Report of the unannounced inspection of Rehabilitation and Community Inpatient Healthcare Services at St. Joseph’s District Hospital, Ballina, Co. Mayo.

Monitoring programme against the National Standards for Safer Better Healthcare

Dates of inspection: 16 January 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.

This inspection programme monitors compliance of Rehabilitation and Community Inpatient Healthcare Services against the National Standards for Safer Better Healthcare\(^1\) (2012). The focus of inspection is on governance and risk management structures, and measures to ensure the prevention and control of healthcare-associated infections and the safe use of medicines.

Inspection findings are grouped under the National Standards dimensions of:

1. Capacity and capability
2. Quality and safety
Report structure

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

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

HIQA assesses Rehabilitation and Community Inpatient Healthcare Services’ provision under the dimensions of quality and safety through aspects of the themes:

- **Person-centred Care and Support: Standard 1.1.** The planning, design and delivery of services are informed by patients’ identified needs and preferences.

- **Safe Care and Support: Standard 3.1.** Service providers protect patients from the risk of harm associated with the design and delivery of healthcare services.

Based on inspection findings, HIQA uses four categories to describe the service’s level of compliance with the National Standards monitored.

These categories included the following:

- **Compliant:** A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant National Standard.

- **Substantially compliant:** A judgment of substantially compliant means that the service met most of the requirements of the National Standard but some action is required to be fully compliant.

- **Partially compliant:** 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.

- **Non-compliant:** A judgment of non-compliant means that this inspection of the service has identified one or more findings which indicate that the relevant standard has not been met, and that this deficiency is such that it represents a significant risk to patients.
1.1 Hospital Profile

St. Joseph’s District Hospital, Ballina, was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 2.* St Joseph’s District Hospital comprised 58 beds that accommodated patients for convalescent, step-down, transitional and palliative care.

Inspectors were informed that the majority of patients were admitted from Mayo University Hospital. Patients were also accepted from other acute hospitals such as University Hospital Galway, Sligo University Hospital and Merlin Park Hospital, Galway. Palliative Care referrals from General Practitioners were also accepted to the Hospital.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Kathryn Hanly, Noreen Flannelly-Kinsella and Denise Lawler on 16 January 2020 between 09.30hrs and 16.10hrs.

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

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

* CHO 2 consists of the three counties of Galway, Mayo and Roscommon.
2.0 Inspection Findings

2.1 Capacity and Capability

**Theme 5: Leadership, Governance and Management**

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

**Judgment: Compliant**

This section describes arrangements for the leadership, governance and management of the service at the hospital, and HIQA’s evaluation of how effective these were in ensuring that a high quality safe service was being provided.

**Corporate and Clinical Governance**

An organisational chart viewed by inspectors outlined responsibility, accountability and authority arrangements and reporting relationships for staff within the organisation. Inspectors found that there were clear lines of accountability and responsibility at St. Joseph’s District Hospital.

The hospital was managed on a day-to-day basis by a Director of Nursing (DoN) who, as the person with overall responsibility for the service, reported to the Manager for Older People’s Services in CHO 2 who in turn reported to the General Manager for Social Care in CHO 2.

Four local General Practitioners were contracted by the HSE to share one whole-time equivalent Medical Officer† position in the hospital. There were well established relationships between the Medical Officers and staff in the hospital and staff reported that they could contact Medical Officers for information and advice. Outside of core working hours‡, medical cover was provided by WestDoc§.

A Consultant Geriatrician from Mayo University Hospital attended the hospital each month to review patients who may require long term care.

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† Medical Officer is a grade of Medical Doctor who has been traditionally employed across the country at district and community hospitals. They are registered on the General Register with the Medical Council and the role is sometimes filled by General Practitioners in the community.

‡ Whole-time equivalent: one whole-time equivalent employee is an employee who works the total number of hours possible for their grade. WTEs are not the same as staff numbers as many staff work reduced hours.

§ For the purpose of this monitoring programme core working hours are considered to be 09.00am-05.00pm.

§ Westdoc is an out of hours urgent GP service part-funded by the Health Service Executive.
Two physiotherapists (1.5 whole time equivalents**) provided in-patient treatment. While physiotherapists were contracted to the District Hospital, they reported to and within the governance structures of Mayo University Hospital.

There was also an x-ray department on site. The radiographer also reported through the Mayo University Hospital structures. X-rays could be viewed on the wards on the National Integrated Medical Imaging System†† (NIMIS) and the Medical Officers also had access to this system in their surgeries.

