-life care is considerably more developed compared to the Republic of Ireland<sup>121</sup>.

If it is accepted that end-of-life care is a core activity of hospitals, then it is not unreasonable to expect that each hospital would express its aspirations for end-of-life care in its documents and business plans. Using this rationale, we allocate a green light to those hospitals which have both a document and a business plan outlining end-of-life policies, procedures, objectives and targets; we allocate an amber light to those where this is contained in either a document or business plan but not both; and

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119 Hospice Friendly Hospitals Programme, 2009:3.

120 O'Shea, Murphy, Larkin, Payne, Froggatt, Casey, Ní Léime, and Keys, 2008:118-119.

121 For example, the Northern Ireland audit revealed the percent (in brackets) of hospitals and hospices with written policies, procedures and guidelines:

- Accessing translation services (94%)
- Do not attempt resuscitation (94%)
- Reporting cases to the coroner (91%)
- Cultural and religious practices (88%)
- Death certification (82%)
- Breaking bad news (77%)
- Care of the dying pathway (74%)
- Care plan for women who experience miscarriage, stillbirth or neonatal death (73%)
- Post-mortem processes (71%)
- Cremation (69%)
- Memorandum of understanding (68%)
- Information for relatives (62%)
- Burial by hospital, if no next-of-kin (61%)
- Advance directives (51%)
- Identification of the deceased (49%)
- Bereavement care (46%)
- Chaplaincy / spiritual care (46%)
- Sudden death protocols (42%)

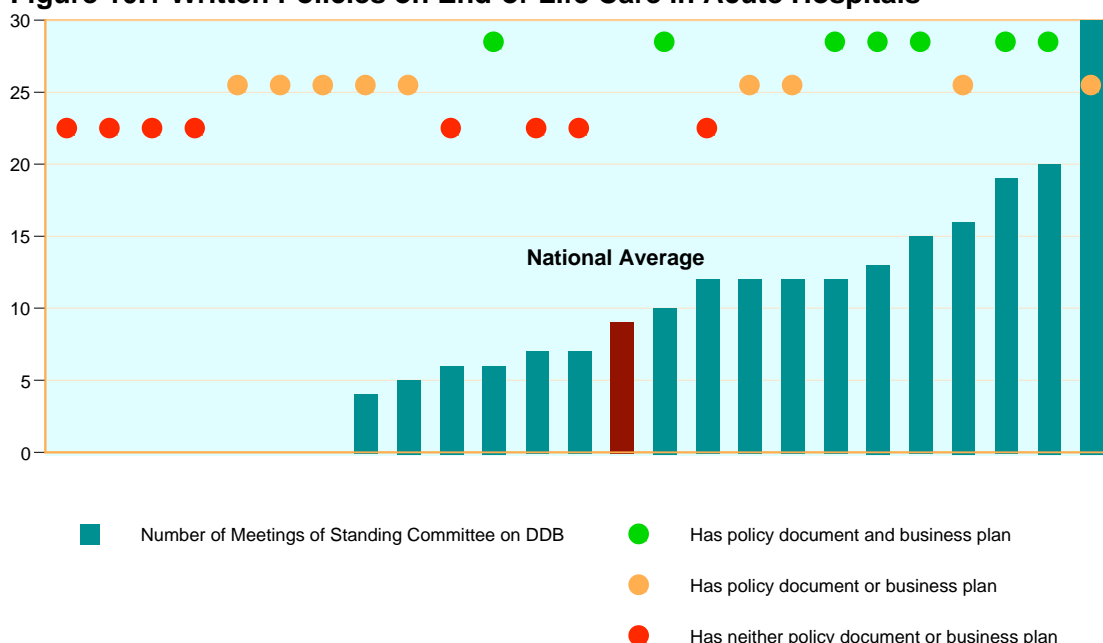
Care after death ('last offices') (over 80% for most items).

(Northern Ireland Health and Social Care Bereavement Network, 2009:13-14). It is worth pointing out that, notwithstanding all these written policies, procedures and guidelines, only 42% of the hospital staff surveyed regarded written guidance / information as excellent or good (Ibid:53).

we allocate a red light to those hospitals who have no written documentation on end-of-life policies, procedures, objectives and targets (Figures 10.1 and 10.2). This reveals that, in the acute sector, 29% merit a green light, 38% merit an amber light, and 33% merit a red light. In the community sector, the pattern is somewhat different in that 16% merit a green light, 68% merit an amber light, and 16% merit a red light.

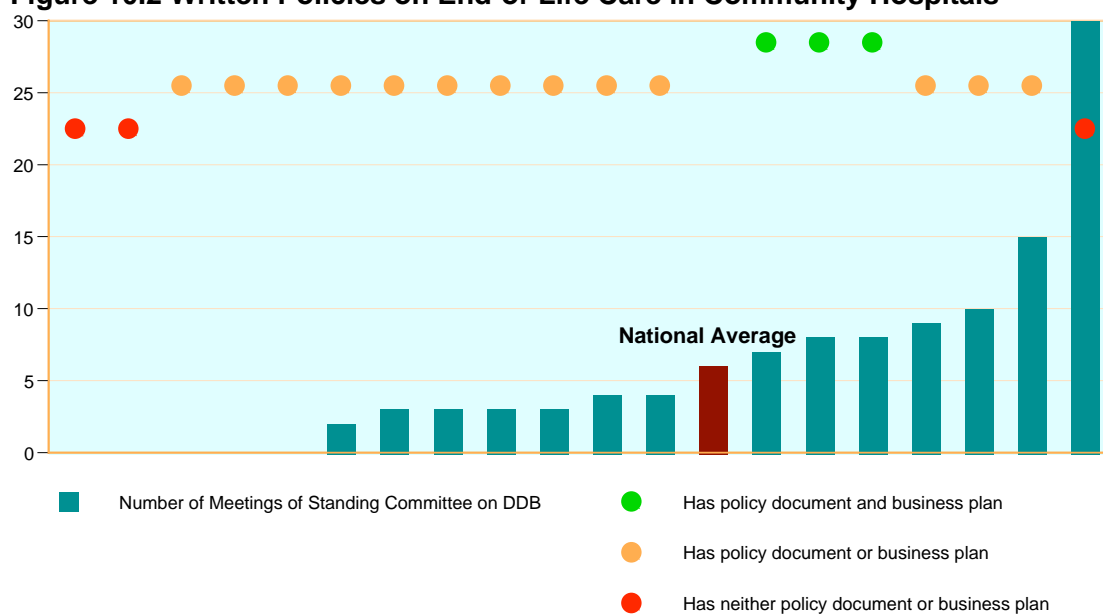
We are aware that having written policies and procedures, objectives and targets for end-of-life care does not necessarily imply that they are implemented in practice. Nevertheless in view of the neglect of end-of-life issues in hospitals, it is nevertheless a useful indicator of a hospital's interest and commitment in this area. Elsewhere in the audit, we assess how staff perceive the hospital's commitment to end-of-life care (Report Four), and we will also examine how this affects the quality of patient care, as perceived by nurses, doctors and relatives (Report Five).

**Figure 10.1 Written Policies on End-of-Life Care in Acute Hospitals**





**Figure 10.2 Written Policies on End-of-Life Care in Community Hospitals**



It is also appropriate to mention in this context that the decision of a hospital to participate in the audit, and other aspects of the HFH programme, is an expression of commitment to end-of-life care. By that measure, all 43 hospitals in the audit have an interest in end-of-life issues.

## 11 Training and Staff Supports

End-of-life care is part of the role of all health care professionals, but especially those professionals who come in direct contact with patients and families. In order to carry out that role, health care professionals require continuing education in different aspects of dying, death and bereavement. The National Advisory Committee on Palliative Care recommended that the specialist palliative care service in each acute hospital should take a lead in 'offering advice and support to health care professionals in the hospital'<sup>122</sup>.

The audit asked each hospital to indicate whether it provided training – either as part of induction or as in-service, and which lasts for half a day or more<sup>123</sup> - on any of following aspects of end-of-life care:

- (i) care of the patient and family at the patient's end-of-life;
- (ii) communication skills about dying, death, and bereavement, including breaking bad news to people;
- (iii) training in what people from different cultures expect at death;
- (iv) understanding the impact of loss, grief and bereavement;
- (v) understanding the legal and ethical issues around end-of-life care;
- (vi) support services for staff who give end-of-life care; and
- (vii) other training.

### 11.1 Induction training

The results of the audit reveal that most hospitals do not provide induction training on any aspect of dying, death and bereavement. In the acute sector, just over a quarter of hospitals (7, 29%) provide induction training compared to over a third (7, 37%) of hospitals in the community sector. Significantly, the presence or absence of induction training bears no relationship to the number of deaths in the hospital. This contrasts with the practice in Northern Ireland where all staff are normally informed about the hospital's policies, procedures and guidelines for end-of-life care during ward induction<sup>124</sup>.

We converted these results into the traffic light system of HealthStat on the basis that hospitals with no induction training modules receive a red-light; those with 1-2 modules receive an amber light and those 3+ modules receive a green light. The results are graphically illustrated in Figures 11.1-11.2. They show that, for induction training, most hospitals merit a red light (71% of acute and 63% of community), some merit an amber light (21% of acute and 26% of community), and a minority merit a green light (8% of acute and 11% of community).

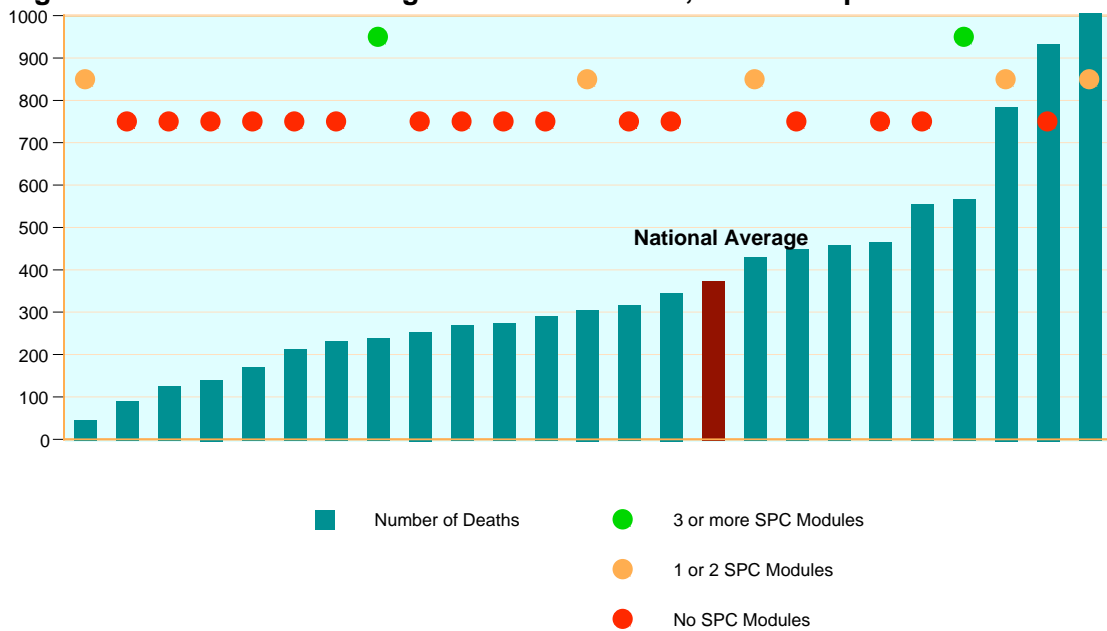
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122 National Advisory Committee on Palliative Care, 2001:81.

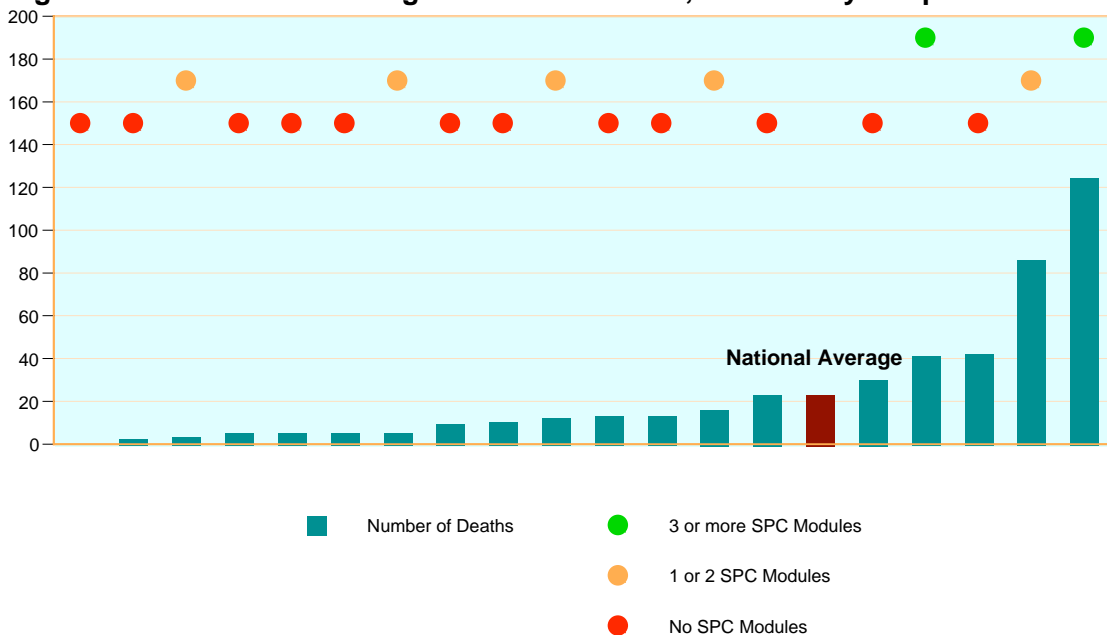
123 It is recognized that the audit may have under-estimated the full extent of induction and in-service training by virtue of defining training as 'any training which lasts half a day or more'. In practice, hospitals also provide training in 1-2 hour slots.

124 Northern Ireland Health and Social Care Bereavement Network, 2009: 14.

**Figure 11.1 Induction Training in End-of-Life Care, Acute Hospitals**



**Figure 11.2 Induction Training in End-of-Life Care, Community Hospitals**



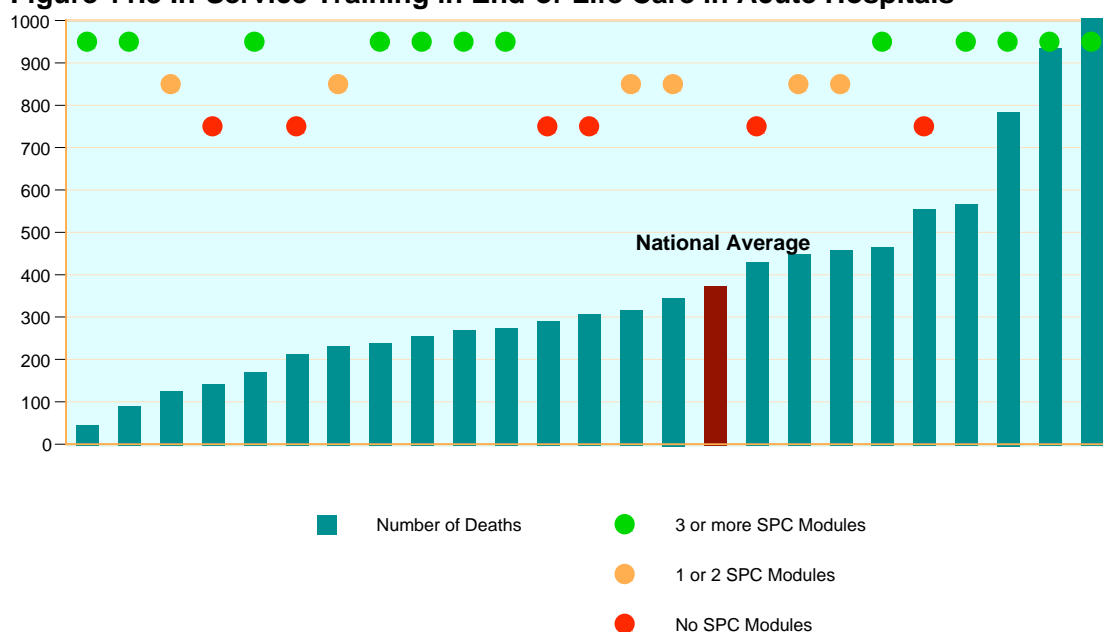
## 11.2 In-Service training

The audit reveals that hospitals are significantly more likely to provide in-service rather than induction training on different aspects of dying, death and bereavement (Tables 11.1 and 11.2). The majority of acute hospitals (19, 79%) provide in-service training, especially in the two areas of: communication skills about dying, death and bereavement including breaking bad news (17, 71%); and caring for the patient and family at the patient’s end of life (14, 58%). This is similar the level of provision for continuing education and training for care of the dying in English hospitals<sup>125</sup>.

125 In 155 English hospitals which use the Liverpool Care Pathway, continuing education and training for care of the dying is provided for medical staff (74%), nursing staff (84%) and non-qualified clinical staff (58%) (Marie Curie Palliative Care Institute Liverpool, 2009:28).

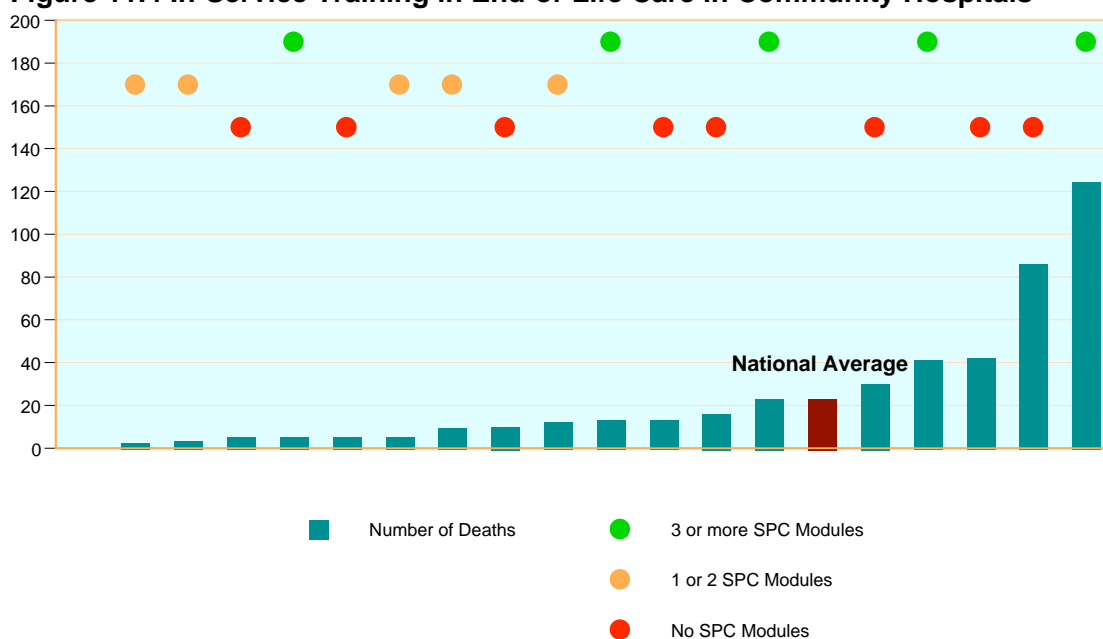
In the community sector, just over half (10, 53%) have provided in-service training, especially in the areas of: understanding the impact of loss, grief and bereavement (8, 42%); and training in what people from different cultures expect at death (7, 37%). As with induction training, the prevalence of in-service training bears little relationship to the number of deaths in the hospital.

