Report of the announced pilot inspection of Rehabilitation and Community Inpatient Healthcare Services at The National Rehabilitation Hospital

Monitoring programme against the National Standards for Safer Better Healthcare

Date of inspection: 30 July 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 Rehabilitation and Community Inpatient Healthcare Services against selected *National Standards for Safer Better Healthcare* (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.

Further information can be found in the *Guidance to HIQA’s monitoring programme against the National Standards for Safer Better Healthcare*, which is available on HIQA’s website: [www.hiqa.ie](http://www.hiqa.ie)

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 National Rehabilitation Hospital was a publicly funded Voluntary Hospital. It was the national tertiary centre for complex rehabilitation\(^2\) and comprised 108 inpatient beds and nine day service beds.

The hospital provided specialist rehabilitation services to adult and paediatric patients who, as a result of an accident, illness or injury, had acquired a physical or cognitive disability and who required specialist medical rehabilitation. Care was delivered by medical consultant-led interdisciplinary teams.

Building of the new hospital on the campus was nearing completion at the time of inspection and is due to be fully operational in April 2020. The new building will provide 120 single en-suite rooms with integrated rehabilitation-specific treatment and therapy spaces.

1.2 Information about this inspection

This inspection report was completed following an announced inspection carried out by Authorised Persons, HIQA; Kathryn Hanly, Bairbre Moynihan and Geraldine Ryan on 30 July 2019 between 9:00 hrs and 15:25 hrs.

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:

- St Margaret’s Ward and St Joseph’s Ward: comprised 16 beds including four high dependency beds, providing care for patients with spinal cord injury and also patients with neurological conditions.
- St Gabriel’s Ward: comprised 13 beds providing care for patients with both traumatic and non-traumatic acquired brain injury, stroke and other neurological conditions.
- St Bridget’s Ward: comprised 17 beds providing care for patients with both traumatic and non-traumatic acquired brain injuries.

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

2.1 Capacity and Capability

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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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<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:</strong> Compliant</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 and reliable service was being provided.

**Corporate 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 organisation. Governance arrangements were made publicly available to view on the hospitals website in line with National standards.

The National Rehabilitation Hospital was a voluntary organisation governed by a Board of Management with a Chief Executive Officer appointed by the Board to manage the services provided at the Hospital. The Chief Executive Officer had overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. An annual report was produced and is publicly available on the hospital’s website. The report included information on Rehabilitation Programme goals and achievements, financial results and provided information about future service developments.

At the time of this inspection the National Rehabilitation Hospital reported to Community Healthcare Organisation (CHO) 6* on a quarterly basis in line with the accountability framework for the HSE. Inspectors were informed that hospital Senior Management met with the designated HSE Senior Managers (CHO 6, Disability Services – Social Care Division and Hospitals Division) on a quarterly basis.

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* Community Health Organisation 6 area consists of South East Dublin, East Wicklow and Dun Laoighaire
Committee structures

Hospital management had established several hospital committees through which to govern services and address quality and safety issues. The Quality Safety and Risk Committee reviewed and discussed reports from a range of hospital committees and reported directly to the Executive Committee, who in turn updated the Board of Directors. Minutes reviewed clearly outlined actions arising from the meetings, persons responsible and timeframes afforded to actions identified. Feedback from patients was a standing agenda item at Board meetings.

Clinical Governance

The Clinical Director provided overall clinical leadership for clinical services within the hospital. The Clinical Director reported to the Hospital CEO and was a senior member of the Hospital Executive Management Team.

Patient care and treatment were delivered by consultant-led interdisciplinary (medical, nursing, health and social care) teams. Ward rounds were held by consultants and the interdisciplinary team members on a weekly basis.

Four specialist rehabilitation programmes operated under the clinical governance structure:

- Brain Injury Programme
- Spinal Cord System of Care Programme
- Prosthetic, Orthotic and Limb Absence Rehabilitation Programme
- Paediatric Family-Centred Rehabilitation Programme.

