Report of the unannounced inspection of Rehabilitation and Community Inpatient Healthcare Services at the Incorporated Orthopaedic Hospital of Ireland, Clontarf.

Monitoring programme against the *National Standards for Safer Better Healthcare*

Dates of inspection: 16 October 2019
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

The Incorporated Orthopaedic Hospital of Ireland, Clontarf was a non-statutory voluntary hospital which provided rehabilitation care for both older people and for patients following orthopaedic surgery.

The hospital had a bed capacity of 160 beds however due to bed closures 144 beds were operational at the time of this inspection. The hospital had two different models of rehabilitation care for patients, namely older people’s rehabilitation services and orthopaedic rehabilitation.

The hospital accepted patients for orthopaedic rehabilitation from six hospitals (from three hospital groups*) and one private hospital. There were 48 beds allocated to orthopaedic rehabilitation care.

A further 96 beds were allocated to active rehabilitation for older people for patients from the Mater Misericordiae University Hospital and Beaumont Hospital.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Noreen Flannelly-Kinsella and Bairbre Moynihan on 16 October 2019 between 09:10hrs and 16:00hrs.

Inspectors spoke with hospital managers, staff and patients. Inspectors also requested and reviewed documentation, data and observed practice within the clinical environment in a sample of clinical areas which included:

- Gracefield Ward: comprised 32 beds for active rehabilitation for older people.
- Vernon Ward: comprised 32 beds for orthopaedic rehabilitation care.

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

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* Hospital groups: The hospitals in Ireland are organised into seven hospital groups. 1. Ireland East Hospital Group. 2. Dublin Midlands Hospital Group. 3. South/South West Hospital Group. 4. Saolta University Health Care Group. 5. University of Limerick Hospitals Group. 6. RCSI Hospitals Group. 7. Children’s Health Ireland Hospital Group.
2.0 Inspection Findings

2.1 Capacity and Capability

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<th>Theme 5: Leadership, Governance and Management</th>
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<tr>
<td><strong>Standard 5.2</strong></td>
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<tr>
<td>Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.</td>
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<td><strong>Judgment: Substantially compliant</strong></td>
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<tr>
<td>Clinical governance arrangements in relation to referring consultants who had overall clinical responsibility for patients at the hospital did not appear to be fully integrated with overall corporate governance structures.</td>
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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.

Inspectors found that there was defined leadership and management arrangements with clear lines of accountability and responsibility at the hospital. However clinical governance arrangements\(^2\) in relation to consultants who had overall clinical responsibility for patients at the hospital did not appear to be fully integrated with the hospital’s overall corporate governance structure.

**Corporate and Clinical Governance**

Hospital management outlined the corporate governance arrangements at the hospital and supporting organisation charts were viewed by inspectors.

The hospital was governed by a Board of Governors who appointed a chief executive officer with overall executive accountably for service provision at the hospital. The hospital’s executive management team, which included the chief executive officer, a consultant geriatrician, the director of nursing, health and social care managers and service leads, held overall responsibility for the operational management of the hospital.

The executive management team, chaired by the chief executive officer was directly accountable to the board. The hospital had a number of sub-committees that reported directly to the board for example audit, and quality, safety and risk management committees.

The hospital produced an annual report which was publicly available on the hospital’s website.\(^3\)
In line with the HSE’s accountability framework the hospital’s senior management team also met with designated senior managers in the Social Care division of the HSE Community Healthcare Organisation (CHO) on a quarterly basis.

Clinical governance arrangements

Hospital management had entered the lack of medical leadership to drive service developments for orthopaedic services as a risk on the hospital’s risk register. Inspectors were told that a business case for additional resources for a medical leadership role had been escalated to the HSE and discussions with senior managers from the acute hospital sector in relation to this issue had also taken place.

The consultants reported to clinical directors at each of their own respective hospitals of employment. While there was no formalised reporting arrangement to the hospital’s chief executive officer, one consultant geriatrician was a member of the hospital’s executive management team. The consultant, in liaison with the hospital’s Human Resource Department, provided 24 hour medical rosters and reported operationally to the chief executive officer.

