Report of the unannounced inspection of Rehabilitation and Community Inpatient Healthcare Services at Killarney Community Hospital.

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

Dates of inspection: 30 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

Killarney Community Hospital was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 4.* Killarney Community Hospital comprised 37 beds: 30 convalescent beds and 7 respite beds and or palliative care beds. The hospital campus also had a designated centre for older persons onsite.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Bairbre Moynihan and Kathryn Hanly 30 October 2019 between 0930 hrs and 1550 hrs.

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

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

2.0 Inspection Findings

2.1 Capacity and Capability

<table>
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<tr>
<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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<tr>
<td><strong>Judgment: Substantially compliant</strong></td>
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<td>The hospital risk register was not maintained in line with national guidance.²</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 were clear lines of accountability and responsibility in relation to corporate and clinical governance arrangements at Killarney Community hospital.

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* Community Health Organisation (CHO) 4 consists of Cork and Kerry Counties
Corporate and Clinical Governance

Hospital management outlined integrated corporate and clinical governance arrangements. An organisational chart was viewed by inspectors. This clearly outlined responsibility, accountability and authority arrangements and reporting relationships for staff within the unit.

The District Unit was managed on a day-to-day basis by a Director of Nursing who, as the person with overall responsibility for the service, reported to the General Manager for Older Persons in CHO 4 who in turn reported to the Chief Officer of CHO 4. Nursing and support staff reported to the Director of Nursing.

Three medical officers from a local practice shared medical cover. The medical officers were available Monday-Friday and performed a medical round on Saturday. Out-of-hours medical cover was provided by SouthDoc.† The medical officers had no formal reporting relationship within the hospital or CHO structures but management reported that there was good daily communication between the medical officers and staff in the District Unit.

Nursing and support staff within the unit reported to the Clinical Nurse Manager. Allied health professionals for example dietitians were community based, attended the district unit two to three times a week and reported to a manager within the community service structures. The physiotherapist based onsite, provided a service from Monday-Friday and reported to the acute and community physiotherapy manager in the Kerry area.

Reporting arrangements in relation to committees

The hospital had established a local Quality and Patient Safety Committee³ to monitor quality and safety of services. Committee meetings followed a structured agenda which was aligned to the eight themes of the national standards.† Terms of reference outlined membership which included the assistant director of nursing, the clinical nurse manager and health and safety representatives. Minutes reviewed by an inspector showed that incidents, infection control and the risk register were discussed at the meeting. However minutes did not include actions arising from the meetings, persons responsible and timeframes afforded to actions identified.

The hospital had also established a local management meeting which was attended by the director of nursing, the assistant director of nursing and clinical nurse manager.

† SouthDoc was an out of hours family doctor service for urgent medical needs
Management attended monthly quality and patient safety meetings and monthly Director of Nursing meetings with Cork and Kerry Hospitals under CHO 4.

The local Quality and Patient Safety Committee submitted a monthly report to the CHO 4 Quality and Patient Safety Committee. A review of this Committee was outside the scope of this inspection. However, the formation of this Committee demonstrated progression towards a coordinated approach to quality and safety at CHO 4 level.

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

If patients needed medical review or if their clinical condition deteriorated, it was reported that they were reviewed by the medical officer during normal working hours. Outside of normal working hours, patients were reviewed on request by the local on call general practitioner services (SouthDoc). The ISBAR (Identify, Situation, Background, Assessment, and Recommendation) structured communication tool\(^4\) was used to relate and document messages about deteriorating patients.

Medical and nursing staff at the hospital had electronic access to laboratory and radiology results from University Hospital Kerry.

Risk management

The hospital had 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 risk register in place. The risk register viewed by an inspector identified existing controls and each risk was risk rated. However, two risks on the risk register had not been reviewed in 2019 and the remaining risks had not been reviewed in the last six months. Risk registers should be reviewed monthly and at minimum, quarterly in line with national guidance.\(^2\)

Inspectors were informed that a ‘safety pause’\(^5\) system was in operation whereby staff communicated information about patient safety issues at the unit shift handover. This was convened daily following the multidisciplinary meeting. The safety pause highlighted patient safety issues for example patients who had an infection, environmental safety issues for example equipment related issues and staff issues for example education sessions. This was an example of good practice.
Monitoring, Audit and Quality assurance arrangements

Inspectors were informed that incidents were reported on a paper-based system and logged on the National Incident Management System (NIMs).‡ Incidents were a standing agenda item at the local quality and patient safety meeting.

