Report of the announced inspection of Rehabilitation and Community Inpatient Healthcare Services at Belmullet Community Hospital

Monitoring programme against the *National Standards for Infection Prevention and Control in Community Services* during the COVID-19 pandemic

Dates of inspection: 29 July 2020
About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA’s mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting services for older people and people with a disability, and children’s special care units.

- **Regulating health services** — Regulating medical exposure to ionizing radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children’s social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland’s health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.
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1.0 Information about this monitoring programme

Under the Health Act Section 8 (1) (c) the Health Information and Quality Authority (HIQA) has statutory responsibility for monitoring the quality and safety of healthcare among other functions. In light of the ongoing global pandemic of COVID-19 and its impact on the quality and safety of care for patients admitted to rehabilitation and community inpatient healthcare services, HIQA has developed a monitoring programme to assess compliance with the *National Standards for Infection Prevention and Control in Community Services.*

The National Standards provide a framework for service providers to assess and improve the service they provide particularly during an outbreak of infection including COVID-19.

Inspection findings are grouped under the National Standards dimensions of:

1. Quality and safety
2. Capacity and capability

Under each of these dimensions, the standards are organised for ease of reporting.

*Figure 1: National Standards for infection prevention and control in community services*
Report structure

The lines of enquiry for this monitoring programme of infection prevention and control in community services will focus on six specific national standards within four of the eight themes of the standards, spanning both the capacity and capability and quality and safety dimensions.

This monitoring programme assesses Rehabilitation and Community Inpatient Healthcare Services’ **capacity and capability** through aspects of the themes:

<table>
<thead>
<tr>
<th>Capacity and Capability</th>
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<tbody>
<tr>
<td><strong>Theme</strong></td>
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<tr>
<td>5: Leadership, Governance and Management</td>
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<td>6: Workforce</td>
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HIQA also assesses Rehabilitation and Community Inpatient Healthcare Services’ provision under the dimensions of **quality and safety** through aspects of the themes:

<table>
<thead>
<tr>
<th>Quality and Safety</th>
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<tbody>
<tr>
<td><strong>Theme</strong></td>
</tr>
<tr>
<td>2: Effective Care &amp; Support</td>
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<tr>
<td>3: Safe Care and Support</td>
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</table>
Judgment Descriptors

The inspection team have used an assessment judgment framework to guide them in assessing and judging a service’s compliance with the National Standards. The assessment judgment framework guides service providers in their preparation for inspection and support inspectors to gather evidence when monitoring or assessing a service and to make judgments on compliance.

Following a review of the evidence gathered during the inspection a judgment has been made on how the service performed. The following judgment descriptors have been used:

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Substantially compliant</th>
<th>Partially compliant</th>
<th>Non-compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant National Standards.</td>
<td>A judgment of substantially compliant means that the service met most of the requirements of the National Standards but some action is required to be fully compliant.</td>
<td>A judgment of partially compliant means that the service met some of the requirements of the relevant National Standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks which could lead to significant risks for patients over time if not addressed.</td>
<td>A judgment of non-compliant means that this inspection of the service has identified one or more findings which indicate that the relevant standard has not been met, and that this deficiency is such that it represents a significant risk to patients.</td>
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</table>
1.1 Hospital Profile

Belmullet Community Hospital, is a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 2. Belmullet Community Hospital comprised 20 beds, a 10-bedded female ward and a 10-bedded male ward.

The hospital accommodated 18 stepdown, convalescent beds and or palliative beds and two respite beds.

Patients were admitted from Mayo University Hospital, Sligo University Hospital and Galway University Hospital. On the day of inspection the hospital remained closed to admissions following a recent COVID-19 outbreak.

A designated centre for older persons and a primary care centre were also onsite.

1.2 Information about this inspection

This inspection report was completed following an announced inspection carried out by Authorised Persons, HIQA; Bairbre Moynihan and Kay Sugrue on 29 July 2020 between 10:30 hrs. and 16:25 hrs.

Inspectors spoke with hospital managers and staff. Inspectors also requested and reviewed documentation, data and observed practice within the clinical environment in the clinical areas.

HIQA would like to acknowledge the cooperation of the hospital management team and staff who facilitated and contributed to this announced inspection.