**Figure 11.3 In-Service Training in End-of-Life Care in Acute Hospitals**



Again, we converted these results into the traffic light system of HealthStat on the basis that hospitals with no in-service training modules receive a red-light; those with 1-2 modules receive an amber light and those 3+ modules receive a green light. The results are graphically illustrated in Figures 11.3-11.4. They show that half the acute hospitals (50%) but only a quarter of community hospitals (25%) merit a green light; similar proportions (29% / 26%) merit an amber light; and community hospitals were much more likely to merit a red light (48%) compared to acute hospitals (21%).

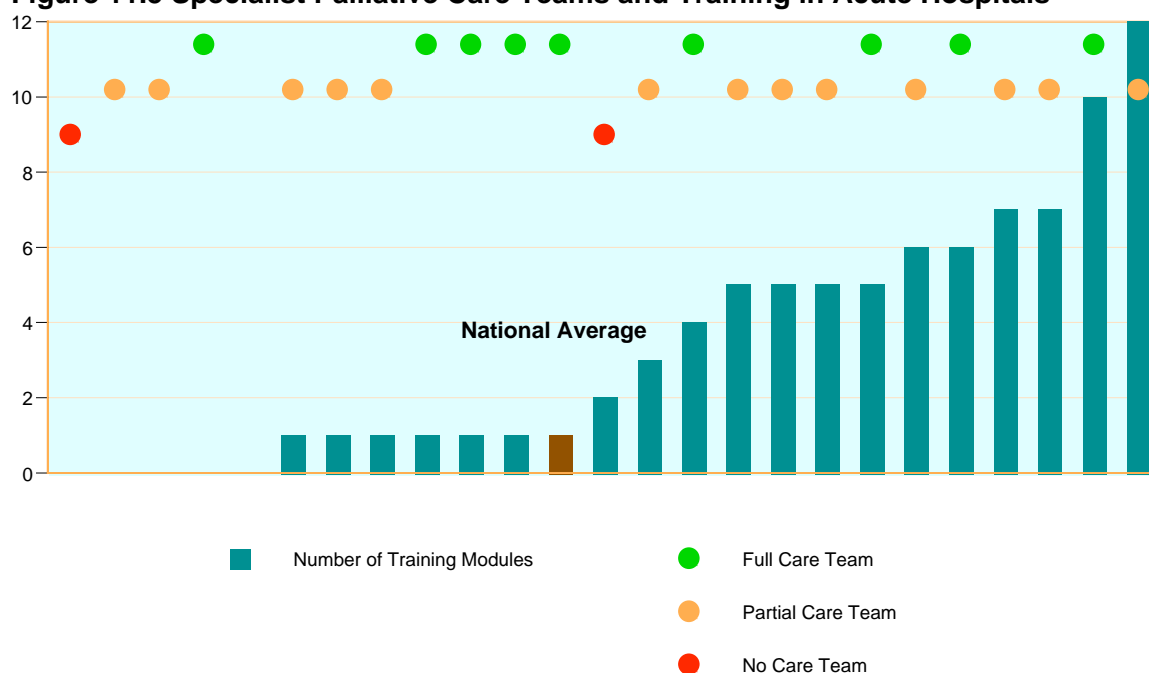
**Figure 11.4 In-Service Training in End-of-Life Care in Community Hospitals**



### 11.3 Role of Specialist Palliative Care Team in Training in Acute Hospitals

As indicated earlier, the National Advisory Committee on Palliative Care recommended that the specialist palliative care service in each acute hospital would take a lead role in ‘offering advice and support to health care professionals in the hospitals’<sup>126</sup>. In order to test how this recommendation has been implemented in practice, we examined whether, in each acute hospital, the prevalence of training (both induction and in-service training combined) is related to the size of the specialist palliative care team (full, partial, none). The results are shown in Figure 11.5 and indicate that training in end-of-life care in acute hospitals is not systematically related to whether there is a full, partial or no specialist palliative care team. This is a significant finding and suggests that, in general, these teams are not fulfilling their expected role of extending specialist palliative care training to other hospital staff.

**Figure 11.5 Specialist Palliative Care Teams and Training in Acute Hospitals**



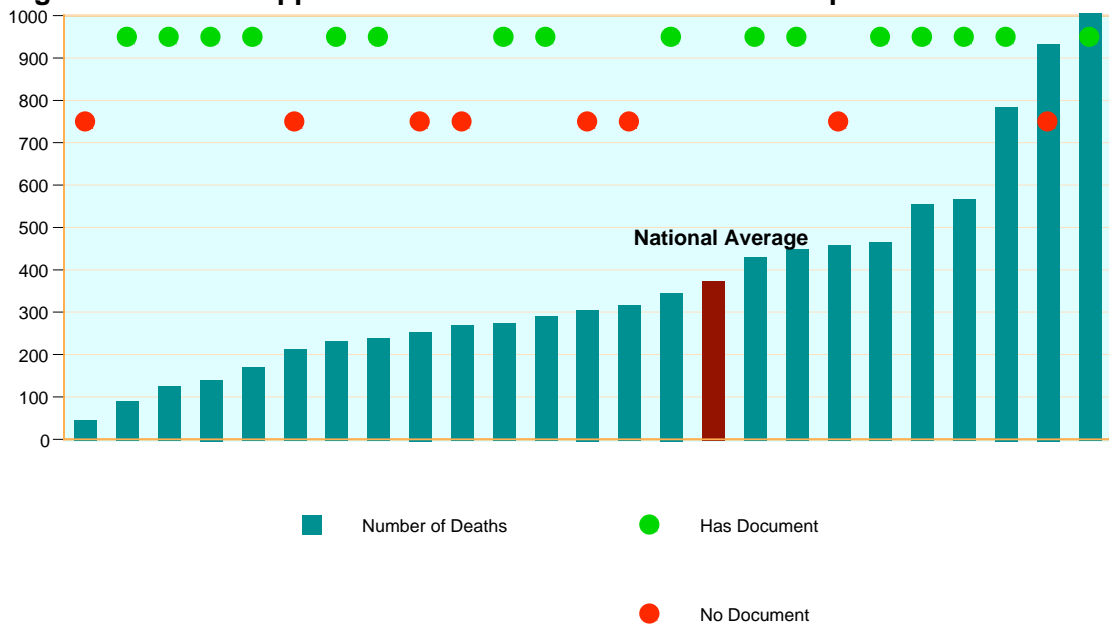
### 11.4 Staff supports

In addition to training, it is widely recognised that staff need to be supported, particularly those involved in end-of-life services who may experience particular upset. These supports can be practical or emotional, and can include opportunities for debriefing, a quiet space in the hospital to reflect after a death, or access to counselling, psychological, psychiatric or bereavement support services, either inside or outside the hospital.

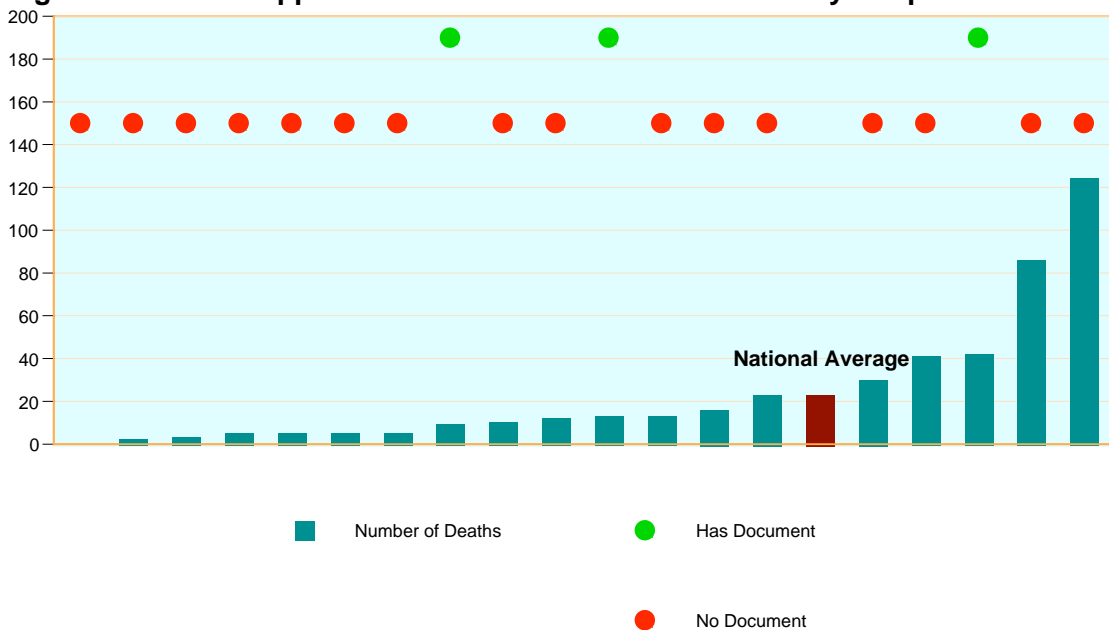
The audit asked: ‘Does the hospital have a document outlining the supports that are available to staff who are involved in end-of-life services or in traumatic incidents?’ The results show that over half the acute hospitals (14, 58%) but less than a fifth of community hospitals (3, 16%) have a document outlining the supports that are available for staff involved in end-of-life care (Table 11.3; Figures 11.6 and 11.7).

126 National Advisory Committee on Palliative Care, 2001:81.

**Figure 11.6 Staff Supports for End-of-Life Care in Acute Hospitals**



**Figure 11.7 Staff Supports for End-of-Life Care in Community Hospitals**



It is acknowledged that the audit is not a comprehensive assessment of the staff support system. Equally, it is acknowledged that the existence of a document may indicate that the issue of staff supports has been considered but is not necessarily a reliable indicator of the quality of those supports. In a subsequent report, the audit will examine how staff perceive the quality of education, training and supports for end-of-life care within the hospital, and will also examine whether having a document outlining those supports is a good indicator of their quality as perceived by staff (Report Four).

## 11.5 Summary

The audit measured the performance of hospitals in terms of providing training and other supports for staff. The results reveal that most hospitals do not provide induction training on any aspect of dying, death and bereavement and, for this reason, most hospitals merit a red light (71% of acute and 63% of community) for their induction training.

Hospitals are significantly more likely to provide in-service rather than induction training, both acute (19, 79%) and community (10, 51%). As a result, half the acute hospitals (50%) merit a green light while a similar proportion of community hospitals (48%) merit a red light for in-service training.

Significantly, the provision of training in end-of-life care in acute hospitals is not related to the number of deaths – a proxy indicator of need for specialist palliative care services. In addition, end-of-life training does not appear to be influenced by the existence of a full, partial, or no specialist palliative care team, a significant finding because it suggests that, in general, these teams are not fulfilling the expected role of extending specialist palliative care training to other hospital staff.

Regarding supports for staff, the audit show that over half the acute hospitals (58%) but less than a fifth of community hospitals (16%) have a document outlining the supports that are available for staff involved in end-of-life care.

## 12 Standard of Mortuary Facilities

The Design and Dignity Guidelines referred to above (Section 8) contains an entire section on the facilities that should be available in a mortuary<sup>127</sup>. In the audit, we listed these facilities and asked each hospital to indicate if these facilities were available in its mortuary using a 'yes/no' response format. Responses were received from all 24 acute hospitals, and the 14 community hospitals which have a mortuary.

The results indicate that, of the 21 mortuary facilities listed, acute hospitals have an average of 45% of the required facilities and community hospitals have an average of 40% (Table 12.1). The facilities that are least likely to be found in mortuaries are: a viewing room that has suitable furniture to facilitate relatives staying overnight (8%), access to a garden (18%), more than one waiting room (18%), and a waiting room providing hot and cold drinks nearby (18%).

These findings are broadly consistent with the independent architectural assessment of 20 hospitals (15 acute and 5 community) carried out in 2007<sup>128</sup>, and referred to above (Section 7). That assessment found mortuary facilities were deficient in terms of viewing rooms, waiting rooms, interview rooms, and rooms for preparing and storing bodies<sup>129</sup>. At the same time, it also found that 'every effort was made' to accommodate different faiths and cultures<sup>130</sup>. Its overall conclusion was that 'there were several examples where the mortuaries and post-mortem rooms were clearly no longer fit for function, for either viewing, body storage or for post-mortems. Conversely, there were one or two examples of some very good to excellent facilities'<sup>131</sup>.

A more recent review of mortuaries in Ireland concluded: 'The current operation of many mortuary services in the State is excellent; yet some others are running less optimally, with inexperienced or unqualified staff with no professional education programme in place; an excessive workload; some policy and SOPs [standard operating procedures] not being in place or up to date. ... . Some mortuaries that have excellent facilities... . Others have good facilities. ... A number of mortuaries are substandard. ... Generally viewing facilities for relatives were not to a high standard and with small amendments to environment could be much improved. ... Mortuaries and post-mortem examination facilities are of a variable standard throughout Ireland.'<sup>132</sup>

We used the performance categories in HSE's HealthStat system – green, amber and red lights - to rate the mortuaries in each hospital. The results are summarised in Figures 12.1 and 12.2 and show that the majority of mortuaries (71%) merit a 'red light' because their facilities are far from the required standard and a further one fifth (21%) merit an 'amber light'; only three hospitals (two acute and one community) merit a 'green light'.

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127 Hospice Friendly Hospitals Programme, 2008:32-34.

128 Tribal, 2007:20-21.

129 Tribal, 2007:20-21.

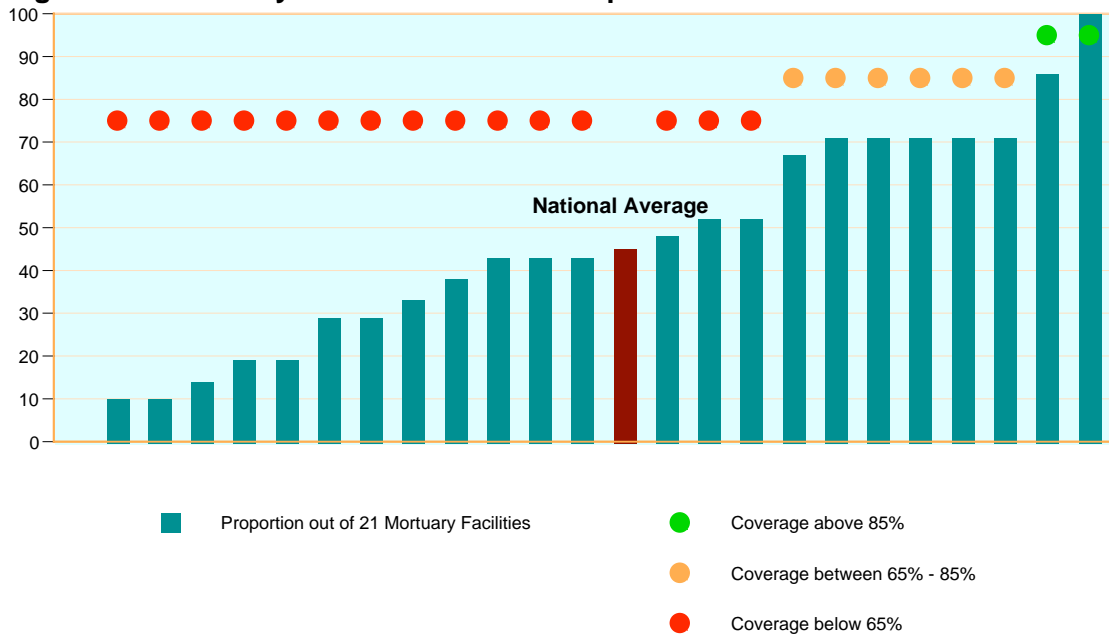
130 Tribal, 2007:20.

131 Tribal, 2007:20.

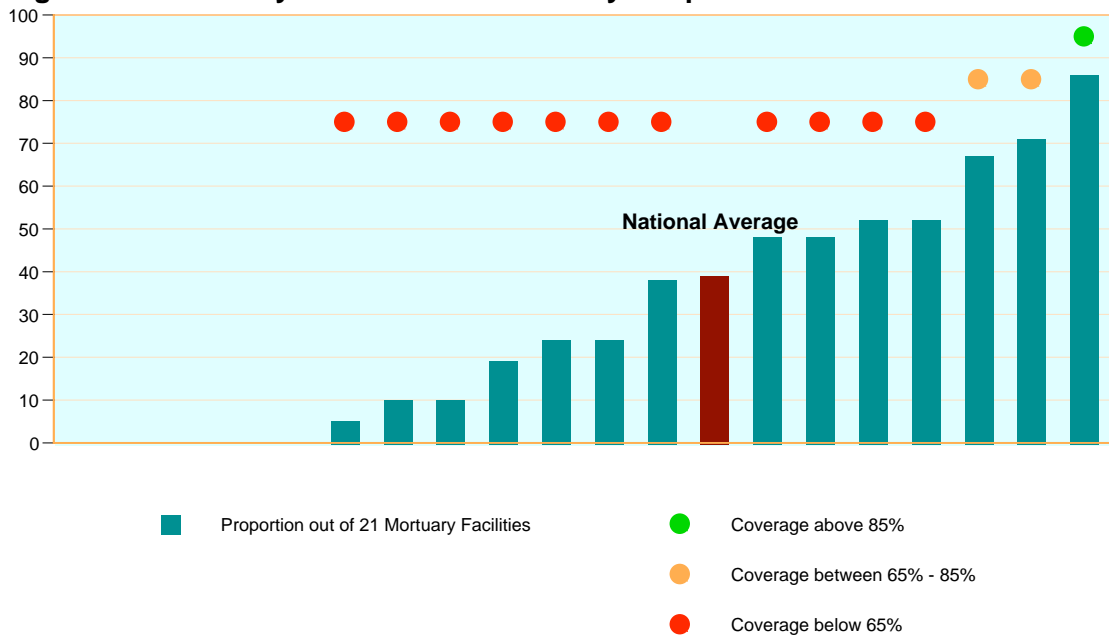
132 Willis, 2009:114.



**Figure 12.1 Mortuary Facilities in Acute Hospitals**



**Figure 12.2 Mortuary Facilities in Community Hospitals**



## 13 Bereavement Services and Facilities

The National Advisory Committee on Palliative Care<sup>133</sup>, whose report is government policy, recommended that bereavement support should be available in all settings 'where specialist palliative care is offered'<sup>134</sup>. Three levels of bereavement support are distinguished: (i) general bereavement support which uses counselling skills but is not counselling *per se*; (ii) bereavement counselling; and (iii) intensive psychotherapy<sup>135</sup>. These forms of bereavement support should be provided by appropriately trained personnel from the available pool of staff in each service<sup>136</sup>. The Draft Quality Standards for End of Life Care in Hospitals require hospitals to regard the dying patient and his / her family as a 'single unit of care' and to offer family members 'bereavement services that respond to their varied grief needs associated with their individual and cultural and spiritual experiences of death'.<sup>137</sup>

The audit asked each hospital if it had a bereavement service, without offering or seeking any particular definition of what this entails. Bearing this limitation in mind, the results indicate that less than half of acute hospitals (10, 42%) have a bereavement service, and even fewer community hospitals (3, 16%) have one (Tables 13.1 and 13.2). This is consistent with the baseline study published by the Irish Hospice Foundation (IHF) in 2006 which found that 'bereavement support services are [also] very uneven, with few designated bereavement coordinators appointed to services around the country'<sup>138</sup>.

The audit asked each hospital to assess the quality of its facilities for delivering a bereavement service, based on six statements taken from the Design and Dignity Guidelines<sup>139</sup>. These statements were rated on a scale from 1 to 10. The results indicate that, in general, hospitals which have a bereavement service also have reasonably good facilities to deliver that service, with a slightly higher standard of facilities in acute hospitals (7.7) compared to community hospitals (6.6). The one facility that is consistently rated below the mid-point on the scale is child-friendly counselling rooms (4.7).

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133 National Advisory Committee on Palliative Care, 2001: Chapter Nine.