A high rate of incident reporting is considered a marker of a strong patient safety culture.⁶ No infection prevention control incidents had been reported in 2019. Similarly the level of medicine incident reporting in the unit was not in line with internationally accepted norms with management reporting only two medicine related incidents reported year-to-date.⁷,⁸ Management must encourage staff to actively report incidents through the establishment of a reporting environment which is open, fair and non-punitive.⁹

Inspectors were provided with a list of audits and key performance indicators that Killarney Community Hospital was required to carry out by Cork Kerry community healthcare and the Antimicrobial Resistance and Infection control team (AMRIC)§. These included for example hand hygiene education, seasonal influenza vaccine uptake by staff.

Audits were conducted on infection prevention and control and safe use of medicine. These will be discussed under Theme 3: Safe Care and Support.

Taking feedback from patients and staff

Inspectors were informed that management aimed to manage complaints at local level but patients could make a complaint under the Health Service Executive policy “your service your say”.¹⁰ The procedure on how to make a complaint under this policy was displayed in the unit area. The complaints process was also outlined in a patient, relatives and friends information booklet on Killarney Community Hospital. Hospital management visited the unit daily, spoke with patients and feedback could also be given through this forum. A patient forum was available and met three to four times a year and patients could raise any issues through this forum.

Management reported that quality and safety walk-rounds were introduced recently. The director of nursing and a clinical nurse manager walk through the ward and talk to patients and staff. The walk-rounds allow patients and staff to discuss quality and risk issues with senior management. Management informed inspectors that staff can

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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

§ Antimicrobial Resistance and Infection Control (AMRIC) team. The AMRIC team was established in response to the challenge of dealing with antimicrobial resistance and infection prevention and control in the HSE.
also provide feedback at report time, privately to management, through staff appraisals or at the multidisciplinary team meeting.

An initiative to ensure the privacy and dignity of the patient was introduced following a staff suggestion in the District Unit called “stop, knock, wait” where signage was placed on the doors of the patients’ rooms so that staff and visitors would knock before entering.

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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<td><strong>Judgment:</strong> Compliant</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

Overall, patients who spoke with inspectors stated that they were happy with the care they received.

A number of patient information leaflets were available at the entrance to the unit for example on citizens’ information and elder abuse. No patient information leaflets were available on safe use of medicines or infection prevention and control. In addition, management need to review the leaflets available on the unit to ensure that the patient information leaflets are appropriate for the patient population of the hospital.

Limited storage space was available for patients with only a bedside locker provided for their belongings.

**Coordination of care within and between services**

The hospital had a community placement co-ordinator who attended University Hospital Kerry four days per week. The community placement co-ordinator liaised with University Hospital Kerry and provided information about the suitability of patients for admission to Killarney Community Hospital. Inspectors were informed that Killarney Community Hospital had similar links in other acute hospitals in the region.

A pre-assessment form was received by Killarney Community Hospital prior to patient transfer. The patients’ discharge letter, prescription and laboratory results was
forwarded to the medical officer where a decision was made on accepting the patient for transfer. Management informed inspectors that this was a new initiative and reported that readmissions to the acute hospital had reduced since its introduction. Although this appears to be a positive initiative, it has yet to be evaluated.

Cork Kerry community healthcare had an admission and discharge policy in place which was up-to-date. An inspector viewed both the pre-admission form and the nursing summary discharge letter. Both forms included the patient’s infection control status. Staff were able to clearly describe to an inspector the admission and discharge process to the District Unit.

**Evaluation of services**

Management informed inspectors that satisfaction cards were given to patients on discharge. Results from a previous satisfaction survey were collated by management and an inspector was informed that few negative comments were raised and that the majority were positive. A patient satisfaction comment book was available at the hospital reception. The comments from these were collated and discussed at the quality and patient safety committee meeting. A “resident’s satisfaction card box” was available at the entrance to the unit.
**Theme 3: Safe Care and Support**

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<th><strong>Standard 3.1</strong></th>
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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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**Judgment: Partially compliant**

The hospital infrastructure and environment were not maintained to a high standard to ensure the effectiveness of infection control practices and prevent the transmission of infection.

Environmental and equipment hygiene audits were not undertaken quarterly in line with the hospital's guidance.