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† Community Health Organisation 2 area consists of the three counties of Galway, Mayo and Roscommon.
2.0 Inspection Findings

2.1 Capacity and Capability

This section describes arrangements for the leadership, governance and management of the service at this hospital, and HIQA’s evaluation of how effective these were in ensuring that a high quality safe service was being provided. It includes how the service provider is assured that there are effective governance structures and oversight arrangements in place for clear accountability, decision-making, risk management and performance assurance. This includes how responsibility and accountability for infection prevention and control is integrated at all levels of the service. This is underpinned by effective communication among staff. Inspectors also reviewed how service providers plan, manage and organise their workforce to ensure enough staff are available at the right time with the right skills and expertise and have the necessary resources to meet the service’s infection prevention and control needs.

Theme 5: Leadership, Governance and Management

<table>
<thead>
<tr>
<th>Standard 5.1</th>
<th>The service has clear governance arrangements in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship.</th>
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<tbody>
<tr>
<td>Findings:</td>
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<tr>
<td>-</td>
<td>Comprehensive auditing, monitoring and assurance arrangements were not in place.</td>
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<td>-</td>
<td>A number of risks identified in two external infection prevention and control reports (November 2019 and April 2020) had not been addressed by the CHO.</td>
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<tr>
<td>-</td>
<td>Infection prevention and control was not a standing agenda item at the CHO2 directors of nursing meetings.</td>
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<td>-</td>
<td>Ongoing antimicrobial stewardship activities were not evident.</td>
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<tr>
<td>-</td>
<td>Admission and transfer forms did not include details of whether the patient had sampling for COVID-19.</td>
</tr>
<tr>
<td>Judgment Standard 5.1:</td>
<td>Partially compliant</td>
</tr>
</tbody>
</table>

Corporate and Clinical Governance

An organisational chart viewed by inspectors outlined responsibility, accountability and authority arrangements and reporting relationships for staff within the organisation.
The hospital was managed on a day-to-day basis by a director of nursing who had overall responsibility for both the community hospital and the designated centre for older people. The director of nursing reported to the manager for older people’s services, who in turn reported to the general manager for social care, and upwards to the chief officer of CHO2. It was clear from discussions held with staff that lines of communication and responsibility were understood locally.

A local general practitioner was contracted by the HSE as a medical officer in Belmullet Community Hospital to provide clinical care to the patients and attended the hospital daily for up to 2 hours per day. The medical officer was available from 9am-6pm daily Monday to Friday. Outside of these hours medical cover was provided by WestDoc‡ or by a rota of local general practitioners.

The director of nursing attended a number of meetings including the CHO2 directors of nursing meeting, a standards management meeting, and local staff meetings.

Inspectors were informed that a director of nursing representative from CHO2 attended the CHO2 infection prevention and control committee meeting. Meeting minutes reviewed did not indicate that ongoing maintenance and infrastructure issues in Belmullet Community Hospital were discussed. Furthermore, there was no evidence in meeting minutes that information from this committee was disseminated at the monthly directors of nursing meetings in CHO2. Infection prevention and control was not a standing agenda item at this meeting.

In addition, the terms of reference of the standards management meeting indicate that an infection prevention control sub-committee would be established with a reporting relationship to the standards management meeting. It is not clear from minutes reviewed that updates from the infection prevention and control sub-committee were provided at the standards management meeting. Information from all meetings needs to be disseminated to guide and inform staff.

**Monitoring, Audit and Quality assurance arrangements**

Inspectors viewed two previous external infection prevention and control reports from November 2019 and April 2020, the latter of which had been completed after the recent COVID-19 outbreak was declared. Hospital management stated that the infrastructure and maintenance risks identified in these reports, which were similar to those identified on the day of inspection, had been escalated through reporting lines within the CHO. However, hospital management acknowledged on the day of the inspection that there was no timebound action plan in place to address these risks.

‡ Westdoc is an out of hours urgent GP service part-funded by the Health Service Executive
Inspectors found that environmental audits were undertaken by the director of nursing and the clinical nurse manager. Inspectors were informed that results of these were communicated back to staff informally.