134 National Advisory Committee on Palliative Care, 2001:98.

135 National Advisory Committee on Palliative Care, 2001:99.

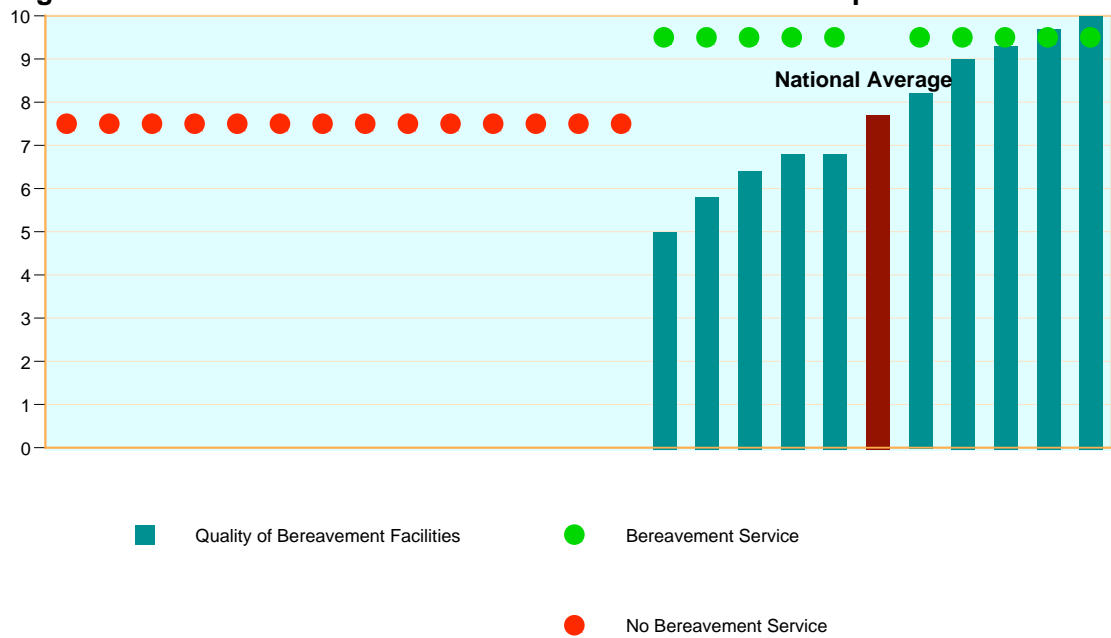
136 National Advisory Committee on Palliative Care, 2001:100.

137 Hospice Friendly Hospitals Programme, 2009:39-40.

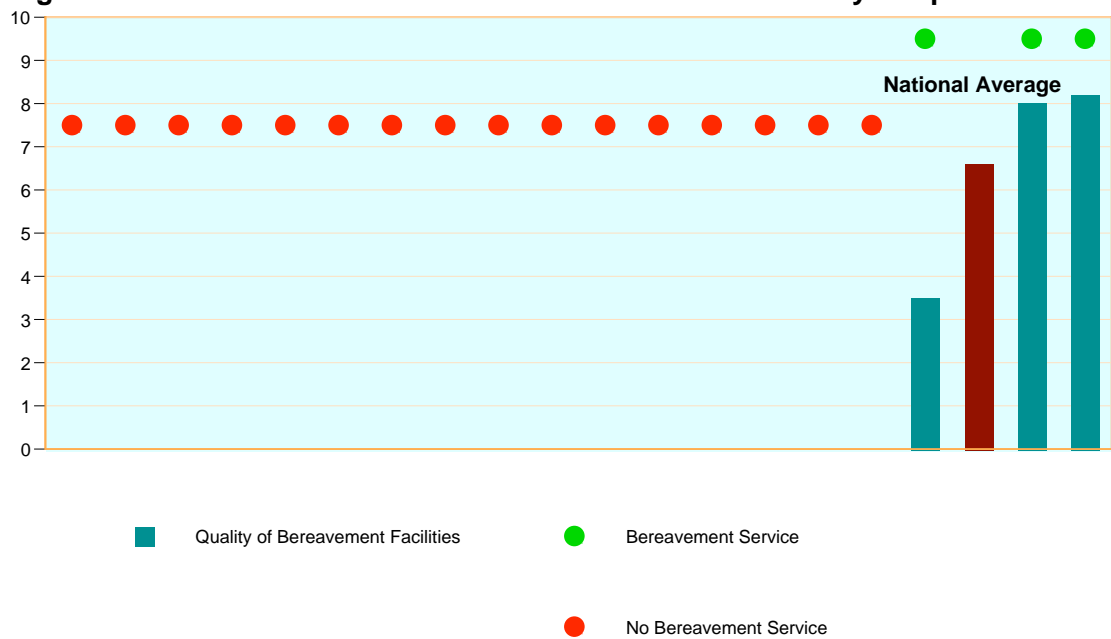
138 Murray, Sweeney, Smyth and Connolly, 2006:14.

139 Hospice Friendly Hospitals Programme, 2008:18.

**Figure 13.1 Bereavement Services and Facilities in Acute Hospitals**



**Figure 13.2 Bereavement Services and Facilities in Community Hospitals**



## 14 Conclusions and Issues for Consideration

Most people die in a hospital or similar setting, outside the home. In Ireland, at least half of all deaths occur in acute hospitals (48%) or hospices (4%); deaths at home still constitute a quarter of the total (25%), and a fifth die in long-stay facilities (20%); the remainder are deaths from suicide and traffic accidents (3%). When you consider that most people are also born in hospital, it becomes clear that hospitals are central to our passage into life and out of it, touching people at the most important and intimate moments of their lives.

It was not always so. Just 120 years ago, in 1885, the vast majority of people in Ireland (85%) died at home but, 120 years later in 2005, that pattern is completely reversed with only 25% of people dying at home. Other developed countries have followed the same path where, in many cases, the proportion dying at home is even smaller.

Given the importance of hospitals in our society, it is useful to remember that the word 'hospital' shares a common linguistic root with words like hospice, home, and especially hospitality. Hospitality – understood as being welcomed and cared for with kindness and attentiveness - is still what everyone seeks when they come to hospital, including patients and their families who are going through the journey of dying, death and bereavement. Understanding the key role of hospitals in helping people making this journey, and recovering the sense of hospitality at the heart of every hospital, is the *raison d'être* for the Hospice Friendly Hospitals programme. It is also the reason why we carried out this audit of end-of-life care.

Hospitals were invited to participate in this audit. There was no coercion, there were few incentives, and there was a disincentive that it would involve considerable extra work. In view of this, it is remarkable that 24 acute and 19 community hospitals participated in the audit. This is equivalent to three quarters of the acute sector in Ireland – in terms of patients, staff, beds, and deaths – and a substantial proportion (20%) of community hospitals. This huge response suggests that hospitals are deeply interested in the care they provide at the end-of-life, and are interested in strengthening the hospitality which they offer to patients and families at this time.

This first audit report focuses on practical matters, notably the hospital's resources and facilities for end-of-life care. All hospitals face a major challenge because they have relatively few single rooms (about 15% of all beds) to allow patients the option of dying in privacy. This is far short of any of the standards that have been proposed for the proportion of single rooms in hospitals, which vary from 50% to 80% to 100%.

Most hospitals have bed-occupancy rates of over 90% and this creates a huge level of activity, making it difficult for nurses and doctors to take the time to be with patients and families. Consider that, in the 30 OECD-countries, the average bed-occupancy rate is 75%.

The recognition that a patient's condition is beyond cure has huge implications for the patient and family, but also for the hospital. Hospitals need the skills of specialist palliative care at this time although the audit shows that a majority of acute hospitals in Ireland do not meet the government-approved standard of having a full specialist palliative care team; a similar proportion of community hospitals do not have access to any specialist palliative care service. The audit was unable to discover any rationale behind the distribution of specialist care services in hospitals since it seems to bear no relationship to the number of deaths in each hospital.

Many hospitals still have some way to go in terms of developing written policies, procedures, objectives and targets for end-of-life care. Much could be learned from hospitals in Northern Ireland who are well ahead in this regard. Equally, end-of-life care rarely features in the induction of staff, unlike the practice in Northern Ireland where it is an integral part of ward induction. On the other hand, both acute and community hospitals are providing some in-service training in end-of-life care. Also of note is that a majority of hospitals do not have a bereavement service.

One of the surprising findings in this part of the audit is that hospitals seem to have poor systems for recording and retrieving information about deaths. This is exemplified by the fact that many hospitals were unable to indicate the number of deaths referred to a coroner, the number of post-mortems, and almost none were able to distinguish between a hospital post-mortem and a coroner's post-mortem. Equally, there were systemic weaknesses in recording the number of 'brought in dead' (BID) and some hospitals seemed to have difficulty distinguishing between those BIDs which are brought to the mortuary and those which are brought in for preparation by funeral directors.

It is important to emphasise that this report is an audit, and not just a piece of research. It is intended to be part of a quality improvement cycle comprising: audit a reflection a planning a implementation a re-audit. The report – which is the first in a set of five - provides each hospital with an opportunity to reflect on its performance against established standards, and to draw up, and implement, a development plan to meet the deficits identified. In order to facilitate that process, we now identify a number of issues which would merit further consideration by individual hospitals and by other interested stakeholders.

## **14.1 Data difficulties**

The process of collecting data for this report was fraught with difficulties. Many hospitals found it a challenge because they do not seem to have information systems which facilitate the easy retrieval of data. This resulted in delays of up to three months in achieving returns from some hospitals, as well as gaps or inconsistencies in the data. An earlier draft of this report was circulated to all hospitals and substantial revisions were suggested which are incorporated in this final draft. The data for each hospital is in the Technical Appendix and, wherever possible, we present the same data from an independent source in order to check the variance.

In devising Questionnaire 6 of the audit, on which this report is based, we were not aware of the scale of these difficulties at hospital level, despite a pilot study in six hospitals using this questionnaire. Nor were we aware that some of the data that was difficult for hospitals to generate could be accessed centrally from HSE through data sources such as FactFile, HealthStat, Health Intelligence, National Employment Monitoring Unit, Consultant Appointments Unit, Office of Consumer Affairs, etc. Notwithstanding the availability of centralised HSE data, we were also unaware of the huge diversity of HSE datasets and the fact that each tends to operate in virtual isolation from the other. Even the most elementary building block of an integrated information system – such as a unique identifier for each hospital - is missing with the result that each hospital tends to be known by a slightly different name and / or acronym in each database. This generated significant extra work in matching the databases. However, this difficulty is not unique to the audit, and it was the same difficulty which led to the setting up of HealthStat in order to provide, for the first time in 2009, a more integrated system for measuring and managing the overall performance of hospitals in the HSE. A recent paper on HealthStat explained the

difficulty as follows: 'From an executive perspective the reporting of performance information was driven by information silos and produced a wide variety of disconnected extracts of information'<sup>140</sup>.

These considerations suggest that Phase 2 of the audit, whatever form it may take, cannot be a simple replication of Phase 1. In addition to setting up a national minimum dataset for recording and retrieving information about deaths – as discussed in the next sub-section - the focus in Phase 2 will be on using centralised data wherever possible in order to reduce the burden on hospitals. In addition, a much more robust system of verification will need to be put in place before data is accepted.

## **14.2 A national minimum dataset on deaths in hospital**

Information about deaths is essential to this audit and yet relatively little data is collected centrally by the HSE about deaths. The uneven pattern of returns made by hospitals to this aspect of the audit suggests that there is huge variation in the systems used by hospitals to record and retrieve information about deaths. This is exemplified by the fact that many hospitals were unable to indicate the number of deaths referred to a coroner, the number of post-mortems, and almost none were able to distinguish between a hospital post-mortem and a coroner's post-mortem. Equally, there were systemic weaknesses in recording the number of 'brought in dead' (BID) and some hospitals seemed to have difficulty distinguishing between those BIDs which are brought to the mortuary and those which are brought in for preparation by funeral directors.

The experience of the audit suggests the need for a national minimum dataset on deaths in hospital - including data definitions, data collection, data reporting, data analysis, and data publishing - so that the HSE can produce a more accurate picture of deaths across all acute and community hospitals. This is a significant undertaking, as a recent and similar proposal illustrates for setting up a minimum dataset for specialist palliative care<sup>141</sup>. The typical steps involved in setting up a dataset on deaths in hospital would include the following:

- Step 1: establish team to lead the project
- Step 2: agree scope of the project
- Step 3: develop a standardised recording form
- Step 4: develop minimum dataset
- Step 5: agree on recording, reporting, analysing and publishing data
- Step 6: finalise implementation plan
- Step 7: commence training and support
- Step 8: roll-out of standardised recording form
- Step 9: roll-out of revised minimum dataset.

## **14.3 Single rooms and bed-occupancy rates**

The understanding of end-of-life care which informs this audit acknowledges that the quality of care is influenced by hospital-level characteristics as well as the individual-level care received by each patient from nurses and doctors. That is why we collected information on single rooms and bed-occupancy rates, since these are hospital-level influences which are assumed to influence end-of-life care. On both of

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140 Turner, 2009:4

141 Astron Consulting, 2009

these characteristics, the audit confirms the challenges facing the Irish hospital system since the overall proportion of single rooms is far short of recommended standards, while the bed-occupancy rate is recognised to be too high to provide the desired level of care. These two characteristics, more than any other, set the background against which end-of-life care is provided in Irish hospitals. In acknowledging these challenges, it is also important to recognise that they are not an obstacle to significant improvements in other areas of end-of-life care.

#### **14.4 Deaths of community hospital residents**

We have seen that most community hospitals do not have access to specialist palliative care. The reasons for this merit further investigation to determine if this arises from the lack of specialist palliative care services in the community, or from the fact that these services have not been properly linked to community hospitals. Possibly because of this, the audit found that a substantial minority of residents in these hospitals (14%) die in acute hospitals. Of particular note is the wide variation between community hospitals in the likelihood of a resident being transferred to an acute hospital to die, and this raises questions about whether there is an agreed and acceptable approach to this issue across the community hospital sector.

The findings of a report on end-of-life care by the National Audit Office in the UK are worth recalling in this context: 'The proportion of care home residents who die in hospital could be reduced. Our survey found that a quarter of care home resident deaths occur in a hospital. There were also wide variations between care homes in the number of residents who die in hospital, ranging from none to all residents. In one PCT [Primary Care Trust], the proportion of residents dying in care homes could have been increased from 61 per cent to 80 per cent, if greater support and advice had been provided to those care homes'<sup>142</sup>. The results of this study suggest that further investigation is merited into the reasons why there is such diversity among community hospitals in transferring residents to an acute setting before they die.

#### **14.5 Hospital processes after death**

The audit revealed significant variation between hospitals in what happens to the patient's body after death. For example, there is huge variation between hospitals in the proportion of deaths that are referred to the coroner. While these referrals are understandably higher in A&E and intensive care compared to other wards, there is also considerable variation between hospitals; some hospitals have 10% or less of deaths referred to a coroner while others have 20% and some have over 40%. This variation may be due to the differing profiles of deceased patients in each hospital, and there may also be some variation in the referral practices of A&E and intensive care departments. This is an issue that would be worth investigating further.

Similarly, hospital practices vary considerably with regard to 'brought in dead'. For example, in six acute hospitals bodies are brought in to be prepared by funeral directors but this does not happen in other hospitals. Moreover there is also huge variation between hospitals in the number of bodies brought in for preparation. In July 2009, the HSE issued a Memorandum<sup>143</sup> to clarify certain issues about embalming including: (i) consent (ii) supervision, credential checks, and indemnity arrangements (iii) service level agreements and standard operating procedures.

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<sup>142</sup> National Audit Office, 2008:5.

<sup>143</sup> HSE Memorandum on Embalming at Hospitals Operated or Funded by the HSE, 2009. This Memorandum implements a number of recommendations from the Retained Organs Audit (Willis, 2009:120-121).

## **14.6 Standard of hospital facilities**

We have seen that hospitals have a much more positive self-perception of their facilities compared to the perceptions of independent observers. This, in turn, suggests that the pattern of response to this aspect of the audit may have less to do with an objective appraisal of the hospital's physical environment and more to do with awareness and attentiveness to evidence-based design in hospitals. The HFH programme has used a number of opportunities to bring international experts to Ireland to speak about evidence-based design, and this is something that needs to continue<sup>144</sup>. The results of the audit indicate that each hospital will need to set targets for improving the physical environment of hospitals – in line with the requirements of the Design and Dignity Guidelines - but it may also be appropriate to ensure that this is accompanied by a process of education and awareness-raising about evidence-based design.

The results of the audit are a salutary reminder of the challenges involved in assessing the physical environment of hospitals. The earlier study for the HFH Programme carried out by independent healthcare consultants also acknowledged that there is 'no recognised structured approach which can be used to assess these conditions [the physical conditions of hospitals] and to compare one hospital with another'<sup>145</sup>. Despite the existence of Design and Dignity Guidelines, it is clear that further work is required to find a more robust methodology for auditing the physical environment of hospitals in a way that yields reliable and consistent results, and which is effective in facilitating quality improvements. It is clear that self-assessment of hospital facilities is not reliable and an alternative approach will have to be found, possibly involving independent observers, for the next phase of the audit.

## **14.7 Distribution of specialist palliative care services**

The audit revealed that only a quarter of acute hospitals in Ireland meet the government-approved standard of having a full specialist palliative care team. It also revealed that specialist palliative care services are unevenly distributed between hospitals and, by virtue of that, patients have unequal access to these services at the end of life. In order to explain this uneven distribution, we suggested that the distribution of specialist palliative care services seems to reflect supply-led considerations – such as some hospitals seeking palliative care resources while others do not – rather than any objective measure of need such as the number of deaths. It is hard to avoid the conclusion that this uneven distribution must result in substantial inequities in the access of patients to specialist palliative care services. This, in turn, highlights the need for a much more explicit resource allocation model for specialist palliative care services that is firmly needs-based, and reflects demand-led rather than supply-led considerations.

## **14.8 Training for end-of-life care**

End-of-life care is a core activity of hospitals and the place where people are most likely to die. Despite this, the audit reveals that end-of-life care rarely features in the induction of staff. While this may be compensated by a substantial amount of in-service training, particularly in acute hospitals, induction training provides an opportunity for the hospitals to signal to new staff the importance it attaches to end-of-life care. The overall approach to end-of-life training in acute hospitals is

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144 One of the world's leading experts on evidence-based design, Roger Ulrich, presented at two events in Dublin organised by the HFH Programme in November 2007 and June 2008.

145 Tribal, 2007:iii.



challenged by the audit, especially the finding that the provision of training is unrelated to either the number of deaths in the hospital – a proxy indicator of need for palliative care services<sup>146</sup> - or the existence of a full, partial, or no specialist palliative care team. This is a challenge because it invites acute hospitals to think more systematically about the link between training and the scale of need, while also calling attention to the expected role of specialist palliative care teams in extending specialist palliative care training to other hospital staff.

#### **14.9 Supporting staff providing end-of-life care**

The audit reveals that a number of acute and community hospitals need to develop written information on their support systems for staff involved in end-of-life care. These supports can be practical or emotional, and can include opportunities for debriefing, a quiet space in the hospital to reflect after a death, or access to counselling, psychological, psychiatric or bereavement support services, either inside or outside the hospital.

#### **14.10 Standard of mortuary facilities**

The results of the audit indicate that the majority of hospitals have substantial work to do in order to bring their mortuaries up to the standards set out in the Design and Dignity Guidelines. The mortuary facilities that particularly require improvement, and which were also highlighted in previous assessments<sup>147</sup>, include: viewing rooms, waiting rooms, interview rooms, and rooms for preparing and storing bodies.

#### **14.11 Bereavement services and facilities**

The majority of acute and community hospitals do not have a bereavement service. This suggests that hospitals should look at how they propose to look at this gap in their services.