There were no Occupational Therapy, Social Work or Dietician services available at the hospital. Inspectors were informed that additional allied health services were accessed on a private basis if required. Risks in relation to the absence these roles had been risk assessed and recorded on the hospital’s risk register.

**Reporting arrangements in relation to committees**

A Standards Management Committee had been established to co-ordinate the implementation of the National Standards for Safer Better Healthcare within the District Hospitals in CHO2. Minutes for these meetings were under the headings of the eight themes of the national standards and demonstrated good oversight of the service with the underlying premise of quality improvement.

The hospital had also established a number of multidisciplinary committees through which to govern services and address quality and safety issues. Committees were led by the Director of Nursing to review aspects of patient care which included for example; clinical governance, nutrition and health and safety. These committees reported into the standards management committee by the submission of the minutes of each meeting. Multidisciplinary staff meetings were attended by nursing and support staff and allied health professionals.

A Drugs and Therapeutics Committee had been established a number of years ago to ensure safe, rational and cost-effective use of medicines within St Joseph’s District Hospital. However, it was explained by nursing management that this Committee had not been operational for since 2016 and was in the process of being re-established. In the interim it was reported that issues related to medicine safety were discussed at the Standards Management Committee.

A local Infection Prevention and Control Committee was in place and met quarterly. This was chaired by the Director of Nursing. The Committees main role was to

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** Whole-time equivalent (WTE): allows part-time workers’ working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

†† National Integrated Medical Imaging System, to captures and store Radiology, Cardiology and other diagnostic images electronically
ensure that there were systems in place to reduce the risk of hospital-acquired infections.

However, it was noted at the time of the inspection that the hospital had a large number of committees and sub-committees when compared to other hospitals of a similar size. The multiple layers and complexity associated with this could pose a risk of confusion due to the need to report to multiple committees. The hospital must ensure that the organisational structure that is in place is resilient, streamlined and has strong communication pathways in place.

Regular performance updates in relation to quality and patient safety were consistently reported through the established governance structures in CHO 2. The CHO Social Care Quality and Safety Committee met monthly. Monthly Director of Nursing management meetings were also held at CHO2 level. A review of these committees was outside the scope of this inspection. However, the formation of these committees demonstrated progression towards a coordinated approach to quality and patient safety at CHO 2 level.

Arrangements with other facilities including transfer when a patient become acutely unwell

In the event of a patient becoming acutely unwell and requiring transfer to an acute hospital, they were transferred by ambulance to the Emergency Department at Mayo University Hospital. The hospital had a transfer policy to guide and inform staff.

Risk management

An organisation-wide risk register was in place and regularly monitored. The risk register was overseen by the DoN. Inspectors viewed the hospital risk register and noted that risks were identified, existing controls to manage risks were in place and a person was assigned to address the risk.

Inspectors were informed that if risks could not be managed locally, they were escalated to the General Manager of Older Persons and if required further escalated to the Chief Officer in CHO2.

Inspectors were informed that incidents were reported on a paper-based system and logged on the National Incident Management System (NIMS). Interviews with staff confirmed that adverse incidents were being trended and reported. For example trending noted that the majority of patient falls occurred in the morning. To address this issue a daily falls safety huddle was held to identify patients at risk of falls and

‡‡ 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.
slipper socks were introduced and this had brought about a reduction in slips trips and falls in the morning.

Adverse incidents involving medicines are one of the most common categories of adverse incidents in Ireland and internationally. However, the level of medicine incident reporting in the hospital was not in line with internationally accepted norms with only five medicine related incidents reported on the male ward in 2019. No medicine incidents were reported on the female ward in 2019. Increased reporting will ensure safety surveillance is improved, learning is shared, and a safety culture is promoted and enhanced across the hospital.

Monitoring, audit and quality assurance arrangements

Infection prevention and control information including data on outbreaks, *Clostridioides difficile*, Carbapenemase Producing *Enterobacteriaceae* (CPE) and antimicrobial prescribing was collected and monitored. An overview of the trends in hospital-acquired infection and antibiotic prescribing was provided to the Chief Officer in CHO2 on a monthly basis. This provided assurance that healthcare-associated infection and antimicrobial resistance related risks were identified and managed in a timely manner. It is important that this data and information is used for action, to inform policy and strategy at CHO2 level.