Audit results viewed by inspectors demonstrated poor compliance with environmental audits conducted in July 2020 where 62% compliance was achieved and 69% in March 2020. This level of compliance is of concern in the context of the recent COVID-19 outbreak experienced by the hospital. The environmental audit identified the hospital had appropriate, cleanable, well maintained fixtures and fittings. This was contrary to maintenance issues identified and documented by the hospital relating to a dirty utility which was in use throughout the recent outbreak. Inspectors found that maintenance and infrastructural issues were such that surfaces in this room could not be adequately cleaned and maintenance throughout the hospital in general was poor. Inspectors were informed that issues relating to the dirty utility had been escalated through reporting lines within the CHO but a timebound plan for actioning was not evident.

Equipment hygiene audits were not available for review and inspectors were informed that audits on compliance with standard and transmission based precautions were not carried out. Inspectors found that environmental auditing frequency had not increased during the recent outbreak despite low compliance levels reported in an environmental audit conducted in March 2020 before the outbreak occurred. Inspectors were not satisfied that there was an appropriate level of comprehensive auditing and monitoring with action plans in place. This meant that there was insufficient assurance provided that issues relating to infection prevention and control could be identified and addressed efficiently or effectively. Findings in relation to the environment and equipment in the clinical areas will be presented in section 2.2 of this report.

High levels of antimicrobial usage increases the number of patients who are colonised or infected with resistant organisms, both in healthcare facilities and in the community. There were no ongoing antimicrobial stewardship activities noted by inspectors within the unit.

Coordination of care within and between services

At the time of inspection the hospital was closed to admissions but management stated that following a meeting with the CHO the hospital was to open to admissions on 4 August 2020.

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5 Rooms equipped for the disposal of body fluids and the decontamination of reusable equipment such as bedpans, urinals, commodes and body fluid measuring jugs. Waste, used linen and contaminated instruments may also be temporarily stored in this room prior to collection for disposal, laundering or decontamination.
If patients were acutely unwell they were transferred via ambulance to Mayo University Hospital.

The hospital needs to review and ensure that the admission and transfer form details the patient’s COVID-19 status including sampling for COVID-19 prior to transfer. An admission form reviewed by inspectors did not include a prompt as to whether the patient had been screened for COVID-19 prior to transfer.

**Standard 5.2:** There are clear management arrangements in place to ensure the delivery of safe and effective infection prevention and control and antimicrobial stewardship within the service.

**Findings:**
- The hospital’s risk register was not managed, reviewed and escalated in line with national policy.²
- Risks that had been escalated within the CHO governance structure in relation to maintenance and infrastructure had not been addressed.
- Infection prevention and control incidents were not tracked and trended.
- Local staff meetings were not held since February 2020.
- Uptake of the influenza vaccine in the 2019/2020 influenza season was below the national uptake target of 60%.³
- Cleaning staff had not received any formal training either at induction or on an ongoing basis.

**Judgment Standard 5.2:**
- Non-compliant

The director of nursing was the designated person with responsibility for infection prevention and control at the hospital for day-to-day operations. Issues which could not be managed locally were escalated through the defined management structure to the chief officer of CHO2.

**Risk and incident management**

The hospital risk register was reviewed by an inspector. The risk register had documented risks in relation to COVID-19 only and did not include the infrastructure and maintenance risks identified and escalated by the hospital through reporting lines within the CHO. It was unclear to inspectors at the time of the inspection or in documentation reviewed following the inspection if infection prevention and control risks identified locally and escalated by the hospital were on the CHO corporate risk register. Inspectors found that there was significant scope to improve the documentation and management of identified risks. For example, the majority of risks were not risk rated and no actions were identified. Risk registers need to be managed, reviewed and escalated in line with national policy.²
The findings in this report would indicate that risks in relation to infrastructure and maintenance issues had been escalated up within the CHO by local management but the risks had not been addressed. These risks are of particular concern in the context of an ongoing pandemic.