#### **14.12 Developing policies, procedures, objectives and targets**

A significant minority of acute and community hospitals do not have documented policies, procedures, objectives or targets for end-of-life care. Compared to hospitals in Northern Ireland, this infrastructure of policies, procedures and guidelines for end-of-life care is relatively weak. The audit provides each hospital with a list of areas where it can set specific objectives and targets for improving its end-of-life care.

#### **14.13 Concluding comment**

As already indicated, this is an audit, and not just a piece of research. In order to encourage hospitals to adopt the perspective of quality improvement which underlies the audit, we conclude by quoting from the Commission on Patient Safety and Quality Assurance on the importance of audits in the health services: “Clinical audit

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<sup>146</sup> It is acknowledged that the number of cancer deaths in a hospital underestimates the level of need for specialist palliative care services in that hospital for two reasons. First, it does not include the number of cancer deaths which are referred by the hospital to hospice or home. In 2007, for example, cancer patients who were discharged from hospital to hospice constituted 16% of the combined cancer deaths in hospitals and hospices (HIPE, 2007). No corresponding data exists on the number of cancer deaths which took place in the home. Second, the need for specialist palliative care arises for patients other than those with cancer. A recent report estimated that, when the needs of patients with heart failure, dementia and chronic obstructive pulmonary disease are added to those with cancer, the estimated number of patients requiring specialist palliative care ‘would increase by at least 50%’ (Health Service Executive and Irish Hospice Foundation, 2008:2). Despite these limitations, the number of cancer deaths in each hospital is still the best available proxy for the need for specialist palliative care, based on existing data.

<sup>147</sup> Tribal, 2007:20-21; Willis, 2009:114-115.

needs to be at the heart of clinical practice, and is something that all health practitioners should be engaged in. Clinical audit is about continuing evaluation and improvement by health professionals working towards delivery of safe, high quality care for patients. Clinical audit arguably constitutes the single most important method which any health care organisation can use to understand and ensure the quality of the service it provides. It is one of the principal methods used to monitor clinical quality and the results provided by clinical audit are a source of indispensable information to patients, the public, clinicians, and healthcare managers. It also provides a powerful mechanism for ongoing quality improvement highlighting incidences where standards are not met and identifying opportunities for improvement”<sup>148</sup>.

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148 Commission on Patient Safety and Quality Assurance, 2008:151. In February 2009, the Minister for Health and Children announced a Government decision to prepare legislation to implement the recommendations in the report of the Commission on Patient Safety and Quality Assurance. Of particular relevance in this context is the Commission’s recommendation that ‘There should be a mandatory licensing system in Ireland to cover both public and private healthcare providers. It must be an equitable and transparent system, with a review of the licences every three years. It will apply to existing and new bodies, with time being given for compliance’ (p.25). A further recommendation states: ‘As part of the licensing process recommended in this Report, all licensed healthcare facilities must demonstrate active participation in local and national clinical audit as appropriate to their services (p.30).

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## 16 Data Appendix



# 1 Introduction

**Table 1.1a: Deaths by Place of Occurrence for Selected Years in Ireland, 1885-2005**

Year	Deaths at Home		Deaths in Hospitals & Institutions		Total Deaths		Un-certified Deaths	Post-Mortems & Inquests
	N	%	N	%	N	%	%	%
1885	76,676	85	14,036	15	90,712	100		2
1890	72,307	84	13,543	16	85,850	100		2
1895	71,075	84	13,320	16	84,395	100		3
1900	72,322	83	15,284	17	87,606	100		3
1905	60,277	80	14,794	20	75,071	100		2
1910	59,456	79	15,438	21	74,894	100		2
1915	60,028	79	16,123	21	76,151	100	23	2
1919	62,197	79	16,415	21	78,612	100	22	1
1925	32,957	76	10,693	24	43,650	100	27	2
1930	30,407	73	11,295	27	41,702	100	21	3
1935	28,541	69	13,002	31	41,543	100	17	3
1940	27,747	66	14,138	34	41,885	100	15	3
1946	26,998	65	14,459	35	41,457	100	12	3
1950	23,625	63	14,116	37	37,741	100	11	4
1955	21,367	58	15,394	42	36,761	100	9	5
1960	16,743	51	15,917	49	32,660	100	6	5
1965	15,285	46	17,737	54	33,022	100	3	6
1970	13,977	41	19,709	59	33,686	100	1	8
1975	12,613	38	20,560	62	33,173	100	1	9
1980	12,946	39	20,526	61	33,472	100	0	11
1985	12,961	39	20,252	61	33,213	100	0	11
1990	12,468	41	18,002	59	30,470	100	0	12
1995	10,382	32	21,877	68	32,259	100	0	12
2000	8,147	26	23,244	74	31,391	100	0	14
2005	7,166	25	21,094	75	28,260	100	0	18

Source: Annual Reports on Vital Statistics, 1885-2005.

**Table 1.1b: Estimated Place of Death in Ireland, 2006**

Place of Death	N	%	Source
All deaths	28,488	100	Annual Report on Vital Statistics 2006
Home	7,219	25	Annual Report on Vital Statistics 2006
Acute Hospital	13,638 12,177(a) 1,461(b)	48	(a) HIPE data, unpublished, covering all acute hospitals, and some community hospitals such as St. Mary's Hospital, Phoenix Park, Dublin. (b) HIPE data excludes A&E deaths. This national audit estimates that 12% of acute hospital deaths are in A&E.
Hospice	1,166	4	Based on 2004 data reported on page 52 of Murray, E., Sweeney, C., Smyth, C., and Conolly, E., 2006.
Suicide & road traffic accidents	828	3	The number of suicides in 2006 was 460, based on the 2008 Annual Report of the National Office for Suicide Prevention. The number of road traffic accidents in 2006 was 368, based on the 2008 Annual Report of An Garda Síochána.
Sub-Total	22,851	80	
Long-stay facilities	5,637	20	There is no published data on deaths in long-stay facilities and the categories used by the CSO are outdated. This is a residual figure.
<b>Total</b>	<b>28,488</b>	<b>100</b>	

## 2 Coverage of the Audit

Table 2.1: List of Acute Hospitals in Audit

Acute Hospital Groups	In HFH Audit	In HFH Pilot of Audit	In RCSI Pilot of Audit	Phase 1 of HFH Prog.	Part of HIPE
<b>Dublin North Hospitals Group</b>					
Mater Misericordiae University Hospital	Yes	Yes	No	Yes	Yes
Beaumont Hospital, Dublin	Yes	No	No	Yes	Yes
Connolly Hospital, Blanchardstown	Yes	No	No	Yes	Yes
<b>Dublin South Hospitals Group</b>					
St. Luke's, Rathgar	Yes	No	No	No	Yes
St. James' Hospital, Dublin	Yes	No	No	No	Yes
St. Vincent's Hospital, Elm Park, Dublin 4	No	No	No	No	Yes
St. Michaels Hospital, Dun Laoghaire	No	No	No	No	Yes
St. Colmcille's Hospital, Loughlinstown	No	No	No	No	Yes
<b>Dublin Midland Hospital Group</b>					
Naas General Hospital	Yes	No	Yes	Yes	Yes
Tallaght Hospital (AMNCH)	Yes	No	No	Yes	Yes
Midland Regional Hospital, Tullamore	Yes	No	No	No	Yes
Midland Regional Hospital, Portlaoise	Yes	No	No	No	Yes
Midland Regional Hospital, Mullingar	No	No	Yes	No	Yes
Our Lady's Hospital, Crumlin	No*	No	No	Yes	Yes*
<b>North Eastern Hospital Group</b>					
Our Lady's of Lourdes Hospital, Drogheda	Yes	No	No	Yes	Yes
Louth County Hospital, Dundalk	Yes	No	No	Yes	Yes
Cavan General Hospital	Yes	No	No	Yes	Yes
Monaghan General Hospital	Yes	No	No	Yes	Yes
Our Lady's Hospital, Navan	Yes	No	No	Yes	Yes
<b>South Eastern Hospital Group</b>					
Waterford Regional Hospital	Yes	No	No	Yes	Yes
St. Luke's General Hospital, Kilkenny	Yes	No	No	Yes	Yes
Wexford General Hospital	Yes	No	No	Yes	Yes
South Tipperary General Hospital, Clonmel	Yes	No	No	Yes	Yes
<b>Southern Hospital Group</b>					
Cork University Hospital	Yes	Yes	No	Yes	Yes
Kerry General Hospital, Tralee	Yes	No	No	No	Yes
Mallow General Hospital	No	No	No	No	Yes
Bantry General Hospital	No	No	No	No	No
Mercy Hospital, Cork	No	No	No	No	Yes
South Infirmary Victoria Hospital, Cork	No	No	No	No	Yes
<b>Mid-Western Hospital Group</b>					
Mid Western Regional Hospital, Limerick	Yes	No	No	No	Yes
Mid Western Regional Hospital, Nenagh	Yes	No	No	No	Yes
Mid Western Regional Hospital, Ennis	No	No	No	No	Yes
St. John's Hospital, Limerick	No	No	No	No	Yes
<b>Western Hospital Group</b>					
Sligo General Hospital	Yes	No	No	Yes	Yes
Letterkenny General Hospital	Yes	No	No	No	Yes
University College Hospital, Galway	No	No	No	No	Yes
Merlin Park Regional Hospital, Galway	No	No	No	No	Yes
Mayo General Hospital, Castlebar	No	No	No	No	Yes
Roscommon County Hospital, Roscommon	No	No	No	No	Yes
Portiuncula Hospital, Ballinasloe	No	Yes	No	Yes	Yes
<b>Totals for yes (out of 40)</b>	<b>24</b>	<b>3</b>	<b>2</b>	<b>18</b>	<b>39</b>

\*Audit includes adult deaths only; not included in the HIPE 38 reference group.

**Table 2.2: List of Community Hospitals in Audit**

Community Hospitals	In HFH Audit	In HFH Pilot of Audit	In RCSI Pilot of Audit	Phase 1 of HFH Programme
<b>East</b>				
Royal Hospital Donnybrook	Yes	No	No	Yes
Bru Chaoimhin	Yes	No	No	Yes
Bell Villa	Yes	No	No	Yes
Meath Community Unit	Yes	No	No	Yes
St. Mary's Hospital	Yes	Yes	No	Yes
Leopardstown Park Hospital	Yes	Yes	No	Yes
Peamount Hospital, Newcastle	Yes	No	Yes	Yes
<b>South East</b>				
St. Columba's, Thomastown, Co. Kilkenny	No	Yes	No	No
<b>Midland</b>				
<b>North West</b>				
St John's Hospital, Sligo	Yes	No	Yes	Yes
<b>North East</b>				
St. Joseph's Hospital, Trim	Yes	No	No	Yes
St. Mary's, Castleblayney	Yes	No	No	Yes
Oriel House, Monaghan Town	Yes	No	No	Yes
Breffni Unit, Ballyconnell, Co. Cavan	Yes	No	No	Yes
Virginia	Yes	No	No	Yes
Lisdarann	Yes	No	No	Yes
Boyne View, Drogheda	Yes	No	No	Yes
Cottage Hospital, Drogheda	Yes	No	No	Yes
St. Mary's Hospital, Drogheda	Yes	No	No	Yes
Sullivan Centre, Cavan	Yes	No	No	Yes
St. Joseph's Hospital, Ardee	Yes	Yes	No	Yes
St. Oliver Plunkett Hospital, Dundalk	No	No	No	Yes
<b>West</b>				
<b>Mid-West</b>				
<b>South West</b>				
<b>Totals for yes (out of 22)</b>	<b>19</b>	<b>4</b>	<b>2</b>	<b>18</b>

**Table 2.3: Number of Acute Hospitals and Beds**

ID	Hospitals	Acute Hospitals		Beds in Acute Hospital	
		Number	%	Number	%
H89	Hospitals in Audit	24	63.2	9,027	74.2
	HIPE 38 (2007)	38	100.0	12,170	100.0

Source: Bed numbers from HSE FactFile, March 2009

**Table 2.4: Patients and Deaths in Acute Hospitals**

ID	Hospitals	Patients in Acute Hospitals		Deaths in Acute Hospitals	
		Number	%	Number	%
H89	Hospitals in Audit	787,481	n/a	8,936	n/a
	HIPE 24 (2007)	839,161	71.6	8,070	70.6
	HIPE 38 (2007)	1,171,437	100.0	11,426	100.0

**Table 2.5: Staff in Hospitals**

ID	Hospitals	Acute Hospitals		Community Hospitals		Acute + Community Hospitals	
		Number	%	Number	%	Number	%
H89	Hospitals in Audit	33,361	72.9	2,839	27.5	36,200	64.5
	HIPE 38 (2007)	45,762	100.0	10,333	100.0	56,095	100.0

Source: HSE National Employment Monitoring Unit

Note: 'HIPE 38 (2007)' refers to the 38 hospitals in the Hospital In-Patient Enquiry (HIPE) who were invited to participate in the HFH Audit (Table 2.1). They are the acute hospital sector after excluding public maternity, orthopaedic and children's hospitals.

### 3 Section A: Accommodation

**Table 3.1: Beds in Hospital at End of 2008**

Q6A1		In-patient Beds		Day-beds		Total	FactFile*
ID	Hospital	Number	%	Number	%	Number	% Difference
A10	Acute Hospital	908	89	114	11	1,022	22
A17	Acute Hospital	727	85	126	15	853	21
A01	Acute Hospital	715	92	58	8	773	27
A21	Acute Hospital	557	88	75	12	632	21
A12	Acute Hospital	568	92	52	8	620	8
A18	Acute Hospital	474	87	71	13	545	1
A02	Acute Hospital	374	79	97	21	471	-8
A14	Acute Hospital	309	82	69	18	378	6
A13	Acute Hospital	329	89	40	11	369	36
A11	Acute Hospital	319	89	40	11	359	0
A05	Acute Hospital	309	91	30	9	339	0
A24	Acute Hospital	240	75	80	25	320	35
A20	Acute Hospital	299	94	18	6	317	2
A08	Acute Hospital	268	98	6	2	274	-27
A19	Acute Hospital	241	90	27	10	268	5
A03	Acute Hospital	206	82	46	18	252	12
A09	Acute Hospital	217	89	27	11	244	3
A23	Acute Hospital	225	93	18	7	243	0
A16	Acute Hospital	152	95	8	5	160	-21
A15	Acute Hospital	139	87	20	13	159	-11
A06	Acute Hospital	129	89	16	11	145	-16
A07	Acute Hospital	121	90	14	10	135	-1
A22	Acute Hospital	75	93	6	7	81	-57
A04	Acute Hospital	55	81	13	19	68	-29
C55	Community Hospital	353	100	0	0	353	-4
C60	Community Hospital	280	100	0	0	280	0
C51	Community Hospital	198	100	0	0	198	-1
C56	Community Hospital	195	100	0	0	195	0
C59	Community Hospital	150	83	30	17	180	5
C50	Community Hospital	170	100	0	0	170	0
C57	Community Hospital	144	100	0	0	144	0
C52	Community Hospital	80	100	0	0	80	0
C63	Community Hospital	65	100	0	0	65	10
C54	Community Hospital	48	89	6	11	54	0
C65	Community Hospital	54	100	0	0	54	35
C53	Community Hospital	50	100	0	0	50	0
C66	Community Hospital	50	100	0	0	50	0
C62	Community Hospital	49	100	0	0	49	0
C68	Community Hospital	35	100	0	0	35	0
C64	Community Hospital	33	100	0	0	33	0
C61	Community Hospital	30	100	0	0	30	0
C67	Community Hospital	27	100	0	0	27	0
C58	Community Hospital	25	100	0	0	25	0
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>7,956</b>	<b>88</b>	<b>1,071</b>	<b>12</b>	<b>9,027</b>	<b>6</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>2,036</b>	<b>98</b>	<b>36</b>	<b>2</b>	<b>2,072</b>	<b>1</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>9,992</b>	<b>90</b>	<b>1,107</b>	<b>10</b>	<b>11,099</b>	<b>5</b>
	<b>HIPE 38 (FactFile*)</b>	<b>11,142</b>	<b>92</b>	<b>1,028</b>	<b>8</b>	<b>12,170</b>	<b>n/a</b>

\*HSE FactFile as of March 2009.



**Table 3.2: Beds in Hospital by Type of Room**

Q6A2	Hospital	Beds in single rooms		Beds in multi-occupancy rooms		Total
		Number	%_	Number	%	Number
A15	Acute Hospital	87	55	72	45	159
A21	Acute Hospital	140	22	492	78	632
A10	Acute Hospital	188	18	834	82	1,022
A13	Acute Hospital	65	18	304	82	369
A01	Acute Hospital	131	17	642	83	773
A18	Acute Hospital	77	14	468	86	545
A17	Acute Hospital	113	13	740	87	853
A08	Acute Hospital	36	13	238	87	274
A24	Acute Hospital	40	13	280	88	320
A19	Acute Hospital	33	12	235	88	268
A12	Acute Hospital	75	12	545	88	620
A14	Acute Hospital	45	12	333	88	378
A05	Acute Hospital	39	12	300	88	339
A16	Acute Hospital	18	11	142	89	160
A09	Acute Hospital	27	11	220	89	247
A07	Acute Hospital	16	11	133	89	149
A02	Acute Hospital	46	10	425	90	471
A03	Acute Hospital	24	10	228	90	252
A20	Acute Hospital	28	9	271	91	299
A23	Acute Hospital	19	8	224	92	243
A06	Acute Hospital	11	8	134	92	145
A22	Acute Hospital	5	6	76	94	81
A04	Acute Hospital	4	6	64	94	68
A11	Acute Hospital					
C67	Community Hospital	21	78	6	22	27
C64	Community Hospital	18	55	15	45	33
C59	Community Hospital	50	28	130	72	180
C60	Community Hospital	63	23	217	78	280
C55	Community Hospital	72	20	281	80	353
C53	Community Hospital	10	20	40	80	50
C68	Community Hospital	7	20	28	80	35
C61	Community Hospital	4	13	26	87	30
C66	Community Hospital	6	12	44	88	50
C54	Community Hospital	6	11	48	89	54
C62	Community Hospital	5	10	44	90	49
C63	Community Hospital	6	9	59	91	65
C65	Community Hospital	4	7	50	93	54
C56	Community Hospital	10	5	185	95	195
C50	Community Hospital	6	4	164	96	170
C52	Community Hospital	2	3	78	98	80
C51	Community Hospital	4	2	194	98	198
C57	Community Hospital	0	0	144	100	144
C58	Community Hospital	0	0	25	100	25
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>1,267</b>	<b>15</b>	<b>7,400</b>	<b>85</b>	<b>8,667</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>294</b>	<b>14</b>	<b>1,778</b>	<b>86</b>	<b>2,072</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>1,561</b>	<b>15</b>	<b>9,178</b>	<b>85</b>	<b>10,739</b>

**Table 3.3: Average Bed-occupancy in 2008**

<b>Q6A3</b>		<b>Average Bed-occupancy</b>
<b>ID</b>	<b>Hospital</b>	<b>%_</b>
A15	Acute Hospital	77.0
A08	Acute Hospital	80.4
A16	Acute Hospital	82.0
A06	Acute Hospital	82.3
A14	Acute Hospital	83.3
A20	Acute Hospital	83.8
A24	Acute Hospital	86.0
A18	Acute Hospital	87.0
A07	Acute Hospital	87.1
A03	Acute Hospital	87.3
A05	Acute Hospital	87.6
A11	Acute Hospital	90.7
A09	Acute Hospital	92.8
A02	Acute Hospital	93.0
A19	Acute Hospital	94.2
A21	Acute Hospital	94.5
A22	Acute Hospital	95.0
A04	Acute Hospital	95.1
A13	Acute Hospital	95.6
A12	Acute Hospital	95.8
A23	Acute Hospital	96.2
A10	Acute Hospital	97.8
A17	Acute Hospital	98.8
A01	Acute Hospital	100.5
C53	Community Hospital	75.0
C65	Community Hospital	78.0
C51	Community Hospital	79.0
C59	Community Hospital	87.5
C50	Community Hospital	90.0
C60	Community Hospital	94.0
C63	Community Hospital	95.0
C54	Community Hospital	96.6
C56	Community Hospital	97.0
C55	Community Hospital	97.5
C52	Community Hospital	98.0
C58	Community Hospital	98.0
C67	Community Hospital	100.0
C64	Community Hospital	100.0
C68	Community Hospital	100.0
C61	Community Hospital	100.0
C66	Community Hospital	100.0
C62	Community Hospital	100.0
C57	Community Hospital	100.0
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>92.4</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>93.0</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>92.5</b>