Inspectors were told that patients transferred to the hospital for orthopaedic rehabilitation care remained under the care of consultants at the referring hospital. While orthopaedic consultants did not attend the hospital, orthopaedic specialist registrars from referring hospitals attended weekly to review patients under their care. Hospital staff told inspectors that these arrangements were monitored and any concerns in relation to attendance were escalated to the relevant consultant. The hospital had also appointed a full-time medical registrar for the care of orthopaedic patients during the normal working week. The hospital medical registrar attended multidisciplinary meetings (which included medical, nursing and allied health professionals) held weekly. It was reported that the hospital medical registrar contacted the orthopaedic teams at referring hospitals for clinical advice, if required.

The hospital accepted patient referrals for older people’s rehabilitation from the Mater Misericordiae University Hospital and Beaumont Hospital. The service was delivered by two consultant geriatricians and a locum general physician. A consultant geriatrician with a joint whole-time equivalent (WTE) appointment with the Mater Misericordiae University Hospital had a 25 hour commitment to the hospital. This consultant was a member of the executive management team and the position was covered by a locum consultant at the time of inspection.

† Community Health Organisation 9 area consists of Dublin North City and County.

‡ 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.
A second consultant geriatrician had a joint WTE position with Beaumont Hospital with a 12 hour commitment to the hospital. As part of a pilot study a locum consultant physician with a 12 hour commitment to the hospital was appointed for general rehabilitation for older people’s rehabilitation from Beaumont Hospital. Each consultant assigned a registrar to their patients during normal working hours. These consultants also undertook ward rounds and held weekly multidisciplinary team meetings.

The director of nursing and health and social care professional managers reported to the hospital’s chief executive officer. Nursing staff, physiotherapists, occupational therapists, medical social workers, dietitians, radiographers, pharmacists and chaplain were employed by the hospital. The speech and language therapist provided services under a contract for services at the hospital.

**Reporting arrangements in relation to committees**

Hospital management had established several hospital committees through which to govern services and address quality and safety issues for example the Infection Prevention and Control and Hospital Hygiene Committee, and the Drugs and Therapeutic Committee. These committees met quarterly and reported directly to the Integrated Quality and Safety Committee.

The Integrated Quality and Safety Committee chaired by the hospital’s risk officer, met quarterly. Multidisciplinary membership included for example the director of nursing, medical registrars, the chief pharmacist, allied health professional managers and clinical nurse managers. Agenda items were aligned to HIQA’s National Standards and items discussed included departmental risk registers, incident reports and reports from hospital committees such as infection control and hygiene and drugs and therapeutics.

The Integrated Quality and Safety Committee was operationally accountable and reported to the executive management team and presented quarterly update reports to the hospital board.

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

In the event of an emergency the medical team arranged the patient’s transfer by ambulance to the nearest acute hospital. For other patients whose condition deteriorated and required treatment in an acute hospital the medical and nursing teams with the patient flow manager arranged the patient’s transfer by ambulance back to the referring hospital.
There were four senior house officers assigned to the hospital. One medical senior house officer was on-call for the hospital during ‘out of hour’ periods. There was no registrar or consultant cover at the hospital during this time. However, if a patient became unwell ‘out of hours’ and required acute care, the senior house officer contacted the on-call team in the Emergency Department (ED) at the Mater Misericordiae Hospital and organised the transfer of the patient to ED at the Mater Misericordiae Hospital.

While the hospital had an up-to-date transfer procedure including pathways of care for example for patients who required acute psychiatric care, the procedure did not include ‘out of hour’ transfer procedures and management need to address this.

Risk management

The hospital had formalised systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections and safe use of medicines. The hospital had a comprehensive corporate risk register which showed that risks entered had been assigned a risk owner, action owner, an action due date and were risk rated. The corporate risk register** was regularly reviewed and monitored at the Integrated Quality and Safety Committee, the executive management team and board meetings. The risk officer presented a risk management department report and a status update at each meeting.

High-rated infection prevention and control risks entered on the hospital’s corporate risk register included infrastructural challenges and acquiring a healthcare-associated infection. A number of existing controls had been put in place for all risks entered. Inspectors were informed by management that high risks were escalated in line with HSE integrated risk management policy.5

Inspectors were told that risks identified and assessed in clinical areas were either addressed at a clinical area level and or documented on a local risk register and escalated to the hospital’s risk officer for action as required. It was evident that risk assessments were undertaken and monitored in relation to infection prevention and control and safe use of medicines in a clinical area inspected.