Management stated that newly acquired healthcare associated infections including COVID-19 were reported on the National Incident Management System (NIMS). However trended infection prevention and control incidents were not available. Infection prevention and control incidents should be tracked and trended and feedback provided to staff with the emphasis on learning and improvement.²

Staff meetings
Inspectors found through discussion with the director of nursing and review of hospital staff minutes that the frequency of meetings were not held every two months in line with the terms of reference. Hospital management stated that no staff meetings were held during the COVID-19 outbreak. The last staff meeting was held in February 2020. Infection prevention and control was an agenda item at this meeting. Documentation indicated that issues relating to infrastructure and infection prevention and control were escalated upwards to CHO2 level. Management reported that regular informal meetings were held since February 2020.

Staff Training
HIQA found that it was mandatory for staff to complete HSElanD⁴ online hand hygiene training programme and breaking the chain of infection training programme every two years. It was reported and documents reviewed indicated that 100% of staff had completed both on the day of inspection.

Management stated that staff received onsite standard and transmission based precautions and donning and doffing of personal protective equipment (PPE) training in April 2020. Documentation reviewed showed that until this time some staff had never received training in donning and doffing of personal protective equipment. It was reported that the majority of staff were present for the training. Following this inspection management reported that donning and doffing of all staff including housekeeping staff involved in direct care had been completed.

Inspectors were informed that cleaning staff had not received any formal training either at induction or on an ongoing basis. Staff informed inspectors that any training related to cleaning was provided on a peer-to-peer basis. Therefore adequate training in these principles should be provided for all personnel responsible for cleaning.

** The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation
Influenza vaccination programme

Inspectors were informed that peer vaccinators delivered influenza vaccinations to staff. However it was reported that uptake rates for influenza vaccine amongst staff was 37% in the 2019/2020 influenza season which was below the national uptake target of 60%. Uptake of the seasonal influenza vaccine in the 2020/2021 influenza season needs to be a focus for improvement to meet the 2020/2021 target of 75%.

Policies Procedures and Guidelines

National guidelines advise that facilities such as community hospitals apply the acute hospital COVID-19 guidelines. Management stated that the hospital were applying residential care facilities COVID-19 guidelines which is not in line with what is recommended. A COVID-19 resource folder was available on the ward. The document management system needs to be reviewed to ensure that the most up-to-date guidelines are available to staff.

Standard and transmission based precautions guidelines were available in the hospital and were up to date.

**Theme 6: Workforce**

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<thead>
<tr>
<th>Theme 6: Workforce</th>
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<tbody>
<tr>
<td><strong>Standard 6.1:</strong> Service providers plan, organise and manage their workforce to meet the services’ infection prevention and control needs.</td>
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</tbody>
</table>

**Findings**
- Expertise available in relation to infection prevention and control was not formalised.

**Judgment: Substantially compliant**

Access to specialist staff with expertise in infection prevention and control

Inspectors were informed that the position of infection prevention and control nurse at CHO2 was vacant at the time of inspection. The hospital had access to infection prevention and control advice from the public health infection prevention and control nurse however this was not formalised. During the COVID-19 outbreak at the hospital, management reported that infection prevention and control advice was available at all times via telephone.

During the hospital’s recent outbreak of COVID-19, infection prevention and control nurses from Saolta Hospital Group attended once onsite and provided infection prevention and control advice and education to staff. Management stated that they
could get advice from this source if required but again this was not a formalised arrangement.

**Staff Crossover**

The hospital had been divided up into two zones††, red and green zone. Inspectors were informed that staff were either allocated to the red zone or green zone within the hospital. Management assured inspectors that crossover of both nursing staff and cleaning staff between both zones did not occur during the outbreak or between the designated centre for older persons and the community hospital. A small number of patients were in the red zone following attendance for procedures at an acute hospital and were isolated on return. On the day of inspection it was noted that nursing staff from the red zone were relieving staff for breaks in the green zone. This practice should be minimised where possible.⁵

### 2.2 Quality and Safety

This section looks at how rehabilitation and community inpatient healthcare services ensure that infection prevention and control outbreak/s including COVID-19, are managed to protect people using the healthcare service. This includes how the services identify any work practice, equipment and environmental risks and put in place protective measures to address the risk, particularly during a pandemic.

It also focuses on how these services ensure that staff adhere to infection prevention control best practice and antimicrobial stewardship to achieve best possible outcomes for people during the ongoing COVID-19 pandemic.