## 4 Section B: Patients

**Table 4.1: In-Patients and Day-Patients**

Q6B1		In-patients		Day-patients		Total	HIPE
ID	Hospital	Number	%	Number	%	Number	2007 Total
A10	Acute Hospital	23,049	20	89,921	80	112,970	71,487
A01	Acute Hospital					82,830	82,830
A17	Acute Hospital	21,775	35	40,801	65	62,576	79,748
A21	Acute Hospital	24,138	46	28,593	54	52,731	63,238
A12	Acute Hospital	16,561	33	33,031	67	49,592	54,754
A14	Acute Hospital	20,467	45	24,649	55	45,116	42,117
A02	Acute Hospital	21,609	52	19,815	48	41,424	52,501
A18	Acute Hospital	23,330	56	17,978	44	41,308	53,441
A11	Acute Hospital	15,707	43	20,403	57	36,110	40,947
A24	Acute Hospital	9,489	29	23,180	71	32,669	30,524
A03	Acute Hospital	13,813	45	17,217	55	31,030	26,772
A05	Acute Hospital	21,422	73	8,108	27	29,530	32,926
A20	Acute Hospital	15,957	63	9,260	37	25,217	22,779
A09	Acute Hospital	16,023	73	5,908	27	21,931	20,884
A08	Acute Hospital	14,721	68	6,920	32	21,641	27,225
A13	Acute Hospital	9,819	56	7,735	44	17,554	16,514
A19	Acute Hospital	12,488	73	4,703	27	17,196	16,694
A16	Acute Hospital	10,955	75	3,571	25	14,526	14,398
A23	Acute Hospital	7,645	70	3,338	30	10,983	10,485
A06	Acute Hospital	6,772	62	4,116	38	10,888	10,628
A07	Acute Hospital	5,110	52	4,770	48	9,880	9,896
A22	Acute Hospital	4,296	56	3,396	44	7,692	8,143
A04	Acute Hospital	2,420	33	4,972	67	7,392	7,725
A15	Acute Hospital	1,802	38	2,893	62	4,695	42,505
C60	Community Hospital	1,221	100	0	0	1,221	n/a
C55	Community Hospital	642	100	0	0	642	n/a
C56	Community Hospital	615	100	0	0	615	n/a
C57	Community Hospital	568	100	0	0	568	n/a
C62	Community Hospital	434	100	0	0	434	n/a
C63	Community Hospital	333	100	0	0	333	n/a
C51	Community Hospital	155	48	171	52	326	n/a
C59	Community Hospital	293	100	0	0	293	n/a
C50	Community Hospital	272	100	0	0	272	n/a
C67	Community Hospital	156	100	0	0	156	n/a
C52	Community Hospital	155	100	0	0	155	n/a
C53	Community Hospital	91	100	0	0	91	n/a
C54	Community Hospital	87	100	0	0	87	n/a
C68	Community Hospital	82	100	0	0	82	n/a
C64	Community Hospital	60	100	0	0	60	n/a
C61	Community Hospital	55	100	0	0	55	n/a
C58	Community Hospital	49	100	0	0	49	n/a
C65	Community Hospital	20	100	0	0	20	n/a
C66	Community Hospital	2	100	0	0	2	n/a
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>319,368</b>	<b>45</b>	<b>385,278</b>	<b>55</b>	<b>787,481</b>	<b>839,161</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>5,290</b>	<b>97</b>	<b>171</b>	<b>3</b>	<b>5,461</b>	<b>n/a</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>324,658</b>	<b>46</b>	<b>385,449</b>	<b>54</b>	<b>792,942</b>	<b>n/a</b>

**Table 4.2: Public and Private In-Patients discharged during 2008**

Q6B2		Public patients		Private patients		Total	HIPE 2007
ID	Hospital	Number	%_	Number	%	Number	% Public
A23	Acute Hospital	7,611	100	34	0	7,645	90
A13	Acute Hospital	8,685	89	1,048	11	9,733	86
A21	Acute Hospital	21,156	88	2,982	12	24,138	82
A14	Acute Hospital	17,469	85	2,998	15	20,467	88
A04	Acute Hospital	1,989	82	431	18	2,420	74
A15	Acute Hospital	1,470	82	332	18	1,802	83
A03	Acute Hospital	11,266	82	2,547	18	13,813	84
A22	Acute Hospital	3,477	81	819	19	4,296	73
A24	Acute Hospital	26,267	80	6,402	20	32,669	84
A06	Acute Hospital	5,340	79	1,432	21	6,772	71
A11	Acute Hospital	12,347	79	3,360	21	15,707	81
A09	Acute Hospital	12,545	78	3,478	22	16,023	78
A10	Acute Hospital	18,031	78	5,018	22	23,049	88
A20	Acute Hospital	12,199	76	3,758	24	15,957	79
A12	Acute Hospital	12,593	76	3,968	24	16,561	84
A16	Acute Hospital	11,030	76	3,496	24	14,526	74
A19	Acute Hospital	9,343	75	3,054	24	12,488	76
A08	Acute Hospital	10,967	74	3,754	26	14,721	85
A01	Acute Hospital	60,930	74	21,900	26	82,830	74
A18	Acute Hospital	17,157	74	6,173	26	23,330	77
A17	Acute Hospital	15,490	71	6,285	29	21,775	84
A05	Acute Hospital	14,819	69	6,603	31	21,422	75
A07	Acute Hospital	6,827	69	3,069	31	9,896	69
A02	Acute Hospital	12,584	57	9,316	43	21,900	64
C60	Community Hospital					1,221	88
C55	Community Hospital	642	100	0	0	642	n/a
C56	Community Hospital	615	100	0	0	615	n/a
C57	Community Hospital	568	100	0	0	568	n/a
C62	Community Hospital	434	100	0	0	434	n/a
C63	Community Hospital	333	100	0	0	333	n/a
C51	Community Hospital	272	100	0	0	272	n/a
C52	Community Hospital	156	100	0	0	156	n/a
C50	Community Hospital	155	100	0	0	155	n/a
C53	Community Hospital	155	100	0	0	155	n/a
C54	Community Hospital	91	100	0	0	91	n/a
C68	Community Hospital	87	100	0	0	87	n/a
C64	Community Hospital	82	100	0	0	82	n/a
C61	Community Hospital	60	100	0	0	60	n/a
C59	Community Hospital	55	100	0	0	55	n/a
C67	Community Hospital	50	100	0	0	50	n/a
C58	Community Hospital	49	100	0	0	49	n/a
C65	Community Hospital	3	15	17	85	20	n/a
C66	Community Hospital	2	100	0	0	2	n/a
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>331,577</b>	<b>76</b>	<b>102,251</b>	<b>24</b>	<b>433,919</b>	<b>n/a</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>3,809</b>	<b>75</b>	<b>17</b>	<b>0</b>	<b>5,047</b>	<b>n/a</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>335,386</b>	<b>76</b>	<b>102,268</b>	<b>23</b>	<b>438,966</b>	<b>n/a</b>
	<b>HIPE 24 (2007)</b>	<b>671,452</b>	<b>80</b>	<b>167,709</b>	<b>20</b>	<b>839,161</b>	<b>80</b>
	<b>HIPE 38 (2007)</b>	<b>941,411</b>	<b>80</b>	<b>230,026</b>	<b>20</b>	<b>1,171,437</b>	<b>80</b>

Note: The 2007 HIPE data refers to both in-patients and day patients, whilst the HFH Audit data refers to in-patients only.

**Table 4.3: Patients with Medical Card**

Q6B3		With Medical Card		No Medical Card		Total	HIPE 2007
ID	Hospital	Number	%	Number	%	Number	% MC_
A17	Acute Hospital					21,775	94
A14	Acute Hospital	11,905	58	8,562	42	20,467	67
A03	Acute Hospital	9,100	66	4,713	34	13,813	64
A18	Acute Hospital					23,330	63
A15	Acute Hospital					1,802	61
A22	Acute Hospital	3,092	72	1,204	28	4,296	60
A19	Acute Hospital					12,488	59
A24	Acute Hospital					9,489	57
A01	Acute Hospital						57
A12	Acute Hospital	9,701	59	6,860	41	16,561	56
A02	Acute Hospital	12,365	57	9,244	43	21,609	55
A09	Acute Hospital	9,150	57	6,873	43	16,023	54
A04	Acute Hospital	1,751	72	669	28	2,420	54
A20	Acute Hospital					15,957	54
A11	Acute Hospital					15,707	53
A07	Acute Hospital					5,110	52
A23	Acute Hospital					7,645	50
A13	Acute Hospital					9,819	46
A10	Acute Hospital	12,941	56	10,108	44	23,049	44
A06	Acute Hospital	3,979	59	2,793	41	6,772	43
A16	Acute Hospital	6,094	56	4,861	44	10,955	41
A08	Acute Hospital					14,721	35
A05	Acute Hospital					21,422	29
A21	Acute Hospital	8,759	36	15,379	64	24,138	28
C60	Community Hospital					1,221	n/a
C55	Community Hospital					642	n/a
C56	Community Hospital					615	n/a
C57	Community Hospital	568	100	0	0	568	n/a
C62	Community Hospital					434	n/a
C63	Community Hospital					333	n/a
C59	Community Hospital	293	100	0	0	293	n/a
C50	Community Hospital	272	100	0	0	272	n/a
C67	Community Hospital	156	100	0	0	156	n/a
C51	Community Hospital					155	n/a
C52	Community Hospital					155	n/a
C53	Community Hospital					91	n/a
C54	Community Hospital					87	n/a
C68	Community Hospital	82	100	0	0	82	n/a
C64	Community Hospital					60	n/a
C61	Community Hospital					55	n/a
C58	Community Hospital	49	100	0	0	49	n/a
C65	Community Hospital	3	15	17	85	20	n/a
C66	Community Hospital	2	100	0	0	2	n/a
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>88,837</b>	<b>28</b>	<b>71,266</b>	<b>22</b>	<b>319,368</b>	<b>n/a</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>1,425</b>	<b>27</b>	<b>17</b>	<b>0</b>	<b>5,290</b>	<b>n/a</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>90,262</b>	<b>28</b>	<b>71,283</b>	<b>22</b>	<b>324,658</b>	<b>n/a</b>
	<b>HIPE 24 (2007)</b>	<b>417,177</b>	<b>53</b>	<b>369,322</b>	<b>47</b>	<b>786,499</b>	<b>53</b>
	<b>HIPE 38 (2007)</b>	<b>603,477</b>	<b>54</b>	<b>511,572</b>	<b>46</b>	<b>1,115,049</b>	<b>54</b>

Note: The 2007 HIPE data refers to both in-patients and day patients, whilst the HFH Audit data refers to in-patients only.

## 5 Section C: Deaths

**Table 5.1: Number of Deaths in Hospital and Deaths as Proportion of In-Patients**

Q6 C1.1		A & E	Intensive Care	Other Wards	Total –	Rate	HIPE (2007)
ID	Hospital	No.	No.	No.	No.	%	Total Deaths
A17	Acute Hospital	156	212	637	1,005	4.6	824
A10	Acute Hospital	133	194	606	933	4.0	860
A12	Acute Hospital	119	164	501	784	4.7	698
A01	Acute Hospital	63	130	373	566		527
A18	Acute Hospital	46	90	418	554	2.4	465
A13	Acute Hospital	82	72	310	464	4.7	313
A21	Acute Hospital	67	112	278	457	1.9	423
A02	Acute Hospital	60	84	304	448	2.1	442
A08	Acute Hospital	27	71	331	429	2.9	374
A11	Acute Hospital	22	59	264	345	2.2	278
A14	Acute Hospital	29	79	208	316	1.5	297
A23	Acute Hospital	52	70	183	305	4.0	231
A09	Acute Hospital	22	34	234	290	1.8	255
A05	Acute Hospital	23	52	198	273	1.3	269
A20	Acute Hospital	23	64	181	268	1.7	269
A24	Acute Hospital	26	46	181	253	2.7	265
A03	Acute Hospital	4	39	194	237	1.7	259
A07	Acute Hospital	35	50	145	230	4.5	182
A19	Acute Hospital	9	50	153	212	1.7	216
A06	Acute Hospital	16	29	116	161	2.4	186
A16	Acute Hospital	14	28	98	140	1.3	111
A22	Acute Hospital	8	17	100	125	2.9	162
A04	Acute Hospital	0	16	73	89	3.7	109
A15	Acute Hospital	0	0	44	44	2.4	55
C55	Community Hospital				124	19.3	n/a
C56	Community Hospital				86	14.0	n/a
C50	Community Hospital				42	15.4	n/a
C57	Community Hospital				41	7.2	n/a
C51	Community Hospital				30	15.2	n/a
C59	Community Hospital				23	7.8	n/a
C68	Community Hospital				16	19.5	n/a
C60	Community Hospital				13	1.1	n/a
C63	Community Hospital				13	3.9	n/a
C66	Community Hospital				12	24.0	n/a
C62	Community Hospital				10	2.3	n/a
C53	Community Hospital				9	9.9	n/a
C52	Community Hospital				5	3.2	n/a
C54	Community Hospital				5	5.7	n/a
C61	Community Hospital				5	9.1	n/a
C65	Community Hospital				5	9.3	n/a
C64	Community Hospital				3	5.0	n/a
C58	Community Hospital				2	4.1	n/a
C67	Community Hospital				0	.0	n/a
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>1,041</b>	<b>1,765</b>	<b>6,130</b>	<b>8,936</b>	<b>2.8</b>	<b>8,070</b>
<b>C88</b>	<b>HFH Community Hosp</b>				<b>444</b>	<b>8.4</b>	<b>n/a</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>1,041</b>	<b>1,765</b>	<b>6,130</b>	<b>9,380</b>	<b>2.9</b>	<b>n/a</b>

*Intensive Care includes ICU, ITU and HDU*

**Table 5.2: Proportion of Deaths in Hospital**

Q6C1		A & E	Intensive Care	Other Wards	Total
ID	Hospital	%	%	%	%
A15	Acute Hospital	.0	.0	100.0	100
A04	Acute Hospital	.0	18.0	82.0	100
A03	Acute Hospital	1.7	16.5	81.9	100
A09	Acute Hospital	7.6	11.7	80.7	100
A22	Acute Hospital	6.4	13.6	80.0	100
A08	Acute Hospital	6.3	16.6	77.2	100
A11	Acute Hospital	6.4	17.1	76.5	100
A18	Acute Hospital	8.3	16.2	75.5	100
A05	Acute Hospital	8.4	19.0	72.5	100
A19	Acute Hospital	4.2	23.6	72.2	100
A24	Acute Hospital	10.3	18.2	71.5	100
A16	Acute Hospital	10.0	20.0	70.0	100
A06	Acute Hospital	9.4	17.1	68.6	100
A02	Acute Hospital	13.4	18.8	67.9	100
A20	Acute Hospital	8.6	23.9	67.5	100
A13	Acute Hospital	17.7	15.5	66.8	100
A01	Acute Hospital	11.1	23.0	65.9	100
A14	Acute Hospital	9.2	25.0	65.8	100
A10	Acute Hospital	14.3	20.8	65.0	100
A12	Acute Hospital	15.2	20.9	63.9	100
A17	Acute Hospital	15.5	21.1	63.4	100
A07	Acute Hospital	15.2	21.7	63.0	100
A21	Acute Hospital	14.7	24.5	60.8	100
A23	Acute Hospital	17.0	23.0	60.0	100
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>11.6</b>	<b>19.8</b>	<b>68.6</b>	<b>100</b>

*Intensive Care includes ICU, ITU and HDU*

**Table 5.3: Place of Death of Community Hospital Residents**

Q6 C4.2		Deaths in Community Hospitals	Deaths in Acute Hospitals	Total Deaths	Deaths in Acute Hospitals _
ID	Hospital	N	N	N	%
C67	Community Hospital	0	1	1	100
C52	Community Hospital	5	8	13	62
C58	Community Hospital	2	2	4	50
C54	Community Hospital	5	3	8	38
C59	Community Hospital	23	11	34	32
C51	Community Hospital	30	10	40	25
C50	Community Hospital	42	10	52	19
C53	Community Hospital	9	2	11	18
C56	Community Hospital	86	18	104	17
C61	Community Hospital	5	1	6	17
C68	Community Hospital	16	3	19	16
C66	Community Hospital	12	1	13	8
C57	Community Hospital	41	2	43	5
C55	Community Hospital	124	5	129	4
C60	Community Hospital	13	0	13	
C62	Community Hospital	10	0	10	
C63	Community Hospital	13	0	13	
C64	Community Hospital	3	0	3	
C65	Community Hospital	5	0	5	
<b>H88</b>	<b>HFH Community Hosp</b>	<b>444</b>	<b>77</b>	<b>521</b>	<b>15</b>

**Table 5.4: Number of Deaths by Medical Card Holder**

ID	Hospital	Deaths with Medical Card		Deaths without Medical Card		Total
		Number	%	Number	%	Number
A19	Acute Hospital	207	96	9	4	216
A22	Acute Hospital	155	96	7	4	162
A20	Acute Hospital	250	93	19	7	269
A09	Acute Hospital	232	91	22	9	254
A16	Acute Hospital	101	91	10	9	111
A14	Acute Hospital	267	90	30	10	297
A07	Acute Hospital	162	89	20	11	182
A03	Acute Hospital	230	89	29	11	259
A18	Acute Hospital	411	88	54	12	465
A23	Acute Hospital	201	87	30	13	231
A04	Acute Hospital	93	85	16	15	109
A24	Acute Hospital	226	85	39	15	265
A02	Acute Hospital	371	84	71	16	442
A12	Acute Hospital	568	82	127	18	695
A13	Acute Hospital	245	79	67	22	312
A01	Acute Hospital	411	78	115	22	526
A11	Acute Hospital	212	77	65	24	277
A15	Acute Hospital	42	76	13	24	55
A06	Acute Hospital	139	75	47	25	186
A17	Acute Hospital	555	67	269	33	824
A10	Acute Hospital	561	65	299	35	860
A05	Acute Hospital	169	63	100	37	269
A08	Acute Hospital	212	57	162	43	374
A21	Acute Hospital	132	31	290	69	422
	<b>HIPE 24 (2007)</b>	<b>6,152</b>	<b>76</b>	<b>1,910</b>	<b>24</b>	<b>8,062</b>
	<b>HIPE 38 (2007)</b>	<b>9,111</b>	<b>80</b>	<b>2,301</b>	<b>20</b>	<b>11,412</b>

Source: HSE HIPE 2007



**Table 5.5: Number of Deaths Referred to Coroner**

Q6C1.2		A & E	Intensive Care	Other Wards	Total
ID	Hospital	Number	Number	Number	Number
A17	Acute Hospital	156	116	0	272
A01	Acute Hospital	63	130	54	247
A02	Acute Hospital	60	25	38	123
A23	Acute Hospital	52	19	5	76
A05	Acute Hospital	13	25	29	67
A18	Acute Hospital	29	15	15	59
A10	Acute Hospital	0	0	58	58
A11	Acute Hospital	11	16	21	48
A08	Acute Hospital	13	9	21	43
A16	Acute Hospital	8	7	11	26
A19	Acute Hospital	6	13	5	24
A22	Acute Hospital	8	8	0	16
A09	Acute Hospital	11	0	0	11
A06	Acute Hospital	7	3	0	10
A03	Acute Hospital	4	1	0	5
A15	Acute Hospital				
A04	Acute Hospital				
A24	Acute Hospital				
A20	Acute Hospital				
A13	Acute Hospital				
A14	Acute Hospital				
A12	Acute Hospital				
A07	Acute Hospital				
A21	Acute Hospital				
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>441</b>	<b>387</b>	<b>257</b>	<b>1,085</b>