Each patient received a pre-admission screening assessment of their medical and rehabilitation needs. Admission to the National Rehabilitation Hospital was based on the preadmission assessment of the level of need and conformance with the relevant rehabilitation programme’s admission criteria.4

Outside of normal working hours, medical cover was provided by a non-consultant hospital doctor on site. Consultants in Rehabilitation Medicine were available off site via the on call consultant rota. A formalised pathway was available for patients that became acutely unwell whereby they were transferred to St. Vincent’s University Hospital by emergency services. Unexpected discharges to acute care were internally reviewed by a Peer Review Committee to assess if there were any opportunities for learning or improving practice.

Quality and safety outcomes

The hospital had developed a suite of key performance indicators to monitor the effectiveness, efficiency of, and access to the inpatient rehabilitation programmes.
For example targets were set to monitor average days waiting for admission, average rehabilitation length of stay, delayed discharges and discharge to home rate. The hospital publicly reported the outcomes of these key performance indicators in their annual report. The four rehabilitation programmes were accredited by the Commission for Accreditation of Rehabilitation Facilities (CARF).†

2.2 Quality and Safety

<table>
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<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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<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.

Views of the patient

As part of their governance and oversight arrangements, hospital management sought and acted on feedback from patients, those acting on their behalf, staff and other stakeholders, so that they could continually evaluate the service and drive improvement.

Inspectors spoke with a number of patients. Patients voiced their satisfaction with the care they received and stated that they were actively involved in their plan of care. Patients attended regular goal-setting meetings with their interdisciplinary team to set rehabilitation goals.

Comments cards for patients, relatives, carers, visitors and staff were available throughout the public areas in the hospital. Feedback from patient comments and suggestion was given in the ‘You Said - We Did’ section of the patient newsletter. Patient experience surveys were also issued to all patients three months post discharge. All patients and family members were invited to attend the monthly Patient Forum meetings.

† CARF International is an independent, nonprofit accreditor. CARF sets standards of quality by which an organisation providing rehabilitation services is assessed and measured on all the clinical and business work practices involved in its delivery and development of those services.
Patient engagement had continued throughout all aspects of the new hospital development. Former patients participated in development of the new hospital build through membership of the Project Team.

Patient information

A comprehensive suite of written information was available to patients and in a number of different languages.

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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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<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: Compliant</strong></td>
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Risk Management

Inspectors identified that the hospital had established systems to ensure an effective flow of information on safety and quality matters to and from the senior management team and front line staff. For example, inspectors attended the ‘Daily Operational Safety Huddle’. The huddle took the form of a 15 minute multidisciplinary meeting for sharing information about potential or existing patient safety or operational risks. Representatives from senior management, all departments, wards and teams attended this meeting each morning. Actions highlighted were documented and tracked to ensure follow up and closure.

Inspectors were informed by management that high risks were escalated in line with HSE risk management processes. Risks identified in clinical areas were addressed at clinical area level or were documented and escalated to the next level of management for action as required. Where risks identified had significant potential to impact on the objectives of the organisation they were added to the organisation’s risk register. Inspectors viewed the corporate risk register, all risks had been assessed for likelihood and consequence. The corporate risk register was subject to ongoing monitoring by the Hospital Executive and Board (and escalated where necessary to the HSE) to ensure that actions identified as required were completed.

Incident Management

The monitoring of adverse incidents was a function of the Risk Management Department. Interviews with front-line staff in all wards inspected confirmed that adverse incidents were being reported and trended. Staff who spoke with inspectors
said that they were provided with regular feedback in relation to the type of incidents reported and the actions required to prevent reoccurrence.

The hospital promoted an open reporting culture for learning from medication-related incidents and near misses. Staff demonstrated knowledge of systems for reporting and addressing medication errors and near misses. Medication-related incidents and near misses were entered onto the HSE National Incident Management System. Senior management reported a good culture of reporting medication–related incidents at the hospital.6

HIQA noted that while there was a positive trend in reporting medication incidents, the majority of reports were submitted by clinical pharmacists. The culture of reporting medication incidents needs to be broadened out to include other healthcare staff to promote and enhanced the safety culture across the organisation.