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5 “Out of hours” was defined as after 17.30 hours on weekdays and 24 hours on the weekends and Bank Holidays.

** A risk register is a database of assessed risks that face any organisation at any one time. Always changing to reflect the dynamic nature of risks and the organisation’s management of them, its purpose is to help hospital managers prioritise available resources to minimise risk and target improvements to best effect. The risk register provides management with a high level overview of the hospital’s risk status at a particular point in time and becomes an active tool for the monitoring of actions to be taken to mitigate risk.
Hospital management informed inspectors that they were in the process of transferring the hospital risks to the HSE risk register template. Documentation reviewed showed that training was provided to staff.

**Monitoring, audit and quality assurance arrangements**

Designated line managers were required to prepare and present a performance report to the executive management team meeting. An incident management report presented by the risk officer showed that incidents were tracked and trended.

Inspectors were informed that incidents were reported on a National Incident Report Form (NIRF) and logged on the National Incident Management System (NIMs). An accompanying action plan was sent with the NIRF to the assistant director of nursing. The risk officer presented monthly incident reports and shared learning from incidents to nursing administration and each clinical area.

A Medication Incident Review Committee met monthly in relation to safe use of medicines incidents. This was a sub-committee of the Drugs and Therapeutics Committee. The actions identified following an incident were discussed at this meeting. Management and staff informed an inspector that a new medication prescription and administration record was being developed following on from a medication related-incident.

Performance updates in relation to mandatory staff training and auditing were also provided to the executive management team. Hospital management maintained an electronic spreadsheet which facilitated tracking, trending and oversight of infection prevention and control audit results and nursing quality care metrics across all clinical areas.

Infection prevention and control audits undertaken in the clinical areas inspected and the safe use of medicines audits completed across the hospital will be discussed under Theme 3: Safe Care and Support.

**Taking feedback from patients and staff.**

The hospital had an electronic feedback mechanism available on the hospital’s website to facilitate service users to make a comment, compliment or a complaint. Inspectors were informed that complaints made at the hospital were generally managed locally and or escalated to the quality, safety and risk management††.

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†† 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.

‡‡ Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance.
department. The risk officer presented monthly data in relation to patient compliments and complaints to the executive management team and hospital board.

Hospital management told inspectors that formalised staff meetings took place. Furthermore management stated that the hospital had an open-door policy for staff to raise relevant issues with the chief executive officer.

2.2 Quality and Safety

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<th>Theme 1: Person-Centred Care and Support</th>
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<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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<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 service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care.¹

As part of the hospital’s overall governance arrangements a former patient was part of the membership of the Board of Governors.

A safety board at the entrance to both clinical areas inspected displayed hospital audit results, for example infection prevention and control and nursing metric results. Notices on hand hygiene and personal protective equipment were also on display.

A comprehensive suite of patient information leaflets including infection prevention and control information was available and clearly displayed in both wards inspected. Information available included hospital-specific information in relation to rehabilitation services.

**Coordination of care within and between services**

The hospital’s patient flow manager was responsible for hospital admissions, discharges and transfer procedures. The hospital had an admission procedure and pathways of care for patients admitted for both orthopaedic rehabilitation and active rehabilitation for older people. Prior to a patient’s admission to the hospital a rehabilitation referral form was completed by the referring hospital and or consultant and submitted to the hospital.
A sample of documentation including a rehabilitation referral form, nursing and medical admission form, and transfer and discharge documentation was reviewed. Information concerning infection prevention and control was evident in the rehabilitation referral form however it was not specifically captured on discharge summaries for public health nurses or general practitioners. Hospital correspondence should inform healthcare workers if a person is colonised or infected with a transmissible infection therefore infection prevention and control triggers may be helpful. Hospital management told inspectors that a review of this documentation was underway.