*Intensive Care includes ICU, ITU and HDU*

**Table 5.6: Proportion of Deaths Referred to Coroner**

Q6C1.2		A & E	Intensive Care	Other Wards	Total
ID	Hospital	%	%	%	%
A01	Acute Hospital	100	100	14	44
A02	Acute Hospital	100	30	13	27
A17	Acute Hospital	100	55		27
A23	Acute Hospital	100	27	3	25
A05	Acute Hospital	57	48	15	25
A16	Acute Hospital	57	25	11	19
A11	Acute Hospital	50	27	8	14
A22	Acute Hospital	100	47		13
A19	Acute Hospital	67	26	3	11
A18	Acute Hospital	63	17	4	11
A08	Acute Hospital	48	13	6	10
A06	Acute Hospital	41	10		6
A10	Acute Hospital			10	6
A09	Acute Hospital	50			4
A03	Acute Hospital	100	3		2
A15	Acute Hospital				
A04	Acute Hospital				
A24	Acute Hospital				
A20	Acute Hospital				
A13	Acute Hospital				
A14	Acute Hospital				
A12	Acute Hospital				
A07	Acute Hospital				
A21	Acute Hospital				
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>42</b>	<b>22</b>	<b>4</b>	<b>12</b>

*Intensive Care includes ICU, ITU and HDU*

**Table 5.7: Number of Deaths followed by Post-mortem**

Q6C2		A & E	Intensive Care	Other Wards	Total	HIPE 2007
ID	Hospital	Number	Number	Number	Number	Number
A01	Acute Hospital	63	130	54	247	43
A10	Acute Hospital	125	38	58	221	123
A17	Acute Hospital	119	62	0	181	167
A12	Acute Hospital	0	73	99	172	159
A13	Acute Hospital	74	25	54	153	29
A05	Acute Hospital	13	26	43	82	38
A23	Acute Hospital	43	19	18	80	25
A18	Acute Hospital	29	16	17	62	28
A11	Acute Hospital	11	17	32	60	34
A02	Acute Hospital	60	0	0	60	59
A08	Acute Hospital	13	10	27	50	9
A14	Acute Hospital	12	13	14	39	6
A09	Acute Hospital	17	9	8	34	29
A07	Acute Hospital	13	8	5	26	0
A16	Acute Hospital	8	7	11	26	11
A19	Acute Hospital	6	13	5	24	14
A03	Acute Hospital	0	1	12	13	2
A04	Acute Hospital	1	3	5	9	0
A22	Acute Hospital	0	1	1	2	0
A24	Acute Hospital	0	0	0	0	5
A20	Acute Hospital					22
A06	Acute Hospital					15
A21	Acute Hospital					7
A15	Acute Hospital					2
C53	Community Hospital				3	n/a
C59	Community Hospital				3	n/a
C52	Community Hospital				2	n/a
C55	Community Hospital				1	n/a
C68	Community Hospital				1	n/a
C50	Community Hospital				0	n/a
C51	Community Hospital				0	n/a
C54	Community Hospital				0	n/a
C56	Community Hospital				0	n/a
C57	Community Hospital				0	n/a
C58	Community Hospital				0	n/a
C60	Community Hospital				0	n/a
C61	Community Hospital				0	n/a
C62	Community Hospital				0	n/a
C63	Community Hospital				0	n/a
C64	Community Hospital				0	n/a
C65	Community Hospital				0	n/a
C66	Community Hospital				0	n/a
C67	Community Hospital				0	n/a
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>531</b>	<b>495</b>	<b>808</b>	<b>1,834</b>	<b>843</b>
<b>C88</b>	<b>HFH Community Hosp</b>				<b>10</b>	<b>n/a</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>531</b>	<b>495</b>	<b>808</b>	<b>1,844</b>	<b>n/a</b>

**Table 5.8: Proportion of Deaths followed by Post-mortem**

Q6 C2.1		A & E	Intensive Care	Other Wards	Total —
ID	Hospital	%	%	%	%
A01	Acute Hospital	100	100	14	44
A13	Acute Hospital	90	35	17	33
A05	Acute Hospital	57	50	22	30
A23	Acute Hospital	83	27	10	26
A10	Acute Hospital	94	20	10	24
A12	Acute Hospital		45	20	22
A16	Acute Hospital	57	25	11	19
A17	Acute Hospital	76	29		18
A11	Acute Hospital	50	29	12	17
A02	Acute Hospital	100			13
A14	Acute Hospital	41	16	7	12
A09	Acute Hospital	77	26	3	12
A08	Acute Hospital	48	14	8	12
A19	Acute Hospital	67	26	3	11
A18	Acute Hospital	63	18	4	11
A07	Acute Hospital	37	16	3	11
A04	Acute Hospital		19	7	10
A03	Acute Hospital		3	6	5
A22	Acute Hospital		6	1	2
A24	Acute Hospital				
A06	Acute Hospital				
A15	Acute Hospital				
A20	Acute Hospital				
A21	Acute Hospital				
C52	Community Hospital				40
C53	Community Hospital				33
C59	Community Hospital				13
C68	Community Hospital				6
C55	Community Hospital				1
C50	Community Hospital				
C51	Community Hospital				
C54	Community Hospital				
C56	Community Hospital				
C57	Community Hospital				
C58	Community Hospital				
C60	Community Hospital				
C61	Community Hospital				
C62	Community Hospital				
C63	Community Hospital				
C64	Community Hospital				
C65	Community Hospital				
C66	Community Hospital				
C67	Community Hospital				
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>51</b>	<b>28</b>	<b>13</b>	<b>21</b>
<b>C88</b>	<b>HFH Community Hosp</b>				<b>2</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>51</b>	<b>28</b>	<b>13</b>	<b>20</b>

**Table 5.9: Number of Deaths ‘Brought In Dead’ (BID) and as a Proportion of all Deaths**

Q6C3.1		BID to A & E	BID to Mortuary	BID to Prepare Body	Total –	Proportion of all Deaths
ID	Hospital	Number	Number	Number	Number	%
A14	Acute Hospital	0	135	41	176	56
A19	Acute Hospital	0	165	0	165	78
A06	Acute Hospital	0	159	0	159	94
A23	Acute Hospital	0	130	0	130	43
A10	Acute Hospital	129	0	0	129	14
A08	Acute Hospital	10	116	0	126	29
A02	Acute Hospital	16	0	100	116	26
A13	Acute Hospital	1	110	0	111	24
A11	Acute Hospital	0	91	0	91	26
A16	Acute Hospital	10	46	23	79	56
A07	Acute Hospital	0	77	0	77	33
A09	Acute Hospital	0	45	0	45	16
A18	Acute Hospital	0	40	5	45	8
A12	Acute Hospital	43	0	0	43	5
A21	Acute Hospital	40	0	0	40	9
A24	Acute Hospital	22	7	7	36	14
A03	Acute Hospital	4	29	0	33	14
A05	Acute Hospital	0	27	0	27	10
A22	Acute Hospital	1	17	0	18	14
A20	Acute Hospital	4	0	0	4	1
A04	Acute Hospital	1	1	0	2	2
A17	Acute Hospital					
A01	Acute Hospital					
A15	Acute Hospital					
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>281</b>	<b>1,195</b>	<b>176</b>	<b>1,652</b>	<b>23</b>

*Acute Hospitals only*

## 6 Section D: Staff

**Table 6.1: Number of Whole -Time Equivalent (WTE) Staff**

Q6 D1	Hospital	Mgmt. Admin	Med. Dental	Nursing	Health Care Prof.	Gen. Support	Other Patient Care	Total _
A10	Acute Hospital	585	403	1,445	594	418	281	3,725
A01	Acute Hospital	439	396	1,412	445	533	103	3,328
A17	Acute Hospital	556	416	1,146	409	446	121	3,094
A12	Acute Hospital	412	344	1,097	397	312	122	2,683
A21	Acute Hospital	469	348	1,017	380	268	141	2,622
A02	Acute Hospital	287	219	748	250	157	226	1,887
A18	Acute Hospital	302	243	733	247	252	69	1,847
A11	Acute Hospital	214	177	601	170	242	88	1,493
A14	Acute Hospital	218	155	553	132	275	139	1,473
A05	Acute Hospital	204	194	579	107	203	78	1,364
A13	Acute Hospital	176	136	516	132	155	74	1,189
A08	Acute Hospital	135	103	478	91	204	26	1,035
A24	Acute Hospital	118	105	400	125	61	227	1,035
A09	Acute Hospital	134	81	389	51	198	42	895
A20	Acute Hospital	112	89	399	59	193	24	876
A19	Acute Hospital	135	83	340	59	131	34	782
A03	Acute Hospital	112	89	327	77	92	69	767
A23	Acute Hospital	111	68	259	111	32	142	723
A16	Acute Hospital	73	70	242	55	21	167	627
A06	Acute Hospital	61	64	207	49	22	97	499
A15	Acute Hospital	83	41	123	150	76	25	498
A07	Acute Hospital	66	33	130	42	100	21	392
A22	Acute Hospital	33	36	116	23	25	40	273
A04	Acute Hospital	39	23	102	17	40	33	254
C55	Community Hospital	24	16	217	27	91	131	507
C60	Community Hospital	32	7	128	38	91	127	421
C59	Community Hospital	19	2	95	11	33	214	374
C51	Community Hospital	23	1	101	37	42	94	298
C56	Community Hospital	11	1	103	7	76	47	245
C50	Community Hospital	4	1	64	1	25	146	241
C57	Community Hospital	7	1	60	5	25	71	169
C52	Community Hospital	3	1	53	3	28	40	128
C65	Community Hospital	5	4	28	3	21	23	84
C54	Community Hospital	2	0	31	2	10	26	72
C63	Community Hospital	5	1	22	5	7	18	58
C53	Community Hospital	0	1	22	3	6	16	48
C68	Community Hospital	2	1	3	42	0	0	48
C66	Community Hospital	0	0	13	0	0	22	35
C67	Community Hospital	0	0	10	1	10	14	35
C64	Community Hospital	0	0	13	3	0	12	28
C58	Community Hospital	1	0	8	0	8	8	25
C61	Community Hospital	1	0	10	1	4	1	17
C62	Community Hospital	0	0	4	1	4	0	9
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>5,073</b>	<b>3,919</b>	<b>13,357</b>	<b>4,169</b>	<b>4,455</b>	<b>2,388</b>	<b>33,361</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>139</b>	<b>37</b>	<b>985</b>	<b>189</b>	<b>479</b>	<b>1,011</b>	<b>2,841</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>5,212</b>	<b>3,956</b>	<b>14,342</b>	<b>4,358</b>	<b>4,935</b>	<b>3,399</b>	<b>36,203</b>
<b>T97</b>	<b>All Acute Hospitals</b>	<b>7,042</b>	<b>5,434</b>	<b>18,385</b>	<b>5,657</b>	<b>5,833</b>	<b>3,411</b>	<b>45,762</b>
<b>T98</b>	<b>All Community Hosp</b>	<b>488</b>	<b>126</b>	<b>4,194</b>	<b>324</b>	<b>1,375</b>	<b>3,825</b>	<b>10,333</b>
<b>T99</b>	<b>All Hospitals</b>	<b>7,530</b>	<b>5,560</b>	<b>22,580</b>	<b>5,982</b>	<b>7,207</b>	<b>7,236</b>	<b>56,094</b>

Reference data source: HSE National Employment Monitoring Unit.

**Table 6.2: Percentage of Whole -Time Equivalent (WTE) Staff**

Q6 D1.1		Mgmt. Admin	Med. Dental	Nursing	Health Care Prof.	Gen. Support	Other Patient Care	Total
ID	Hospital							
A10	Acute Hospital	16	11	39	16	11	8	100
A01	Acute Hospital	13	12	42	13	16	3	100
A17	Acute Hospital	18	13	37	13	14	4	100
A12	Acute Hospital	15	13	41	15	12	5	100
A21	Acute Hospital	18	13	39	14	10	5	100
A02	Acute Hospital	15	12	40	13	8	12	100
A18	Acute Hospital	16	13	40	13	14	4	100
A11	Acute Hospital	14	12	40	11	16	6	100
A14	Acute Hospital	15	11	38	9	19	9	100
A05	Acute Hospital	15	14	42	8	15	6	100
A13	Acute Hospital	15	11	43	11	13	6	100
A08	Acute Hospital	13	10	46	9	20	3	100
A24	Acute Hospital	11	10	39	12	6	22	100
A09	Acute Hospital	15	9	43	6	22	5	100
A20	Acute Hospital	13	10	46	7	22	3	100
A19	Acute Hospital	17	11	43	8	17	4	100
A03	Acute Hospital	15	12	43	10	12	9	100
A23	Acute Hospital	15	9	36	15	4	20	100
A16	Acute Hospital	12	11	39	9	3	27	100
A06	Acute Hospital	12	13	41	10	4	19	100
A15	Acute Hospital	17	8	25	30	15	5	100
A07	Acute Hospital	17	8	33	11	26	5	100
A22	Acute Hospital	12	13	42	8	9	15	100
A04	Acute Hospital	15	9	40	7	16	13	100
C55	Community Hospital	5	3	43	5	18	26	100
C60	Community Hospital	8	2	30	9	22	30	100
C59	Community Hospital	5	1	25	3	9	57	100
C51	Community Hospital	8	0	34	12	14	32	100
C56	Community Hospital	4	0	42	3	31	19	100
C50	Community Hospital	2	0	27	0	10	61	100
C57	Community Hospital	4	1	36	3	15	42	100
C52	Community Hospital	2	1	41	2	22	31	100
C65	Community Hospital	6	5	33	4	25	27	100
C54	Community Hospital	3	0	43	3	14	36	100
C63	Community Hospital	9	2	38	9	12	31	100
C53	Community Hospital	0	2	46	6	13	33	100
C68	Community Hospital	4	2	6	88	0	0	100
C66	Community Hospital	0	0	37	0	0	63	100
C67	Community Hospital	0	0	29	3	29	40	100
C64	Community Hospital	0	0	46	11	0	43	100
C58	Community Hospital	4	0	32	0	32	32	100
C61	Community Hospital	6	0	59	6	24	6	100
C62	Community Hospital	0	0	44	11	44	0	100
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>15</b>	<b>12</b>	<b>40</b>	<b>12</b>	<b>13</b>	<b>7</b>	<b>100</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>5</b>	<b>1</b>	<b>35</b>	<b>7</b>	<b>17</b>	<b>36</b>	<b>100</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>14</b>	<b>11</b>	<b>40</b>	<b>12</b>	<b>14</b>	<b>9</b>	<b>100</b>
<b>T97</b>	<b>All Acute Hospitals</b>	<b>15</b>	<b>12</b>	<b>40</b>	<b>12</b>	<b>13</b>	<b>7</b>	<b>100</b>
<b>T98</b>	<b>All Community Hosp</b>	<b>5</b>	<b>1</b>	<b>41</b>	<b>3</b>	<b>13</b>	<b>37</b>	<b>100</b>
<b>T99</b>	<b>All Hospitals</b>	<b>13</b>	<b>10</b>	<b>40</b>	<b>11</b>	<b>13</b>	<b>13</b>	<b>100</b>

Reference data source: HSE National Employment Monitoring Unit

**Table 6.3: Staffing Characteristics**

Q6 D1-3		Actual Staff / WTE	Employed less than 1 year	Rate of Days Lost*	HealthStat Absenteeism **	Level of Concern
ID	Hospital	%	%	%	%	Score
A07	Acute Hospital	100		8	12	8
A04	Acute Hospital	115	7	16	9	8
A03	Acute Hospital	112	8	0	9	7
A05	Acute Hospital			0	9	
A19	Acute Hospital	130	13	3	8	7
A02	Acute Hospital			13	8	8
A09	Acute Hospital				8	
A16	Acute Hospital	114	0	7	7	8
A20	Acute Hospital				7	
A14	Acute Hospital	84		7	7	7
A23	Acute Hospital	114	6		7	
A06	Acute Hospital	108	7	6	6	5
A11	Acute Hospital	100	3		6	8
A18	Acute Hospital	108	6		6	8
A24	Acute Hospital	113	11	7	6	10
A08	Acute Hospital	100	25		6	
A22	Acute Hospital	127	6	1	6	5
A01	Acute Hospital				6	
A17	Acute Hospital	112	15	10	6	4
A13	Acute Hospital	111	13	10	5	10
A21	Acute Hospital	115			5	
A12	Acute Hospital	110			4	
A10	Acute Hospital	115		3	4	8
A15	Acute Hospital	102	6	4	4	1
C67	Community Hospital	115	3	12		8
C54	Community Hospital	102	1	10		5
C68	Community Hospital	135		10		10
C50	Community Hospital	115	2	9		
C52	Community Hospital	279	2	8		10
C56	Community Hospital	122	3	8		10
C51	Community Hospital	106	18	6	3	
C66	Community Hospital	100		6		10
C59	Community Hospital	116	0	4	4	8
C60	Community Hospital	100	26	4	4	7
C58	Community Hospital	121		4		6
C64	Community Hospital	113		4		10
C55	Community Hospital	101	14	3		3
C65	Community Hospital			3		10
C57	Community Hospital	100	5	2		9
C53	Community Hospital	112	2	1		10
C61	Community Hospital	100		1		.
C63	Community Hospital	42		0		6
C62	Community Hospital					7
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>110</b>	<b>15</b>	<b>4</b>	<b>6</b>	<b>7</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>111</b>	<b>14</b>	<b>5</b>		<b>8</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>110</b>	<b>15</b>	<b>4</b>		<b>8</b>

\*The rate of days lost is calculated as the total number of days lost in the year due to sickness and other reasons divided by the total number of available days which is estimated to be 230 based on the assumption of 20 days annual leave and 10 days of public holidays. \*\* Reference data on absenteeism is based on HSE HealthStat.