Medication reconciliation was not formally carried out in the unit.

Antimicrobial guidelines had been specifically designed for use in University Hospital Kerry and had not been adapted or approved for local use.

Management reported that intravenous medicines were given infrequently in the District Unit and resultantly it was difficult for staff to maintain their competence.

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

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

Staff had access to infection prevention and control advice from the community infection prevention and control nurse, CHO 4 via telephone. The community infection prevention and control nurse attended onsite as required. Microbiology advice was obtained from University Hospital Kerry via the medical officer.

**Outbreak management**

The hospital had peer vaccinators in place for flu vaccinations and management stated that staff could get the vaccine in other locations through a voucher scheme.

It was reported that there has been no recent outbreaks of infection. The hospital had an outbreak management policy in place and this was due for revision.

**Infrastructure**

HIQA noted that the fabric and infrastructure of the hospital presented ongoing challenges to the maintenance and upkeep of the building. Management informed inspectors that a new community nursing unit with 130 beds was planned for 2021.
In the interim of this development, 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.

A small number of hand hygiene sinks in the District Unit were not compliant with HBN 00-10 Part C: Sanitary assemblies. Inspectors noted that minimal spatial separation between beds in two of the multi-occupancy rooms did not comply with best practice guidelines.

Storage space on the unit was limited for example there was inappropriate storage of equipment and used linen in a patient shower room.

**Equipment and Environment hygiene**

Overall the environment in the District Unit was clean with few exceptions. However the environment had not been managed and maintained in line with national standards for example damage to paintwork on walls and window sills, doors, skirting boards and radiators was noted. Furthermore flooring was in a state of disrepair in a number of rooms and exposed piping was noted throughout the ward.

Additionally, bedside lockers were damaged, bed tables were chipped, a drip stand and a commode were in a state of disrepair. This did not aide effective cleaning.

Management informed staff that environmental and equipment hygiene audits were carried out on a quarterly basis. The last environmental and equipment hygiene audits viewed by an inspector were completed in February 2019. Management must ensure that environmental and equipment hygiene audits are carried out in line with the hospital's guidance and contain timebound action plans.

**Environmental monitoring**

The hospital had outsourced the legionella monitoring and control measures to an external company. The programme was overseen by the Estates Department.

National guidelines recommend that every risk assessment be reviewed on an annual basis and independently reviewed every two years. A formal legionella hospital-site risk assessment had last been performed at the hospital in October 2019.

**Policies, procedures and guidelines**

The hospital had a number of infection prevention and control guidelines for staff including standard and transmission based precautions. However, many of these guidelines required revision at the time of the inspection.

The hospital had piloted a decision-making aide “placement and infection prevention and control precautions in non-acute healthcare facilities”. This tool had yet to be formally evaluated.
Staff training

The Community Infection Prevention and Control Nurse position had been vacant until April 2019. It was reported that this had impacted on the provision of ongoing infection prevention and control education onsite. However the position had been filled and training on standard precautions had been planned for November 2019. Management reported that it was mandatory for staff to complete the HSElanD online hand hygiene training programme and breaking the chain of infection training. Hand hygiene training was mandatory every 2 years. It was reported that 100% of staff had completed hand hygiene training within the past two years.

Safe use of medicines

Pharmacy arrangements

The hospital had an onsite pharmacist contracted for eight hours per week and attended on Monday, Tuesday, Wednesday and Friday. The pharmacist was available by phone outside of these hours. Out-of-hours, the onsite pharmacy could be accessed by hospital management.

Audit

The hospital had undertaken audits using auditing software. This was a cyclical process with the usage and legibility of five prescription charts audited every month. Having consistently achieved 100% compliance for an extended period of time management should now endeavour to focus audits on areas where issues have been identified. Scheduling of audits should be done using a risk-based approach taking into account previous audit results and ensuring that changes made have improved practice.

Medication reconciliation

A medication reconciliation policy was in place. However inspectors were informed that formalised medication reconciliation** was not routinely carried out in the unit. Management stated that patients’ prescriptions were received on the day of admission. A three day prescription was also received so medication could be dispensed by nursing staff while awaiting the medications to be prescribed on the medication record by the medical officer. Any discrepancies were followed up with the referring hospital by the clinical nurse manager. The pharmacist completed medicines record reviews at the request of the medical officer and highlighted any transcription errors to the clinical nurse manager who completed a national incident

** 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.
report form. It is recommended that the hospital implements a regular and formalised review of medicine records.