**Theme 2: Effective Care and Support**

**Standard 2.2:** Care is provided in a clean and safe environment that minimises the risk of transmitting a healthcare-associated infection.

**Findings:**

- The hospital infrastructure was dated and in a state of disrepair.
- No active maintenance programme was in place for the hospital.
- Hand hygiene facilities did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.⁷
- Multi-task attendants had dual cleaning and catering duties between 17:30hrs and 20:30hrs in the hospital which is not best practice.
- Cleaning products were stored in an unsecured room.
- There was no designated cleaner’s room.

†† Zoning means that staff and equipment are dedicated to a specific area and are not rotated from other areas.
Cleaning records reviewed were not consistently completed during the COVID-19 outbreak. Managerial oversight of same was not evident.

Judgment: Partially compliant

Environment and infrastructure

It is essential that hospital infrastructure is maintained at a high standard to ensure the effectiveness of infection control practices and prevent the transmission of infection.

Inspectors found that the hospital’s infrastructure was dated. The layout of the hospital was not optimal from an infection prevention and control perspective. For example, a single room opened directly into a communal sitting area and multi-occupancy rooms were used as thoroughfares to single rooms. Single rooms used for isolation purposes were small in size with no en-suite facilities or appropriate hand hygiene facilities. Multi-occupancy rooms did not have ensuite toilet and or shower facilities.

Furthermore, a number of maintenance issues were identified requiring immediate attention. As previously mentioned, inspectors found the dirty utility on the female ward which was in the red zone accommodating confirmed and suspected COVID-19 patients was in very poor repair and in its current state was not fit for purpose. This room had not been maintained according to relevant national and international standards to reduce the risk of infection to patients. Maintenance and infrastructural issues should be addressed as a matter of urgency following on from this inspection and in the context of risks posed by the ongoing pandemic.

Maintenance issues were also observed in relation to surfaces on shelving, storage facilities and cupboard doors throughout the hospital which had degraded over time and therefore could not be effectively cleaned. Improvements relating to the maintenance of walls, ceilings, floor coverings and ceiling surfaces which were not intact were required. Rust was evident on the internal surfaces on a number of domestic waste bins.

Hand hygiene facilities

Wall-mounted alcohol hand-rub was readily available throughout the hospital. However antimicrobial soap was located at a number of hand hygiene sinks. When alcohol-based hand rub is available in the healthcare facility for hand hygiene, the use of antimicrobial soap is not recommended. Antimicrobial soap is associated with skin care issues and it is not necessary for use in every day practice. Management need to review this practice.
Hospital management acknowledged that only one of the hand hygiene sinks in the hospital conformed to Health Building Note 00-10 Part C: Sanitary assemblies. Inspectors were informed that external contractors had reviewed the hospital’s requirement for hand hygiene sinks and were awaiting quotes for the installation of these. A date for completion for the update of hand hygiene sinks was not provided to inspectors at the time of the inspection.

**Patient placement**

On the day of inspection there were no patients in the hospital with COVID-19 or suspected COVID-19. Patients were appropriately isolated following return from an acute hospital. The hospital was zoned in to red and green zones. The red zone was separated from the green by closed doors in line with national guidelines.

**Cleaning resources**

Cleaning and hygiene duties were undertaken by multi-task attendants. One cleaner was rostered for each zone. Inspectors were informed that cleaning resources had been increased recently to provide cover for each day. It was reported that multi-task attendants had dual cleaning and catering duties between 17:30hrs and 20:30hrs in the hospital. Dual catering and cleaning roles should be reviewed as the operational norm in most hospitals is that catering duties and cleaning duties in clinical areas are performed by separate staff positions. There is a risk that dual responsibilities may dilute the effectiveness of both roles and may increase the risk of transmission of infection.

The hospital had recently introduced new cleaning trolleys with a flat mop system and colour coded mops. The flat mops were reprocessed onsite. Staff clearly described the process to an inspector.

Inspectors were informed that there were sufficient cleaning resources to meet the needs of the unit. Large supplies of cleaning products were stored in an unsecured room and there was no designated cleaner’s room at the time of the inspection. This meant that cleaning trolleys and equipment was inappropriately stored on corridors when not in use.