**Table 6.4a: Percentage of Actual Employment over WTE**

Q6 D1		Mgm. Admin	Medic. Dental	Nursing	Health Care Profs.	Gen. Support	Other Patient Care	Total
ID	Hospital							
H87	HFH Acute Hospitals	114	100	108	109	115	114	110
H88	HFH Community Hosp	114	144	99	155	120	103	111
H89	All HFH Hospitals	114	101	107	112	115	112	110

**Table 6.4b: Percent of Staff employed less than one year**

Q6 D2		Mgm. Admin	Medic. Dental	Nursing	Health Care Profs.	Gen. Support	Other Patient Care	Total
ID	Hospital							
H87	HFH Acute Hospitals	4.3	49.4	21.0	12.6	5.1	8.6	15.0
H88	HFH Community Hosp	8.1	208.1	18.5	17.9	11.9	16.0	13.7
H89	All HFH Hospitals	4.4	50.7	20.8	13.0	6.0	9.8	14.9

**Table 6.4c: Percentage of Days lost, excluding annual leave**

Q6 D3		Mgm. Admin	Medic. Dental	Nursing	Health Care Profs.	Gen. Support	Other Patient Care	Total
ID	Hospital							
H87	HFH Acute Hospitals	5.0	1.0	3.2	5.9	7.2	7.4	4.1
H88	HFH Community Hosp	2.6	1.9	4.1	13.4	9.6	5.2	5.4
H89	All HFH Hospitals	4.9	1.0	3.3	6.2	7.5	6.6	4.2
T97	Acute Hospital *	6.1	0.9	6.1	4.3	8.4	8.5	6.0
T98	Community Hospital *	6.3	3.2	7.1	5.4	8.1	8.5	6.9

\* Source: HSE HealthStat

## 7 Section F: Standard of Facilities in Hospital

**Table 7.1: Year in which Hospital was built**

Q6F1		Year built _
ID	Hospital	
A24	Acute Hospital	2006
A21	Acute Hospital	1998
A18	Acute Hospital	1994
A03	Acute Hospital	1989
A17	Acute Hospital	1986
A08	Acute Hospital	1980
A01	Acute Hospital	1978
A09	Acute Hospital	1976
A14	Acute Hospital	1960
A07	Acute Hospital	1959
A05	Acute Hospital	1957
A02	Acute Hospital	1955
A13	Acute Hospital	1955
A15	Acute Hospital	1950
A20	Acute Hospital	1941
A11	Acute Hospital	1940
A22	Acute Hospital	1936
A04	Acute Hospital	1935
A16	Acute Hospital	1930
A12	Acute Hospital	1861
A19	Acute Hospital	1853
A06	Acute Hospital	1841
A23	Acute Hospital	1838
A10	Acute Hospital	1727
C54	Community Hospital	2004
C62	Community Hospital	2003
C61	Community Hospital	2001
C53	Community Hospital	1998
C66	Community Hospital	1987
C64	Community Hospital	1978
C67	Community Hospital	1974
C57	Community Hospital	1950
C63	Community Hospital	1945
C59	Community Hospital	1918
C60	Community Hospital	1912
C65	Community Hospital	1900
C58	Community Hospital	1869
C56	Community Hospital	1855
C50	Community Hospital	1800s
C52	Community Hospital	1800s
C68	Community Hospital	1800s
C55	Community Hospital	1769
C51	Community Hospital	1743
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>Pre-1960: 15, 63%</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>Pre-1960: 12, 63%</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>Pre-1960: 27, 63%</b>

**Table 7.2: Rating on 1-10 Scale of Each Hospital Facility**

<b>Q6F2</b>	<b>Hospital Facility</b>	<b>Acute Hospitals</b>	<b>Community Hospitals</b>	<b>All Hospitals</b>
F2.1	Access by public transport	7.6	6.8	7.3
F2.2	Adequate visitor car-parking	7.8	6.4	7.2
F2.3	Supervised set-down area	7.5	5.7	6.7
F2.4	Easy finding way around	7.4	7.3	7.4
<b>F2.5</b>	<b>Choice of a single room at end of life</b>	4.9	4.8	4.9
F2.6	Space around patient bed	4.6	4.7	4.6
F2.7	Quiet sitting room on each ward	4.3	5.0	4.6
F2.8	Child-friendly TV lounge on each ward	2.2	3.1	2.6
<b>F2.9</b>	<b>Private meeting room on each ward</b>	6.5	5.9	6.2
F2.10	Access to room suitable for therapies	2.1	5.6	3.6
<b>F2.11</b>	<b>Storage for personal items of deceased</b>	5.0	4.6	4.8
F2.12	Visitor toilets on each ward	6.5	5.4	6.0
F2.13	Relative's room close to each ward	2.2	4.0	3.0
F2.14	Snacks and beverages near each ward	6.0	6.0	6.0
F2.15	Multi-faith space in hospital	5.8	5.6	5.7
F2.16	Citizen information service	5.1	4.7	4.9
F2.17	Display of artwork in hospital	6.4	7.0	6.7
F2.18	Space for performing arts	4.4	6.3	5.2
F2.19	Access to outdoor gardens, patios, courtyards,	4.7	8.2	6.2
F2.20	Staff rooms	8.3	6.5	7.5
F2.21	Meeting rooms for staff	9.4	6.5	8.1
F2.22	Dining area for staff	8.9	7.6	8.3
	<b>Average Score</b>	<b>5.8</b>	<b>5.8</b>	<b>5.8</b>

**Table 7.3: Rating on 1-10 Scale of End-of-Life (EOL) Hospital Facilities**

Q6 F2		EOL Item Choice of a single room at end of life	EOL Item Private meeting room on each ward	EOL Item Storage of personal items of deceased	Average Score for 3 EOL Items	Average Score for All 22 Items
ID	Hospital	Score	Score	Score	Score	Score
A15	Acute Hospital	10	10	10	10.0	9.9
A13	Acute Hospital	9	10	10	9.7	7.6
A01	Acute Hospital	5	4	7	5.3	7.1
A08	Acute Hospital	5	10	3	6.0	7.0
A12	Acute Hospital	6	7	9	7.3	7.0
A18	Acute Hospital	1	5	1	2.3	6.7
A21	Acute Hospital	2	5	2	3.0	6.7
A17	Acute Hospital	4	7	9	6.7	6.6
A14	Acute Hospital	4	10	1	5.0	6.5
A23	Acute Hospital	1	10	1	4.0	6.4
A03	Acute Hospital	3	10	10	7.7	6.3
A10	Acute Hospital	4	7	2	4.3	6.0
A09	Acute Hospital	6	1	8	5.0	6.0
A24	Acute Hospital	5	8	5	6.0	5.8
A04	Acute Hospital	3	8	3	4.7	5.6
A11	Acute Hospital	7	1	1	3.0	5.6
A20	Acute Hospital	9	4	8	7.0	5.2
A19	Acute Hospital	5	10	5	6.7	4.6
A16	Acute Hospital	9	1	9	6.3	4.5
A06	Acute Hospital	7	5	3	5.0	4.1
A02	Acute Hospital	3	6	5	4.7	4.0
A22	Acute Hospital	6	8	1	5.0	4.0
A05	Acute Hospital	1	7	7	5.0	3.8
A07	Acute Hospital	3	1	1	1.7	3.5
C65	Community Hospital	10	10	10	10.0	8.4
C61	Community Hospital	10	10	6	8.7	7.8
C51	Community Hospital	2	10	4	5.3	7.6
C66	Community Hospital	9	9	5	7.7	7.5
C53	Community Hospital	10	1	1	4.0	7.3
C68	Community Hospital	1	10	8	6.3	7.0
C54	Community Hospital	3	10	5	6.0	7.0
C64	Community Hospital	10	10	7	9.0	6.8
C52	Community Hospital	4	3	5	4.0	6.0
C67	Community Hospital	8	8	5	7.0	5.9
C50	Community Hospital	5	1	1	2.3	5.8
C62	Community Hospital	6	6	5	5.7	5.5
C56	Community Hospital	1	4	10	5.0	5.2
C57	Community Hospital	1	1	1	1.0	4.7
C63	Community Hospital	8	4	5	5.7	4.5
C58	Community Hospital	1	10	5	5.3	4.3
C59	Community Hospital	1	1	1	1.0	3.5
C55	Community Hospital	1	2	2	1.7	3.0
C60	Community Hospital	1	2	1	1.3	2.4
<b>A87</b>	<b>HFH Acute Hospitals</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>5.5</b>	<b>5.8</b>
<b>C88</b>	<b>HFH Community Hosp</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>5.1</b>	<b>5.8</b>
<b>T89</b>	<b>All HFH Hospitals</b>	<b>5</b>	<b>6</b>	<b>5</b>	<b>5.3</b>	<b>5.8</b>

**Table 7.4: Rating on 1-10 Scale of Hospital Facilities**

<b>Q6K2</b>	<b>Hospital</b>	<b>Unsatisfactory 'Red' &lt;6.5</b>	<b>Average 'Amber' 6.5&lt;8.5</b>	<b>Good 'Green' 8.5-10.0</b>
H87	HFH Acute Hospitals	15	8	1
H88	HFH Community Hosp	11	8	0
H89	All HFH Hospitals	26	16	1
H87	HFH Acute Hospitals	63%	33%	4%
H88	HFH Community Hosp	58%	42%	0%
H89	All HFH Hospitals	60%	37%	2%

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## 8 Section E: Specialist Palliative Care Service

Table 8.1: Presence of Specialist Palliative Care Service

Q6 E1		Total Deaths	Palliative Care Service	WTE Palliative Care Staff		Palliative Care Team (i)	Consultant Palliative Medicine (ii)	
ID	Hospital	HIPE (2007)	Yes/No	WTE	per 100 Deaths	full partial none	Hours per week	per Death _
A15	Acute Hospital	55	yes	4.0	7.3	partial	18	17.0
A05	Acute Hospital	269	yes	4.9	1.8	partial	48	9.3
A18	Acute Hospital	465	yes	14.0	3.0	full	59	6.6
A24	Acute Hospital	265	yes	2.3	0.9	partial	33	6.5
A20	Acute Hospital	269	yes	5.4	2.0	partial	26	5.0
A03	Acute Hospital	259	yes	2.2	0.8	partial	23	4.6
A06	Acute Hospital	186	yes	1.2	0.6	partial	14	3.9
A01	Acute Hospital	527	yes	5.0	0.9	full	33	3.3
A04	Acute Hospital	109	yes	0.5	0.5	partial	6	2.9
A21	Acute Hospital	423	yes	4.5	1.1	full	21	2.6
A08	Acute Hospital	374	yes	6.6	1.8	full	18	2.5
A07	Acute Hospital	182	yes	0.9	0.5	partial	8	2.3
A11	Acute Hospital	278	yes	3.0	1.1	partial	12	2.2
A02	Acute Hospital	442	yes	4.0	0.9	full	18	2.1
A23	Acute Hospital	231	yes	3.3	1.4	partial	9	2.0
A09	Acute Hospital	255	yes	1.7	0.7	partial	9	1.8
A13	Acute Hospital	313	yes	3.8	1.2	full	9	1.5
A10	Acute Hospital	860	yes	7.5	0.9	full	21	1.3
A19	Acute Hospital	216	yes	2.5	1.2	partial	5	1.2
A12	Acute Hospital	698	yes	3.4	0.5	partial	12	0.9
A17	Acute Hospital	824	yes	7.0	0.8	full	10	0.6
A14	Acute Hospital	297	yes	10.5	3.5	full	0	0.0
A22	Acute Hospital	162	yes	1.0	0.6	none	0	0.0
A16	Acute Hospital	111	no	0.0	0.0	none	0	0.0
C55	Community Hospital		yes	0				
C50	Community Hospital		partial	0				
C57	Community Hospital		partial	0				
C58	Community Hospital		partial	0				
C63	Community Hospital		partial	0				
C67	Community Hospital		partial	0				
C51	Community Hospital		no	0				
C52	Community Hospital		no	0				
C53	Community Hospital		no	0				
C54	Community Hospital		no	0				
C56	Community Hospital		no	0				
C59	Community Hospital		no	0				
C60	Community Hospital		no	0				
C61	Community Hospital		no	0				
C62	Community Hospital		no	0				
C64	Community Hospital		no	0				
C65	Community Hospital		no	0				
C66	Community Hospital		no	0				
C68	Community Hospital		no	0				
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>8,070</b>	<b>23</b>	<b>105.3</b>	<b>1.3</b>		<b>412</b>	<b>2.7</b>
<b>H88</b>	<b>HFH Community Hosp</b>		<b>3.5</b>	<b>0</b>				
<b>H89</b>	<b>All HFH Hospitals</b>		<b>58.5</b>	<b>105.3</b>				

**Table 8.2: Number of WTE Staff in Specialist Palliative Care Services**

Q6 E2		Consultant Doctor	Non-Cons. Doctor	SPC Nurse	Social Work	Administration	Past. Care	Physiotherapy	Occ. Therapy
ID	Hospital	SPCT	SPCT	SPCT	SPCT	SPCT			
A18	Acute Hospital	2	4	2.5	1	0.5	0.5	0.5	0.5
A14	Acute Hospital	1	3	1	0	0.5	4	0	0
A10	Acute Hospital	2	1	3	1	0.5	0	0	0
A17	Acute Hospital	1	1	3	1	1	0	0	0
A08	Acute Hospital	0.6	2	1	1	1	0	1	0
A20	Acute Hospital	0.2	0.2	2.5	0	1	0.5	0	0.5
A01	Acute Hospital	1	0	3	0.5	0.5	0	0	0
A05	Acute Hospital	1.5	1.5	1	0.1	0	0.3	0	0
A21	Acute Hospital	1	1	2	0	0.5	0	0	0
A02	Acute Hospital	0.5	0.5	3	0	0	0	0	0
A15	Acute Hospital	1	1	2	0	0	0	0	0
A13	Acute Hospital	0.3	0.5	1	1	1	0	0	0
A12	Acute Hospital	0.4	1	2	0	0	0	0	0
A23	Acute Hospital	0.2	0	1.8	0.8	0.5	0	0	0
A11	Acute Hospital	1	2	0	0	0	0	0	0
A19	Acute Hospital	1	0	1.5	0	0	0	0	0
A24	Acute Hospital	0.3	0	0	0	0.5	0.5	0	0
A03	Acute Hospital	0.7	0.7	0.7	0.1	0	0	0	0
A09	Acute Hospital	0.2	0	1.5	0	0	0	0	0
A06	Acute Hospital	0.4	0.4	0.3	0.1	0	0	0	0
A22	Acute Hospital	0	0	1	0	0	0	0	0
A07	Acute Hospital	0.2	0.2	0.3	0.1	0	0.1	0	0
A04	Acute Hospital	0.2	0.2	0.1	0	0	0	0	0
A16	Acute Hospital								
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>16.7</b>	<b>20.2</b>	<b>34.2</b>	<b>6.7</b>	<b>7.5</b>	<b>5.9</b>	<b>1.5</b>	<b>1</b>
cont.		Speech Therapy	Nutritionist	Pharmacist	Care Attendant	Volunteer Coord.	Librarian	Total	SPC Team
A18	Acute Hospital	0.5	0.5	0.5	0.5	0	0.5	14.0	full
A14	Acute Hospital	0	0	1	0	0	0	10.5	full
A10	Acute Hospital	0	0	0	0	0	0	7.5	full
A17	Acute Hospital	0	0	0	0	0	0	7.0	full
A08	Acute Hospital	0	0	0	0	0	0	6.6	full
A20	Acute Hospital	0	0	0	0	0	0.5	5.4	part
A01	Acute Hospital	0	0	0	0	0	0	5.0	full
A05	Acute Hospital	0	0	0.5	0	0	0	4.9	part
A21	Acute Hospital	0	0	0	0	0	0	4.5	full
A02	Acute Hospital	0	0	0	0	0	0	4.0	part
A15	Acute Hospital	0	0	0	0	0	0	4.0	full
A13	Acute Hospital	0	0	0	0	0	0	3.8	full
A12	Acute Hospital	0	0	0	0	0	0	3.4	part
A23	Acute Hospital	0	0	0	0	0	0	3.3	part
A11	Acute Hospital	0	0	0	0	0	0	3.0	part
A19	Acute Hospital	0	0	0	0	0	0	2.5	part
A24	Acute Hospital	0	0	0	0	0.5	0.5	2.3	part
A03	Acute Hospital	0	0	0	0	0	0	2.2	part
A09	Acute Hospital	0	0	0	0	0	0	1.7	part
A06	Acute Hospital	0	0	0	0	0	0	1.2	part
A22	Acute Hospital	0	0	0	0	0	0	1.0	none
A07	Acute Hospital	0	0	0	0	0	0	0.9	part
A04	Acute Hospital	0	0	0	0	0	0	0.5	part
A16	Acute Hospital								none
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>0.5</b>	<b>0.5</b>	<b>2</b>	<b>0.5</b>	<b>0.5</b>	<b>1.5</b>	<b>99.2</b>	

## 9 Section G: Complaints

Table 9.1: Official Complaints

Q6 G1,2		Total Complaints	Complaints about End-of- Life Issues	Complaints about End-of- Life Issues	Total Complaints per 1,000 Patients _
ID	Hospital	Number	Number	%	Number
A12	Acute Hospital	664			13
A17	Acute Hospital	794	33	4	13
A23	Acute Hospital	109	2	2	10
A13	Acute Hospital	158	6	4	9
A21	Acute Hospital	464			9
A18	Acute Hospital	345	0		8
A10	Acute Hospital	631	36	6	6
A15	Acute Hospital	22	0		5
A22	Acute Hospital	34	0		4
A16	Acute Hospital	62	2	3	4
A07	Acute Hospital	42	0		4
A06	Acute Hospital	45	1	2	4
A05	Acute Hospital	115	6	5	4
A14	Acute Hospital	157	4	3	3
A24	Acute Hospital	111	2	2	3
A20	Acute Hospital	82	2	2	3
A02	Acute Hospital	130	0		3
A19	Acute Hospital	47	0		3
A08	Acute Hospital	51	3	6	2
A11	Acute Hospital	78	0		2
A09	Acute Hospital	46	0		2
A04	Acute Hospital	9	0		1
A03	Acute Hospital	31	3	10	1
A01	Acute Hospital				
C51	Community Hospital	9	0		28
C64	Community Hospital	1	0		17
C59	Community Hospital	4	0		14
C54	Community Hospital	1	0		11
C57	Community Hospital	6	0		11
C53	Community Hospital	1	0		11
C55	Community Hospital	6	0		9
C60	Community Hospital	9	0		7
C63	Community Hospital	2	0		6
C50	Community Hospital	0	0		
C52	Community Hospital	0	0		
C56	Community Hospital	0	0		
C58	Community Hospital	0	0		
C61	Community Hospital	0	0		
C62	Community Hospital	0	0		
C65	Community Hospital	0	0		
C66	Community Hospital	0	0		
C67	Community Hospital	0	0		
C68	Community Hospital	0	0		
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>4,227</b>	<b>100</b>	<b>2</b>	<b>6</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>42</b>	<b>0</b>		<b>8</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>4,269</b>	<b>100</b>	<b>2</b>	<b>6</b>



**Table 9.2: Official Complaints to HSE Office of Consumer Affairs**

Q6 G1,2		Total Complaints	Total Complaints to HSE Office of Consumer Affairs	Complaints per 1,000 Patients to HSE Office of Consumer Affairs _	Percentage Difference from HFH Hospital Returns
ID	Hospital	Number	Number	Number	%
A12	Acute Hospital	664	654	11.9	2
A23	Acute Hospital	109	109	10.4	0
A17	Acute Hospital	794	805	10.1	-1
A13	Acute Hospital	158	152	9.2	4
A21	Acute Hospital	464	464	7.3	0
A10	Acute Hospital	631	461	6.4	37
A16	Acute Hospital	62	62	4.3	0
A07	Acute Hospital	42	42	4.2	0
A06	Acute Hospital	45	45	4.2	0
A01	Acute Hospital		346	4.2	-100
A22	Acute Hospital	34	34	4.2	0
A24	Acute Hospital	111	111	3.6	0
A05	Acute Hospital	115	115	3.5	0
A14	Acute Hospital	157	130	3.1	21
A02	Acute Hospital	130	141	2.7	-8
A08	Acute Hospital	51	58	2.1	-12
A11	Acute Hospital	78	81	2.0	-4
A18	Acute Hospital	345	95	1.8	263
A20	Acute Hospital	82	27	1.2	204
A03	Acute Hospital	31	31	1.2	0
A19	Acute Hospital	47	16	1.0	194
A04	Acute Hospital	9	6	0.8	50
A15	Acute Hospital	22	21	0.5	5
A09	Acute Hospital	46	6	0.3	667
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>4,227</b>	<b>4,012</b>	<b>4.8</b>	<b>5</b>
<b>T97</b>	<b>All Acute Hospitals</b>		<b>5,697</b>		

Source: HSE Office of Consumer Affairs.