The hospital had a limited number of assurance processes in place in relation to the standard of environmental and patient equipment hygiene within the hospital. These will be discussed further in section 2.2.

2.2 Quality and Safety

<table>
<thead>
<tr>
<th>Theme 1: Person-Centred Care and Support</th>
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<tr>
<td><strong>Standard 1.1</strong></td>
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<tr>
<td>The planning, design and delivery of services are informed by patients’ identified needs and preferences.</td>
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<tr>
<td><strong>Judgment: Compliant</strong></td>
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Person-centred care and support places service users at the centre of all that the service does. It does this by advocating for the needs of patients, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care.

Overall, patients who spoke with inspectors stated that they were happy with the care they received. Patients were very complimentary about the care they received. While patients were aware of their discharge plans not all were aware of the name of the Medical Officer responsible for their care.
A suite of generic patient information leaflets were available and a specific information leaflet about the hospital was also available. However, there was scope for improvement in the quality and selection of the patient information leaflets available.

Limited written medicine information was available to patients. Inspectors were informed that that nursing staff provided informal education and support to patients on medicine management. A well-informed patient and or family are less likely to make medicine errors at home and can help prevent hospital staff from making medicine errors.

The hospital was involved in a patient centred initiative called “End PJ paralysis” which was a campaign to encourage patients to get up and dressed each day. The initiative aimed to change hospital culture and attitude to care which involved helping people to stay independent, maximising wellbeing and improving health and improving health.

**Coordination of care within and between services**

The DoN/deputy was responsible for accepting patients for admission. Defined criteria for patient referral and or admission were in place. Hospital management informed inspectors that the majority of patients were transferred from Mayo University Hospital following an episode of care for an acute illness. A pre-admission assessment form had been developed for local use and included information regarding, medicines, activities of daily living§§ and the patients infection control status.

The clinical needs, goals and preferences of patients were recorded in their care plans on admission and regularly updated. Care plans were developed by nursing staff in collaboration with patients or their representatives and the multidisciplinary team.

**Evaluation of services**

The hospital had established a patient forum to seek views and feedback from service users on a variety of topics. The patient forum met approximately every three months and was attended by patients, volunteers and staff representatives from the hospital.

Staff participated in the national staff satisfaction survey in 2019. The aim of this survey was to access current staff opinions in order to identify opportunities for improvement, to help build a better health service for all. The overall survey findings, as well as customised reports for individual organisations were issued to the Chief

§§ Activities of daily living is a term used in healthcare to refer to people's daily self-care activities
Officer of CHO 2 and discussed at the CHO 2 Director of Nursing management meeting.

A patient satisfaction survey was conducted in November 2019. It was reported that patient surveys were carried out approximately three times a year. Questions regarding ward hygiene, medicines information, pain control, meals and discharge planning were included on the questionnaire.

There was a clear complaints procedure that set out how complaints would be managed in the hospital. Complaints were dealt with in the National HSE Complaints policy “Your Service, Your Say”.9

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<th>Theme 3: Safe Care and Support</th>
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<tr>
<td><strong>Standard 3.1</strong></td>
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<tr>
<td>Service providers protect patients from the risk of harm associated with the design and delivery of healthcare services.</td>
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<td><strong>Judgment: Partially Compliant</strong></td>
</tr>
<tr>
<td>▪ Improvements in environmental and equipment hygiene and oversight of same required.</td>
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<td>▪ Issues identified with infrastructure and maintenance.</td>
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<tr>
<td>▪ Limited number of medicine safety initiatives.</td>
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<td>▪ Formalised medicine reconciliation*** was not routinely carried out.</td>
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Prevention and control of healthcare-associated infections

**Access to specialist staff with expertise in infection prevention and control**

Clinical infection prevention and control advice was provided by the Department of Public Health in Merlin Park, Galway. Infection prevention and control education was also provided by the Department of Public Health on request.

However, there was no infection prevention and control nurse post at CHO2 level. As a result regular onsite infection prevention and control presence was not available. Inspectors found that this had impacted on the provision of ongoing infection prevention and control practices within the hospital. For example inspectors noted that staff donned surgical masks while caring for a patient being cared for with contact precautions when there was no indication to do so. Staff should select the

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*** Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies.
appropriate personal protective equipment based on a risk assessment of the task to be carried out.