**Evaluation of services**

A patient satisfaction survey conducted in July 2019 showed that 74% of inpatients completed the survey. Overall patient experiences were positive in relation to dignity, respect and privacy across the hospital. Areas requiring improvement were also identified for example patient involvement in discharge processes in the clinical areas inspected. Hospital management requested relevant department managers to complete time-bound action plans to address areas for improvement identified in the survey.

Inspectors spoke with patients who generally voiced satisfaction about the care they received and were aware of their discharge date and place of discharge. One issue brought to management’s attention on the day of inspection was in relation to the number of toilet facilities available in six-bedded patient care rooms.

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<th>Theme 3: Safe Care and Support</th>
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<td><strong>Standard 3.1</strong></td>
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<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: Compliant</strong></td>
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**Prevention and control of healthcare-associated infections**

The hospital had an established infection prevention and control programme. The Infection Prevention and Control and Hospital Hygiene Committee, chaired by the chief executive officer met quarterly. An action plan was put in place identifying time-bound actions and responsible person for each action. The chief executive officer also reported to the hospital board on infection prevention and control and hospital hygiene.
Clinical nurse managers attended daily safety huddles with the patient flow manager where information in relation to admissions, transfers and discharges including relevant infection prevention and control issues was communicated.

The hospital had recently adapted universal screening\(^{55}\) for Carbapenemase Producing *Enterobacteriales* (CPE)\(^{***}\) which was in excess of national recommendations on screening patients for CPE. This helped identify at risk patients and for appropriate control measures to be put in place.

The hospital also screened patients for Methicillin-resistant *Staphylococcus aureus* (MRSA). Alert organism\(^{†††}\) surveillance took place and performance updates were reported at infection control and hygiene committee and management oversight committee meetings.

Antibiotic stewardship\(^{‡‡‡}\) featured as an agenda item on the Drugs and Therapeutic Committee.

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

The hospital had recently appointed a consultant microbiologist who had a service level agreement for six hours (two sessions) per week. It was explained that in light of this new position at the hospital antimicrobial stewardship would be an area of focus going forward.

The infection prevention and control nurse position had been vacant since May 2019. Hospital management stated that they were actively recruiting to fill this position. In the interim the director of nursing had assumed this role until the position was filled.

Inspectors were informed that support and advice was also provided by the community infection prevention and control nurse, surveillance staff in the Health Protection Surveillance Centre and the HSE’s national clinical and nurse lead for healthcare-associated infection and antimicrobial resistance.

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\(^{55}\) Performing active surveillance cultures, active screening tests or contact screening of at-risk patients to detect colonisation with Carbapenemase Producing *Enterobacteriales*.

\(^{***}\) Carbapenemase Producing *Enterobacteriales* (CPE), are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat.

\(^{†††}\) Alert organisms are micro-organisms that pose a significant risk of transmission to non-infected patients or healthcare workers. Alert organisms are those that may give rise to outbreaks.

\(^{‡‡‡}\) Antimicrobial stewardship describes a system of collection of measures introduced into a healthcare setting which aims to improve the quality of antimicrobial usage across a patient population, to optimize outcomes, reduce adverse events, minimise the emergence of antimicrobial resistance and reduce treatment costs.
Outbreak management

The hospital had systems in place to manage and control infection outbreaks. Inspectors were told that single rooms were prioritised for patients with a suspected or confirmed transmissible infection. All patients requiring isolation were in a single room on the day of inspection. If an isolation room was not available staff reported this as an incident.

There was a total of six single rooms with en-suite toilet and shower facilities in the clinical areas inspected. Signage to communicate isolation precautions were observed. Hand hygiene sinks located in the patient rooms inspected in both clinical areas were compliant with HBN 00-10 Part C: Sanitary assemblies and hand hygiene information signage was observed. However inspectors noted that minimal spatial separation between beds in multi-occupancy rooms did not comply with best practice guidelines in both clinical areas inspected.

An outbreak committee was convened due to an influenza outbreak in 2019 and an outbreak report reviewed showed that learning outcomes and recommendations were made. The local Public Health Department had been informed.

On the day of inspection it was evident that the hospital had commenced a flu vaccine campaign and was actively promoting staff uptake. Inspectors were told that a peer-to-peer vaccination programme had commenced and to date staff uptake rate was 25%. The national HSE’s target for staff uptake of the flu vaccine was 60% in 2018/2019 influenza season.