Medication incidents were tracked and trended to identify medication safety trends and opportunities for improving patient safety and reducing medication errors. Safe prescribing workshops were held for doctors and nurses to highlight issues identified through incident reporting. The Pharmacy Department also produced a Drugs and Therapeutics newsletter to highlight issues identified by incident analysis.

Inspectors were also informed that acquisitions of alert organisms and alert conditions‡ in the hospital were reported to the Risk Management Department.

**Safe use of medicines**

Governance for medication safety was provided by the hospital’s Drug and Therapeutic Steering Committee. The Committee was chaired by a Consultant in Rehabilitation Medicine and reported directly into the hospital’s Quality, Safety and Risk Committee. The hospital had recently developed a Medication Safety strategy which was awaiting approval by the Quality Safety and Risk Committee.

The hospital had resourced all inpatient wards with a designated clinical pharmacist§. This was an important patient safety initiative. For example clinical pharmacists:

- Dispensed individualised patient medications.
- Counselled patients on their medications. An individual “Medicine List” was provided to each patient. This list included indications, dosage, frequency and special instructions. Patients informed inspectors that medication information was delivered in a way that was easy to read and understandable.

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‡ Alert organisms and alert conditions are those that may give rise to outbreaks.
§ Clinical pharmacy describes the activity of pharmacy teams in ward and clinic settings.
- Provided medication reconciliation** of all admission and discharge prescriptions in line with recommended practice.\textsuperscript{7,8,9,10} A gold standard pre-admission medication list†† was compiled using a designated admission medication reconciliation form.
- Attended weekly consultant-led ward rounds and weekly antimicrobial stewardship rounds with the Consultant Microbiologist.
- Provided medication safety education at induction to non-consultant hospital doctors and nursing staff.
- Carried out regular medication safety audits including six-monthly audits of medication prescribing administration records.

The hospital had embedded a number of additional medication safety initiatives. These included:

- Red aprons were worn by nurses dispensing medications during medication rounds to remind others not to distract them as interruptions could potentially lead to error.
- The medication prescription and administration chart was redesigned with a section designated for antimicrobial prescribing.
- Participation in the HSE’s Venous thromboembolism\textsuperscript{‡‡} (VTE) collaborative§§.
- A list of high risk medications that present a heightened risk of causing significant patient harm if not used correctly had been identified. It was based on the acronym ‘APINCH’.\textsuperscript{11} A high risk medication e-learning programme was available for all medical and nursing staff.

Policies, procedures, protocols

The hospital had developed a suite of intravenous drug administration guidelines used to assist staff in the safe administration of intravenous medicines. These were available to view on computer desktops at the nursing office on each ward. However this information was not available to staff at the point where intravenous drugs were prepared. This information should be available where medications were prepared to

** 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.

†† 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).

§§ This was a collaboration among multidisciplinary teams in Irish adult public acute and voluntary hospitals to achieve appropriate thromboprophylaxis for their hospital’s inpatients, to reduce the risk of venous thromboembolism and to minimise harm and expenditure associated with unnecessary thromboprophylaxis.
provide staff with a quick reference guide to support the safe and effective preparation and administration of intravenous medications.

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

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

The Infection Prevention and Control team consisted of a Consultant Microbiologist who was available 28.5 hours per week, and one whole time equivalent *** Infection Prevention and Control Clinical Nurse Specialist.

The Hygiene, Infection Prevention and Control Committee, chaired by the Director of Nursing, had multidisciplinary membership and met on a monthly basis.

A number of positive infection prevention and control practices were noted in the three wards inspected for example:

**Surveillance**

Surveillance of alert organisms and alert conditions was carried out daily. Regular performance updates in relation to infection prevention and control were reported through the established hospital governance structures.