**Outbreak management**

A hierarchy of isolation prioritisation for management of patients with transmissible infection was available. This ensured a rational and consistent approach to the prioritisation of single room usage which was good practice.

The hospital had systems in place to manage and control infection outbreaks in a timely and effective manner. Inspectors were informed that a patient recently admitted from an acute hospital was confirmed to have influenza on admission. Concerted infection prevention and control interventions, including ward closure and screening succeeded in preventing cross transmission of influenza and prevented an influenza outbreak.

However, it was reported that, despite efforts to increase staff knowledge and increase vaccine uptake rates, flu vaccine uptake amongst staff remained considerably below the HSE uptake target of 75% for the 2019/2020 influenza season.\(^\text{10}\)

**Environment and equipment hygiene**

Unacceptable levels of dust were present on the undercarriages of beds, floor edges, behind lockers and casements over patients’ beds. Outlets of hand hygiene sinks throughout the ward appeared unclean. The design of clinical hand wash sinks in the male ward did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.\(^\text{11}\) Sinks have been linked to a number of outbreaks of serious infections in hospitals representing one of the most frequently implicated reservoirs for multidrug-resistant gram-negative organisms.

The hospital demonstrated awareness of the issues related to hygiene and had acted to address some of the deficiencies identified. For example a deep cleaning schedule had recently been put in place and hygiene walkabouts had been scheduled to be undertaken every four to six weeks. However, the last record of a walk around was August 2019.

Staff reported that cleaning resources allocated to the ward were insufficient to meet the daily activity levels. Irrespective of whether cleaning services are provided in-house or whether an external contractor is engaged, the accountability for all aspects of cleaning and cleaning staff lies with the hospital management.\(^\text{12}\)

During the inspection it was noted that items of frequently used patient equipment such as commodes were observed to be unclean. This was brought to the attention of the ward staff to be addressed immediately.
Inspectors observed tubs of alcohol wipes throughout the ward and were informed these were used for cleaning frequently used items of equipment. Disinfectant-only wipes (such as alcohol) have no cleaning action. Furthermore alcohol wipes are not sporicidal and can damage equipment with prolonged use. Cleaning agents should be reviewed to ensure they are effective for their intended use.

There were insufficient local assurance mechanisms in place to ensure that the environment and patient equipment was cleaned in accordance with national standards. For example, there was no evidence of checklists for daily cleaning of patient equipment. An equipment cleaning schedule should be developed and include all items of equipment. Evidence of regular environmental hygiene audits were not available.

Maintenance and Infrastructure

Inspectors observed ward wide issues related to maintenance in the male ward inspected. Surfaces, finishes and flooring throughout the ward were worn and poorly maintained and as such did not facilitate effective cleaning. Inspectors were informed that the maintenance service was provided by Mayo University Hospital, however this service was reactive in nature.

The infrastructure of the male ward was not optimal from an infection prevention and control perspective for example:

- the number of patient showering facilities was inadequate
- limited space between beds in multi-occupancy rooms
- the clean utility room was small in size and poorly ventilated
- storage space throughout the ward was limited
- there was no dedicated cleaner’s room
- there were no patient wardrobes.

Environmental monitoring

The hospital had outsourced the legionella monitoring and control measures to an external company.

A local legionella hospital-site risk assessment had last been performed at the hospital in 2019. However inspectors were informed that an independent audit of the Legionella risk assessment had not been carried out. National guidelines recommend that every risk assessment be reviewed on an annual basis and independently reviewed every two years.

Policies, procedures and guidelines

The hospital had an up-to-date suite of infection prevention and control policies, procedures and guidelines.
Hand Hygiene

Hand hygiene training was delivered by local hand hygiene trainers. Documentation reviewed indicated that 83% of staff had completed hand hygiene training within the previous two years. Hand hygiene observations audits had also recently commenced.

Safe use of medicines

The hospital had embedded a limited number of medicine safety initiatives. For example red aprons were worn by nurses dispensing medicines during medicine rounds to remind others not to distract them as interruptions could potentially lead to error.

A new drug chart had been developed for local use. Inspectors were informed that anecdotal evidence suggested that this had resulted in fewer medicine errors. However, the effectiveness of this initiative had not been formally evaluated. The new chart included a section for antimicrobial prescribing which included the indication for antimicrobials and a prompt to review antimicrobial prescriptions within three days.