Infection prevention and control audits

The hospital had a number of key performance indicators for infection prevention and control. A recent hand hygiene compliance audit showed that 80% and 87% compliance was achieved in Gracefield and Vernon Wards respectively. Furthermore a recent audit of the ‘Bare below the elbow’ standard by hospital staff showed 100% compliance across most hospital staff disciplines including contract cleaning staff. The audits outlined an action plan and a plan to re-audit.

The hospital also undertook an audit to measure compliance with the hospital’s standard operating procedure for safe and effective blood glucose monitoring in August 2019. This audit showed that 100% compliance was achieved in both clinical areas inspected.

A monthly audit in relation to the integrity of bed mattresses was also undertaken.

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*Bare Below Elbow* is an initiative aiming to improve hand hygiene performed by health care workers as the effectiveness of hand hygiene is improved when: skin is intact, nails are natural, short and unvarnished; hands and forearms are free of jewellery (one plain finger band allowed); and sleeves are above the elbow.
Additionally a nursing metric review of nursing documentation had been undertaken in Gracefield Ward in September 2019. As a result the hospital developed a Meticillin Resistant *Staphylococcus Aureus* (MRSA) treatment flow sheet and Carbapenem Resistant *Enterobacteriaceae* flow sheet for monitoring microbiological results.

**Environmental and equipment hygiene**

There was good local ownership of environmental and patient equipment hygiene in both clinical areas inspected. The patient environment and equipment appeared clean with few exceptions. In general surfaces and finishes facilitated cleaning. A review of the findings from the recent patient satisfaction survey in relation to both clinical areas inspected showed that 100% of patients surveyed found the ward and toilets very clean.

Environmental and patient equipment hygiene cleaning specifications and checklists were in place. The clinical nurse managers identified a staff member for the periodic cleaning of patient equipment in line with cleaning schedules. Patient equipment cleaning check lists were signed off weekly by the clinical nurse manager. Labelling to identify cleaned items of patient equipment had been consistently applied in one clinical area inspected.

However some opportunities for improvement were identified for example in relation to cleaning undercarriages of beds. HIQA acknowledges that this issue had been identified by hospital management prior to this inspection and was being actively addressed. The under surfaces of armchairs and bed tables also needed to be included in ward cleaning schedules.

In both clinical areas inspected general wear and tear was noted on some walls and furnishings including wood finishes and as such did not facilitate effective cleaning. Inspectors were told that some furnishings for example bedside lockers were due to be replaced shortly.

Environmental and patient equipment hygiene audits were carried out on a quarterly basis by hospital management and results communicated to ward managers. Auditing procedures also examined compliance with the management of blood and body fluids and spillage kits, laundry and linen and safe handling of sharps. Hospital hygiene audit teams included the chief executive officer and director of nursing.

The most recent hospital hygiene report from Gracefield Ward showed an environmental score of 88% and an equipment hygiene score of 79%.

In Vernon Ward a hygiene audit undertaken showed that 73% and 85% compliance was achieved for the patient environment and patient equipment respectively in August 2019. The audit team produced an action plan to address deficiencies identified in the audit.
Documentation reviewed showed that an independent external hygiene audit by an infection prevention and control consultant showed 87% compliance was achieved in Vernon Ward in September 2019.

Additionally regular environmental hygiene audits were undertaken by the contract cleaning company providing cleaning services at the hospital. An audit report showed that over 90% compliance was achieved in all clinical areas in 2019.

Both clinical areas inspected had a number of ancillary facilities which included facilities for storage of patient equipment and environmental cleaning equipment. However there was no dedicated room for storage of linen in both clinical areas inspected. Linen was either stored with ward supplies or in the egress of a utility room where medications were prepared. This was brought to management’s attention. Hospital management told inspectors that a review by an external construction professional which included facilities for linen storage was underway and it had been placed on the hospital risk register.

Inspectors noted that there was no restricted entry to ancillary rooms in both clinical areas inspected. To prevent unauthorised access to ancillary rooms in particular where sterile supplies such as syringes are stored, access should be reviewed in these areas so that it is limited to clinical and support staff.