## 10 Section H: Policies and Procedures

**Table 10.1: Policies and Procedures on End-of-Life Services**

Q6 H1-4		Docu ment (1)	Objec tive (2)	Memo (3)	Co- ord (4)	Co- ord (5)	SC DDB (6)	SC DDB (7)	SC DDB (8) _
ID	Hospital	y/n	y/n	y/n	y/n	Year	y/n	Year	No
A10	Acute Hospital	1	0	0	0		1	2000	30
A03	Acute Hospital	1	1	1	1	2007	1	2005	20
A20	Acute Hospital	1	1	1	1	2007	1	2007	19
A09	Acute Hospital	2	0	1	1		1	2007	16
A06	Acute Hospital	1	1	1	1	2007	1	2006	15
A12	Acute Hospital	1	1	1	1	2007	1	2007	13
A05	Acute Hospital	1	1	1	1	2006	1	2006	12
A19	Acute Hospital	1	0	0	1	2007	1	2007	12
A11	Acute Hospital	0		1	1	2007	1	2007	12
A13	Acute Hospital	1	3	1	1	2007	1	2007	12
A18	Acute Hospital	1	1	1	1	2007	1	2008	10
A07	Acute Hospital	0	3	1	1	2008	1	2008	7
A04	Acute Hospital	0	0	0	1	2008	1	2008	7
A01	Acute Hospital	1	1	1	1	2008	1	2008	6
A21	Acute Hospital	0	3		1	2007	1	2007	6
A23	Acute Hospital	0	1	1	1	2008	1	2008	5
A17	Acute Hospital	2	0	1	1	2008	1	2008	4
A02	Acute Hospital	1	0	0	0				
A15	Acute Hospital	1	0		0				
A22	Acute Hospital	0	3	0	0				
A24	Acute Hospital	0	3	0	0				
A14	Acute Hospital	0	1	1	1	2009			
A08	Acute Hospital	0	0	0	0				
A16	Acute Hospital	0	0	0	0				
C51	Community Hospital	0	3	1	1	2007	1	2007	30
C68	Community Hospital	0	1	1	1	2007	1	2007	15
C52	Community Hospital	1	3	0	1	2007	1	2007	10
C55	Community Hospital	2	0	1	1	2008	1	2008	9
C54	Community Hospital	1	1	1	1	2008	1	2008	8
C57	Community Hospital	1	1	0	1	2007	1	2007	8
C60	Community Hospital	1	1	1	1	2007	1	2007	7
C53	Community Hospital	2	3	1	0		1	2008	4
C56	Community Hospital	0	1	1	0		1	2008	4
C64	Community Hospital	1	0	0	0		1	2008	3
C65	Community Hospital	1	0	0	0		1	2008	3
C66	Community Hospital	1	0	0	0		1	2008	3
C50	Community Hospital	0	1	1	1	2008	1	2008	3
C58	Community Hospital	1	0	1	0		1	2008	2
C61	Community Hospital	2	0	1	0		0		0
C67	Community Hospital	1	0	0	0		0		0
C62	Community Hospital	1	0	0	0		1	2008	0
C59	Community Hospital	0	3	1	1	2008	0		0
C63	Community Hospital	0	3	0	0		0		0
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>14</b>	<b>9</b>	<b>14</b>	<b>17</b>		<b>17</b>		
<b>H88</b>	<b>HFH Community Hosp</b>	<b>12</b>	<b>6</b>	<b>11</b>	<b>9</b>		<b>15</b>		
<b>H89</b>	<b>All HFH Hospitals</b>	<b>26</b>	<b>15</b>	<b>25</b>	<b>26</b>		<b>32</b>		

## 11 Section J: Induction and In-service Training

**Table 11.1: Induction Training on End-of-Life Care**

Q6 J1		Care (1)	Comm (2)	Cult (3)	Loss (4)	Ethic (5)	Supp (6)	Other (7)	Total (..)
ID	Hospital	y/n	y/n	y/n	y/n	y/n	y/n	y/n	
A03	Acute Hospital	1	1	1	1	1	1		6
A01	Acute Hospital	1	1		1	1	1		5
A20	Acute Hospital								
A15	Acute Hospital		1						1
A12	Acute Hospital							1	1
A17	Acute Hospital							1	1
A10	Acute Hospital								
A06	Acute Hospital								
A05	Acute Hospital								
A04	Acute Hospital								
A13	Acute Hospital								
A24	Acute Hospital								
A22	Acute Hospital								
A21	Acute Hospital								
A07	Acute Hospital								
A14	Acute Hospital								
A02	Acute Hospital								
A11	Acute Hospital								
A18	Acute Hospital								
A23	Acute Hospital	1							1
A08	Acute Hospital						1		1
A16	Acute Hospital								
A19	Acute Hospital								
A09	Acute Hospital								
C57	Community Hospital	1	1	1	1	1	1		6
C59	Community Hospital								
C60	Community Hospital								
C55	Community Hospital	1	1	1	1				4
C54	Community Hospital								
C65	Community Hospital			1	1				2
C64	Community Hospital				1				1
C66	Community Hospital				1				1
C53	Community Hospital								
C58	Community Hospital								
C56	Community Hospital		1						1
C68	Community Hospital		1						1
C51	Community Hospital								
C63	Community Hospital								
C50	Community Hospital								
C52	Community Hospital								
C61	Community Hospital								
C62	Community Hospital								
C67	Community Hospital								
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>7</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>2</b>	<b>4</b>	<b>3</b>	<b>5</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>7</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>5</b>	<b>7</b>	<b>4</b>	<b>7</b>	<b>3</b>	<b>4</b>	<b>2</b>	<b>14</b>

Table is sorted in descending order of the combined totals of Tables 11.1 and 11.2.

**Table 11.2: In-service Training on End-of-Life Care**

Q6 J1		Care (1)	Comm (2)	Cult (3)	Loss (4)	Ethic (5)	Supp (6)	Other (7)	Total ( _ )
ID	Hospital	y/n	y/n	y/n	y/n	y/n	y/n	y/n	
A03	Acute Hospital	1	1	1	1	1	1		6
A01	Acute Hospital	1	1		1	1	1		5
A20	Acute Hospital	1	1	1	1	1	1	1	7
A15	Acute Hospital	1	1	1	1	1	1		6
A12	Acute Hospital	1	1	1	1		1		5
A17	Acute Hospital	1	1	1	1	1			5
A10	Acute Hospital	1	1	1	1	1			5
A06	Acute Hospital	1	1	1	1			1	5
A05	Acute Hospital	1	1	1	1	1			5
A04	Acute Hospital	1	1		1		1	1	5
A13	Acute Hospital	1	1	1	1				4
A24	Acute Hospital	1	1		1				3
A22	Acute Hospital	1	1						2
A21	Acute Hospital		1						1
A07	Acute Hospital		1						1
A14	Acute Hospital							1	1
A02	Acute Hospital	1							1
A11	Acute Hospital		1						1
A18	Acute Hospital		1						1
A23	Acute Hospital								
A08	Acute Hospital								
A16	Acute Hospital								
A19	Acute Hospital								
A09	Acute Hospital								
C57	Community Hospital	1	1	1	1	1	1		6
C59	Community Hospital	1	1	1	1	1			5
C60	Community Hospital	1	1	1	1	1			5
C55	Community Hospital	1	1	1	1				4
C54	Community Hospital		1	1	1		1		4
C65	Community Hospital			1	1				2
C64	Community Hospital				1				1
C66	Community Hospital				1				1
C53	Community Hospital			1					1
C58	Community Hospital	1							1
C56	Community Hospital								
C68	Community Hospital								
C51	Community Hospital								
C63	Community Hospital								
C50	Community Hospital								
C52	Community Hospital								
C61	Community Hospital								
C62	Community Hospital								
C67	Community Hospital								
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>14</b>	<b>17</b>	<b>9</b>	<b>12</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>19</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>5</b>	<b>5</b>	<b>7</b>	<b>8</b>	<b>3</b>	<b>2</b>	<b>0</b>	<b>9</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>19</b>	<b>22</b>	<b>16</b>	<b>20</b>	<b>10</b>	<b>8</b>	<b>4</b>	<b>27</b>

Table is sorted in descending order of the combined totals of Tables 11.1 and 11.2.

**Table 11.3: Document Outlining Supports for Staff Involved in End-of-Life Care**

<b>Q6 J2</b>		<b>Total Number of Deaths _</b>	<b>Hospital has document</b>
<b>ID</b>	<b>Hospital</b>	<b>Number</b>	<b>yes/no</b>
A17	Acute Hospital	1,005	Yes
A10	Acute Hospital	933	No
A12	Acute Hospital	784	Yes
A01	Acute Hospital	566	Yes
A18	Acute Hospital	554	No
A13	Acute Hospital	464	No
A21	Acute Hospital	457	No
A02	Acute Hospital	448	Yes
A08	Acute Hospital	429	Yes
A11	Acute Hospital	345	Yes
A14	Acute Hospital	316	No
A23	Acute Hospital	305	No
A09	Acute Hospital	290	Yes
A05	Acute Hospital	273	Yes
A20	Acute Hospital	268	No
A24	Acute Hospital	253	No
A03	Acute Hospital	237	Yes
A07	Acute Hospital	230	Yes
A19	Acute Hospital	212	No
A06	Acute Hospital	169	Yes
A16	Acute Hospital	140	Yes
A22	Acute Hospital	125	Yes
A04	Acute Hospital	89	Yes
A15	Acute Hospital	44	No
C55	Community Hospital	124	No
C56	Community Hospital	86	No
C50	Community Hospital	42	Yes
C57	Community Hospital	41	No
C51	Community Hospital	30	No
C59	Community Hospital	23	No
C68	Community Hospital	16	No
C63	Community Hospital	13	No
C60	Community Hospital	13	Yes
C66	Community Hospital	12	No
C62	Community Hospital	10	No
C53	Community Hospital	9	Yes
C52	Community Hospital	5	No
C54	Community Hospital	5	No
C61	Community Hospital	5	No
C65	Community Hospital	5	No
C64	Community Hospital	3	No
C58	Community Hospital	2	No
C67	Community Hospital	0	No
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>8,936</b>	<b>14 / 24</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>444</b>	<b>3 / 19</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>9,380</b>	<b>18 / 43</b>

## 12 Section K: Standard of Mortuary Facilities

**Table 12.1: Per Cent of Mortuaries with Each Facility**

<b>Q6K2</b>	<b>Mortuary Facilities</b>	<b>Acute Hospitals %</b>	<b>Community Hospitals %</b>	<b>All Hospitals %</b>
K2.1	Entrance protected from weather	46	54	49
K2.2	Inner reception area	50	50	50
K2.3	Waiting room for more than one family	46	14	34
K2.4	More than one waiting room	17	21	18
K2.5	Waiting room providing hot and cold drinks nearby	25	7	18
K2.6	Waiting room with toilets nearby	75	64	71
K2.7	Viewing room that can hold several relatives at the same time	75	79	76
K2.8	Viewing room that can be adapted to the needs of different faiths and cultures	83	71	79
K2.9	Viewing room that can be adapted for baby and child deaths	65	10	48
K2.10	Viewing room that has suitable furniture to facilitate relatives to stay overnight	8	7	8
K2.11	Viewing room where people can wash their hands	33	43	37
K2.12	Viewing room with toilets nearby	79	64	74
K2.13	More than one viewing room	38	21	32
K2.14	A multi-faith room	46	29	39
K2.15	A meeting or interviewing room	33	29	32
K2.16	A preparatory room for ritual washing	58	21	45
K2.17	A storage area for extra furniture or religious symbols of different faiths	46	50	47
K2.18	Access to a garden	21	14	18
K2.19	A covered route from the hospital to the mortuary	29	43	34
K2.20	Sufficient car parking at the mortuary	46	71	55
K2.21	Good access and exit routes to avoid congestion	35	71	49
<b>K2</b>	<b>Overall standard of mortuary facilities</b>	<b>45</b>	<b>40</b>	<b>43</b>

**Table 12.2: Number of Facilities in Each Mortuary**

<b>Q6 K1-2 ID</b>	<b>Hospital</b>	<b>Hospital has mortuary yes/no</b>	<b>Number of Facilities Number</b>	<b>% of Maximum Facilities (21) _ %</b>
A21	Acute Hospital	Yes	21	100
A01	Acute Hospital	Yes	18	86
A02	Acute Hospital	Yes	15	71
A10	Acute Hospital	Yes	15	71
A17	Acute Hospital	Yes	15	71
A23	Acute Hospital	Yes	15	71
A24	Acute Hospital	Yes	15	71
A15	Acute Hospital	Yes	14	67
A09	Acute Hospital	Yes	11	52
A22	Acute Hospital	Yes	11	52
A12	Acute Hospital	Yes	10	48
A03	Acute Hospital	Yes	9	43
A14	Acute Hospital	Yes	9	43
A20	Acute Hospital	Yes	9	43
A16	Acute Hospital	Yes	8	38
A18	Acute Hospital	Yes	7	33
A07	Acute Hospital	Yes	6	29
A13	Acute Hospital	Yes	6	29
A06	Acute Hospital	Yes	4	19
A08	Acute Hospital	Yes	4	19
A05	Acute Hospital	Yes	3	14
A04	Acute Hospital	Yes	2	10
A11	Acute Hospital	Yes	2	10
A19	Acute Hospital	Yes		
C61	Community Hospital	Yes	18	86
C51	Community Hospital	Yes	15	71
C60	Community Hospital	Yes	14	67
C59	Community Hospital	Yes	11	52
C68	Community Hospital	Yes	11	52
C50	Community Hospital	Yes	10	48
C57	Community Hospital	Yes	10	48
C55	Community Hospital	Yes	8	38
C53	Community Hospital	Yes	5	24
C56	Community Hospital	Yes	5	24
C62	Community Hospital	Yes	4	19
C54	Community Hospital	Yes	2	10
C66	Community Hospital	Yes	2	10
C65	Community Hospital	Yes	1	5
C52	Community Hospital	No		
C58	Community Hospital	No		
C63	Community Hospital	No		
C64	Community Hospital	No		
C67	Community Hospital	No		
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>23</b>	<b>10</b>	<b>45</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>14</b>	<b>8</b>	<b>39</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>37</b>	<b>9</b>	<b>43</b>

**Table 12.3: Rating of Hospitals Against HFH Standard for Mortuary Facilities**

Q6K2	Hospital	Unsatisfactory 'Red' <65% of standard	Average 'Amber' 65%<85% of standard	Good 'Green' 85%-100% of standard
H87	HFH Acute Hospitals	16	6	2
H88	HFH Community Hosp	11	2	1
H89	All HFH Hospitals	27	8	3
H87	HFH Acute Hospitals	66.7%	25.0%	8.3%
H88	HFH Community Hosp	78.6%	14.3%	7.1%
H89	All HFH Hospitals	71.1%	21.1%	7.9%

*Hospitals with Mortuary only*

## 13 Section L: Bereavement Services and Facilities

**Table 13.1: Rating on 1-10 Scale of Each Bereavement Facility**

Q6L2	Bereavement Facility	Acute Hospitals	Community Hospitals	All Hospitals
L2.1	Suitable location in hospital	8.2	7.0	7.9
L2.2	Easy to access within hospital	8.9	7.3	8.5
L2.3	Calm atmosphere in counselling rooms	7.6	6.3	7.3
L2.4	Confidential space in counselling rooms	9.1	9.7	9.2
L2.5	Child-friendly counselling rooms	4.7	1.0	4.0
L2.6	Easy access to toilets	7.6	5.7	7.2
	<b>Average Score</b>	<b>7.7</b>	<b>6.2</b>	<b>7.4</b>



**Table 13.2: Bereavement Services and Average Rating on 1-10 Scale for Bereavement Facilities**

<b>Q6 L2</b>		<b>Bereavement Service</b>	<b>Average Score of 6 Items _</b>
<b>ID</b>	<b>Hospital</b>		
A21	Acute Hospital	Yes	10.0
A08	Acute Hospital	Yes	9.7
A15	Acute Hospital	Yes	9.3
A23	Acute Hospital	Yes	9.0
A03	Acute Hospital	Yes	8.2
A13	Acute Hospital	Yes	6.8
A17	Acute Hospital	Yes	6.8
A10	Acute Hospital	Yes	6.4
A01	Acute Hospital	Yes	5.8
A12	Acute Hospital	Yes	5.0
A02	Acute Hospital	No	
A04	Acute Hospital	No	
A05	Acute Hospital	No	
A06	Acute Hospital	No	
A07	Acute Hospital	No	
A09	Acute Hospital	No	
A11	Acute Hospital	No	
A14	Acute Hospital	No	
A16	Acute Hospital	No	
A18	Acute Hospital	No	
A19	Acute Hospital	No	
A20	Acute Hospital	No	
A22	Acute Hospital	No	
A24	Acute Hospital	No	
C68	Community Hospital	Yes	8.2
C55	Community Hospital	Yes	8.0
C51	Community Hospital	Yes	3.5
C50	Community Hospital	No	
C52	Community Hospital	No	
C53	Community Hospital	No	
C54	Community Hospital	No	
C56	Community Hospital	No	
C57	Community Hospital	No	
C58	Community Hospital	No	
C59	Community Hospital	No	
C60	Community Hospital	No	
C61	Community Hospital	No	
C62	Community Hospital	No	
C63	Community Hospital	No	
C64	Community Hospital	No	
C65	Community Hospital	No	
C66	Community Hospital	No	
C67	Community Hospital	No	
<b>H87</b>	<b>HFH Acute Hospitals</b>	<b>10</b>	<b>7.7</b>
<b>H88</b>	<b>HFH Community Hosp</b>	<b>3</b>	<b>6.6</b>
<b>H89</b>	<b>All HFH Hospitals</b>	<b>13</b>	<b>7.4</b>

**Table 13.3: Rating of Hospitals Against HFH Standard for Bereavement Facilities**

Q6L2	Hospital	Unsatisfactory 'Red' <65% of standard	Average 'Amber' 65%<85% of standard	Good 'Green' 85%-100% of standard
H87	HFH Acute Hospitals	3	3	4
H88	HFH Community Hosp	1	2	0
H89	All HFH Hospitals	4	5	4
H87	HFH Acute Hospitals	30.0%	30.0%	40.0%
H88	HFH Community Hosp	33.3%	66.7%	0.0%
H89	All HFH Hospitals	30.8%	38.5%	30.8%

*Hospitals with Bereavement Service only*

## Notes to Tables

### Notes to Table 8.1 and 8.2

(i) A specialist palliative care team has been defined by the National Advisory Committee on Palliative Care as comprising the following: a consultant in palliative medicine, a non-consultant doctor, a specialist palliative care nurse, a social worker, and a medical secretary<sup>149</sup>. A full SPC team is when all of these specialisms are present. A partial SPC team exists when at least a doctor (either consultant or non-consultant) and a nurse are present, but not all specialisms are present. No SPC team is when none of the specialisms are present.

(ii) Data supplied by the HSE's Consultant Appointment Unit.

### Notes to Table 10.1:

(1) Does the hospital have a document outlining its policies and procedures for its end-of-life care?  
1 = Yes, as a separate document, 2 = Yes, as part of another document, 0 = No.

(2) In the hospital's current business plan, are there specific objectives or targets for improving its end-of-life care? 1 = Yes, 2 = No, 3 = No business plan

(3) Has the hospital signed a memorandum of understanding with the Hospice friendly Hospitals (HFH) Programme? 1 = Yes, 0 = No

(4) Does the hospital have a HFH Development Coordinator? 1 = Yes, 0 = No

(5) Year the HFH Development Coordinator started working?

(6) Does the hospital have a standing committee on dying, death, and bereavement, or equivalent?  
1 = Yes, 2 = No

(7) In what year was standing committee on dying, death, and bereavement set up?

(8) How many meetings have there been of the standing committee on dying, death, and bereavement?

### Notes to Tables 11.1 and 11.2:

(1) Care of the patient and family at the patient's end-of-life 1=Yes 0=No

(2) Communication skills about dying, death, and bereavement, including breaking bad news to people  
1=Yes 0=No

(3) Training in what people from different cultures expect at death 1=Yes 0=No

(4) Understanding the impact of loss, grief and bereavement 1=Yes 0=No

(5) Understanding the legal and ethical issues around end-of-life care 1=Yes 0=No

(6) Support services for staff who give end-of-life care 1=Yes 0=No

(8) Other 1=Yes 0=No