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

Policies on the supply and administration of medicines including a standard operating procedure on the disposal of medications were available. The hospital pharmacist informed inspectors that he was involved in the development of local guidelines.

Antimicrobial guidelines viewed by an inspector were from University Hospital Kerry from 2016-2017. The medication administration guidance document had been specifically designed for use in University Hospital Kerry and had not been adapted or approved for local use.

Staff had access to medicines information via the British National Formulary (BNF) online and in print format. However the print version viewed by an inspector was out of date. Posters on the “10 rights of medication” and “commonly used medications for patients with swallowing difficulties” were displayed in the clinical room.

**Storage of medicines**

Medicines were stored in locked drug trolleys and presses. Controlled drugs†† were locked in a separate cupboard from other medicinal products in line with Misuse of Drugs legislation.16

Designated fridges for medicines requiring storage at a required temperature were available. Fridge temperatures noted by an inspector were recorded on a daily basis.

**Staff training**

The HSElAnD medication management online training programme15 was mandatory for Registered General Nurses annually. The pharmacist reported that informal education sessions were done on occasion for example on Novel Oral Anticoagulants (NOACs).

Training for staff on administration of intravenous‡‡ medicines was not mandatory for staff. Management reported that intravenous medicines were given infrequently in the District Unit and resultantly it was difficult for staff to maintain their competence. Management must ensure that staff administering intravenous

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†† Substances, products or preparations, including certain medicines, that are either known to be, or have the potential to be, dangerous or harmful to human health, including being liable to misuse or cause social harm, are subject to control under the Misuse of Drugs Acts 1977 to 2016. They are known as “controlled drugs”.

‡‡ Intravenous is a way of administering medicines directly into the vein via an injection or infusion
medicines are appropriately trained and maintain their competence in administration of intravenous medicines.

3.0 Conclusion

Effective leadership, governance and management arrangements were evident around the prevention and control of healthcare-associated infection and safe use of medicines in Killarney Community Hospital.

Leadership, Governance and Management

Inspectors found that there were clear lines of accountability and responsibility in relation to corporate and clinical governance arrangements at Killarney Community hospital.

The hospital had systems in place to identify and manage risks. However, the risk register required updating at the time of the inspection and should be managed in line with national guidance. The hospital had systems in place for the reporting of clinical incidents. Management must encourage staff to actively report incidents through the establishment of a reporting environment which is open, fair and non-punitive.

The hospital had established a local quality and patient safety meeting.

A daily safety pause was implemented on the District Unit. This is an example of good practice.

Regular audits to monitor patient safety and promote care quality were undertaken. The quality and scheduling of ongoing audit programmes should be evaluated as part of the wider clinical governance agenda.

A number of the infection prevention and control related guidelines viewed were due for review.

Person-centred care and support

Hospital management had recently introduced a new initiative for the admission of patients and management reported that it has resulted in reducing the number of admissions back to the acute hospital. Hospital management need to formally evaluate this new initiative.

Although a number of patient information leaflets were available for patients none were available on infection prevention and control and the safe use of medicines. The patient information leaflets should be reviewed so that they are appropriate for the patients who are inpatients in the unit.
**Safe care and support**

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

Overall HIQA found that the hospital was committed to improving infection prevention and control practices and was endeavouring to fully implement the National Standards for infection prevention and control in community services.

Notwithstanding the many good practices that HIQA identified during the inspection, areas for further improvement included:

- general maintenance of the physical environment and equipment
- storage of equipment
- environmental and equipment audits.

**Safe use of medicines**

The hospital had processes in place for the safe use of medicines. The hospital had a pharmacist contracted for eight hours per week. Medications were stored securely and in line with legislation.\(^{16}\)

The unit should implement a formal structured process to ensure all patients admitted to the hospital receive accurate and timely medication reconciliation at admission, transfer of care and on discharge. This should be supported by a hospital policy, audit and staff training.

Management need to review the antimicrobial guidelines that are in use from University Hospital Kerry to ensure that they are adapted and approved for local use. Management must ensure that staff administering intravenous medicines are appropriately trained and ongoing competency assessments are undertaken.

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* and other existing national healthcare standards.
4.0 References


15. Health Service Executive. HSELaND. [Online]. Available online from: http://www.hseland.ie/dash/Account/Login

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