**Environmental monitoring**

The hospital had outsourced the management of water-borne infections to an external company. The legionella control programme was overseen by the Infection Prevention and Control and Hospital Hygiene Committee. A formal legionella hospital-site risk assessment had last been performed at the hospital in 2013 and was due to be repeated at the time of inspection. The hospital had implemented a number of control measures including water flushing regimes and water testing schedules.

**Policies, procedures and guidelines and other information**

The hospital had a suite of up-to-date infection prevention and control policies, both hard and soft copies, to guide and support staff.

Inspectors noted that the hospital had nursing care plans in place to guide nursing staff on the management of patients with an antibiotic-resistant and multidrug-resistant infection.

**Staff training**

The hospital monitored staff training and a report reviewed showed that 94% of hospital staff had completed hand hygiene training in the previous two years.
Inspectors were informed that staff also completed the HSEland hand hygiene online training programme and standard precautions training on an annual basis.

The report showed that 93% and 96% compliance with hand hygiene training was achieved for nursing and healthcare assistant staff in Gracefield Ward and Vernon Ward respectively.

A human resource department report showed that good compliance was achieved in relation to hand hygiene training uptake across the hospital for example 85% of medical staff and 95 to 100% of nursing, healthcare assistants, physiotherapists, occupational therapists were up to date.

**Safe use of medicines**

The hospital had processes in place for the safe use of medicines and practices were reviewed and monitored regularly.

Staff in a clinical area inspected informed an inspector that the medication information was explained to the patient but patient information leaflets were not generally provided. However management stated that certain patients were provided with patient information leaflets for example on Direct Oral Anticoagulants (DOAC).

Site-specific patient information leaflets included venous thromboembolism (VTE) prophylaxis and information on bi-phosphonates.

**Pharmacy arrangements**

The hospital had an onsite pharmacy from Monday to Friday. Nursing administration accessed the pharmacy outside of these hours. All pharmacy staff were available by phone outside of these hours but this arrangement was not formalised.

**Drugs and Therapeutics Committee**

The hospital had a Drugs and Therapeutics Committee. Terms of reference viewed by an inspector outlined its purpose and who it reports to within the hospital. The meeting was chaired by the chief pharmacist and membership included pharmacy, nursing, medical staff and hospital management. Drugs and therapeutics meetings were held quarterly. Sample minutes were reviewed. Agenda items included medicine incidents, antimicrobial stewardship, medicines education and clinical audit. Persons were assigned to the actions arising from the meeting but timeframes for the actions were not identified. Inspectors were informed that the medication safety

*** Venous thromboembolism (VTE): a blood clot consisting of deep veins thrombus (DVT) and pulmonary embolism (PE). Blood clots (thrombus) can form within deep veins (DVT) and these clots can fragment and travel to lungs leading to Pulmonary Embolism (PE).
group was a sub-committee of the Drugs and Therapeutics Committee. This committee met two-monthly.

Audit

The hospital had undertaken multiple safe use of medicines audits. Examples of clinical audits undertaken included an audit of the medication prescription and administration record (MPAR), and an audit of the VTE/bleeding risk assessment. A medication administration interruption audit was done in December 2018. A number of interventions following a re-audit included the introduction of a disposable red tabard which was worn by staff during medication rounds. Initial audit results showed that interruptions were generally from patients or staff in the ward and on re-audit interruptions from medical staff, allied health professionals and phone calls were reduced.

Samples of the HSE’s medication safety metrics were viewed from April to September 2019. Reports indicated 86 to 100% compliance with medication storage and custody. Medication safety results varied from 84 to 100%. Audit results were discussed at the Drugs and Therapeutics Committee but it was not clear that an action plan was implemented to address audit findings.

Medication reconciliation

Pre-admission medication reconciliation†††† was carried out by pharmacy. The hospital had a policy in place to guide staff on medication reconciliation. The medication reconciliation policy reviewed on the ward was out of date and differed to the policy shown in the pharmacy department which had an expiry date of 2021. Management must ensure that staff are aware of how to access the most up-to-date policies in the clinical area and that previous versions are removed.