Inspectors viewed cleaning records for May and June 2020. These records indicated that areas should be cleaned twice daily if there was infection in the area. Inspectors found that cleaning records reviewed were not consistently completed during the COVID-19 outbreak. Furthermore, these records were not consistently signed off by the nurse-in-charge within the hospital.
Linen management

Segregation of infected linen was evident. Alginate bags were available but inspectors observed that they were not consistently used in line with national guidelines.\(^5\)

Clean linen was stored inappropriately with patient clothing and property.

<table>
<thead>
<tr>
<th>Standard 2.3: Equipment is decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection.</th>
</tr>
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<tbody>
<tr>
<td><strong>Findings</strong></td>
</tr>
<tr>
<td>• Frequently used patient equipment such as commodes and blood glucose monitoring equipment were unclean.</td>
</tr>
<tr>
<td>• Equipment audits were not available for inspectors to review.</td>
</tr>
<tr>
<td>• Inadequate supply of patient monitoring equipment to cover both the red and green zones in the hospital</td>
</tr>
<tr>
<td>• Single use blood pressure cuffs for the patient monitoring equipment were out of stock on the day of inspection.</td>
</tr>
<tr>
<td><strong>Judgment:</strong></td>
</tr>
<tr>
<td>• Partially Compliant</td>
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Overall, inspectors found that there was a need to improve the management of patient equipment. Management must ensure that all equipment is safe to use and is cleaned appropriately. The non-compliances observed during the inspection indicated that equipment was not being fully cleaned in accordance with national and evidence-based guidelines.

During the inspection it was noted that some equipment was clean. However items of frequently used patient equipment such as commodes were observed to be unclean despite a label identifying system in place recording the commodes as being cleaned. Furthermore, evidence viewed showed that blood glucose monitoring equipment was brought to the patient bedside in a holder containing multiple clean supplies for blood sampling. This practice has the potential to contaminate clean supplies in the holder and increase the risk of transmission of blood borne viruses and is not in line with best practice guidance. This was brought to the attention of staff and was addressed immediately.
Equipment audits were not available for inspectors to review. In the absence of equipment audits, hospital management did not have an assurance mechanism in place for hospital equipment hygiene.

Inspectors noted that the hospital had an inadequate supply of patient monitoring equipment to cover both the red and green zones in the hospital. Single use blood pressure cuffs for the patient monitoring equipment were out of stock on the day of inspection. Where equipment is shared between patients, processes need to be in place to ensure that all equipment is cleaned adequately between each patient.

**Theme 3: Safe Care and Support**

<table>
<thead>
<tr>
<th><strong>Standard 3.4:</strong> Outbreaks of infection are identified, managed, controlled and documented in a timely and effective manner</th>
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<tbody>
<tr>
<td><strong>Findings:</strong></td>
</tr>
<tr>
<td>• The hospital’s emergency management plan had not been approved by the appropriate governance structures.</td>
</tr>
<tr>
<td>• Minutes and outcomes of meetings with the regional department of public health were not recorded.</td>
</tr>
<tr>
<td><strong>Judgment:</strong> Substantially compliant</td>
</tr>
</tbody>
</table>

**COVID-19 Preparedness**

The director of nursing was the designated lead for COVID-19 preparedness and response within the hospital. Hospital management stated that two staff were trained to perform COVID-19 sampling and performed the sampling on staff only. The National Ambulance Service performed sampling if required on patients.

The hospital had an emergency management plan in place to respond to an outbreak of COVID-19. The hospital had developed a local emergency management plan for COVID-19. However this had not been approved by the CHO. Such plans should be approved and signed off by senior management and or relevant governance process, confirming that such plans meet the standard required.9

Staff spoken with on the day demonstrated their knowledge of the management of COVID-19. Inspectors were informed that staff had access to occupational health and were aware to report signs and symptoms of COVID-19 to the nurse-in-charge.