Inspectors identified ambiguity among staff as to what types of medicines were considered high-risk†††. Initiatives such as improving information about high-risk medicines should be further explored, implemented and underpinned by policies, procedures and guidelines.\(^{15}\)

Pharmacy arrangements

The hospital had a part time pharmacist contracted by the hospital who managed pharmacy requirements for the hospital. At the time of the inspection the pharmacy service within the hospital was restricted to dispensing. Out-of-hours medicines could be readily accessed from the hospital pharmacy by nursing management if required.

Audit

An audit of medicine charts carried out in November 2019 achieved 94% compliance with audit criteria. An audit of the medicine transcribing guidelines was undertaken in February 2019 and achieved 80% compliance. However, inspectors noted that there was no medicine safety audit schedule in place with audits undertaken infrequently.

††† High-risk medication lists are maintained to determine which medications require special safeguards to reduce the risk of errors.
Medicine reconciliation

Formalised medicine reconciliation‡‡‡ was not routinely carried out in the hospital. It was reported to inspectors that patients’ medicines were checked by nurses on admission.

Policies, procedures and guidelines and other information

Inspectors were informed that District Hospitals Standards Management Committee had established a network with the DoNs from the district hospitals in the region§§§ to develop and share medicine management policies, procedures, guidelines and practices. Hard copies of medicine safety alerts were available for reference in the clinical areas. Clinical staff also had access to the British National Formulary at the point of clinical decision-making.

Storage of medicines

All medicinal products were stored in a secure manner, either in a locked trolley or clinical room. Controlled drugs**** were locked in a separate cupboard from other medicinal products in line with the Misuse of Drugs Act 1977. A designated fridge for medicines requiring storage at a required temperature was available.

Staff training

Inspectors were informed that the HSELanD medicine management online training programme18 was completed by all registered general nurses employed in the hospital in the previous year.

3.0 Conclusion

Leadership, Governance and Management

Inspectors found that there were clear lines of accountability and responsibility in relation to governance arrangements at the hospital. However, it was noted at the time of the inspection that the hospital had a large number of committees and sub-committees when compared to other hospitals of a similar size and function. Hospital management should endeavour to keep the number of committees limited and focused on critical issues to ensure staff are not overburdened by meeting and committee attendance.
The hospital had systems in place to identify and manage risks and good oversight of incident management. Incidents were tracked and trended and communicated to staff at staff meetings.

The hospital’s senior management team monitored performance data including patient outcomes, service user feedback and patient safety incidents to provide assurance on the safety of the service provided at the hospital.

The hospital had an up-to-date suite of policies, procedures and guidelines which had been developed within a network of DoN from the district hospitals in the region.

**Person-centred care and support**

Good communication and information sharing underpins safe and effective transfers of care. This was partly achieved through the development of a formalised record verbal handover for transfers.

The patient forum provided feedback and opinions on services provided by the hospital from a patient and public perspective that helped shape improvements to the overall patient experience.

**Safe care and support**

**Prevention and control of healthcare-associated infections**

The absence of an infection prevention and control nurse in CHO2 impacted on the hospitals capacity and capability to deliver a wider infection prevention and control programme and onsite infection prevention and control advice.

HIQA notes the infrastructural challenges of the male ward. Notwithstanding this, hospital managers at the hospital should strive to maintain and improve the hospital infrastructure and environment. HIQA recommends that the hospital reviews the mechanisms in place to assure itself that the physical environment, equipment and resources are developed and managed to minimise the risk of infection and be compliant with relevant national standards.\(^{12}\)

**Safe use of medicines**

Errors associated with medicine usage constitutes one of the major causes of patient harm in hospital. Medicine safety should therefore be a priority area for the hospital as they seek to ensure a high quality and safe service for patients.

Arrangements for improving reporting and learning from medicine incidents should be part of clinical governance structures in the hospital. This would help ensure medicine safety quality improvement initiatives are strategically driven by learning gained from analyses of medicine incidents or near misses.
A high-risk medicine list should be maintained to determine which medicines require special safeguards to reduce the risk of errors. Risk-reduction initiatives should be implemented and underpinned by policies, procedures and guideline. The effectiveness of quality improvement initiatives should be evaluated.

Inspectors were informed that staff did not take a systematic approach to medicine reconciliation. Medicines reconciliation should be carried out in a structured manner by trained and competent health professionals with the requisite knowledge, skills and expertise.

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 Safer Better Healthcare\textsuperscript{1} and other existing national healthcare standards.\textsuperscript{12}
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