Staff were knowledgeable about the process of medication reconciliation. An audit undertaken of the pre-admission medication reconciliation showed medication reconciliation was done on all prescriptions received in the pharmacy from January 2019 to September 2019. In addition, the percentage of prescriptions received pre-admission had improved from 77% in January to 91% in September. Staff completed a national incident report form if any errors were noted during the process.

†††† 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.
Policies, procedures and guidelines and other information

The hospital had an up-to-date suite of polices on the safe use of medicines. The medication management policy included for example the disposal of medications, access to medications out of hours and supply and administration of medications.

Staff had access to medication information for example the British National Formulary (BNF). Inspectors were informed that antimicrobial guidelines were available on the desktops in clinical areas.

Medication safety newsletters were emailed quarterly to staff. For example a medication safety newsletter was distributed following the introduction of a “hypo box” with an associated algorithm for the treatment and management of hypoglycaemia in adults with diabetes mellitus. Medication safety alerts were also emailed to staff when required. This was evidenced in both clinical areas inspected.

Storage of medications

Medications were stored in locked drug trolleys or presses in both wards inspected. However, an inspector noted that a medication fridge stored in an open access utility room in one clinical area inspected was unlocked. Furthermore the cardiac arrest trolley where emergency drugs were stored was unlocked. These were brought to management’s attention on the day.

Fridge temperatures were recorded however an inspector noted a lack of consistency in one clinical areas inspected. Management need to ensure that fridge temperatures are recorded consistently.

Staff training

Staff were required to complete HSEland online medicines management programme yearly. Intravenous medicines training was provided on induction and staff competencies were assessed prior to administering intravenous medications as a once off or repeated if required.
3.0 Conclusion

Overall, this inspection identified that the hospital was actively endeavouring to fully implement the National Standards for Safer Better Healthcare and National Standards for infection prevention and control in community services.

Leadership, governance and management

The hospital had strong leadership and management arrangements with clear lines of accountability and responsibility in place. Management had established several committees to govern service provision including the prevention and control of healthcare-associated infection and safe use of medicines.

The executive management team provided good oversight of the hospital’s performance and had put structures and processes in place for the active management of incident and risk. It was evident that action plans had been implemented and responsible persons with time-bound actions had been identified for closing of issues. Good local ownership was also evident in both clinical areas inspected.

However clinical governance arrangements did not appear to be fully integrated with the hospital’s overall corporate governance arrangements. This is of particular importance in light of the number of hospitals referring orthopaedic patients for rehabilitation care at Clontarf Hospital. The hospital had escalated a risk in relation to the lack of medical leadership for orthopaedic services and discussions with senior managers in the acute hospital sector had also taken place.

Person-centred care and support

The hospital had recently completed a patient satisfaction survey. This was a good initiative and management should re-evaluate the service following implementation of the action plan.

Safe care and support

Prevention and control of healthcare-associated infections

HIQA found that the hospital had clear management and formalised support arrangements in place to support infection prevention and control practices. A consultant microbiologist with a six-hour commitment to the hospital had been recently appointed. The hospital was actively recruiting to fill the infection prevention and control nurse position and had put temporary arrangements in place to cover the position. Ongoing commitment to the infection prevention and control programme was evident on the day of inspection.
Monitoring and oversight of infection prevention and control performance data by the executive management team was clearly evident. The hospital had implemented universal screening for CPE which is commendable. An infection prevention and control training programme was in place and good compliance in relation to mandatory hand hygiene training was achieved across all clinical staff. Overall the patient environment and equipment appeared clean in both clinical areas inspected with few exceptions.

Safe use of medicines

Inspectors found that the safe use of medicines agenda was being actively progressed by the Drugs and Therapeutic Committee. The hospital had structures, processes and outcome measures in place for the safe use of medicines and practices were reviewed and monitored. The hospital had a policy to guide medication reconciliation and a business case for a clinical pharmacist to ensure implementation of the full process in relation to medication reconciliation was underway.

An opportunity for improvement was identified in relation to the safe storage and custody of medication in medication fridges and cardiac arrest trolleys in a clinical area inspected.

Following this inspection the hospital requires the support of the CHO to effectively address issues highlighted in order to facilitate full compliance with the National Standards for Safer Better Healthcare and other existing national healthcare standards.
4.0 References


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