**Outbreak Management**

The hospital declared an outbreak of COVID-19 on 2 April 2020. The outbreak was reported to the regional department of public health. Following instruction from the CHO the hospital closed to admissions on 12 May 2020. Inspectors were informed
that daily outbreak telephone calls between the director of nursing, senior staff nurse were held with the regional department of public health. However, minutes and outcomes of these telephone calls were not recorded. Detailed minutes should be taken at every meeting where outbreak control is the main agenda item and should document all decisions taken, actions agreed, and person and or people responsible for executing each action. Following this inspection management reported that the head of service, older people’s services attended COVID-19 response team meetings where Belmullet Community Hospital was discussed and detailed minutes were taken. There is a potential to improve awareness of these meetings at hospital level.

Daily staff and patient line listing was submitted by the director of nursing to the CHO and public health. Inspectors were informed by hospital management that public health also communicated daily updates on the outbreak to CHO2. The outbreak was closed on 25 May 2020.

Hospital management were unaware if an outbreak report was completed following the outbreak. Final outbreak reports should be completed within twelve weeks of the formal closure of an outbreak and lessons identified disseminated.
3.0 Conclusion

Overall, this inspection identified that Belmullet Community Hospital was substantially compliant with two of the National Standards for infection prevention and control in community services assessed, partially compliant with three and non-compliant with one standard.

Leadership, Governance and Management

Inspectors found that there were lines of accountability responsibility and authority for infection prevention and control and antimicrobial stewardship within the service. However, inspectors were not assured of oversight of infection prevention and control within the governance structures responsible for the service. Infection prevention and control was not a standing agenda item at the CHO2 director’s of nursing meetings.

The hospital risk register had not been managed, reviewed and escalated in line with national policy. Furthermore infrastructural and maintenance issues identified on two previous external reports and on inspection had been escalated to the CHO but had no timebound action plan in place for mitigating these risks. Management of risks needs to be embedded at all levels of the CHO.

Inspectors found there was a lack of formal training provided at induction or on an ongoing basis to multi-task attendants on the cleaning systems, processes and procedures in place at the hospital. This needs to be addressed to ensure that cleaning practices are standardised, consistent and in line with best practice.

Environmental auditing had taken place but consistently poor results had not been addressed despite maintenance issues being escalated to CHO2. Inspectors were not satisfied that there was an appropriate level of comprehensive auditing and monitoring with action plans in place.

These deficits indicate that governance and risk management arrangements at Belmullet Community Hospital need to be considerably strengthened to ensure the quality and safety of care to patients is provided in a safe and well maintained environment in line with national standards and guidance.

Workforce

Access to specialist staff with expertise in infection prevention and control was available at the time of the inspection through the public health department or Saolta Hospital Group, however this was not formalised. The arrangements in place are not sustainable in the long-term and should be addressed to ensure that Belmullet Community Hospital has the requisite ongoing access to infection prevention and control advice and support.
Effective Care & Support

Inspectors found a significant need to improve the management and maintenance of the hospital clinical environment. While the infrastructure and layout is dated, much can be done to improve the environment to ensure it can be effectively cleaned. Risk management structures need to be strengthened to ensure that infrastructure and maintenance issues identified are effectively addressed in a timely manner. Significant infrastructural deficits and maintenance issues related to the dirty utility on the female ward need to be immediately addressed following on from this inspection.

A number of areas for improvement were identified in relation to the hygiene of the clinical environment. Improvement was also required in the oversight and monitoring of cleaning processes. Environmental audits conducted locally indicate less than optimal compliance levels which should be a focus for improvement. Inspectors also found that there was scope for improvement in the management of patient equipment relating to the supply of single patient use equipment and cleaning of patient equipment.

Safe care and support

The director of nursing was the designated lead for COVID-19 preparedness and response within the hospital. An emergency management plan from June 2020 was in place however it had not been approved by appropriate governance structures in line with national guidance. This needs to be reviewed and approved in line with national guidance.9

Daily communication with and support from the regional department of public health was evident throughout the outbreak. However, detailed minutes and outcomes of these meetings were not documented. While hospital management stated that they had learned lessons following the outbreak an outbreak report had not been received by the hospital. When received, learning needs to be disseminated to all staff.

Following this inspection the hospital needs to address the areas for improvement identified in this report and requires the support of the CHO to effectively address issues highlighted in order to facilitate compliance with the National Standards for infection prevention and control in community services and other existing national healthcare standards.
4.0 References


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