The hospital screened all patients on admission for Methicillin-resistant *Staphylococcus aureus* (MRSA) and Vancomycin-related *Enterococci* (VRE), ESBL and CPE in line with national guidelines.12,13,14

A multidrug resistant organism committee had been established in an effort to review systems for the management of patients referred to the hospital who were colonised with multidrug resistant organisms.

The infection prevention and control team had devised a hierarchy of isolation prioritisation for management of patients with transmissible infection to ensure a rational and consistent approach to the prioritisation of single room usage which was good practice. In the absence of sufficient numbers of single rooms, patients colonised with multidrug-resistant organisms were risk assessed and cared for in shared rooms with contact precautions.

**Outbreak management**

The hospital had systems in place to manage and control infection outbreaks in a timely and effective manner. Discussion with staff and review of documentation

*** 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.
showed that outbreak control teams were convened to advise and oversee the management of outbreaks of infection at the hospital.

An outbreak committee was convened in 2018 due to an increase in the detection of Carbapenemase Producing Enterobacteriales (CPE) from screening samples. Concerted infection prevention and control interventions, including ward closure and enhanced hygiene measures succeeded in preventing cross transmission and promptly halted the CPE outbreak.15,16

The infection prevention and control team prepared an outbreak report at the conclusion of the CPE outbreak. The report summarised how the outbreak was detected, the investigations conducted and interventions carried out to control it. Learning and recommendations were detailed in the outbreak report viewed.

It was reported that uptake rates for flu vaccine amongst staff reached the national uptake target of 60% in 2018/2019 influenza season.

Environment and equipment hygiene

Building of the new hospital on the campus was nearing completion at the time of inspection and due to be operational in April 2020. In the interim of the move to the new building the hospital was effectively managing risks in respect of the hospital’s dated infrastructure through ongoing maintenance of existing facilities.

There was good local ownership in relation to infection prevention and control in the wards inspected despite the challenging circumstances posed by the ward infrastructure. Overall, the general environment and equipment in the three wards inspected were clean and well maintained with few exceptions. Storage of unused clinical equipment was optimised and as a result areas were generally well ordered, organised and free from clutter.

Inspectors viewed daily and weekly equipment cleaning checklists and schedules and noted they were consistently completed. An electronic hospital hygiene auditing system facilitated regular trending, analysis and oversight of hygiene audit results at both local and senior management level.

Environmental monitoring

Oversight in relation to water-borne infections was the responsibility of the Water Management Steering Group who in turn reported to the Hygiene Infection and Control Committee at the hospital. A formal legionella hospital-site risk assessment
had been performed at the hospital in 2018. The hospital had implemented a number of control measures in relation to legionella prevention including the installation of a copper silver ionisation system.

Policies, procedures and guidelines

The hospital had a suite of infection prevention and control policies. Some of these were out of date at the time of this inspection. However inspectors were informed that the majority of infection control policies were in the process of being revised at the time of the inspection.

Patients were encouraged to practice good hand hygiene. A hand hygiene video was shown to patients and a hand hygiene information leaflet was provided.
3.0 Conclusion

Overall, this inspection identified that the National Rehabilitation Hospital was compliant with all three of the National Standards for Safer Better Healthcare assessed. Findings from the inspection were therefore very positive overall.

Inspectors found that there were clear lines of accountability and responsibility in relation to governance and management arrangements at the National Rehabilitation Hospital. Regular reports on safety and quality indicators and other safety and quality performance data were monitored at executive and Board level of governance.

The planning, design and delivery of services were informed by service users’ identified needs and preferences. Feedback from patients was used to continuously improve the experience for patients.

Inspectors found that a medication safety agenda was being actively progressed. The hospital had implemented a number of quality improvement initiatives to reduce medication errors and had developed a number of medication policies.

The hospital was endeavouring to fully implement the National Standards for the prevention and control of healthcare-associated infections in acute healthcare services\textsuperscript{17}. Effective leadership, governance and management arrangements were evident around the prevention and control of healthcare-associated infection.
4.0 References


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